RACE 1

Column 103-104
Length 2
Source of Standard: SEER/COC

Description:

THIS IS A REQUIRED DATA FIELD

Code for the patient's primary race. All tumors for the same patient should carry the same race codes.

If patient is multi-racial, code all races using the *Race1-Race5* fields.

Race is coded separately from Spanish/Hispanic Origin. If the patient is of Hispanic/ Spanish origin, code the reported races in the *Race1- Race 5* fields and the Hispanic ethnicity in the Spanish/ Hispanic Origin field.

Rationale:

Racial origin has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The Race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race-specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration even if the state population does not contain many of the race categories.

General Guidelines:

If the patient's race is stated to be a combination of white and any other race, code the *other* race in this field and code white in the next race field. Code all remaining *Race* items 88.

If *Race Coding System-Current* is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.

If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System-Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

If a patient's race is stated to be a combination of Hawaiian and any other race (s), code the patient's primary race as Hawaiian and code the other races in the *Race 2- Race 5* fields.

When the race is stated to be "Oriental", "Mongolian", or "Asian" and the birthplace is recorded as a specific Asian nation, code the race based on the birthplace information.

> ***Example:*** The race is coded as "Asian" and the birthplace is coded as Japan, code the race is Japanese.

If a specific Asian race is coded in the *Race 1* field, do not code "Asian, NOS" (code 96) in a subsequent race field.

If only one race is reported for a patient, use code 88 in the subsequent race fields.

RACE 1 (Cont'd)

Do not code race from name alone, especially for females with no maiden name given.

If *Race 1* is coded 99 (unknown), the subsequent race fields must also be coded 99.

When completing *Race 1- Race 5*, a specific race code (other than blank, 88 or 99) should only be coded once.

Example: Do not code "Japanese" in *Race 1* for one parent, and "Japanese" in *Race 2* for the other parent.

Codes	Description
01	White.
02	Black.
03	American Indian, Aleutian, or Eskimo.
04	Chinese.
05	Japanese.
06	Filipino.
07	Hawaiian.
08	Korean.
09	Asian Indian, Pakistani.
10	Vietnamese.
11	Laotian.
12	Hmong.
13	Kampuchean (including Khmer and Cambodian).
14	Thai.
20	Micronesian, NOS.
21	Chamorran.
22	Guamanian, NOS.
25	Polynesian, NOS.

RACE 1 (Cont'd)

Codes (Cont'd)	Description
26	Tahitian.
27	Samoan.
28	Tongan.
30	Melanesian, NOS.
31	Fiji Islander.
32	New Guinean.
96	Other Asian, Asian, NOS, Oriental, NOS.
97	Pacific Islander, NOS.
98	Other.
99	Unknown.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the race code.

or

Select the appropriate race code from the drop-down table.

Click OK or press ENTER.

RACE 2

Column	105-106
Length	2
Source of Standard:	SEER/COC

Description:

THIS IS A REQUIRED DATA FIELD WHEN APPLICABLE

Code for the patient's second reported race. All tumors for the same patient should carry the same race code.

If patient is multi-racial, code all races using the *Race 1- Race 5* fields.

Race is coded separately from Spanish/Hispanic Origin. If the patient is of Hispanic/ Spanish origin, code the reported races in the *Race1- Race 5* fields and the Hispanic ethnicity in the Spanish/ Hispanic Origin field.

Rationale:

Since racial origin has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration even if the state population does not contain many of the race categories.

General Guidelines:

Use this field to record the patient's second documented race. If only one race is reported, code *Race 2-Race 5* as "88".

If the patient's race is stated to be a combination of white and any other race, code the *other* race in this field and code white in the next race field. Code all remaining *Race* items 88.

If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System-Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

If a patient's race is stated to be a combination of Hawaiian and any other race (s), code the patient's primary race as Hawaiian and code the other races in the *Race 2- Race 5* fields.

If a specific Asian race is coded in the *Race 1* field, do not code "Asian, NOS" (code 96) in a subsequent race field.

Do not code race from name alone, especially for females with no maiden name given.

If *Race 1* is coded 99 (unknown), the subsequent race fields must also be coded 99.

RACE 2 (Cont'd)

When completing *Race 1- Race 5*, a specific race code (other than blank, 88 or 99) should only be coded once.

Example: Do not code "Japanese" in Race 1 for one parent, and "Japanese" in *Race 2* for the other parent.

Codes	Description
01	White.
02	Black.
03	American Indian, Aleutian, or Eskimo.
04	Chinese.
05	Japanese.
06	Filipino.
07	Hawaiian.
08	Korean.
09	Asian Indian, Pakistani.
10	Vietnamese.
11	Laotian.
12	Hmong.
13	Kampuchean (including Khmer and Cambodian).
14	Thai.
20	Micronesian, NOS.
21	Chamorran.
22	Guamanian, NOS.
25	Polynesian, NOS.

RACE 2 (Cont'd)

Codes (Cont'd)	Description
26	Tahitian.
27	Samoan.
28	Tongan.
30	Melanesian, NOS.
31	Fiji Islander.
32	New Guinean.
96	Other Asian, Asian, NOS, Oriental, NOS.
97	Pacific Islander, NOS.
98	Other.
99	Unknown.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the race code.

or

Select the appropriate race code from the drop-down table.

Click OK or press ENTER.

RACE 3

Column 107-108
Length 2
Source of Standard: SEER/COC

Description:

THIS IS A REQUIRED DATA FIELD WHEN APPLICABLE

Code for the patient's third reported race. All tumors for the same patient should carry the same race code.

If patient is multi-racial, code all races using the *Race 1- Race 5* fields.

Race is coded separately from Spanish/Hispanic Origin. If the patient is of Hispanic/ Spanish origin, code the reported races in the *Race1- Race 5* fields and the Hispanic ethnicity in the Spanish/ Hispanic Origin field.

Rationale:

Since racial origin has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration even if the state population does not contain many of the race categories.

General Guidelines:

Use this field to record the patient's third documented race. If only one race is reported, code *Race 2-Race 5* as "88".

If the patient's race is stated to be a combination of white and any other race, code the *other* race in this field and code white in the next race field. Code all remaining *Race* items 88.

If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System-Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

If a patient's race is stated to be a combination of Hawaiian and any other race (s), code the patient's primary race as Hawaiian and code the other races in the *Race 2- Race 5* fields.

If a specific Asian race is coded in the *Race 1* field, do not code "Asian, NOS" (code 96) in a subsequent race field.

If only one race is reported for a patient, use code 88 in the subsequent race fields.

Do not code race from name alone, especially for females with no maiden name given.

If *Race 1* is coded 99 (unknown), the subsequent race fields must also be coded 99.

RACE 3 (Cont'd)

When completing *Race 1- Race 5*, a specific race code (other than blank, 88 or 99) should only be coded once.

> *Example:* Do not code "Japanese" in Race 1 for one parent, and "Japanese" in *Race 2* for the other parent.

Codes	Description
01	White.
02	Black.
03	American Indian, Aleutian, or Eskimo.
04	Chinese.
05	Japanese.
06	Filipino.
07	Hawaiian.
08	Korean.
09	Asian Indian, Pakistani.
10	Vietnamese.
11	Laotian.
12	Hmong.
13	Kampuchean (including Khmer and Cambodian).
14	Thai.
20	Micronesian, NOS.
21	Chamorran.
22	Guamanian, NOS.
25	Polynesian, NOS.

RACE 3 (Cont'd)

Codes (Cont'd)	Description
26	Tahitian.
27	Samoan.
28	Tongan.
30	Melanesian, NOS.
31	Fiji Islander.
32	New Guinean.
96	Other Asian, Asian, NOS, Oriental, NOS.
97	Pacific Islander, NOS.
98	Other.
99	Unknown.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the race code.

or

Select the appropriate race code from the drop-down table.

Click OK or press ENTER.

RACE 4

Column 109-110
Length 2
Source of Standard: SEER/COC

Description:

THIS IS A REQUIRED DATA FIELD WHEN APPLICABLE

Code for the patient's fourth reported race. All tumors for the same patient should carry the same race code.

If patient is multi-racial, code all races using the *Race 1- Race 5* fields.

Race is coded separately from Spanish/Hispanic Origin. If the patient is of Hispanic/ Spanish origin, code the reported races in the *Race1- Race 5* fields and the Hispanic ethnicity in the Spanish/ Hispanic Origin field.

Rationale:

Since racial origin has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration even if the state population does not contain many of the race categories.

General Guidelines:

Use this field to record the patient's fourth documented race. If only one race is reported, code *Race 2- Race 5* as "88".

If the patient's race is stated to be a combination of white and any other race, code the *other* race in this field and code white in the next race field. Code all remaining *Race* items 88.

If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System-Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

If a patient's race is stated to be a combination of Hawaiian and any other race (s), code the patient's primary race as Hawaiian and code the other races in the *Race 2- Race 5* fields.

If a specific Asian race is coded in the *Race 1* field, do not code "Asian, NOS" (code 96) in a subsequent race field.

If only one race is reported for a patient, use code 88 in the subsequent race fields.

Do not code race from name alone, especially for females with no maiden name given.

If *Race 1* is coded 99 (unknown), the subsequent race fields must also be coded 99.

RACE 4 (Cont'd)

When completing *Race 1- Race 5*, a specific race code (other than blank, 88 or 99) should only be coded once.

> *Example:* Do not code "Japanese" in Race 1 for one parent, and "Japanese" in *Race 2* for the other parent.

Codes	**Description**
01	White.
02	Black.
03	American Indian, Aleutian, or Eskimo.
04	Chinese.
05	Japanese.
06	Filipino.
07	Hawaiian.
08	Korean.
09	Asian Indian, Pakistani.
10	Vietnamese.
11	Laotian.
12	Hmong.
13	Kampuchean (including Khmer and Cambodian).
14	Thai.
20	Micronesian, NOS.
21	Chamorran.
22	Guamanian, NOS.
25	Polynesian, NOS.

RACE 4 (Cont'd)

Codes (Cont'd)	**Description**
26	Tahitian.
27	Samoan.
28	Tongan.
30	Melanesian, NOS.
31	Fiji Islander.
32	New Guinean.
96	Other Asian, Asian, NOS, Oriental, NOS.
97	Pacific Islander, NOS.
98	Other.
99	Unknown.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the race code.

or

Select the appropriate race code from the drop-down table.

Click OK or press ENTER.

RACE 5

Column	111-112
Length	2
Source of Standard:	SEER/COC

Description:

THIS IS A REQUIRED DATA FIELD WHEN APPLICABLE

Code for the patient's fifth reported race. All tumors for the same patient should carry the same race code.

If patient is multi-racial, code all races using the *Race 1- Race 5* fields.

Race is coded separately from Spanish/Hispanic Origin. If the patient is of Hispanic/ Spanish origin, code the reported races in the *Race1- Race 5* fields and the Hispanic ethnicity in the Spanish/ Hispanic Origin field.

Rationale:

Since racial origin has a significant association with cancer rates and outcomes, a comparison between areas with different racial distributions may require an analysis of race to interpret the findings. The race codes listed correspond closely to race categories used by the U.S. Census Bureau to allow calculation of race specific incidence rates. The full coding system should be used to allow accurate national comparison and collaboration even if the state population does not contain many of the race categories.

General Guidelines:

Use this field to record the patient's fifth documented race. If only one race is reported, code *Race 2-Race 5* as "88".

If the patient's race is stated to be a combination of white and any other race, code the *other* race in this field and code white in the next race field. Code all remaining *Race* items 88.

If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System-Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

If a patient's race is stated to be a combination of Hawaiian and any other race (s), code the patient's primary race as Hawaiian and code the other races in the *Race 2- Race 5* fields.

If a specific Asian race is coded in the *Race 1* field, do not code "Asian, NOS" (code 96) in a subsequent race field.

If only one race is reported for a patient, use code 88 in the subsequent race fields.

If *Race 1* is coded 99 (unknown), the subsequent race fields must also be coded 99.

Do not code race from name alone, especially for females with no maiden name given.

RACE 5 (Cont'd)

When completing *Race 1- Race 5*, a specific race code (other than blank, 88 or 99) should only be coded once.

> *Example:* Do not code "Japanese" in *Race 1* for one parent, and "Japanese" in *Race 2* for the other parent.

Codes	Description
01	White.
02	Black.
03	American Indian, Aleutian, or Eskimo.
04	Chinese.
05	Japanese.
06	Filipino.
07	Hawaiian.
08	Korean.
09	Asian Indian, Pakistani.
10	Vietnamese.
11	Laotian.
12	Hmong.
13	Kampuchean (including Khmer and Cambodian).
14	Thai.
20	Micronesian, NOS.
21	Chamorran.
22	Guamanian, NOS.
25	Polynesian, NOS.

RACE 5 (Cont'd)

Codes (Cont'd)	Description
26	Tahitian.
27	Samoan.
28	Tongan.
30	Melanesian, NOS.
31	Fiji Islander.
32	New Guinean.
96	Other Asian, Asian, NOS, Oriental, NOS.
97	Pacific Islander, NOS.
98	Other.
99	Unknown.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses. Code 14 was adopted for use effective with 1994 diagnoses.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the race code.

or

Select the appropriate race code from the drop-down table.

Click OK or press ENTER.

RACE CODING SYSTEM-- CURRENT

Column 113-113
Length 1
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

Code that best describes how the race is currently coded. If the data has been converted, this field shows the system it has been converted to.

Codes	Description
1	4-value coding: 1=White, 2=Black, 3=Other, 9=Unknown.
2	SEER < 1988 (1-digit).
3	1988+ SEER & COC (2-digit).
4	1991+ SEER & COC (added codes 20-97, additional Asian and Pacific Islander codes).
5	1994+ SEER & COC (added code 14, Thai).
6	2000+SEER & COC*.
9	Other.

**Note:* Code 88 (No further race documented) was added. Race 2 – Race 5 fields added.

ABSTRACT PLUS:

This data item is generated by the computer software and coded to 6.

RACE CODING SYSTEM-- ORIGINAL

Column 114-114
Length 1
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

Code that best describes how race was originally coded. If the data has been converted, this field identifies the coding system originally used to code the patient's race.

Codes	Description
1	4-value coding: 1=White, 2=Black, 3=Other, 9=Unknown.
2	SEER < 1988 (1-digit).
3	1988+ SEER & COC (2-digit).
4	1991+ SEER & COC (added codes 20-97, additional Asian and Pacific Islander codes).
5	1994+ SEER & COC (added code 14, Thai).
6	2000+SEER & COC*.
9	Other.

**Note:* Code 88 (No further race documented) was added. Race 2 – Race 5 fields added.

ABSTRACT PLUS:

This data item is generated by the computer software and coded to 6.

RAD—BOOST DOSE CGY

Column 913-917
Length 5
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the additional radiation dose delivered to the anatomical target being treated. A boost treatment is provided to a smaller volume within the same volume as regional radiation in order to enhance the effect of the regional treatment. The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and be followed by brachytherapy to provide the boost dose. Not all patients will have a boost treatment.

Rationale:

To evaluate patterns of radiation oncology care, it is necessary to describe the prescribed boost radiation dose. As in chemotherapy, outcomes are strongly related to the dose given.

General Guidelines:

Do not include the amount of the regional dose in this field. Generally, the boost dose is the difference between the maximum prescribed dose and the regional dose.

Use code 88888 if the patient is treated with brachytherapy or radioisotopes (codes 50-62 in the *Boost Treatment Modality* field).

The dose may be described in "rads". The term rad is equivalent to centigray (cGy). Five rads equal five cGy.

Boost treatment dosage information can usually be found in the radiation oncology summary report. The International Council for Radiation Protection recommends reporting doses at the axis point when applicable. If there is no clear axis point, report the dose as indicated in the summary report.

Codes	Description
------	Record the actual boost dose delivered.
00000	Boost radiation therapy was not administered.
88888	Not applicable, brachytherapy or radioisotopes given to the patient.
99999	Boost radiation therapy administered, but boost dose unknown.

RAD—BOOST DOSE CGY (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the boost dose.

Click OK or press ENTER.

RAD—BOOST RX MODALITY

Column 911-912
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the modality used to deliver the most clinically significant boost dosage to the anatomical target during the first course of treatment.

Rationale:

Radiation treatment is often delivered in two or more phases that can be summarized as regional and boost treatments. When evaluating patterns of care, it is important to know which radiation resources were employed to deliver the therapy.

General Guidelines:

If more than one modality is used to deliver the radiation boost dose, code the dominant modality.

In this data field, only report the modality used to deliver the boost treatment. The modality used to deliver the regional treatment is coded in the *Regional Treatment Modality* field.

In some circumstances, the boost treatment may be given before the regional treatment.

When coding this data field, consider photons and xrays as equivalent.

Codes	Description
00	No boost treatment.
20	External beam, NOS (Not enough information to determine the specific modality).
21	Orthovoltage.
22	Cobalt-60, Cesium-137 (Intracavitary use should be coded as 50 or 51).
23	Photons (2-5 MV).
24	Photons (6-10 MV).
25	Photons (11-19 MV).
26	Photons (> 19 MV).

RAD—BOOST RX MODALITY (Cont'd)

Codes (Cont'd)	Description
27	Photons (mixed energies).
28	Electrons.
29	Photons and electrons mixed.
30	Neutrons, with or without photons/ electrons.
31	IMRT (Intensity modulated radiation therapy).
32	Conformal or 3-D therapy.
40	Protons.
41	Stereotactic radiosurgery, NOS (Stereotactic technique used, but type not specified).
42	Linac radiosurgery.
43	Gamma Knife..
50	Brachytherapy, NOS (Brachytherapy, interstitial implants, molds, seed, needles, or intracavitary applicators not otherwise specified).
51	Brachytherapy, Intracavitary. LDR.
52	Brachytherapy, Intracavitary, HDR.
53	Brachytherapy, Interstitial, LDR.
54	Brachytherapy, Interstitial, HDR.
55	Radium.
60	Radioisotopes, NOS (Iodine-131, Phosphorus-32, etc).
61	Strontium-89.
62	Strontium-90.
98	Other, NOS (Radiation therapy given, but modality not specified or is unknown).
99	Unknown if radiation therapy administered.

RAD—BOOST RX MODALITY (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Highlight the appropriate code in the drop-down table.

Click OK or press ENTER.

RAD—LOCATION OF RX

Column 907-907
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the location where radiation therapy was administered during first course of therapy.

Rationale:

This information can be used to access the quality and outcome of radiation therapy by delivery site and for understanding referral patterns.

Codes	Description
0	No radiation therapy or diagnosed at autopsy.
1	All radiation therapy at this facility.
2	Regional treatment at this facility, radiation boost elsewhere.
3	Radiation Boost at this facility, regional treatment elsewhere.
4	All radiation therapy elsewhere
8	Other (Radiation treatment was administered, but does not fit into any of the above categories).
9	Unknown (Radiation treatment was administered, but location unknown, not stated; or it is unknown if radiation treatment was administered. Death certificate only).

If the radiation treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the radiation administered in the items *Palliative Care* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

RAD—LOCATION OF RX (Cont'd)

Highlight the appropriate code in the drop-down table.

Click OK or press ENTER.

RAD—NO OF TREATMENT VOL

Column 900-901
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the total number of radiation treatment sessions (fractions) during the first course of treatment. This is the sum of the number of fractions of regional treatment and the number of fractions of boost treatment.

Rationale:

Used to access patterns of radiation treatments and treatment schedules.

General Guidelines:

Count brachytherapy or implants as a single treatment or fraction.

Codes	Description
00	None (None administered to the patient or diagnosis at autopsy).
01-98	Number of treatments (Total number of treatment sessions administered to the patient).
99	Unknown (Radiation therapy given, but number of treatments unknown; or it is unknown if radiation therapy was given. Death certificate only).

ABSTRACT PLUS:

In the CURRENT VALUE box, type the number of treatment sessions administered to the patient during the first course of treatment.

Click OK or press ENTER.

RAD—REGIONAL DOSE: CGY

Column 895-899
Length 5 Column
Source of Standard COC

Description:

THIS DATA IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the dominant or most clinically significant dosage of regional radiation administered to the patient during the first course of treatment.

Rationale:

Used to evaluate patterns of care. In addition, outcomes are highly related to the radiation dose delivered.

General Guidelines:

Do not include the amount of the radiation boost dose in this field.

Use code 88888 if the patient is treated with brachytherapy or radioisotopes (codes 50-62 in the *Regional Treatment Modality* field.)

The dose may be described in "rads". The term rad is equivalent to centigray (cGy).

Regional dose information can usually be found in the radiation oncology summary report. The International Council for Radiation Protection recommends reporting doses at the axis point when applicable. If there is no clear axis point, report the dose as indicated in the summary report.

Codes	Description
-------	Actual regional dose delivered.
00000	Radiation therapy not administered/diagnosed at autopsy.
88888	Not applicable, brachytherapy or radioisotopes administered
99999	Radiation therapy was administered, but the dose is unknown; or it is unknown if radiation therapy was administered. Death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the regional dose delivered or the appropriate code.

Click OK or press ENTER.

RAD—REGIONAL RX MODALITY

Column 909-910
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the modality used to deliver the most clinically significant regional dose to the anatomical target during the first course of treatment.

Rationale:

Radiation treatment is often delivered in two or more phases that can be summarized as regional and boost treatments. When evaluating patterns of care, it is important to know which radiation resources were employed to deliver the therapy.

General Guidelines:

If more than one modality is used to deliver the regional dose, code the dominant modality.

In this data field, only report the modality used to deliver the regional treatment. The modality used to deliver the radiation boost is coded in the *Boost Treatment Modality* field.

In some circumstances, the boost treatment may be given before the regional treatment.

When coding this data field, consider photons and xrays as equivalent.

Codes	**Description**
00	No radiation treatment.
20	External beam, NOS (Not enough information to determine the specific modality).
21	Orthovoltage.
22	Cobalt-60, Cesium-137 (Intracavitary use should be coded as 50 or 51).
23	Photons (2-5 MV).
24	Photons (6-10 MV).
25	Photons (11-19 MV).
26	Photons (> 19 MV).

RAD—REGIONAL RX MODALITY (Cont'd)

Codes (Cont'd)	Description
27	Photons (mixed energies).
28	Electrons.
29	Photons and electrons mixed.
30	Neutrons, with or without photons/ electrons.
31	IMRT (Intensity modulated radiation therapy).
32	Conformal or 3-D therapy.
40	Protons.
41	Stereotactic radiosurgery, NOS (Stereotactic technique used, but type not specified).
42	Linac radiosurgery.
43	Gamma Knife..
50	Brachytherapy, NOS (Brachytherapy, interstitial implants, molds, seed, needles, or intracavitary applicators not otherwise specified).
51	Brachytherapy, Intracavitary. LDR.
52	Brachytherapy, Intracavitary, HDR.
53	Brachytherapy, Interstitial, LDR.
54	Brachytherapy, Interstitial, HDR.
55	Radium.
60	Radioisotopes, NOS (Iodine-131, Phosphorus-32, etc).
61	Strontium-89.
62	Strontium-90.
80*	Combination modality, specified (Combination of external beam and either radioactive implants or radioisotopes).
85*	Combination of radiation treatment modalities not specified in code 80.
98	Other, NOS (Radiation therapy given, but modality not specified or is unknown).

RAD—REGIONAL RX MODALITY (Cont'd)

Codes (Cont'd)	Description
99	Unknown if radiation therapy administered.

Note:* For cases diagnosed before January 1, 2003, this data item described any radiation given to the patient during first course of treatment. Codes 80 and 85 illustrate specific converted descriptions of radiation therapy coded according to *ROADS Manual* and the *DAM* rules. **Codes 80 and 85 should not be used to record regional radiation for cases diagnosed on January 1, 2003 or later.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Highlight the appropriate code in the drop-down table.

Click OK or press ENTER.

RAD—TREATMENT VOLUME

Column 905-906
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the anatomic target of the most clinically significant regional radiation treatment administered during first course of treatment.

Rationale:

Provides data regarding the anatomical structures targeted by regional radiation and can be used to determine whether the primary site, regional site, or distant site was targeted. Used to evaluate patterns of care.

Codes	Description
00	No radiation therapy.
01	Eye/orbit.
02	Pituitary.
03	Brain (NOS) (Tumors within substance of brain or its meninges).
04	Brain (limited) (Less than whole brain or less than all its meninges).
05	Head and neck (NOS) (Primary tumor of oropharyngeal complex).
06	Head and neck (limited) (Limited volume treatment of head and neck primary).
07	Glottis.
08	Sinuses.
09	Parotid.
10	Chest/lung (NOS) (Targets combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures).
11	Lung (limited) (Targets one region of the lung without nodal irradiation).
12	Esophagus (Includes tumors of the gastroesophageal junction).

RAD—TREATMENT VOLUME (Cont'd)

Codes (Cont'd)	Description
13	Stomach.
14	Liver (Targets liver for either primary or metastatic disease).
15	Pancreas.
16	Kidney.
17	Abdomen (NOS) (Targets abdominal contents not separately listed).
18	Breast (Targets intact breast. No attempt made to irradiate reg. lymph nodes).
19	Breast/lymph nodes (Deliberate attempt to target intact breast and reg. lymph nodes).
20	Chest wall.
21	Chest wall/lymph nodes.
22	Mantle, mini-mantle (Targets all reg. lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar nodes (mantle), or most of them (mini-mantle).
23	Lower extended field (Targets lymph nodes below the diaphragm along the paraaortic chain and may include on side of the pelvis. Includes "hockey stick" field used to treat seminomas).
24	Spine (Bones of spine and sacrum. See code 40 for spinal cord).
25	Skull.
26	Ribs.
27	Hip.
28	Pelvic bones (Bones of the pelvis excluding hip and sacrum).
29	Pelvis, NOS (Targets soft tissues within the pelvic region and excludes areas covered under codes 34-36).
30	Skin (Targets skin for skin primaries. Metastases of the skin are usually subcutaneous and should be coded as 31).
31	Soft tissue.

RAD—TREATMENT VOLUME (Cont'd)

Codes (Cont'd)	Description
32	Hemibody (A single target encompassing either all structures above or below the diaphragm).
33	Whole body (A single target encompassing the entire body).
34	Bladder and pelvis (Use for bladder primary. Bladder and all or most of the pelvis is treated).
35	Prostate and pelvis (Use for prostate primary. Prostate and all or most of the pelvis is treated).
36	Uterus and cervix (Targets uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique. If a portion of the treatment includes the entire pelvis, use code 29).
37	Shoulder (Targets proximal humerus, scapula, clavicle, or other components of the shoulder complex).
38	Extremity bone, NOS (Use code 27 for proximal femur. Use code 37 for proximal humerus).
39	Inverted Y (Target encompasses paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port).
40	Spinal cord (Targets spinal cord or its meninges).
41	Prostate.
50	Thyroid.
60	Lymph node region, NOS (Targets a group of lymph nodes not previously listed, i.e., isolated treatment of cervical, supraclavicular, or inguinofermoral region).
98	Other.
99	Unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

RAD—TREATMENT VOLUME (Cont'd)

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

READM SAME HOSP 30 DAYS

Column 938-938
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Records a readmission to the same hospital, for the same illness, within 30 days of discharge following hospitalization for surgical resection of the primary site.

Rationale:

Provides data related to the quality of care.

General Guidelines:

Only report a readmission related to the treatment of this cancer.

Codes	Description
0	No surgical procedure to the primary site was performed. Patient not readmitted to the same hospital within 30 days of discharge.
1	Patient was surgically treated and then readmitted to the same hospital within 30 days of discharge. Readmission was unplanned.
2	Patient was surgically treated and then readmitted to the same hospital within 30 days of discharge. Readmission was planned. (Planned revision of colostomy, insertion of chemotherapy port, etc.).
3	Patient was surgically treated and both a planned and unplanned readmission to the same facility occurred within 30 days of discharge.
9	Unknown if surgery to the primary recommended or performed. Unknown if patient readmitted to the same hospital within 30 days of discharge. Death certificate only case.

READM SAME HOSP 30 DAYS (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

REASON FOR NO RADIATION

Column 885-885
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Code for the reason the patient did not receive radiation treatment to the primary site as part of first course of therapy.

General Guidelines:

Use code 0 if radiation therapy was performed.

If data item, *Regional Treatment Modality*, is coded 00, review the patient's records to determine why radiation was not performed. Select the code based on the documentation in the records.

Use code 1 when several treatment options were offered and the patient selected a treatment plan that did not include radiation therapy.

If the patient is offered radiation therapy as a treatment option, but refuses it, use code 7. If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 7.

Use code 9 if several treatment plans were offered, but it is unknown which, if any treatment was provided.

If coded as 8, the case should be followed up and updated when the information becomes available.

Codes	Description
0	Radiation therapy was performed.
1	Radiation was not performed because it was not part of the planned first course treatment.
2	Radiation was not performed because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc.).
5	Radiation was not performed because the patient died prior to the recommended treatment.
6	Radiation was recommended, but not performed as part of first-course treatment. No reason indicated in chart.
7	Radiation recommended, but refused by the patient, patient's family member, or guardian. Refusal noted in chart.

REASON FOR NO RADIATION (Cont'd)

Codes (Cont'd)	Description
8	Radiation recommended, but unknown if performed. Later follow-up recommended.
9	Unknown if radiation was recommended or performed. Death certificate-only case and autopsy-only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the code to highlight it.

Click OK or press ENTER.

REASON FOR NO CA DIRECTED SURGERY
(Also known as REASON FOR NO SURGERY OF PRIMARY SITE)

Column 868-868
Length 1
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Code for the reason no cancer-directed surgery was performed on the primary site.

Rationale

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

General Guidelines:

Use code 0 if cancer-directed surgery was performed on the primary site.

If data item *Surgical Procedure of Primary Site* is coded 00, review the patient's records to determine why no cancer directed surgery was performed. Select the code based on the documentation in the records.

Use code 1 when several treatment options were offered and the patient selected a treatment plan that did not include surgery of the primary site.

Code 1 if *Surgical Procedure of Primary Site* is coded 98.

Sometimes a treatment option for a patient is to have "no treatment". If the patient accepts the offer of "no treatment", use code 1.

If the patient is offered surgery as a treatment option, but refuses surgical treatment, use code 7. If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 7.

Use code 9 if several treatment plans were offered, but it is unknown which, if any treatment was provided.

If coded as 8, the case should be followed up and updated when the information becomes available.

Codes	Description
0	Surgery of the primary site performed.
1	Surgery of the primary site not performed because it was not part of the planned first-course treatment.

REASON FOR NO CA DIRECTED SURGERY (Cont'd)

Codes (Cont'd)	Description
2	Surgery of the primary site not performed because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site not performed because the patient died prior to the recommended surgery.
6	Surgery of primary site recommended, but not performed as part of first-course treatment. No reason indicated in chart.
7	Surgery of primary site recommended, but refused by the patient, patient's family member, or guardian. Refusal noted in chart.
8	Surgery of primary site recommended, but unknown if performed. Later follow-up recommended.
9	Unknown if surgery was recommended or performed. Death certificate-only case and autopsy-only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the appropriate code to highlight it.

Click OK or press ENTER.

RECORD TYPE

Column 1-1
Length 1
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

Generated field identifying which of the five NAACCR data exchange record types is being used in a file of data exchange records. A file should have records of only one type.

Codes	Description
I	Incidence-only record type (Non-confidential coded data). Length = 1946
C	Confidential record type (Incidence record plus confidential data). Length = 2644
A	Full case Abstract record type (Incidence and confidential data plus text summaries; used for reporting to central registries). Length = 6694
U	Correction/Update record type (Short format record used to submit corrections to data already submitted). Length = 850
R	Analysis/Research record type (Incidence record plus appended error flags and recoded values). Length = 2215
M	Record Modified since previous submission to central registry (identical in format to the A record type). Length = 6694
L	Path Lab

ABSTRACT PLUS:

This field is system generated.

RECURRENCE DATE—1ST

(Also known as DATE OF FIRST RECURRENCE)

Column 1342-1349
Length 8
Source of Standard COC

Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Records the date of the first recurrence of this tumor.

General Guidelines:

Report the date the physician diagnoses metastatic or recurrent cancer.

The format for all dates is numeric (MMDDCCYY), with 99 for unknown day, month, year, or century. It is best to approximate the date if the exact date is not available.

Codes	Description
00000000	If the patient became disease-free after treatment, never had a recurrence, or if the patient was never disease-free. Diagnosed at autopsy.
99999999	When it is unknown if the patient had a first recurrence or the case was identified by death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date of the first recurrence.

Click OK or press ENTER.

RECURRENCE TYPE—1ST

Column 1353-1354
Length 2
Source of Standard COC

Description:

THIS IS A SUPPLEMENTARY/ RECOMMENDED DATA ITEM

Records the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale:

This information is used to evaluate treatment efficacy, as well as, a long-term prognostic factor.

General Guidelines:

Codes 00 – 70 form a hierarchical coding system. Report the highest-numbered applicable.

If the originally diagnosed malignancy was in situ, use codes 00, 06, 16, 17, 26, 27, 36, 46, 88, and 99 to code the recurrence.

If the originally diagnosed malignancy was invasive, do not use codes 06, 16, 17, 26, 27, 36 or 46.

Codes 51-59 (organ or organ system of distance recurrence) should only be used if all first occurrences were in a single category. Within the distant location there could be multiple metastases (or seedings).

Leukemias that are in remission should be coded to 00. Use code 59, if the patient has a relapse.

If the patient had more than one primary tumor and the physician is unable to determine which has recurred, code the recurrence for each tumor. Revise the codes, if the recurrence is later determined to be from a particular primary.

Codes	Description
00	Pt became disease-free and has had no recurrence.
04	In situ recurrence of an invasive tumor
06	In situ recurrence of an in situ tumor
10	Local recurrence and there is insufficient information available to code to 13-17. Recurrence is confined to the remnant of the organ of origin; to the organ of origin; to the anastomosis; or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.

RECURRENCE TYPE—1ST (Cont'd)

Codes (Cont'd)	Description
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor.
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21-27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/ or regional lymph nodes (20-25) AND local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/ or regional lymph nodes (26 or 27) and local and/ or trocar recurrence (16 or 17).
40	Distant recurrence and there is insufficient information available to code to 46-62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surface of all structures within the abdominal cavity and/ or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.

RECURRENCE TYPE—1ST (Cont'd)

Codes (Cont'd)	Description
55	Distant recurrence of an invasive tumor in the bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, and generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51-58) and local, trocar, and/ or regional recurrence (10-15, 20-25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the code from the drop-down table to highlight it.

Click OK or press ENTER.

REGIONAL NODES EXAMINED

Column 541-542
Length 2
Source of Standard SEER/COC

Description

THIS IS A REQUIRED DATA ITEM

Records the total number of regional lymph nodes, examined by a pathologist, which were removed during first course treatment.

General Guidelines:

1. Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the “CS Mets at Dx” field.

2. Rules for coding Regional Nodes Examined are the same for in situ and invasive cases.

3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 00. If it is unknown whether nodes were removed or examined, code as 99.

4. Record the total number of regional lymph nodes removed and examined by the pathologist.

   a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
   b. If lymph nodes are aspirated and other lymph nodes are removed, use code 98.
   c. This field is to be recorded regardless of whether the patient received preoperative treatment.

5. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

6. For the following primary sites and histologies, the Regional Nodes Examined field is always coded as 99.

   Brain and Cerebral Meninges
   Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
   Hodgkin and non-Hodgkin Lymphoma
   Other and Ill-Defined Primary Sites
   Other Parts of Central Nervous System
   Placenta
   Unknown Primary Site

REGIONAL NODES EXAMINED (Cont'd)

Code	Description
00	No nodes were examined.
01-89	1-89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional 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 lymph 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 nodes were examined; not applicable or negative; not stated in patient record.

ABSTRACT PLUS

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

REGIONAL NODES POSITIVE

Column 539-540
Length 2
Source of Standard SEER/COC

Description

THIS IS A REQUIRED DATA ITEM

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

General Guidelines:

1. Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the "CS Mets at Dx" field.

2. Rules for coding Regional Nodes Positive are the same for both in situ and invasive cases.

3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 98.

4. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

    a. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

    b. This field is to be recorded regardless of whether the patient received preoperative treatment.

5. Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes should be coded to 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.

6. For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99.

    Placenta
    Brain and Cerebral Meninges
    Other Parts of Central Nervous System
    Hodgkin and non-Hodgkin Lymphoma
    Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    Other and Ill-Defined Primary Sites
    Unknown Primary Site

REGIONAL NODES POSITIVE (Cont'd)

Code	Description
00	All nodes examined are negative.
01-89	1-89 nodes are positive. (Code exact number of nodes positive)
90	90 or more nodes are positive.
95	Positive aspiration of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

ABSTRACT PLUS

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

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REGISTRY TYPE

Column 10-10
Length 1
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM

A computer generated code that best describes the type of registry generating the record; used when cases are pooled from multiple registries. (A hospital-based registry reporting to a state should have a "3" in this field.)

Rationale

Allows the data from multiple registries to be pooled.

Codes	Description
1	Central registry (population-based).
2	Central registry or hospital consortium (not population-based).
3	Single hospital/free standing center.

ABSTRACT PLUS:

Must be coded as 3.

REPORTING HOSPITAL
(Also known as INSTITUTION ID NUMBER)

Column 382-391
Length 10
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM.

Code for the facility reporting the case.

Rationale:

This number is used to identify a reporting facility in the central registry database.

Instructions for coding:

Use the Tennessee Cancer Registry assigned code.

The number must be right justified in the field, and the remaining spaces should be filled with leading zeroes to a total length of 10.

ABSTRACT PLUS:

In the CURRENT VALUE box, type your institution ID number

or

In the CURRENT VALUE box, type the name of your facility until it is highlighted in the drop-down listing.

Click OK or press ENTER.

RX CODING SYSTEM—CURRENT

Column 888-889
Length 2
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM.

Code describing how treatment for this case is now coded.

Codes	Description
00	Treatment data not coded/transmitted (i.e., all treatment fields blank*).
01	Treatment data coded using 1-digit surgery codes (obsolete).
02	Treatment data coded according to 1983-1992 SEER manuals and 1983-1995 COC manuals.
03	Treatment data coded according to 1996 ROADS manual.
04	Treatment data coded according to 1998 ROADS supplement.
05	Treatment data coded according to 1998 SEER manual.
06	Treatment data coded according to FORDS manual.
99	Other coding, including partial or non-standard coding.

ABSTRACT PLUS:

Disregard this data item.

RX DATE—DX/ STG PROC

Column 851-858
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale:

It is useful to record the dates on which different treatment modalities were started. It is also useful in determining if a treatment was part of first course or a subsequent course of treatment.

General Guidelines:

Enter the date on which the surgical diagnostic and/or staging procedure was performed at this or any facility.

Record date in month, day and year format (MMDDYYYY).

Codes (in addition to valid dates)	**Description**
00000000	No surgical diagnostic or staging procedure performed; autopsy only case.
99999999	Unknown if surgical diagnostic or staging procedure performed; date unknown, or death certificate only case.

Note: This is a COC item and for cases diagnosed from January 1, 1996 through December 31, 2002, may describe the date on which diagnostic, staging, and palliative procedures were performed. Beginning with cases diagnosed on or after January 1, 2003, palliative procedures are collected in the *RX Summ—Palliative Proc and RX Hosp—Palliative Proc.* fields.

Do not code surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350). Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Additionally, do not record the date of surgical procedures that aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). Record the date of this surgical procedure in the data item *Date of First Course of Treatment* (NAACCR Item #1270) and /or *Date of First Surgical Procedure* (NAACCR Item #1200), as appropriate.

RX DATE—DX/ STG PROC (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date on which the surgical diagnostic and/ or staging procedure was performed.

Click OK or press ENTER.

RX DATE—MOST DEFIN SURG

(Also known as DATE OF MOST DEFINITIVE SURGICAL RESECTION OF THE PRIMARY SITE)

Column 763-770
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Date of the most definitive surgical resection of the primary site performed as part of the first course of treatment at this or any facility.

Rationale:

Used to measure the lag time between diagnosis and the most definitive surgery of the primary site or survival following the procedure. Also used to calculate the duration of hospitalization following the most definitive primary site surgical procedure to evaluate treatment efficacy.

General Guidelines:

Record date in month, day, and year format (MMDDYYYY).

Codes	**Description**
00000000	No surgical resection of the primary site performed. Diagnosed at autopsy.
99999999	Unknown if any surgical procedure of the primary site was performed, or date is unknown, or death-certificate only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date the most definitive surgical resection of the primary site was performed. Use month, day, year format (MMDDYYYY).

Click OK or press ENTER.

RX DATE--OTHER

Column 827-834
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Identifies the date on which "other treatment" began at any facility during first course of treatment.

Rationale:

It is useful to record the dates on which different treatment modalities were started, the sequence in which they were given, and the intervals between treatments.

General Guidelines:

"Other treatment" includes any and all cancer directed therapy designed to modify, destroy, remove, or control cancer cells that cannot be defined as surgery, radiation, chemotherapy, hormone therapy, or immunotherapy as defined in the *FORDS* manual.

Examples of Other Treatment:

Experimental treatments or medication
Cancer treatments ordered and administered by nonmedical personnel
Laetrile
Hyperbaric oxygen (as adjunct to definitive treatment)
Hyperthermia
PUVA (Psoralen and ultraviolet A light)

For hematopoietic diseases, other treatment includes phlebotomy and transfusions.

For essential thrombocythemia, aspirin for thinning of platelets in the blood should be coded as other treatment. (Aspirin treatment for essential thrombocythemia is usually given in low doses, such as 70-100 mg daily.) Aspirin for pain or cardiovascular protection is not considered other treatment and should be ignored.

Record the date other treatment began in month, day, and year format (MMDDYYYY).

Codes (in addition to valid dates)	**Description**
00000000	No other treatment administered; autopsy only case.
99999999	Unknown if any radiation therapy administered; date unknown, or death certificate only case.

RX DATE—OTHER (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date first course other treatment began using the month, day, and year (MMDDYYYY) format.

Click OK or press ENTER.

RX DATE—RADIATION

Column 779-786
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Identifies the date on which radiation began at any facility during first course of treatment. If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, the date radiation started is the same as date of first course of treatment.

Rationale:

It is useful to record the dates on which different treatment modalities were started, the sequence in which they were given, and the intervals between treatments. It is also useful in determining if a treatment was part of first course or a subsequent course of treatment.

General Guidelines:

Enter the date first course of treatment radiation therapy began.

If coded as 88888888, the case should be followed up and updated when the information becomes available.

Record date radiation therapy began in month, day, and year format (MMDDYYYY).

Codes (in addition to valid dates)	**Description**
00000000	No radiation therapy administered; autopsy only case
88888888	Radiation therapy was planned as part of first course of treatment, but had not started at the time of the most recent follow-up. The date should be revised at next follow-up.
99999999	Unknown if any radiation therapy administered; unknown date; or death certificate only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date first course radiation treatment began using month, day, and year (MMDDYYYY) format.

Click OK or press ENTER.

RX DATE—RADIATION ENDED

Column 787-794
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Records the date on which the patient receives the last radiation treatment during the first course of treatment. Includes information from this or any facility.

Rationale:

The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful in evaluating the quality of care and the success of patient support programs designed to maintain continuity of treatment.

General Guidelines:

Record the date in month, day, year format (MMDDYYYY).

If coded as 88888888, the case should be followed and updated when the information becomes available.

Codes (in addition to valid dates)	Description
00000000	Radiation therapy was not administered. Diagnosed at autopsy.
88888888	Radiation was administered and was ongoing at the time of most recent follow-up.
99999999	Unknown if radiation therapy was administered; date radiation ended is unknown; or death certificate only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date of the last radiation treatment given during the first course of treatment using month, day, year (MMDDYYYY) format.

Click OK or press ENTER.

RX DATE—SURGERY
(Formerly called DATE OF CANCER-DIRECTED SURGERY)

Column	755-762
Length	8
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

The earliest date on which any first course cancer directed surgery was performed.

Rationale:

It is useful to record the dates on which different treatment modalities were started, the sequence in which they were given, and the intervals between treatments. It is also useful in determining if a treatment was part of first course or a subsequent course of treatment.

General Guidelines:

Enter the date of the earliest cancer directed surgery at this or any facility. Evaluate the data fields *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, and Surgical Procedure/Other Site* and use the date of the earliest surgery to complete this data field.

Record date of the first cancer directed surgery in month, day, and year format (MMDDYYYY).

If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* (NAACCR Item #1270).

Codes (in addition to valid dates)	**Description**
00000000	No cancer-directed surgery performed; autopsy only case.
99999999	Unknown if any cancer-directed surgery performed, date unknown, or death certificate-only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date of the first cancer directed surgical procedure using month, day, and year format (MMDDYYYY).

Click OK or press ENTER.

RX DATE—SURGICAL DISCH

Column	771-778
Length	8
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgical Procedure of the Primary Site* and *Date of Most Definitive Surgical Resection.*

Rationale:

Length of stay is an important quality of care and financial measure.

General Guidelines:

If the patient dies after the primary site surgery, but before being discharged from the treating facility, use the date of death to complete this data item.

If the patient received outpatient surgery, use the surgery date to complete this data item.

Record the date in month, day, year format (MMDDYYYY).

Codes (in addition to valid dates)	Description
00000000	No surgical treatment of the primary site was performed. Diagnosed at autopsy.
99999999	Unknown whether surgical treatment was performed; date is unknown; or death certificate only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date the patient was discharged following primary site surgery using month, day, year format (MMDDYYYY).

Click OK or press ENTER.

RX DATE—SYSTEMIC

Column 795-802
Length 8
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Identifies the date on which systemic therapy began during first course of treatment. Systemic therapy includes administration of chemotherapy agents, hormone agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/ or radiation endocrine therapy.

Rationale:

It is useful to record the dates on which different treatment modalities were started, the sequence in which they were given, and the intervals between treatments. It is also useful in determining if a treatment was part of first course or a subsequent course of treatment.

General Guidelines:

Enter the date first course of treatment systemic therapy began.

If coded as 88888888, the case should be followed up and updated when the information becomes available.

Record date systemic therapy began in month, day, and year format (MMDDYYYY).

Codes (in addition to valid dates)	Description
00000000	No systemic therapy administered. Diagnosed at autopsy.
88888888	Systemic therapy was planned as part of first course of treatment, but had not started at the time of the most recent follow-up. The date should be revised at next follow-up.
99999999	Unknown if any systemic therapy administered; unknown date; or death certificate only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the date first course systemic treatment began using month, day, and year (MMDDYYYY) format.

Click OK or press ENTER.

RX HOSP—BRM (Biological Response Modifier or Immunotherapy)

Column 468-469
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of biological response modifier therapy (immunotherapy) given, or the reason it was not given, during first course of treatment at this facility.

General Guidelines:

Only report immunotherapy received at this facility. Do not report immunotherapy given at other facilities.

Use code 00 if the patient did not have immunotherapy and immunotherapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include immunotherapy.

If immunotherapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

If the patient is offered immunotherapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

Bone marrow transplants and stem cell transplants should be coded in the new field, *RX SUMM-Transplnt/ Endocr*, effective with cases diagnosed on or after January 1, 2003.

If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes	Description
00	None, immunotherapy was not part of first course therapy; not customary therapy for this cancer. Diagnosed at autopsy.
01	Immunotherapy given as part of first course therapy.
82	Immunotherapy not recommended/ given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).

RX HOSP—BRM (Cont'd)

Codes (Cont'd)	Description
85	Immunotherapy not given because patient died prior to planned or recommended Therapy.
86	Immunotherapy was recommended, but was not given as part of first course therapy; no reason indicated in chart.
87	Immunotherapy was recommended, but patient, patient's family member or guardian refused; refusal noted in chart.
88	Immunotherapy was recommended, but unknown if administered.
99	Unknown if immunotherapy was recommended or given; death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the code to highlight it.

Click OK or press ENTER.

RX HOSP—CHEMOTHERAPY

Column 464-465
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of chemotherapy given, or the reason it was not given, during first course of treatment at this facility.

General Guidelines:

Only report chemotherapy received at this facility. Do not report chemotherapy administered at other facilities.

Use code 00 if the patient did not have chemotherapy and chemotherapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include chemotherapy.

If chemotherapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

Only code the agents used during first course of therapy in this data field. A change in chemotherapy agents due to initial treatment failure or disease progression represents the start of second course of treatment and should not be coded in this data field.

If the patient is offered chemotherapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes	Description
00	None, chemotherapy was not part of first course of therapy; not customary therapy for this cancer.
01	Chemotherapy, NOS (type or number of agents not documented).
02	Chemotherapy, single agent

RX HOSP—CHEMOTHERAPY (Cont'd)

Codes (Cont'd)	Description
03	Chemotherapy, multiple agents.
82	Chemotherapy not recommended/given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).
85	Chemotherapy not given because patient died prior to planned or recommended Therapy.
86	Chemotherapy was recommended, but not given as part of first course therapy; no reason indicated in chart.
87	Chemotherapy was recommended, but patient, patient's family member, or guardian refused; refusal noted in chart.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	Unknown if recommended or given; death certificate case only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on the code to highlight it.

Click OK or press ENTER.

RX HOSP—DX/ STG PROC
(Also known as SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY)

Column 471-472
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage the disease. Includes information from this facility only.

General Guidelines:

Code the type of procedure performed as part of the initial diagnosis and work-up at this facility.

Do not report brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) in this field. They are not considered surgical procedures.

Do not record palliative surgical procedures in this field. Use the *Palliative Procedure* field to code these procedures.

Do not record surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an attempt to diagnose and/or stage disease in this field. Use the *Scope of Regional Lymph Node Surgery* field to code these procedures.

Do not record excisional biopsies with clear or microscopic margins in this field. Use the *Surgical Procedure of Primary Site* field to code these procedures.

Codes	Description
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done of the primary site.
03	A surgical exploratory only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but biopsy was not done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.

RX HOSP—DX/ STG PROC (Cont'd)

Codes	Description
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information about whether a diagnostic or staging procedure was done.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX HOSP—HORMONE

Column	466-467
Length	2
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of hormonal treatment given, or the reason it was not given, as part of the first course treatment at this facility.

General Guidelines:

Only report hormone therapy received at this facility. Do not report hormone therapy administered at other facilities.

Only drugs which are hormones, have hormonal properties or which alter the natural production of hormones are coded here. Effective with cases diagnosed January 1, 2003, surgery and radiation therapy for hormonal effect should be coded in the new field, RX Summ-Transplnt/ Endocr.

Adrenocorticotropic hormones (i.e., Prednisone) are usually considered therapeutic only for leukemia, lymphoma and multiple myeloma; therefore, Prednisone given to reduce edema is NOT to be recorded. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP or COPP. Do not code it when it is administered for reasons other than chemotherapeutic treatment.

Hormone-producing tissue may be destroyed by cancer cells or treatment attempting to remove or control cancer cells. Replacement hormones may be given to the patient to maintain normal metabolic function. Hormone replacement therapy is NOT coded as part of first course of treatment.

Exception: Thyroid hormone replacement inhibits production of TSH (thyroid stimulating hormone) which can stimulate the growth of tumor cells. Thyroid replacement therapy should be coded as 01.

Use code 00 if the patient did not have hormone therapy and hormone therapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include hormone therapy.

If hormone therapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

If the patient is offered hormone therapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item

Palliative Care at This Facility (NAACCR Item #3280).

Note: Any therapy codes 02-03 should have been converted to the appropriate code in the new field, RX SUMM-Transplant/Endocr (3250). Codes 02-03 should not be used for tumors diagnosed on or after January 1, 2003.

Codes	**Description**
00	None, hormone therapy was not part of first course therapy; not customary therapy for this cancer. Diagnosed at autopsy.
01	Hormone therapy given as part of first course therapy.
82	Hormone therapy not recommended/ given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).
85	Hormone therapy not given because patient died prior to planned or recommended therapy.
86	Hormone therapy was recommended, but was not given as part of first course therapy. No reason indicated in chart.
87	Hormone therapy was recommended, but patient, patient's family member or guardian refused. Refusal noted in chart.
88	Hormone therapy was recommended, but unknown if administered.
99	Unknown if hormone therapy was recommended or given; death certificate case only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the code to highlight it.

Click OK or press ENTER.

RX HOSP—OTHER (OTHER CANCER-DIRECTED THERAPY)

Column 470-470
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the use of other cancer-directed treatment, performed at this facility, that cannot be defined as surgery, radiation, or systemic therapy as defined in the *FORDS* manual.

Definition of Other Treatment:

"Other treatment" includes any and all cancer directed therapy designed to modify, destroy, remove, or control cancer cells that cannot be defined as surgery, radiation, chemotherapy, hormone therapy, or immunotherapy as defined in the *FORDS* manual.

Examples of Other Treatment:

Experimental treatments or medication
Cancer treatments ordered and administered by nonmedical personnel.
Laetrile
Hyperbaric oxygen (as adjunct to definitive treatment)
Hyperthermia
PUVA (Psoralen and ultraviolet A light)

Use code 1 for hematopoietic diseases (M9950- 9989) treated by phlebotomy and transfusions.

Use code 1 for essential thrombocythemia treated by aspirin for thinning of platelets in the blood. (Aspirin treatment for essential thrombocythemia is usually given in low doses, such as 70-100 mg daily.) Aspirin for pain or cardiovascular protection is not considered other treatment and should be ignored.

If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes	Description
0	No other cancer-directed therapy except as coded elsewhere. Diagnosed at autopsy.
1	Other cancer-directed therapy.
2	Other experimental cancer-directed therapy (not included elsewhere).
3	Double-blind study, code not yet broken.

RX HOSP—OTHER (Cont'd)

Codes (Cont'd)	Description
6	Unproven therapy-cancer treatments administered by nonmedical personnel (laetrile, krebiozen, etc).
7	Patient or patient's guardian refused therapy, which would have been coded 1-3 above.
8	Other cancer-directed therapy recommended, unknown if administered.
9	Unknown if other cancer-directed therapy administered. Death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX HOSP—PALLIATIVE PROC

Column 473-473
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies any procedure performed in an effort to palliate or alleviate symptoms **at this facility.** Palliative procedures are performed to relieve symptoms and/or relieve pain or to make the patient comfortable.

Rationale:

This data item allows the tracking of the use of procedures that are considered palliative rather than therapeutic, diagnostic, or used for staging.

General Guidelines:

Palliative procedures are used to relieve symptoms and/or relieve pain or to make the patient comfortable. They are not used to diagnose, stage, or treat the primary tumor.

Examples:

> Due to the body's reaction to a tumor in the lung, fluid increases and a thoracentesis is performed to alleviate pressure. *Code as 1.*

Surgical procedures, radiation therapy, and systemic therapy that are part of first course of treatment should be coded in their respective fields.

Codes	Description
0	No palliative care provided.
1	Surgery (which may involve a bypass procedure) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy given to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs given to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Pain management therapy with no other palliative care.
5	Any combination of codes 1,2, and/or 3 without code 4.

RX HOSP—PALLIATIVE PROC (Cont'd)

Codes	Description
6	Any combination of codes 1,2, and/or 3 with code 4.
7	Palliative care was performed, but no information on the type of procedure is available in the patient record.
9	Unknown if palliative care was performed; not stated in patient record.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX HOSP-SCOPE REG 98-02

(Also known as SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY COC))

Column	480-480
Length	1
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Records the removal, biopsy, or aspiration of regional lymph nodes either at the time of surgery to the primary site or during a separate surgical event at the reporting facility. This field is to be used to code *Scope of Regional Lymph Node Surgery* at the reporting facility for all cases diagnosed prior to January 1, 2003.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX HOSP-- SCOPE REGIONAL LYMPH NODE SURGERY

(Also known as SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY)

Column 459-459
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the removal, biopsy, or aspiration of regional lymph nodes either at the time of surgery to the primary site or during a separate surgical event at the reporting facility.

General Guidelines:

Scope of regional lymph node surgery is to be coded even if surgery to the primary site is not performed.

Do not code distant lymph nodes removed during surgery in this field. Removal of distant lymph nodes is to be coded in the *Surgical Procedure/ Other Site* field.

The regional lymph node surgery codes are hierarchical. When only one procedure can be recorded, select the procedure with the numerically higher code.

Use code 9 for the following primary sites and histologies:

Unknown or ill-defined primary (C76.0- C76.8, C80.9)
Brain, meninges, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0- C71.9, C72.0- C72.9)
Lymphomas (M 9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0- C77.9).
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).

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes	Description
0	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.
2	Sentinel lymph node biopsy.

RX HOSPSCOPE REGIONAL LYMPH NODE SURGERY (Cont'd)

Codes (Cont'd)	**Description**
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS.
4	1-3 regional lymph nodes removed.
5	4 or more regional lymph nodes removed (Sampling or dissection of regional lymph nodes with at least 4 nodes found in the specimen. Procedure not a sentinel node biopsy).
6	Sentinel node biopsy and code 3, 4, or 5 at the same time or timing not stated.
7	Sentinel node biopsy and code 3, 4, or 5 at different times.
9	Unknown; not applicable; death certificate-only case.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX HOSP– SURG OTH 98-02

(Also known as SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S) AT THIS FACILITY (COC) and SURGICAL PROCEDURE/OTHER SITE AT THIS FACILILY

Column	481-481
Length	1
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this facility. This field is to be used to code *Surgery Other Regional/Distant Sites* at the reporting facility for all cases diagnosed prior to January 1, 2003.

ABSTACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX HOSP– SURGERY OTHER REG/DIS

(Also known as SURGICAL PROCEDURE/OTHER SITE AT THIS FACILITY)

Column 460-460
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Codes the removal of distant lymph nodes or other tissue(s)/ organ(s) beyond the primary site at this facility.

General Guidelines:

Code the removal of non-primary site tissue that was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

DO NOT CODE the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than suspected malignancy.

> **Example**: During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gall bladder. Do not code removal of the gall bladder.

Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-76.8, 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).

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes	**Description**
0	None; no surgery to other regional or distant sites; autopsy only case.
1	Surgery to other site(s), NOS; unknown if regional or distant.
2	Regional site resection.
3	Distant lymph node resection.
4	Distant site resection.
5	Combination of 2, 3, or 4.

RX HOSP– SURGERY OTHER REG/DIS (Cont'd)

Codes	Description
9	Unknown; Death certificate only case

ABSTACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX HOSP -- SURGERY OF PRIMARY SITE

(Also known as SURGICAL PROCEDURE OF PRIMARY SITE AT THIS FACILITY)

Column	457-458
Length	2
Source of Standard	COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Describes the surgical procedures used to treat the primary site of the tumor during first course of treatment at this facility.

General Guidelines:

Record surgeries performed to the primary site only. Removal of regional tissue or organs is recorded in this field only if the tissue/ organs are removed with the primary site in an EN BLOC (all in one piece at the same time) resection. Non en bloc removal of regional tissue or organs should be coded in the *Surgical Procedure/ Other Site* field.

If the patient has multiple cancer-directed surgeries of the primary site, code the most invasive, definitive surgery (highest code numerically).

If no surgical procedure was done on the primary site, code 00.

Codes 00-79 are hierarchical. If more than one code describes the procedure performed, use the higher code.

Code 98 has priority over code 00.

Use codes 80 and 90 only if better information is not available.

Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.

If a surgical procedure that partially removed the primary site is followed by surgery that removes the remainder of the primary site, code as total removal of the primary site.

Use code 00 for autopsy only cases.

Use code 99 for death certificate only cases.

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).

Codes:

See the TCR manual, Appendix F for site-specific surgical codes.

RX HOSP -- SURGERY OF PRIMARY SITE (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code describing the surgery to the primary site performed.

Click OK or press ENTER.

RX HOSP-SURG SITE 98-02

(Also known as CANCER-DIRECTED SURGERY AT THIS FACILITY, RX HOSPITAL-CANCER DIRECTED SURGERY and SURGICAL PROCEDURE OF PRIMARY SITE)

Column 478-479
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS.

Describes surgical procedures used to treat the primary site of the reportable tumor. This item records that portion of the first course of treatment given at the reporting facility. This field is to be used to code *Surgery Primary Site* at the reporting facility for all cases diagnosed before January 1, 2003.

Codes (in addition to the site-specific codes)	**Description**
00	No cancer-directed surgery performed.
99	Unknown if cancer-directed surgery performed.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM—BRM (Biological Response Modifier or Immunotherapy)

Column 882-883
Length 2
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of biological response modifier therapy (immunotherapy) given, or the reason it was not given, during first course of treatment at this or any facility.

General Guidelines:

Use code 00 if the patient did not have immunotherapy and immunotherapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include immunotherapy.

If immunotherapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

If the patient is offered immunotherapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

Bone marrow transplants and stem cell transplants should be coded in the new field, *RX SUMM-Transplnt/Endocr*, effective with cases diagnosed on or after January 1, 2003.

If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care.*

Codes	Description
00	None, immunotherapy was not part of first course therapy; not customary therapy for this cancer. Diagnosed at autopsy.
01	Immunotherapy given as part of first course therapy.
82	Immunotherapy not recommended/ given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).
85	Immunotherapy not given because patient died prior to planned or recommended therapy.

RX SUMM—BRM (Cont'd)

Codes (Cont'd)	Description
86	Immunotherapy was recommended, but was not given as part of first course therapy; no reason indicated in chart.
87	Immunotherapy was recommended, but patient, patient's family member or guardian refused; refusal noted in chart.
88	Immunotherapy was recommended, but unknown if administered.
99	Unknown if immunotherapy was recommended or given; death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the code to highlight it.

Click OK or press ENTER.

RX SUMM—CHEMOTHERAPY

Column 878-879
Length 2
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of chemotherapy given, or the reason it was not given, during first course of treatment at this or any facility.

General Guidelines:

Use code 00 if the patient did not have chemotherapy and chemotherapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include chemotherapy.

If chemotherapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

Only code the agents used during first course of therapy in this data field. A change in chemotherapy agents due to initial treatment failure or disease progression represents the start of second course of treatment and should not be coded in this data field.

If the patient is offered chemotherapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care.*

Codes	Description
00	None, chemotherapy was not part of first course of therapy; not customary therapy for this cancer.
01	Chemotherapy, NOS (type or number of agents not documented).
02	Chemotherapy, single agent
03	Chemotherapy, multiple agents.

RX SUMM—CHEMOTHERAPY (Cont'd)

Codes (Cont'd)	**Description**
82	Chemotherapy not recommended/given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).
85	Chemotherapy not given because patient died prior to planned or recommended Therapy.
86	Chemotherapy was recommended, but not given as part of first course therapy; no reason indicated in chart.
87	Chemotherapy was recommended, but patient, patient's family member, or guardian refused; refusal noted in chart.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	Unknown if recommended or given; death certificate case only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table.   Click on the code to highlight it.

Click OK or press ENTER.

RX SUMM—DX/ STG PROC
(Also known as RX SUMM-DX/STG/PALL PROC; NON CANCER-DIRECTED SURGERY (COC); SURGICAL, DIAGNOSTIC and STAGING PROCEDURE 1996-2002)

Column 869-870
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage the disease. Include all information from this or any facility.

General Guidelines:

Code the type of procedure performed as part of the initial diagnosis and work-up.

Do not report brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) in this field. They are not considered surgical procedures.

Use code 02 if both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done.

Do not record palliative surgical procedures in this field. Use the *Palliative Procedure* field to code these procedures.

Do not record surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an attempt to diagnose and/or stage disease in this field. Use the *Scope of Regional Lymph Node Surgery* field to code these procedures.

Do not record excisional biopsies with clear or microscopic margins in this field. Use the *Surgical Procedure of Primary Site* field to code these procedures.

Codes	Description
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done of the primary site.
03	A surgical exploratory only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but biopsy was not done.

RX SUMM—DX/ STG PROC (Cont'd)

Codes (Cont'd)	**Description**
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information about whether a diagnostic or staging procedure was done.

Note: For cases diagnosed between 1996 and 2002 this field may have described palliative care. For cases diagnosed on or after January 1, 2003 palliative care is reported in a new field (*RX Summ—Palliative Proc.)*

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX SUMM—HORMONE

Column	880-881
Length	2
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the type of hormonal treatment given, or the reason it was not given, as part of the first course treatment at this or any facility.

General Guidelines:

Only drugs which are hormones, have hormonal properties or which alter the natural production of hormones are coded here. Effective with cases diagnosed January 1, 2003, surgery and radiation therapy for hormonal effect should be coded in the new field, RX Summ-Transplnt/ Endocr.

Adrenocorticotropic hormones (i.e., Prednisone) are usually considered therapeutic only for leukemia, lymphoma and multiple myeloma; therefore, Prednisone given to reduce edema is NOT to be recorded.

Hormone-producing tissue may be destroyed by cancer cells or treatment attempting to remove or control cancer cells. Replacement hormones may be given to the patient to maintain normal metabolic function. Hormone replacement therapy is NOT coded as part of first course of treatment.

Exception: Thyroid hormone replacement inhibits production of TSH (thyroid stimulating hormone) which can stimulate the growth of tumor cells. Thyroid replacement therapy should be coded as 01.

Use code 00 if the patient did not have hormone therapy and hormone therapy is not usually given for this type or stage of cancer.

Use code 00 if the patient was given multiple treatment options, and selected a treatment option that did not include hormone therapy.

If hormone therapy is usually given for this type or stage of cancer, but was not given, code the reason it was not administered. Use codes 82, 85, 86, or 87.

If the patient is offered hormone therapy as a treatment option, but refuses it, use code 87.
If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care.*

RX SUMM—HORMONE (Cont'd)

Codes	Description
00	None, hormone therapy was not part of first course therapy; not customary therapy for this cancer. Diagnosed at autopsy.
01	Hormone therapy given as part of first course therapy.
82	Hormone therapy not recommended/ given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc).
85	Hormone therapy not given because patient died prior to planned or recommended therapy.
86	Hormone therapy was recommended, but was not given as part of first course therapy. No reason indicated in chart.
87	Hormone therapy was recommended, but patient, patient's family member or guardian refused. Refusal noted in chart.
88	Hormone therapy was recommended, but unknown if administered.
99	Unknown if hormone therapy was recommended or given; death certificate case only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

In the drop-down listing, click on the code to highlight it.

Click OK or press ENTER.

RX SUMM—OTHER (OTHER CANCER-DIRECTED THERAPY)

Column	884-884
Length	1
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the use of other cancer-directed treatment, performed at this or any facility, that cannot be defined as surgery, radiation, or systemic therapy as defined in the *FORDS* manual.

Definition of Other Treatment:

"Other treatment" includes any and all cancer directed therapy designed to modify, destroy, remove, or control cancer cells that cannot be defined as surgery, radiation, chemotherapy, hormone therapy, or immunotherapy.

Examples of Other Treatment:

Experimental treatments or medication
Cancer treatments ordered and administered by nonmedical personnel
Laetrile
Hyperbaric oxygen (as adjunct to definitive treatment)
Hyperthermia
PUVA (Psoralen and ultraviolet A light)

Use code 1 for hematopoietic diseases (M9950- 9989) treated by phlebotomy and transfusions.

Use code 1 for essential thrombocythemia treated by aspirin for thinning of platelets in the blood. (Aspirin treatment for essential thrombocythemia is usually given in low doses, such as 70-100 mg daily.) Aspirin for pain or cardiovascular protection is not considered other treatment and should be ignored.

If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care.*

Codes	Description
0	No other cancer-directed therapy except as coded elsewhere. Diagnosed at autopsy.
1	Other cancer-directed therapy.
2	Other experimental cancer-directed therapy (not included elsewhere).
3	Double-blind study, code not yet broken.

RX SUMM—OTHER (Cont'd)

Codes (Cont'd)	Description
6	Unproven therapy-cancer treatments administered by nonmedical personnel (laetrile, krebiozen, etc).
7	Patient or patient's guardian refused therapy, which would have been coded 1-3 above.
8	Other cancer-directed therapy recommended, unknown if administered.
9	Unknown if other cancer-directed therapy administered. Death certificate only.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX SUMM—PALLIATIVE PROC

Column 871-871
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies any procedure performed in an effort to palliate or alleviate symptoms. Include palliative procedures performed at this or any facility. Palliative procedures are performed to relieve symptoms and/ or relieve pain.

Rationale:

This data item allows the tracking of the use of procedures that are considered palliative rather than therapeutic, diagnostic, or used for staging.

General Guidelines:

Palliative procedures are used to relieve symptoms and/or relieve pain. They are not used to diagnose, stage, or treat the primary tumor.

Examples:

> Due to the body's reaction to a tumor in the lung, fluid increases and a thoracentesis is performed to alleviate pressure. *Code as 1.*

Surgical procedures, radiation therapy, and systemic therapy that are part of first course of treatment should be coded in their respective fields.

Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded palliative care **and** as first course therapy if that procedure removes or modifies either primary or secondary malignant tissue.

Codes	Description
0	No palliative care provided.
1	Surgery (which may involve a bypass procedure) performed to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy given to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.

RX SUMM—PALLIATIVE PROC (Cont'd)

Codes (Cont'd)	Description
3	Chemotherapy, hormone therapy, or other systemic drugs given to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Pain management therapy with no other palliative care.
5	Any combination of codes 1,2, and/or 3 without code 4.
6	Any combination of codes 1,2, and/or 3 with code 4.
7	Palliative care was performed, but no information on the type of procedure is available in the patient record.
9	Unknown.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on your selection to highlight it.

Click OK or press ENTER.

RX SUMM-SCOPE REG 98-02
(Also known as SCOPE OF REGIONAL LYMPH NODE SURGERY SEER/COC)

Column 941-941
Length 1
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the removal, biopsy, or aspiration of regional lymph nodes either at the time of surgery to the primary site or during a separate surgical event at all facilities. This field is to be used to code *Scope of Regional Lymph Node Surgery* at all facilities for all cases diagnosed prior to January 1, 2003.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM-- SCOPE REGIONAL LYMPH NODE SURGERY

Column	861-861
Length	1
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Records the removal, biopsy, or aspiration of regional lymph nodes either at the time of surgery to the primary site or during a separate surgical event at this or any facility during the initial work-up or first course of therapy.

General Guidelines:

Scope of regional lymph node surgery is to be coded even if surgery to the primary site is not performed.

Do not code distant lymph nodes removed during surgery in this field. Removal of distant lymph nodes is to be coded in the *Surgical Procedure/ Other Site* field.

The regional lymph node surgery codes are hierarchical. When only one procedure can be recorded, select the procedure with the numerically higher code.

Use code 9 for the following primary sites and histologies:

> Unknown or ill-defined primary (C76.0- C76.8, C80.9)
> Brain, meninges, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0-C70.9, C71.0- C71.9, C72.0- C72.9)
> Lymphomas (M 9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0- C77.9).
> 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).

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care.*

The Scope of Regional Lymph Node field is **cumulative**; add the number of all of the lymph nodes removed during each surgical procedure performed as part of the first course of treatment.

If the operative report lists a lymph node dissection, but **no nodes were found by the pathologist,** code the Scope of Regional Lymph Node Surgery to 0 (No lymph nodes removed)

If the patient has **two primaries with common regional lymph nodes**, code the removal of regional nodes for both primaries.

RX SUMM-- SCOPE REGIONAL LYMPH NODE SURGERY (Cont'd):

Codes	Description
0	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.
2	Sentinel lymph node biopsy.
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS; not specified as sentinel node biopsy.
4	1-3 regional lymph nodes removed; not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed; not specified as sentinel node biopsy.
6	Sentinel node biopsy and code 3, 4, or 5 at the same time or timing not stated.
7	Sentinel node biopsy and code 3, 4, or 5 at different times.
9	Unknown; not applicable; death certificate-only case; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM– SURG OTH 98-02

(Also known as SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODES SEER/COC; SURGICAL PROCEDURE/OTHER SITE)

Column	942-942
Length	1
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at all facilities as part of the first course of treatment. This field is to be used to code *Surgery Other Regional/Distant Sites* at all facilities for all cases diagnosed prior to January 1, 2003.

ABSTACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM – SURGERY OTHER REG/DIS

Column 862-862
Length 1
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Codes the removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site at this or any other facility.

General Guidelines:

Code the removal of non-primary site tissue that was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

DO NOT CODE the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than suspected malignancy. Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer.

> **Example**: During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gall bladder. Do not code removal of the gall bladder.

Code 0 when no surgical procedures were performed that removed distant lymph node(s) or other tissue(s) or organ(s) beyond the primary site.

The codes are hierarchical. Code the procedure that is numerically higher.

Codes 1-5 have priority over codes 0 and 9.

Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-76.8, 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).

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).

Codes	Description
0	None; no surgery to other regional or distant sites; autopsy only case.
1	Surgery to other site(s), NOS; unknown if regional or distant.
2	Regional site resection.

RX SUMM – SURGERY OTHER REG/DIS (Cont'd)

Codes (Cont'd)	**Description**
3	Distant lymph node resection.
4	Distant site resection.
5	Combination of 2, 3, or 4.
9	Unknown; Death certificate only case.

ABSTACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM -- SURGERY OF PRIMARY SITE

Column	859-860
Length	2
Source of Standard	SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM

Describes the surgical procedures used to treat the primary site of the tumor during first course of treatment at this or any facility.

General Guidelines:

Record surgeries performed to the primary site only. Removal of regional tissue or organs is recorded in this field only if the tissue/ organs are removed with the primary site in an EN BLOC (all in one piece at the same time) resection. Non en bloc removal of regional tissue or organs should be coded in the *Surgical Procedure/ Other Site* field.

If the patient has multiple cancer-directed surgeries of the primary site, code the most invasive, definitive surgery (highest code numerically).

If no surgical procedure was done on the primary site, code 00.

Codes 00-79 are hierarchical. If more than one code describes the procedure performed, use the higher code.

Code 98 has priority over code 00.

Use codes 80 and 90 only if better information is not available.

If a surgical procedure that partially removed the primary site is followed by surgery that removes the remainder of the primary site, code as total removal of the primary site.

Use code 00 for autopsy only cases.

Use code 99 for death certificate only cases.

Biopsies that remove all of the tumor and/or leave only microscopic margins are to be coded in this item.

If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*.

Codes:

See the TCR manual, Appendix F for site-specific surgical codes.

RX SUMM -- SURGERY OF PRIMARY SITE (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code describing the surgery to the primary site performed.

Click OK or press ENTER.

RX SUMM -- SURG/RAD SEQUENCE

Column 875-875
Length 1
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Codes for the sequencing of radiation and cancer-directed surgery given as part of the first course of treatment. Includes treatment given at all facilities.

General Guidelines:

Assign code 0 when the patient did not have either surgery or radiation; the patient had surgery but not radiation; the patient had radiation but not surgery.

Assign codes 2-9 when first course of therapy consists of both cancer-directed surgery and radiation therapy.

Codes	Description
0	No radiation and/or no cancer-directed surgery. Diagnosed at autopsy.
2	Radiation before surgery
3	Radiation after surgery
4	Radiation both before and after surgery
5	Intraoperative radiation
6	Intraoperative radiation with other radiation given before or after surgery
9	Sequence unknown, but both surgery and radiation were given. Death certificate only.

Note: Codes were site-specific (1998-2002), and have been changed to be generic across all disease sites.

RX SUMM -- SURG/RAD SEQUENCE (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table.

Click OK or press ENTER.

RX SUMM--SURGICAL MARGINS

Column 866-866
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Describes the final status of surgical margins after resection of the primary tumor.

General Guidelines:

This field should be coded based on the information found in the pathology report.

Residual tumor refers only to the tumor at the primary site. DO NOT code margin status from regional lymph node surgery.

Codes 0-3 are hierarchical. If two codes describe the margin status, use the numerically higher code.

If no surgery of the primary site was performed, code 8.

Use code 9 for:

> Lymphomas (M9590- 9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9)
> Unknown or ill-defined primary (C76.0-C76.8, C80.9)
> 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)

Codes	Description
0	All margins grossly and microscopically negative.
1	Margins involved, NOS.
2	Microscopic involvement.
3	Macroscopic residual tumor.
7	Margins cannot be assessed (indeterminate).
8	No cancer-directed surgery of primary site; diagnosed at autopsy.

RX SUMM --SURGICAL MARGINS (Cont'd):

Codes (Cont'd)	Description
9	Unknown whether margins were involved or negative; 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.

Note: Codes were site specific (1998-2002), and have been changed to be generic across all disease sites.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table.

Click OK or press ENTER.

RX SUMM-SURG SITE 98-02
(Also known as CANCER-DIRECTED SURGERY or SURGERY OF PRIMARY SITE-SEER/COC)

Column 939-940
Length 2
Source of Standard SEER/COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Describes surgical procedures used to treat the primary site of the reportable tumor. This includes treatment given at all facilities as part of first course of treatment. This field is to be used to code *Surgery Primary Site* at all facilities for all cases diagnosed before January 1, 2003.

Codes (in addition to the site-specific codes)	**Description**
00	No cancer-directed surgery performed.
99	Unknown if cancer-directed surgery performed.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

Click OK or press ENTER.

RX SUMM—TRANSPLNT/ENDOCR

Column 876-877
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Identifies systemic therapeutic procedures given, or the reason they were not given, during the first course of treatment at this or any facility. These include bone marrow transplants, stem cell harvests, and surgical and radiation endocrine therapy.

Rationale:

Allows for evaluation of patterns of treatment, which involve the alteration of the immune system or change the patient's response to tumor cells, but does not involve the administration of antineoplastic agents.

General Guidelines:

Autologous bone marrow transplants (when the bone marrow is taken from the patient) should be coded to 11.

Allogeneic bone marrow transplants (when the bone marrow is donated by a person other than the patient) should be coded to 12.

Stem cell harvest consists of the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.

Endocrine irradiation and/or endocrine surgery suppress hormonal activity in the patient and result in long-term control of the cancer's growth. In order to be coded as endocrine surgery or radiation, the procedure must be bilateral.

> ***Exception:*** If the patient only has one intact gland at the beginning of treatment, the surgery or radiation to the remaining gland would qualify as endocrine surgery or endocrine radiation and would be coded in this data field.

Use code 00 if the patient is given multiple treatment options, and selected a treatment option that did not include an endocrine procedure or transplant.

Use code 00 if the patient did not have an endocrine procedure or transplant and these procedures are not usually given for this type or stage of cancer.

If a transplant procedure or endocrine procedure is usually given for this type or stage of cancer, but was not given, code the reason it was not given. Use code 82, 85, 86, or 87.

RX SUMM—TRANSPLNT/ENDOCR (Cont'd)

If the patient is offered a transplant procedure or endocrine procedure as a treatment option, but refuses it, use code 87. If the patient refuses all recommended treatment or refuses all treatment before it is recommended, use code 87.

If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care* and/or *Palliative Care at This Facility,* as appropriate.

Codes	Description
00	None, transplant procedure or endocrine therapy was not part of first course of therapy; not customary therapy for this cancer. Diagnosed at autopsy.
10	Bone marrow transplant, NOS. (Type not specified).
11	Bone marrow transplant, autologous.
12	Bone marrow transplant, allogeneic.
20	Stem cell harvest infusion (stem cell transplant) as first course therapy.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of a transplant procedure with endocrine surgery and/or radiation (combination of 30 with 10, 11, 12, or 20).
82	Transplant procedure and/or endocrine therapy was not recommended/ given because it was contraindicated due to other conditions (comorbid conditions, advanced age, etc.).
85	Transplant procedure and/or endocrine therapy was not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine therapy was recommended, but was not given as part of first course therapy. No reason indicated in chart.
87	Transplant procedure and/or endocrine therapy was recommended, but patient, patient's family members, or guardian refused. Refusal noted in chart.
88	Transplant procedure and/or endocrine therapy was recommended, but unknown if administered.
99	It is unknown if a transplant procedure or endocrine surgery and/or radiation were recommended or administered. Death certificate only case.

RX SUMM—TRANSPLNT/ENDOCR (Cont'd)

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate code.

or

Select the appropriate code from the drop-down table. Click on the code to highlight it.

Click OK or press ENTER.

RX TEXT – BRM (BIOLOGICAL RESPONSE MODIFIER)

Column	5325-5424
Length	100
Source of Standard	NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about biological response modifier treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding the biological response modifier treatment.

Include dates (beginning and ending, if known), agents, and dosage, BRM procedures (bone marrow transplant, stem cell transplant, etc.).

Do not repeat information from other text fields.

Example of BRM text:

5/4/01-7/5/01 10 mg Interferon

RX TEXT – CHEMO

Column 4925-5124
Length 200
Source of Standard NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about chemotherapy treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding the chemotherapy treatments.

Include dates (beginning and ending, if known), agents, and dosages.

Do not repeat information from other text fields.

Example of chemotherapy text:

7/6/01- 10/30/01 45 mg Adriamycin, 500 mg Cytoxan, 400 mg 5-FU

RX TEXT -- HORMONE

Column	5125-5324
Length	200
Source of Standard	NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about hormones given as cancer-directed treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding hormones given as cancer-directed treatment.

Include dates (beginning and ending, if known), agents, and dosage, and type of endocrine surgery or radiation (orchiectomy, etc.).

Do not repeat information from other text fields.

Example of hormone text:

2/16/01- 20 mg Tamoxifen

RX TEXT -- OTHER

Column	5425-5524
Length	100
Source of Standard	NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text field for information about any other cancer-directed treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding other cancer-directed treatment.

Include dates (beginning and ending, if known) and details about the treatment.

Example of other treatment text:

3/21/01- 6/30/01 Hyperthermia 2x weekly

RX TEXT RADIATION (BEAM)

Column 4625-4774
Length 150
Source of Standard NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about beam radiation given as cancer treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding beam radiation treatments given as cancer treatment.

Include dates (beginning and ending, if known), type of radiation therapy, field (anatomic site) being treated, dosage (optional), and intent of treatment (curative or palliative, if known).

Do not repeat information from other text fields

Example of beam radiation text:

4/8/01- 5/24/01 Xray to breast, 5000 cGY & 1500 cGY boost, curative.

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RX TEXT RADIATION OTHER

Column	4775-4924
Length	150
Source of Standard	NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about radiation treatments, other than beam radiation, given for cancer therapy.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensure the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding radiation treatments, other than beam radiation, given as cancer treatment.

Include dates (beginning and ending, if known), type of non-beam radiation therapy, field (anatomic site) being treated, dosage (optional), and intent of treatment (curative or palliative, if known).

Do not repeat information from other text fields.

Example of non-beam radiation text:

11/15/01 I-125 seeds in prostate, curative

or

11/15/01 Brachytherapy, I-125, prostate, curative

RX TEXT – SURGERY

Column	4475-4624
Length	150
Source of Standard	NAACCR

Description:

THIS IS A REQUIRED TEXT ITEM FOR ACOS, COC APPROVED CANCER PROGRAMS

Text area for information about surgical procedures performed as part of treatment.

Rationale:

Text is needed to justify the codes selected for the data items and to allow recording information that is not coded at all. It is a component of a complete electronic abstract, and allows for the full abstract to be printed or reviewed on the screen as needed. The text is used for quality control and special studies. As the purpose of text information is to provide an opportunity for documenting and checking coded values, information documenting the disease process should be entered from the medical record and should not be generated electronically from coded values.

Note: Prioritize text to ensue the most important information is transmitted to the central registry during data exchange.

General Guidelines:

Include any and all pertinent data regarding surgical procedures performed as part of treatment.

Include all procedures (including excisional biopsies), dates, procedure titles, and site laterality (if applicable), lymph nodes removed, regional tissues removed, metastatic sites, positive and negative findings, recording positive findings first.

Do not repeat information from other text fields.

Example of surgery text:

5/18/01 Rt lumpectomy (or abbreviate as Rt lump)
6/12/01 Rt Modified radical mastectomy (or abbreviate as Rt MRM)