

TREATMENT FOR BREAST, COLORECTAL, AND CHRONIC MYELOID LEUKEMIA

This section contains the non-NAACCR standard data items that will be collected through the CDC Comparative Effectiveness Research (CER) Project. **These items are required for cases diagnosed as of January 1, 2011.**

Note: For cases **not diagnosed in 2011** or that **do not meet the site/histology criteria**, these items may be left blank.

Note: Each facility may choose to 1) code and report this information to the TCR, or 2) provide necessary information for the TCR to collect/code the non-standard items for breast, colorectal, and CML cases.

If your facility chooses to request that TCR code the CER Non-NAACCR Standard Data Items, the instructions will be made available.

In order to collect more complete treatment information on first course and subsequent therapies while still maintaining the critical data submission timelines for the project, abstractors are required to consider all treatment information available through twelve months following the patient's date of diagnosis.

Note: All first course treatment information is **required** for all breast, colorectal, and Chronic Myeloid Leukemia (CML) patients. Both male and female patients are to be included for all sites/histologies. All **subsequent** course treatment information is **requested** as available for all breast, colorectal and CML patients.

Cases Eligible for Data Collection of Non-NAACCR Standard Data Items

Case	ICD-O-3 Site Code	Histology	Behavior	Gender	Dx Year
*Breast	C500-C509	All except 9050-9055, 9140, and 9590-9992	Insitu, Malignant	Male and female	2011
**Colorectal	C180-C189, C199, C209	All except 9050-9055, 9140, and 9590-9992	Insitu, malignant	Male and female	2011
Chronic Myeloid Leukemia	C421	Include 9863, 9875, 9876, 9945, and 9946	Malignant	Male and female	2011

*The CSv2 Manual provides directions to access a list of inclusion histology codes.

**Colon and Rectum are divided into separate schemas in the CSv2 Manual and the sections of each provide directions to access a list of histology codes.

Note: If Chemotherapy (NAACCR item 1390), Hormone (NAACCR item 1400) or Immunotherapy (NAACCR item 1410) are coded as 00, not done, then the corresponding CER items will auto fill when the case is saved.

NSC Number

The term “NSC” (number) refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in *SEER*Rx*. If *SEER*RX* lists more than one NSC number for an agent, use the first NSC number listed. If the NSC number is not available contact your regional TCR representative. TCR will provide a spreadsheet on the website with the newly assigned NSC codes as they become available. In the rare event that more than 6 chemotherapy drugs are administered as first course treatment, fill in the agents using the date administered when entering the first six agents. For all additional chemotherapy agents beyond the first six please record the related information for those agents in the text fields.

Chemo 1 NSC Number (Non NAACCR Standard Item 9751) (Source CDC/NPCR-CER)

Description

NSC number for the first chemotherapy agent administered or planned as all or part of the first course of treatment at any facility.

Coding Instructions

1. Code original agent NSC numbers as a 6 digit number using the most current *SEER*Rx* <http://seer.cancer.gov/tools/seerrx/index.html>. Include treatment given at all facilities as all or part of the first course of therapy.
2. If the NSC number is 5 digits, enter a leading 0 to code a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; OR if the record states only that agent was recommended and patient refused without specifying which agent was recommended; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code.
999999	Unknown if chemotherapy planned OR not required for this primary site/histology.

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Examples:

a. **Regimen** The chart states that the patient’s first course of treatment was “FLOX regimen”. Go to *SEER*Rx* database and type FLOX in the “Search for Regimen” entry box at the bottom of the screen. *SEER*Rx* will return a screen that shows the FLOX regimen consists of 5-fluorouracil (code as chemotherapy), folinic acid--generic name leucovorin (this is an ancillary agent, and is not collected), and oxaliplatin (code as chemotherapy). Click on each chemotherapy drug name to obtain the corresponding NSC number and enter the NSC number in the Chemo_NSC data fields in order:

- i. Chemotherapy Agent #1 NSC Number would correspond to 5-fluorouracil (entry = 027640)
- ii. Chemotherapy Agent #2 NSC Number would correspond to oxaliplatin (entry = 266046)
- iii. Chemotherapy Agents #3-6 would correspond to “no additional chemotherapy documented” (entry = 000000)

b. **Single Agent** The chart states that the patient’s first course of treatment was a single chemotherapeutic agent, Gemzar. Go to the SEER*Rx database and type Gemzar in the “Search for a Drug” box to obtain the NSC number.

- i. Chemotherapy Agent #1 NSC number entry = 613327
- ii. Chemotherapy Agents #2-6 would correspond to “no additional chemotherapy documented (entry = 000000)

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agents’ information is consistently entered in the same order across all chemotherapy fields (the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Chemo 2-6 NSC Number (Non NAACCR Standard Items 9752, 9753, 9754, 9755, 9756) (Source CDC/NPCR-CER)

Description

NSC number for the second through sixth chemotherapy agent administered or planned as all or part of the first course of therapy at any facility.

Coding Instructions

1. Code original agent NSC numbers as a 6 digit number using the most current SEER*Rx <http://seer.cancer.gov/tools/seerrx/index.html>. Include treatment given at all facilities as all or part of the first course of therapy.
2. If the NSC number is 5 digits, enter a leading 0 to code a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommended; the code “999998” is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx assigned NSC codes.
999999	Unknown if chemotherapy planned OR not

Code	Description
999999 cont'd	required for this primary site/histology.

Note: Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Chemo 1 Num Doses Planned (Non NAACCR Standard Item 9761) (Source CDC/NPCR-CER)

Description

For the first chemotherapy agent, this item records the total number of chemotherapy doses planned to be delivered to the patient as all or part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the total number of chemotherapy doses planned.

Code	Description
00	Chemotherapy was not planned OR no additional chemotherapy agents were planned
01-96	Actual number of chemotherapy doses planned*
97	97 or more chemotherapy doses planned
98	Chemo was planned and/or administered, but number doses is unknown
99	Unknown if chemotherapy planned OR not required for this primary site/histology.

*For doses 1-9, use a leading 0.

Note: If the agent is given via a prescription to be taken at home and/or self administered, the total number of doses planned should be coded 98.

Example: Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m² iv bolus weekly x 6; LV, 500 mg/m² iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m² iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3.

Drug	Dose	Schedule (D= Day #)	# of Cycles	Total # Doses Planned	Total Dose
5-FU	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	3	6 x 3 = 18	14,490 mg
Folinic Acid/Leucovorin *	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	Not Applicable	Not Applicable	Not Applicable
Oxaliplatin	85 mg/m ²	Week 1, 3, and 5 (D 1, 15, 29)	3	3 x 3 = 9	1232 mg

***Folinic Acid/Leucovorin is considered an ancillary agent; no information related to it will be collected.**

In the above example, for the set of variables, the relevant coding would be:

Chemotherapy Agent #1 Planned Number of Doses is 18 (corresponding to the 5-FU, which is also the corresponding chemotherapy agent collected in variable Chemo 1 NSC previously)

Chemotherapy Agent #2 Planned Number of Doses is 09 (corresponding to the oxaliplatin, which is also the corresponding chemotherapy agent collected in variable Chemo 2 NSC previously)

Chemotherapy Agent #3 - 6 Planned Number of Doses will be coded 00, no additional chemo agent received.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Chemo 2-6 Num Doses Planned (Non NAACCR Standard Items 9762, 9763, 9764, 9765, 9766)
(Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agents, this item records the total number of chemotherapy doses planned to be delivered to the patient as all or part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the total number of chemotherapy doses planned

Code	Description
00	Chemotherapy was not planned OR no additional chemotherapy agents were planned
01-96	Actual number of chemotherapy doses planned*
97	97 or more chemotherapy doses planned
98	Chemo was planned and/or administered, but number doses is unknown
99	Unknown if chemotherapy planned OR not required for this primary site/histology.

*For doses 1-9, use a leading 0.

Note: If the agent is given via a prescription to be taken at home and/or self administered, code the total number of doses planned as 98.

Chemotherapy 1 Planned Dose and Planned Dose Units (Non NAACCR Standard Items 9771 and 9781) (Source CDC/NPCR-CER)

Description

For the first chemotherapy agent, this item records the planned total dose to be delivered to the patient as all or part of the first course of treatment at any facility.

Note: This is the total dosage, not the total number of doses. **SEE page 212 for instructions for calculating the planned dose.**

Total dose for a given agent is the sum of each dose planned for that agent. Add all doses planned into a single total value; do not record per dose rate or individual dose value.

Coding Instructions

1. Record the overall total chemotherapy dose planned, including the units.
2. When dose volume is less than 6 digits, use leading zeros.

Chemo1PlanDose Enter Dose Volume (as numbers):	Description
#####	Chemotherapy dose planned
000000	Chemotherapy was not planned OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the dose planned is unknown
999999	Unknown if chemotherapy planned or not required for this primary site/histology
Chemo1PlanDoseUnits	Description
00	Chemo was not planned OR no additional chemo therapy agents were planned
01	Mg
02	Grams
07	Other (please specify in chemo text field)
98	Chemo was planned and/or administered, but dose planned unk
99	Unk if chemo planned or not required for this primary site/histology

Note: If the agent is given via prescription to be taken at home and/or self administered, code the planned dose 999998 and unit 98.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Chemotherapy 2-6 Planned Dose and Planned Dose Units (Non NAACCR Standard Items 9772, 9773, 9774, 9775, 9776 and 9782, 9783, 9784, 9785 and 9786) (Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agent, this item records the planned total dose to be delivered to the patient as all or part of the first course of treatment at any facility.

Note: This is the total dosage, not the total number of doses. **SEE Page 212 for instructions for calculating dose**

Total dose for a given agent is the sum of each dose planned for that agent. Add all doses planned into a single total value; do not record per dose rate or individual dose value.

Coding Instructions

1. Record the overall total chemotherapy dose planned, including the units.

2. When dose volume is less than 6 digits, use leading zeros.

Chemo2-6PlanDose Enter Dose Volume (as numbers):	Description
#####	Chemotherapy dose planned
000000	Chemotherapy was not planned OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the dose planned is unknown
999999	Unknown if chemotherapy planned or not required for this primary site/histology
Chemo2-6PlanDoseUnits	Description
00	Chemo was not planned OR no additional chemo therapy agents were planned
01	Mg
02	Grams
07	Other (please specify in chemo text field)
98	Chemo was planned and/or administered, but dose planned unk
99	Unk if chemo planned or not required for this primary site/histology

Note: If the agent is given via a prescription to be taken at home and/or self administered, code planned dose 999998 and units 98.

Chemo 1 Number Doses Received (Non NAACCR Standard Item 9791) (Source CDC/NPCR-CER)

Description

For the first chemotherapy agent, this item records the total number of chemotherapy doses delivered to the patient as all or part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the total number of chemotherapy doses received.

Code	Description
00	Chemotherapy was not received OR no additional chemotherapy agents were received
01 - 96	Actual number of chemotherapy doses received*
97	97 or more chemotherapy doses received
98	Chemotherapy was received, but the number of doses is unknown
99	Unknown if chemotherapy received or not required for this primary site/histology

*For doses 1-9, use a leading 0.

Note: If the agent is given as a prescription to be taken at home code as 99.

Example: Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m² iv bolus weekly x 6; LV, 500 mg/m² iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m² iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3. Patient became too ill to finish third cycle (as planned), and

missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin.

Drug	Dose	Schedule (D= Day #)	# of Cycles	Total # Doses Received	Total Dose Received
5-FU	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	3	6 x 3 = 18 Less 2 doses = 16 total	12,880 mg
Folinic Acid/Leucovorin*	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	Not Applicable	Not Applicable	Not Applicable
Oxaliplatin	85 mg/m ²	Week 1, 3, and 5 (D 1, 15, 29)	3	3 x 3 = 9 Less 1 dose = 8 total	1095 mg

*Folinic Acid/Leucovorin is considered an ancillary agent; no information related to it will be collected.

In the above example, for this set of variables, the relevant coding would be:

Chemotherapy Agent #1 Received Number of Doses is 16 (corresponding to the 5-FU, which is also the corresponding chemotherapy agent collected in variable Chemo 1 NSC and Chemo 1 Plan Dose previously).

Chemotherapy Agent #2 Received Number of Doses is 08 (corresponding to the oxaliplatin, which is also the corresponding chemotherapy agent collected in variable Chemo 2 NSC and Chemo 2 Plan Dose previously).

Chemotherapy Agent #3 through #6 Received Number of doses will be coded 00, no additional chemo agent Received Number of Doses.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Chemo 2-6 Number Doses Received (Non NAACCR Standard Item 9792, 9793, 9794, 9795, 9796) (Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agent, this item records the total number of chemotherapy doses delivered to the patient as all or part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the total number of chemotherapy doses received.

Code	Description
00	Chemotherapy was not received OR not additional chemotherapy agents were received
01 - 96	Actual number of chemotherapy doses received*
97	97 or more chemotherapy doses received
98	Chemotherapy was received, but the number of doses is unknown
99	Unknown if chemotherapy received or not required for this primary site/histology

*For doses 1-9, use a leading 0.

Note: If the agent is given as a prescription to be taken at home code as 99.

Chemo 1 Received Dose and Received Dose Units (Non NAACCR Standard Items 9801, 9811)
(Source CDC/NPCR-CER)

Description

For the first chemotherapy agent, this item records the total dose actually delivered to patient as all or part of the first course of treatment at any facility.

Note: This is the total dosage received, not the total number of doses. Total dose for a given agent is the sum of each dose given for that agent. Add all doses received into a single total value; do not record per dose rate or the individual dose value. **SEE page 212 for instructions for calculating the received dose.**

Coding Instructions

1. Record the overall total chemotherapy dose received, including the units.
2. When dose volume is less than 6 digits, use leading zeros.

Chemo1RcvDose Enter Dose Volume (as number):	Description
#####	Chemotherapy dose received
000000	Chemotherapy was not received OR no additional chemo agents were received
999998	Chemotherapy was received, but the dose received is unknown
999999	Unknown if chemotherapy received Or not required for this primary site/histology
Chemo1RcvDoseU Select Units	Description
00	Chemo was not received OR no additional chemotherapy agents were received
01	Mg
02	Grams
07	Other (please specify in chemo text field)
98	Chemo received, but dose received unknown
99	Unk if chemo received OR not required for this site/histology

Note: If the agent is given via prescription to be taken at home and/or self-administered, code received dose 999999 and unit 99.

Chemo 2-6 Received Dose and Received Dose Units (Non NAACCR Standard Items 9802, 9803, 9804, 9805, 9806 and 9812, 9813, 9814, 9815, 9816) (Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agent, this item records the total dose actually delivered to patient as all or part of the first course of treatment at any facility.

Note: This is the total dosage received, not the total number of doses.

Total dose for a given agent is the sum of each dose given for that agent. Add all doses received into a single total value; do not record per dose rate or the individual dose value.

Coding Instructions

1. Record the overall total chemotherapy dose received, including the units.
2. When dose volume is less than 6 digits, use leading zeros.

Chemo2-6RcvDose Enter Dose Volume (as number):	Description
#####	Chemotherapy dose received
000000	Chemotherapy was not received OR no additional chemo agents were received
999998	Chemotherapy was received, but the dose received is unknown
999999	Unknown if chemotherapy received Or not required for this primary site/histology
Chemo2-6RcvDoseU Select Units	Description
00	Chemo was not received OR no additional chemotherapy agents were received
01	Mg
02	Grams
07	Other (please specify in chemo text field
98	Chemo received, but dose received unknown
99	Unk if chemo received OR not required for this primary site/histology

Note: If the agent is given via a prescription to be taken at home and/or self-administered, code received dose 999999 and unit 99.

Chemo 1 Start Date (Non NAACCR Standard Item 9821) (Source CDC/NPCR-CER)

Description

For the first chemotherapy agent, this item records the date for the first day of the first cycle that the patient started chemotherapy as all or part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for

obtaining this data.

Coding Instructions:

1. Record the first date the patient received the first cycle of chemotherapy as all or part of the first course of treatment.

Example: Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m² iv bolus weekly x 6; LV, 500 mg/m² iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m² iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3. Patient's first treatment was on May 24, 2011. Patient became too ill to finish third cycle (as planned), and missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin. Last day chemotherapy administered was October 4, 2011 for 5-FU and LV (patient missed October 11 and 18 planned treatments) and September 27 for oxaliplatin (patient missed October 11 planned treatment).

Cycle 1: Week 1 (Day 1): May 24, 2011 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): May 31, 2011 Continue 5-FU, LV
Week 3 (Day 15): June 7, 2011 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): June 14, 2011 Continue 5-FU, LV
Week 5 (Day 29): June 21, 2011 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): June 28, 2011 Continue 5-FU, LV
Week 7 (Day 43): July 5, 2011 No chemo agents scheduled
Week 8 (Day 50): July 12, 2011 No chemo agents scheduled

Cycle 2: Week 1 (Day 1): July 19, 2011 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): July 26, 2011 Continue 5-FU, LV
Week 3 (Day 15): August 2, 2011 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): August 9, 2011 Continue 5-FU, LV
Week 5 (Day 29): August 16, 2011 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): August 23, 2011 Continue 5-FU, LV
Week 7 (Day 43): August 30, 2011 No chemo agents scheduled
Week 8 (Day 50): September 6, 2011 No chemo agents scheduled

Cycle 3: Week 1: September 13, 2011 Start 5-FU, LV; oxaliplatin
Week 2: September 20, 2011 Continue 5-FU, LV
Week 3: September 27, 2011 Continue 5-FU, LV; oxaliplatin
Week 4: October 4, 2011 Continue 5-FU, LV
Week 5: October 11, 2011 Continue 5-FU, LV; oxaliplatin -- Patient became too ill to finish third cycle and missed this treatment
Week 6: October 18, 2011 Continue 5-FU, LV -- Patient became too ill to finish third cycle and missed this treatment
Week 7: October 25, 2011 No chemo agents scheduled
Week 8: November 1, 2011 No chemo agents scheduled

In the above example, for this variable, the relevant coding would be:

Chemotherapy Agent #1 Start Date is 20110524

Chemotherapy Agent #2 Start Date is 20110524

Chemotherapy Agent #3, #4, #5, and #6 Start Date is Blank

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Note: If the agent is given via a prescription to be taken at home and/or self-administered, the start date should be left blank and the corresponding date flag should be coded *12*.

Chemo 1 Start Date Flag (Non NAACCR Standard Item #9831) (Source CDC/NPCR-CER)

Description

This flag explains why no appropriate value is in the field, Chemo 1 Start Date (9821).

Code	Explanation
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered).
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. (This event occurred, but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g. chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 1 Start Date (9821), or the date was not expected to have been transmitted.

Chemo 2-6 Start Date (Non NAACCR Standard Items 9822, 9823, 9824, 9825, 9826) (Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agents, these items record the date of the first day of the first cycle that the patient started chemotherapy as all of part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the first date the patient received the first cycle of chemotherapy as all or part of the first course of treatment.

Note: If the agent is given via a prescription to be taken at home and/or self-administered, the start date should be left blank and the corresponding date flag should be coded *12*

Chemo 2-6 Start Date Flag (Non NAACCR Standard Item 9832, 9833, 9834, 9835, 9836) (Source CDC/NPCR-CER)**Description**

This flag explains why no appropriate value is in the field, Chemo (2-6) Start Date.

Code	Explanation
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered).
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g. chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 2-6 Start Date, or the date was not expected to have been transmitted.

Chemo 1 End Date (Non NAACCR Standard Item 9841) (Source CDC/NPCR-CER)**Description**

For the first chemotherapy agent, this item records the date for the last day of the last cycle that the patient received chemotherapy as all or part of the first course of treatment at any facility. Patient's medical records and pharmacy data sets should be included as potential sources for obtaining data.

Note: Reporters and/or facilities will need to follow back on those cases where chemotherapy is started but has not been completed by the time of record submission.

Coding Instructions

1. Record the last date that the patient received chemotherapy as all or part of the first course of treatment.

Note: If the agent is given via prescription to be taken at home and/or self-administered, the date should be left blank and the corresponding date flag should be coded *I2*.

Example:

Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m² iv bolus weekly x 6; LV, 500 mg/m² iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m² iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3. Patient's first treatment was on May 24, 2011.

Patient became too ill to finish third cycle (as planned), and missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin. Last day chemotherapy administered was October 4, 2010 for 5-FU and LV (patient missed October 11 and 18 planned treatments) and September 27 for oxaliplatin (patient missed October 11 planned treatment). See chart for full listing of how dates correspond to 3 cycles, 8 weeks each:

Cycle 1: Week 1 (Day 1): May 24, 2011 Start 5-FU, LV; oxaliplatin
 Week 2 (Day 8): May 31, 2011 Continue 5-FU, LV
 Week 3 (Day 15): June 7, 2011 Continue 5-FU, LV; oxaliplatin

Week 4 (Day 22): June 14, 2011 Continue 5-FU, LV
 Week 5 (Day 29): June 21, 2011 Continue 5-FU, LV; oxaliplatin
 Week 6 (Day 36): June 28, 2011 Continue 5-FU, LV
 Week 7 (Day 43): July 5, 2011 No chemo agents scheduled
 Week 8 (Day 50): July 12, 2011 No chemo agents scheduled

Cycle 2: Week 1 (Day 1): July 19, 2011 Start 5-FU, LV; oxaliplatin
 Week 2 (Day 8): July 26, 2011 Continue 5-FU, LV
 Week 3 (Day 15): August 2, 2011 Continue 5-FU, LV; oxaliplatin
 Week 4 (Day 22): August 9, 2011 Continue 5-FU, LV
 Week 5 (Day 29): August 16, 2011 Continue 5-FU, LV; oxaliplatin
 Week 6 (Day 36): August 23, 2011 Continue 5-FU, LV
 Week 7 (Day 43): August 30, 2011 No chemo agents scheduled
 Week 8 (Day 50): September 6, 2011 No chemo agents scheduled

Cycle 3: Week 1: September 13, 2011 Start 5-FU, LV; oxaliplatin
 Week 2: September 20, 2011 Continue 5-FU, LV
 Week 3: September 27, 2011 Continue 5-FU, LV; oxaliplatin
 Week 4: October 4, 2011 Continue 5-FU, LV
 Week 5: October 11, 2011 Continue 5-FU, LV; oxaliplatin -- Patient became too ill to finish third cycle and missed this treatment
 Week 6: October 18, 2011 Continue 5-FU, LV -- Patient became too ill to finish third cycle and missed this treatment
 Week 7: October 25, 2011 No chemo agents scheduled
 Week 8: November 1, 2011 No chemo agents scheduled

In the above example, for this variable, the relevant coding would be:

- i. Chemotherapy Agent #1 End Date is 20111004**
- ii. Chemotherapy Agent #2 End Date is 20110927**
- iii. Chemotherapy Agent #3, #4, #5, and #6 End Date is Blank**

Chemo 1 End Date Flag (Non NAACCR Standard Item 9851) (Source CDC/NPCR-CER)

Description

This flag explains why no appropriate value is in the field, Chemo 1 End date.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).

Code	Description
Blank	A valid date value is provided in item Chemo 1 End Date (9841), or the date was not expected to have been transmitted.

Chemo 2-6 End Date (Non NAACCR Standard Items 9842, 9843, 9844, 9845, 9846) (Source CDC/NPCR-CER)

Description

For the second through sixth chemotherapy agents, this item records the date for the last day of the last cycle that the patient received chemotherapy as all of part of the first course of treatment at any facility. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record the last date that the patient received chemotherapy as all or part of the first course of treatment.

Note: If the agent is given via prescription to be taken at home and/or self-administered, the start date should be blank and the corresponding date flag should be coded *12*.

Chemo 2-6 End Date Flag (Non NAACCR Standard Item 9852, 9853, 9854, 9855, 9856) (Source CDC/NPCR-CER)

Description

This flag explains why no appropriate value is in the field Chemo (2-6) End Date.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 1 End Date (9841), or the date was not expected to have been transmitted.

Chemotherapy Completion Status (Non NAACCR Standard Item 9859) (Source CDC/NPCR-CER)

Description

This data item is used to code the completion status of chemotherapy for the first course of treatment. The chemotherapy must be part of the first course of treatment. Chemotherapy not complete includes only the situation that chemotherapy was terminated prematurely. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Code indicating whether or not the patient's chemotherapy was completed as outlined in the initial

treatment plan.

Code	Description
0	No chemo treatment
1	Treatment completed as planned
2	Chemo not completed as planned, patient health/complications
3	Chemo not completed as planned, patient expired
4	Chemo not completed as planned, patient/family choice
5	Chemo not completed as planned, cytopenia
6	Chemo not completed as planned, other reason Note: This includes if the chemotherapy was not completed due to a shortage of the agent. Document this reason in the text field.
*7	Chemo treatment extends beyond the end of data collection for this project
8	Chemo administered, unknown if completed
9	Unknown if Chemo given or not required for this primary site/histology

* Items are required for cases diagnosed between January 1, 2011, and December 31, 2011.

Note: If the agent is given via prescription to be taken at home and/or self-administered, the completion status should be coded 8.

GranulocyteCSF Status (Non NAACCR Standard Item 9880) (Source CDC/NPCR-CER)

Description

This data item is used to code if the patient was given Granulocyte-Growth Factors/Cytokines (G-CSF) agents during the twelve months after diagnosis. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

SEER*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens, including G-CSF agents. The SEER*Rx screen provides information on generic name, brand name, drug category and subcategory. If it is uncertain that the agent is a G-CSF agent, look up the agent name at <http://seer.cancer.gov/tools/seerrx/index.html>.

For additional information and descriptions on growth factors/cytokines for cancer please reference the following website: <http://www.cancer.gov/cancertopics/factsheet/Therapy/biological>
Examples of agents that fall into this category are Filgrastim (Neopogen®), Pegfilgrastim (Neulasta®), and Lenograstim (Granocyte®).

Coding Instructions

1. Code indicating whether or not the patient received G-CSF agents during the first twelve months of treatment after date of diagnosis.

Code	Description
0	No G-CSF treatment given
1	G-CSF treatment was given
7	G-CSF treatment prescribed--patient, patient's family member, or patient's guardian refused
8	G-CSF treatment prescribed, unknown if administered
9	Unknown if G-CSF therapy given or not required for this primary site/histology

Erythro Growth FactorSta (Status) (Non NAACCR Standard Item 9881) (Source CDC/NPCR-CER)**Description**

This data item is used to code if the patient was given Erythrocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

The SEER*Rx screen provides information on generic name, brand name, drug category and subcategory. If it is uncertain that the agent is an EGF agent, look up the agent name at <http://seer.cancer.gov/tools/seerrx/index.html>.

For additional information and descriptions on growth factors/cytokines for cancer please reference the following website: <http://www.cancer.gov/cancertopics/factsheet/Therapy/biological>

Examples of agents that fall into this category are Epoetin alfa (Procrit®) and Darbepoietin alfa (Aranesp®).

Coding Instructions

1. Code indicating whether or not the patient received Erythrocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis.

Code	Description
0	No Erythrocyte-Growth Factors/Cytokines treatment given
1	Erythrocyte-Growth Factors/Cytokines therapy was given
7	Erythrocyte-Growth Factors/Cytokines treatment prescribed--patient, patient's family member, or patient's guardian refused
8	Erythrocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Erythrocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology

Thrombocyte Growth FactSta (Status) (Non NAACCR Standard Item 9882) (Source CDC/NPCR-CER)**Description**

This data item is used to code if the patient was given Thrombocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis. Patient's medical records and available pharmacy data sets should be included potential sources for obtaining this data.

The SEER*Rx screen provides information on generic name, brand name, drug category and subcategory. If it is uncertain that the agent is a TGF agent, look up the agent name at <http://seer.cancer.gov/tools/seerrx/index.html>.

For additional information and descriptions on growth factors/cytokines for cancer please reference

the following website: <http://www.cancer.gov/cancertopics/factsheet/Therapy/biological>
An example of an agent that falls into this category is the Oprelvekin (Neumega®)

Coding Instructions

1. Code indicating whether or not the patient received Thrombocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis.

Code	Description
0	No Thrombocyte-Growth Factors/Cytokines treatment given
1	Thrombocyte-Growth Factors/Cytokines treatment was given
7	Thrombocyte-Growth Factors/Cytokines treatment prescribed--patient, patient's family member, or patient's guardian refused
8	Thrombocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Thrombocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology

Hormone 1 NSC Number (Non NAACCR Standard Item 9861) (Source CDC/NPCR-CER)

Description

NSC number for the first hormonal agent administered or planned as all or part of the first course of treatment at any facility.

Coding Instructions

- Code original agent NSC number using the most current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/index.html>). Include treatment given at all facilities as all or part of the first course of treatment.
- NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommend; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Example: If the chart states that patient's first course of treatment included Tamoxifen go to the SEER*Rx database and type Tamoxifen in the "Search for Drug" entry box. SEER*Rx will return a screen that displays information on Tamoxifen. Look for the corresponding NSC number and enter the number in the data fields using the following pattern:

Hormonal Agent #1 NSC Number would correspond to Tamoxifen (entry = 180973)

Hormonal Agent #2 NSC Number would correspond to “No additional hormonal therapy documented” (entry = 000000)

Note: Record prednisone as hormonal therapy when administered as one of the treatment agents used in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone) whether it affects cancer cells or not.

Note: Do not code prednisone as therapy when it is administered for reasons other than chemotherapeutic treatment.

Note: Do not code hormone therapy used to prolong a patient’s life by controlling symptoms, to alleviate pain or to make the patient more comfortable.

Hormone 2 NSC Number (Non NAACCR Standard Item 9862) (Source CDC/NPCR-CER)

Description

NSC number for the second hormonal agent administered or planned as all or part of the first course of treatment at any facility.

Coding Instructions

1. Code original agent NSC number using the most current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/>). Include treatment given at all facilities as all or part of the first course of treatment.

2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommend; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

BRM (Immunotherapy) 1 NSC Number (Non NAACCR Standard Item 9871) (Source CDC/NPCR-CER)

Description

NSC number for the first BRM agent administered or planned as all or part of the first course of treatment at any facility.

Coding Instructions

1. Code the original agent NSC numbers using the most Current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/index.html>). Include treatment given at all facilities as all or part of the first course of therapy.
2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.
3. For bone marrow transplant, stem cell harvest or surgical and/or radiation endocrine therapy enter 777777.

Code	Description
#####	NSC Number (actual number)
000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommend; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Example: The chart states that patient's first course of treatment included diftitox. Go to the SEER*Rx database and type diftitox in the "Search for Drug" entry box in the middle of the screen. SEER*Rx will return a screen that displays information on diftitox including the NSC number 714744. Enter 714744 in the *BRM 1 NSC Number* field. If no additional BRM therapy was administered leave the *BRM 2 NSC Number* field blank.

Note: If there is more than one BRM agent planned, the order in which they are entered as agent 1 or agent 2 is unimportant.

BRM (Immunotherapy) 2 NSC Number (Non NAACCR Standard Item 9872) (Source CDC/NPCR-CER)

Description

NSC number for the second BRM agent administered or planned as all or part of the first course of treatment at any facility.

Coding Instructions

1. Code the original agent NSC numbers using the most Current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/>). Include treatment given at all facilities as all or part of the first course of therapy.
2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

3. For bone marrow transplant, stem cell harvest or surgical and/or radiation endocrine therapy enter 777777.

Code	Description
#####	NSC Number (actual number)
000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; Or if the record states only that agent was recommended and the patient refused without specifying which agent was recommended; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Reason Subsequent Rx (Non NAACCR Standard Item 9920) (Source CDC/NPCR-CER)

Description

This data item is used to code the reason that the patient received subsequent treatment, as available. Subsequent treatment begins after first course is completed, stopped or changed. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Code indicating the reason that the patient received subsequent or palliative treatment beyond the first course of treatment.

Code	Description
0	No subsequent or palliative treatment
1	Subsequent or palliative treatment due to disease progression*
2	Subsequent or palliative treatment due to recurrence of disease*
4	Subsequent palliative treatment due to development of medical condition (e.g., heart failure or liver disease develops in patient)
5	Subsequent or palliative treatment due to other reason
9	Unknown if subsequent or palliative therapy given or not required for this primary site/histology

*Note: Usually, the treating physician will note in the patient's medical record explicitly if subsequent treatment is being given as a result of disease progression or disease recurrence. If it is not noted explicitly, please use the following guideline to determine which code applies.

- a. If the disease progresses, the interval between initial treatment and a change in treatment will be zero.
- b. If there is a recurrence, there will be a time interval that passes before new therapy shows up in the record.

Subsequent Rx 2nd Course Date (Non NAACCR Standard Item 1660) (Source CDC/NPCR-CER)**Description**

Date of initiation of subsequent treatment, as available. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Code the date of subsequent therapy.

Date format is:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

Subsq Rx 2nd DateFlag CER (Non NAACCR Standard Item 9955) (Source CDC/NPCR-CER)**Description**

This flag explains why no appropriate value is in the field, Subsq Rx 2nd Course Date (1660).

Coding Instructions

1. Code the reason there is no date in the corresponding date field (1669).

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., subsequent therapy given, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., subsequent therapy ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item Subs Rx 2 nd Course Date (1660), or the date was not expected to have been transmitted.

Subsq Rx 2nd Crs Surg (Non NAACCR Standard Item 9921) (Source CDC/NPCR-CER)**Description**

This variable is used to code the type of surgery given as part of the subsequent course of treatment when the information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records should be included as potential sources for obtaining this data. Subsequent surgery is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent surgery is also a treatment consideration when other planned first

course of treatment fails.

Coding Instructions

1. Refer to primary site schema in Appendix A to determine if subsequent surgery is local, regional or for distant metastasis. Code 00 for no subsequent surgery.

Code	Description
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
10	Surgery to local site
20	Surgery to regional site/lymph nodes
30	Surgery to distant site/lymph nodes
90	Surgery, NOS; a subsequent surgical procedure was done, but no information on the type of surgical procedure is provided.

Subsq Rx 2nd CrsRad (Non NAACCR Standard Item 9922) (Source CDC/NPCR-CER)

Description

This variable is used to code radiation therapy as subsequent treatment when the information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records should be included as potential sources for obtaining this data.

Subsequent radiation therapy is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent radiation therapy is also a treatment consideration when other planned first course of treatment fails. Subsequent radiation may be administered as part of other subsequent treatments (surgery, chemotherapy, etc.)

Subsequent radiation:

- a. May be localized (at the primary site)
- b. May be directed to regional site and/or to regional lymph nodes
- c. May be directed to a distant or metastatic site or lymph nodes

Coding Instructions

1. Refer to the schema for the primary site in Appendix A to determine if subsequent radiation is for local, regional or distant progression or metastasis. Code 00 if no subsequent radiation.

Code	Description
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
10	Local radiation
20	Regional radiation
30	Distant radiation, NOS OR other radiation
31	Bone

Code	Description
32	Brain
33	Liver
34	Lung
35	Other distant sites/lymph nodes or more than one distant site

Subsq Rx 2nd Crs Chemo (Non NAACCR Standard Item 9923) (Source CDC/NPCR-CER)

Description

This variable is used to code for the type of chemotherapy given as part of the subsequent course of treatment when the information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Code 00 if no subsequent chemotherapy
2. Refer to the SEER*Rx at <http://seer.cancer.gov/tools/seerrx/index.html>.
3. If the managing physician changes one of the agents in a combination regimen and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy.

Code	Description
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Chemotherapy administered as subsequent therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as subsequent therapy.
03	Multiagent chemotherapy administered as subsequent therapy.

Subsq Rx 2nd Crs Horm (Non NAACCR Standard Item 9924) (Source CDC/NPCR-CER)

Description

This variable is used to code for the type of hormonal therapy given as part of the subsequent course of treatment when this information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Record prednisone as hormonal therapy when administered in combination with chemotherapy,

such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

2. Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
3. Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part subsequent course therapy.
4. Code 00 if hormone therapy was not administered as subsequent treatment.
5. Refer to SEER*Rx at <http://seer.cancer.gov/tools/seerrx/index.html>.

Code	Description
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Hormone therapy administered as subsequent therapy.

Subsq Rx 2nd Crs BRM (Immunotherapy) (Non NAACCR Standard Item 9925) (Source CDC/NPCR-CER)

Description

This variable is used to code for the type of biological response therapy (immunotherapy) given as part of the subsequent course of treatment when this information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Code 00 if immunotherapy was not administered as subsequent treatment.
2. Refer to SEER*Rx at <http://seer.cancer.gov/tools/seerrx/index.html>.

Code	Description
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Immunotherapy administered as subsequent therapy.

Subsq Rx 2nd Crs Trans/End (Non NAACCR Standard Item 9927) (Source CDC/NPCR-CER)

Description

This variable is used to code for the type of transplant/endocrine therapy given as part of the subsequent course of treatment when that information is available. Subsequent treatment is defined as

all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
2. Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
3. Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
4. Code 00 if a subsequent transplant or endocrine procedure was not administered to the patient.

Code	Description
00	None OR Not applicable (e.g., not required for this primary sit/histology) OR Unknown information
10	A bone marrow transplant procedure was administered, but the type was not specified
11	Bone marrow transplant--autologous
12	Bone marrow transplant--allogeneic
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant
30	Endocrine surgery and/or endocrine radiation therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12 or 20)

Subsq Rx 2ndCrs Oth (Non NAACCR Standard Item 9926) (Source CDC/NPCR-CER)

Description

This variable is used to code for the type of other treatment given as part of the subsequent course of treatment when that information is available. Subsequent treatment is defined as all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding Instructions

1. The principal treatment for certain reportable hematopoietic diseases could be supportive care that

does not meet the usual definition of treatment that “modifies, controls, removes, or destroys” proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin.

Code	Instructions
0	None-All subsequent cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy) OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information.
1	Other-subsequent treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy, hematopoietic cases such as phlebotomy, transfusion, or aspirin).
2	Other-Experimental. This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other-Double Blind. A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven Cancer treatments administered by nonmedical personnel.

Subsq RX 2nd Chemo 1 NSC (Non NAACCR Standard Item 9931) (Source CDC/NPCR-CER)

Description

NSC number for the first chemotherapy agent administered as all or part of the subsequent course of treatment at any facility as this information is available.

Coding Instructions

1. Code original agent NSC numbers as a 6 digit number using the most current SEER*Rx <http://seer.cancer.gov/tools/seerrx/index.html>. Include treatment given at all facility as all or part of the first course of therapy.

2. If the NSC number is 5 digits, enter a leading 0 to code a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; *the code “999998” is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx assigned NSC codes.
999999	Unknown if chemotherapy planned OR not required for this primary site/histology.

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Subsq Rx 2nd Chemo 2-6 NSC (Non NAACCR Standard Item 9932, 9933, 9934, 9935, and 9936)
(Source CDC/NPCR-CER)

Description

NSC number for the second through sixth chemotherapy agent administered as all or part of the subsequent course of treatment at any facility when this information is available.

Coding Instructions

1. Code original agent NSC numbers as a 6 digit number using the most current SEER*Rx <http://seer.cancer.gov/tools/seerrx/index.html>. Include treatment given at all facility as all or part of the first course of therapy.

2. If the NSC number is 5 digits, enter a leading 0 to code a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned
999998	Chemotherapy was planned and/or administered, but the agent NSC code is unknown; *the code "999998" is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx assigned NSC codes.
999999	Unknown if chemotherapy planned OR not required for this primary site/histology.

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Subsq Rx 2nd Horm1 NSC (Non NAACCR Standard Item 9941) (Source CDC/NPCR-CER)

Description

NSC number for the first hormonal agent administered as all or part of the subsequent course of treatment at any facility when this information is available.

Coding Instructions

1. Code original agent NSC number using the most current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/index.html>). Include treatment given at all facilities as all or part of the first course of treatment.

2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)

Code	Description
000000	Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Note: Record prednisone as hormonal therapy when administered as one of the treatment agents used in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone) whether it affects cancer cells or not.

Note: Do not code prednisone as therapy when it is administered for reasons other than chemotherapeutic treatment.

Note: Do not code hormone therapy used to prolong a patient's life by controlling symptoms, to alleviate pain or to make the patient more comfortable.

Subsq Rx 2nd Horm2 NSC (Non NAACCR Standard Item 9942) (Source CDC/NPCR-CER)

Description

NSC number for the second hormonal agent administered as all or part of the subsequent course of treatment at any facility when this information is available.

Coding Instructions

- Code original agent NSC number using the most current SEER*Rx (<http://seer.cancer.gov/tools/seerrx/index.html>). Include treatment given at all facilities as all or part of the first course of treatment.
- NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (enter the actual number)
000000	Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned
999998	Hormone therapy was planned, but the agent NSC code is unknown; the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes
999999	Unknown if hormonal therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Subsq Rx 2nd BRM (Immunotherapy) 1 NSC (Non NAACCR Standard Item 9951) (Source CDC/NPCR-CER)

Description

NSC number for the first BRM agent administered as all or part of the subsequent course of treatment at any facility when this information is available.

Coding Instructions

1. Code the original agent NSC numbers using the most Current SEER*Rx (<http://seer.cancer.gov/tools/seerrx//index.html>). Include treatment given at all facilities as all or part of the first course of therapy.
2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (actual number)
000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

Subsq Rx 2nd BRM (Immunotherapy) 2 NSC (Non NAACCR Standard Item 9952) (Source CDC/NPCR-CER)

Description

NSC number for the second BRM agent administered as all or part of the subsequent course of treatment at any facility when this information is available.

Coding Instructions

1. Code the original agent NSC numbers using the most Current SEER*Rx (<http://seer.cancer.gov/tools/seerrx//index.html>). Include treatment given at all facilities as all or part of the first course of therapy.
2. NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry.

Code	Description
#####	NSC Number (actual number)
000000	BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned

Code	Description
777777	Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy
999998	BRM therapy was planned, but the agent NSC code is unknown; *the code 999998 is a temporary code that registries should use while they contact their TCR representative to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes.
999999	Unknown if BRM therapy was planned or not required for this primary site/histology

***Note:** Do not delay submitting an abstract because the NSC number is not available. Submit with code 999998 and document the name of the drug in the text field. TCR will revise when the permanent number is available.

BCR ABL

Cytogenetic testing in CML is important because it examines cells for the Philadelphia Chromosome or Philadelphia translocation. Most cases of CML share this chromosome abnormality. This translocation is designated as t(9;22)(q34;11). Cytogenetic testing is more sensitive than hematologic testing. Test results can help doctors understand how an individual may respond to treatment. Test results will be found on pathology reports.

Example:

Bone marrow aspirate, core biopsy and peripheral blood smear:

Chronic Myeloid Leukemia, **BCR/ABL positive**

Cytogenetics: 46,XY,t(9;22)(q34;q11.2)[20]

FISH analysis for BCR/ABL: Positive [185/200]

Example:

Date received: 3/31/11

Source: Whole Blood

BCR/ABL Quantitative: Positive: There is evidence of the bcr/abl fusion transcript by **RT-PCR analysis**.

For more information please see <http://www.mycmlcare.com/default.aspx>. Click on CML Tests on the right, then Cytogenetic Testing.

Additional information can be found at <http://www.genzyme genetics.com/Our-Services/Oncology-Testing.aspx> or <http://www.genzyme genetics.com/For-Clients/sample-reports.aspx>

BCR-ABLCytogenetic (Non NAACCR Standard Item 9900) (Source CDC/NPCR-CER)

Description

Records the results of the cytogenetic analysis for BCR-ABL t(9;22)(q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Cytogenetic analysis may be used to monitor disease response to therapy and relapse.

Note: This item is only collected for CML. Include histologies 9863, 9875, 9876, 9945, and 9946.

Note: Do not record results of this test after initiation of treatment.

Note: Other names for this test include: Karyotyping, conventional cytogenetics, Philadelphia

chromosome analysis, chromosomal banding analysis.

Code	Description
000	*Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered, results not in source records
010	Positive

***Note:** This variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding 000 for a given case.

BCR-ABLCytogeneticDate (Non NAACCR Standard Item 9901) (Source CDC/NPCR-CER)

Description

Record the date of the cytogenetic analysis for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Cytogenetic analysis may be used to monitor disease response to therapy and relapse.

Note: This item is only collected for CML.

Note: Use the date that the specimen was obtained and sent for analysis and not the report date. Do not record date related to results of this test after initiation of treatment.

Coding Instructions:

Date format is:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

BCR-ABLCytogenDateFlag (Non NAACCR Standard Item 9902) (Source CDC/NPCR-CER)

Description

This flag explains why no appropriate value is in the field *BCR-ABLCytogeneticDate* (9901).

Note: The field is collected only for CML.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: Cytogenetic test done)
11	No proper value s applicable in this context e.g., no BCR-ABL: Cytogenetic test not done or not applicable
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: Cytogenetic test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g.,

15 cont'd	BCR-ABL: Cytogenetic test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: Cytogenetic Date (9901), or the date was not expected to have been transmitted

BCR-ABL FISH (Non NAACCR Standard Item 9903) (Source CDC/NPCR-CER)

Description

Record the results of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

Note: Record this data item only for CML.

BCR-ABL FISH may be used to monitor disease response to therapy and relapse.

Note: Do not record results of this test after initiation of treatment.

Code	Description
000	*Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered, results not in source records.
010	Positive

***Note:** This variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding 000 for a given case.

BCR-ABL FISHDate (Non NAACCR Standard Item 9904) (Source CDC/NPCR-CER)

Description

Record the date of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

BCR-ABL FISH may be used to monitor disease response to therapy and relapse.

Note: This data item is collected only for CML.

Note: Use the date the specimen was obtained and sent for analysis and not the report date. Do not record results of this test after initiation of treatment.

Coding Instructions:

Date format is:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

BCR-ABLFISHDateFlag (Non NAACCR Standard Item 9905) (Source CDC/NPCR-CER)

Description

This flag explains why no appropriate value is in the field, BCR-ABL: FISH Date (9904)

Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: FISH done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: FISH done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: FISH test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: FISH test ordered, but has not been done at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: FISH date (9904), or the date was not expected to have been transmitted.

BCR-ABL RT-PCR QUAL (Non NAACCR Standard Item 9906) (Source CDC/NPCR-CER)

Description

Record the results of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for

BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

RT-PCR Qualitative may be used to monitor disease response to therapy and relapse.

Note: Record this data item only for CML.

Note: Do not record results of this test after initiation of treatment.

Code	Description
000	*Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR test ordered, results not in source records
010	Positive

***Note:** This variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding 000 for a given case.

BCR-ABL RT PCR QUAL DATE (Non NAACCR Standard Item 9907) (Source CDC/NPCR-CER)**Description**

Record the date of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. RT-PCR Qualitative may be used to monitor disease response to therapy and relapse.

Note: Record this data item only for CML.

Note: Do not record results of this test after initiation of treatment.

Coding Instructions:

Date format is:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

BCR-ABL RT PCR Qual Date Flag (Non NAACCR Standard Item 9908) (Source CDC/NPCR-CER)**Description**

This flag explains why no appropriate value is in the field, BCR-ABL: RT-PCR Qual Date (9907)

Codes

Code	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Qual test done)
11	No proper value is applicable in this contest (e.g., no BCR-ABL: RT-PCR Qual test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Qual test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Qual test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: RT-PCR Qual date (9907), or the date was not expected to have been transmitted

BCR-ABL RT PCR QUANT (Non NAACCR Standard Item 9909) (Source CDC/NPCR-CER)**Description**

Record results of the quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for

BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in the source records, use results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Quantitative RT-PCR may be used to monitor disease response to therapy and relapse. Other names for this test include real time RT-PCR and BCR-ABL Gene Rearrangement Analysis.

Note: Record this data item only for CML.

Note: Do not record results of this test after initiation of treatment.

Quantitative units for BCR-ABL transcript levels are reported as a ratio of fusion gene transcript to β -2-microglobulin reference gene transcript.

Coding

Code	Description
000	*Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR Test ordered, results not in source records.
001 - 998	Ratio of 0.001 to 0.998 (enter exact ratio)
999	Ratio greater than or equal to 0.999

***Note:** This variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding “000” for a given case.

BCR-ABL RT-PCR QUANT DATE (Non NAACCR Standard Item 9910) (Source CDC/NPCR-CER)

Description

Record date of quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in source records, use date related to results that are closest to date of diagnosis. This variable refers to all BCR-ABL transcriptions including BCR-ABL2. Quantitative RT-PCR may be used to monitor disease response to therapy and relapse. Other names for this test include real time RT-PCR and BCR-ABL Gene Rearrangement Analysis.

Note: Record this data item only for CML.

Coding Instructions

Date format is:

YYYYMMDD – when complete date is known and valid

YYYYMM – when year and month are known and valid, and day is unknown

YYYY – when year is known and valid, and month and day are unknown

Blank – when no known date applies

BCR-ABL RT PCR Quant Date Flag (Non NAACCR Standard Item 9911) (Source CDC/NPCR-CER)**Description**

This flag explains why no appropriate value is in the field BCR-ABL: RT-PCR Quan Date (9910)

Note: Record this data item only for CML

Codes

Codes	Description
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Quant test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: RT-PCR Quant test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Quant test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Quant test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: RT-PCR Quant Date (9910), or the date was not expected to have been transmitted.

Calculating Planned Dose Unit and Received Dose Unit

To calculate the Planned Dose Unit or Received Dose Unit, the patient's height and weight must first be used to determine Body Surface Area (BSA). There are many websites which can be utilized to calculate BSA. This website will calculate both BSA and the dose:

<http://www.halls.md/body-surface-area/bsa.htm>

Example: Patient's planned first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m² iv bolus weekly x 6; LV, 500 mg/m² iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m² iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3.

Drug	Dose	Schedule (D= Day #)	# of Cycles	Total # Doses Planned	Total Dose
5-FU	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	3	6 x 3 = 18	14,490 mg
Folinic Acid/Leucovorin *	500 mg/m ²	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	Not Applicable	Not Applicable	Not Applicable
Oxaliplatin	85 mg/m ²	Week 1, 3, and 5 (D 1, 15, 29)	3	3 x 3 = 9	1232 mg

Height = 63 inches

Weight = 128 lbs

Planned dose of 5-FU is 500mg/m²

Number of doses planned is 18.

Calculate the BSA using <http://www.halls.md/body-surface-area/bsa.htm> BSA for the given height and weight is 1.61.

a. Multiple BSA (1.61) x 5-FU dose (500mg) = 805

Multiply 805 x total doses planned (18) = 14,490 mg. **Code the planned dose of 5-FU as 014490.**

b. Multiply BSA (1.61) x Oxaliplatin dose (85mg) = 136.85

Multiply 136.85 x total doses planned (9) = 1231.65 **Code the planned dose of Oxaliplatin as 001232.**