

TREATMENT STANDARD TABLES**Scope of Regional Lymph Node Surgery**

Note: For specific instructions on coding this data field see page 119 of this manual.

Code	Description	Definition	General Instructions
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.	
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.	<p>The operative report states that a SLNBx was performed. Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination.</p> <p>When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional nonsentinel nodes may be discovered by the pathologist or selectively removed</p> <p>The operative report states that a SLNBx was performed.</p> <p>Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a</p>

Code	Description	Definition	General Instructions
			<p>lymph node (possibly more than one) for removal/examination.</p> <p>When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional nonsentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.</p>
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure).
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7).
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	<p>Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only.</p> <p>Code 5 (4 or more regional lymph nodes removed). If a</p>

Code	Description	Definition	General Instructions
			<p>relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7).</p> <p>Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.</p>
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5; or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.	<p>SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known</p> <p>Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined,</p>

Code	Description	Definition	General Instructions
			<p>review the operative report to confirm whether the procedure was limited to a SLNBx only.</p> <p>Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.</p>
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.	<p>SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events.</p> <p>Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes.</p> <p>If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.</p>
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item <i>Surgery of Primary Site</i> [NAACCR Item #1290]). Review surgically treated cases coded 9 in <i>Scope of Regional Lymph Node Surgery</i> to confirm the code.

Scope of Regional Lymph Node Surgery for Breast**Note:** For specific instructions on coding this data field see page A-288 of this manual.

Code	Description	Definition	Instructions Specific to Breast
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.	
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.	<p>If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND).</p> <p>Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items <i>Regional Lymph Nodes Examined</i> (NAACCR Item #830) and <i>Regional Lymph Nodes Positive</i> (NAACCR Item #820).</p>
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node

Code	Description	Definition	Instructions Specific to Breast
	removed, NOS		dissection during the same procedure (code 6 or 7)
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5; or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.	Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.	Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item <i>Surgery of Primary Site</i> [NAACCR Item #1290]). Review surgically treated cases coded 9 in <i>Scope of Regional Lymph Node Surgery</i> to confirm the code.

Surgery Codes**Note:** See Site Specific Surgery Codes in Appendix A

Code	Type	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to <i>Appendix A</i> for correct site-specific procedure code.
20-80	Site-specific codes; resection	Refer to <i>Appendix A</i> for correct site-specific procedure code.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific surgery codes; special	Special codes for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative diseases; ill-defined sites; and unknown primaries, except death certificate only. Refer to <i>Appendix A</i> for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

RX Summ—Radiation**Note:** For specific instructions on coding this data field see page 134 of this manual.

Code	Description
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS-method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

Radiation-Regional Treatment Modality**Note:** For specific instructions on coding this data field see page 136 of this manual.

Code	Type	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient
20	External beam, NOS	The treatment is known to be external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of

Code	Type	Definition
		kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 11-19 MV.
26	Photons (>19 MV)	External beam therapy using a photon-producing machine with beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using neutron beam.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using proton therapy.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles or intracavitary applicators of radioactive material not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissue) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy,	Interstitial (direct insertion into tissues) radioisotope treatment

Code	Type	Definition
	Interstitial, HDR	using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes. *Do not use for cases diagnosed on or after January 1, 2003
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80. *Do not use for cases diagnosed on or after January 1, 2003.
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown
99	Unknown	It is unknown whether radiation therapy was administered because it is not stated in patient record. Death certificate only.

Chemotherapy

Note: For specific instructions on coding this data field see page 145 of this manual.

Code	Definition
00	None; chemotherapy was not part of the first course of therapy
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Hormone Therapy

Note: For specific instructions on coding this data field see page 149 of this manual.

Code	Definition
00	None; hormone therapy was no not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to

	patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Immunotherapy

Note: For specific instructions on coding this data field see page 153 of this manual.

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

RX Summ-Transplant/Endocrine

Note: For specific instructions on coding this data field see page 156 of this manual.

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

Other Treatment

Note: For specific instructions on coding this data field see page 162 of this manual.

Codes	Type	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases.
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been

		coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.