SEER Treatment Field Names, Edition Numbers, NAACCR Data Item Name, NAACCR Data Item Identifier, and NAACCR Version 10 Position

SEER Item Name SPCM* 3rd ed.	SEER Item Name SPCM* 3rd ed., rev. 1	Page in SPCM* 3rd ed, rev. 1	NAACCR Data Item Name	NAACCR Data Item Identifier	NAACCR version 10 position
Surgery of Primary Site	Surgery of Primary Site 98-02	124-126a	RX Summ--Surg Site 98-02	1646	939-940
---------	Surgery of Primary Site 2003+	126b-126d	RX Summ--Surg Prim Site	1290	859-860
Scope of Regional Lymph Node Surgery	Scope of Regional Lymph Node Surgery 98-02	127a	RX Summ--Scope Reg 98-02	1647	941-941
---------	Scope of Regional Lymph Node Surgery 2003+	127b-127c	RX Summ--Scope Reg LN Surg	1292	861-861
Number of Regional Lymph Nodes Examined	Number of Regional Lymph Nodes Examined	128	RX Summ--Reg LN Examined	1296	863-864
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) 98-02	129a	RX Summ--Surg Oth 98-02	1648	942-942
---------	Surgical Procedure of Other Site	129b	RX Summ--Surg Oth Reg/Dis	1294	862-862
Reconstruction--First Course	Reconstruction--First Course	130	RX Summ--Reconstruct 1st	1330	867-867
Radiation	RX Summ--Radiation	134a-134c	RX Summ--Radiation	1360	873-873
Chemotherapy	Chemotherapy	137a-137c	RX Summ--Chemo	1390	878-879
Hormone Therapy	Hormone Therapy	138a-138c	RX Summ--Hormone	1400	880-881
Immunotherapy	Immunotherapy	139a-129c	RX Summ--BRM	1410	882-883
---------	Hematologic Transplant and Endocrine Procedures	139d-139e	RX Summ--Transplnt/Endocr	3250	876-877

* SEER Program Code Manual

Note: this is a replacement for Page 2 in the SEER Program Code Manual. The Character Position listed refers to the SEER data submission format which has been replaced by NAACCR version 10. See separate table of SEER data items in the corresponding NAACCR format.

Section	Field Number		Length	Char. Pos.
IV DESCRIPTION OF THIS NEOPLASM (cont.)				
	IV.07	Tumor Markers		
	A	Tumor Marker 1	1	91
	B	Tumor Marker 2	1	92
	C	Tumor Marker 3	1	93
	IV.08	Diagnostic Confirmation	1	94
	IV.09	Diagnostic Procedures (1973-87)	2	95-96
	IV.10	Field Not Used	1	97
	IV.11	Coding System for Extent of Disease	1	98
	IV.12	Extent of Disease (EOD)		
	A	2-Digit Nonspecific Extent of Disease (1973-82)	2	99-100
	or B	2-Digit Site-Specific Extent of Disease (1973-82)		
	C	13-Digit (Expanded) Site-Specific Extent of Disease (1973-82)	13	101-113
	D	4-Digit Extent of Disease (1983-87)	4	114-117
	E	10-Digit Extent of Disease–EOD 88 (1988+)	10	118-127
	F	2-digit Pathologic Extension for Prostate (1995+)	2	128-129
	IV.13	Field Not Used	8	130-137
V FIRST COURSE OF CANCER-DIRECTED THERAPY				
	V.01	Date Therapy Initiated	6	138-143
	V.02	Surgery		
	A	Surgery of Primary Site 98-02	2	144-145
	B	Scope of Regional Lymph Node Surgery 98-02	1	146
	C	Number of Regional Lymph Nodes Examined	2	147-148
	D	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) 98-02	1	149
	E	Reconstruction--First Course	1	150
	F	Site-Specific Surgery (1983-1997)	2	151-152
	G	Reason for No Cancer-Directed Surgery	1	153
	H	Surgery of Primary Site	2	
	I	Scope of Regional Lymph Node Surgery	1	
	J	Surgical Procedure of Other Site	1	
	V.03	Radiation	1	154
	V.04	Radiation to the Brain and/or Central Nervous System	1	155
	V.05	Radiation Sequence with Surgery	1	156
	V.06	Chemotherapy		
	A	Chemotherapy 98-02	1	157
	B	Chemotherapy 2003+	2	
	V.07	Hormone Therapy		
	A	Hormone Therapy 98-02	1	158
	B	Hormone Therapy 2003+	2	
	V.08	Immunotherapy		
	A	Immunotherapy 98-02	1	159
	B	Immunotherapy 2003+	2	
	C	Hematologic Transplant and Endocrine Procedures	2	
	V.09	Other Cancer-Directed Therapy	1	160
	V.10	Field Not Used	11	161-171

GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY

| **Effective with cases diagnosed between January 1, 1998, and December 31, 2002**, for each primary site, the site-specific surgery scheme consists of four data fields.

V.02.A	Surgery of Primary Site 98-02	2 digits
V.02.B	Scope of Regional Lymph Node Surgery 98-02	1 digit
V.02.C	Number of Regional Lymph Nodes Examined	2 digits
V.02.D	Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) 98-02	1 digit

In addition, for breast cancer, a fifth field, Reconstruction--First Course is recorded.

V.02.E	Reconstruction--First Course (breast only)	1 digit

These codes for these fields are included as Appendix C of this manual.

For the fields listed above SEER codes are identical to those in the *Standards of the Commission on Cancer, Volume II: Standards Registry Operations and Data Standards, Appendix D, 1/98 revision*.

| **Effective with cases diagnosed January 1, 2003** and after, for each primary site, the site-specific surgery
| scheme consists of three data fields.
|

V.02.H	Surgery of Primary Site 2003+	2 digits
V.02.I	Scope of Regional Lymph Node Surgery 2003+	1 digit
V.02.J	Surgical Procedure of Other Site	1 digit

|
| The site-specific codes for Surgery of Primary Site 2003+ are found in Appendix F of this manual.
| The codes for Scope of Regional Lymph Node Surgery 2003+ and Surgical Procedure of Other Site are
| uniform for all sites. See revised pages 127b and 129b.
|
| For the fields listed above, SEER codes are identical to those in the *Facility Oncology Registry Data
| Standards* (FORDS) manual of the American College of Surgeons Commission on Cancer.
|
| **Note**: For cases diagnosed 01/01/2003 and after, the fields Reconstruction and Number of Lymph Nodes
| Examined should be submitted as blank. Reconstruction (for breast) is incorporated into Surgery of Primary
| Site, and Number of Lymph Nodes Examined is incorporated into Scope of Regional Lymph Node Surgery.
|
| ***NOTE FOR 2003 CASES***
| SEER will allow 2003 cases to be transmitted using codes in either the *SEER Program Code Manual, 3rd
| Edition* (compatible with ROADS codes) above **OR** the *SEER Program Code Manual, 3rd Edition, revision
| 1* (compatible with FORDS codes). For 2003 cases *only*, SEER participants will chose which set of treatment
| fields are completed for each person/tumor. For a particular person/tumor, the codes must be from the same
| set of definitions, either the *SEER Program Code Manual, 3rd edition* or the *SEER Program Code Manual,
| 3rd edition, revision 1*. The codes in the *SEER Program Code Manual, 3rd Edition revision 1* are preferred.
|

GENERAL INSTRUCTIONS FOR CODING SITE-SPECIFIC SURGERY (cont.)

Coding Guidelines

These surgical codes record surgical procedures rather than specific cancer-directed surgery.

Once it is determined that was performed, use the best information in the operative/pathology reports to determine the operative procedure. Read the complete reports; do not code the procedure solely on the basis of the procedure name.

If the operative report is unclear as to what was excised or if there is a discrepancy between the operative and pathology reports, use the pathology report, unless there is reason to doubt its accuracy.

If a surgical procedure removes the remaining portion of an organ which had been partially resected previously for any condition, code as total removal of the organ. If none of the primary organ remains, the code should indicate that this is the case.

For example:

1. Resection of a stomach which had been partially excised previously is coded as total removal of stomach.
2. Removal of a cervical stump is coded as total removal of uterus.
3. Lobectomy of a lung with a previous wedge resection is coded as total removal of lobe.

For purposes of this program a lymph node dissection is defined as any lymph node dissection done within the first course of therapy. Any lymph node dissection done as a separate procedure within the first course of therapy is to be coded.

If an excisional biopsy is followed by "re-excision" or "wide excision" within the first course of therapy, include that later information in coding surgery.

If multiple primaries are excised at the same time, code the appropriate surgery for each site. *For example:* 1) if a total abdominal hysterectomy was done for a patient with two primaries, one of the cervix and one of the endometrium, code each as having had a total abdominal hysterectomy. 2) If a total colectomy was done for a patient with multiple primaries in several segments of the colon, code total colectomy for each of the primary segments.

Ignore surgical approach in coding procedures. Ignore surgical margins when coding procedures.

Ignore the use of laser if used only for the initial incision.

Surgical procedures performed solely for the purpose of establishing a diagnosis/stage or for the relief of symptoms, and procedures such as brushings, washings, and aspiration of cells (except for aspiration of lymph nodes) as well as hematologic findings (peripheral blood smears) are not considered treatment for the purposes of this program and are not to be coded.

Surgery for extranodal lymphomas should be coded using the scheme for the extranodal site.
For example:

A lymphoma of the stomach is to be coded using the scheme for stomach.

| **Surgery of Primary Site 98-02**

Record surgeries only of the primary site. Surgery to remove regional tissue or organs is coded in this field only if the tissue/organs are removed with the primary site in an **en bloc** resection. An en bloc resection is the removal of organs in one piece at one time.

Example When a patient has a modified radical mastectomy, since the breast and axillary contents are removed in one piece (en bloc), surgery of primary site is coded as a modified radical mastectomy ('50') even if the pathologist finds no nodes in the specimen.

The range of codes from '00' to '84' are hierarchical. If more than one code describes the procedure, use the numerically higher code.

Record a non en bloc resection of a secondary or metastatic site in the data field "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

A single set of fields summarizing surgical treatment during the first course should be reported to SEER. Use the following guidelines to determine the priority of codes:

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

Example Patient has a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report identifies carcinoma extending into the stalk ("Surgery of Primary Site" code '27'). A week later, the patient has a hemicolectomy ("Surgery of Primary Site" code '40'). Code the hemicolectomy since it is the most invasive, definitive surgery and has the numerically higher code.

C If no primary site surgical procedure was done, code '00.'

Priority of Codes

In the Surgery of Primary Site codes, the following priorities hold:

C Codes '10' - '90' have priority over code '99.'
C Codes '10' - '84' have priority over codes '90' and '99.'
C Codes '10' - '79' have priority over codes '80,' '90,' and '99,' where '80' is site-specific surgery, not otherwise specified (for example, prostatectomy, NOS)

| **Site-Specific Surgery Codes 98-02**

Site-Specific Surgery Codes are available in Appendix C for the following sites:

C00.0 - C06.9	Lip and oral cavity
C07.9 - C08.9	Parotid and other unspecified salivary glands
C09.0 - C14.0	Pharynx
C15.0 - C15.9	Esophagus
C16.0 - C16.9	Stomach
C18.0 - C18.9	Colon
C19.9	Rectosigmoid
C20.9	Rectum
C21.0 - C21.8	Anus
C22.0 - C22.1	Liver and intrahepatic bile ducts
C25.0 - C25.9	Pancreas
C32.0 - C32.9	Larynx
C34.0 - C34.9	Lung
C40.0 - C41.9, C47.0 - C47.9, C49.0 - C49.9	Bones, joints , and articular cartilage; peripheral nerves and autonomic nervous system; connective, subcutaneous and other soft tissues
C42.2, C77.0 - C77.9	Spleen and lymph nodes
C44.0 - C44.9	Skin
C50.0 - C50.9	Breast
C53.0 - C53.9	Cervix uteri
C54.0 - C55.9	Corpus uteri
C56.9	Ovary
C61.9	Prostate
C62.0 - C62.9	Testis
C64.9 - C66.9	Kidney, renal pelvis, and ureter
C67.0 - C67.9	Bladder
C70.0 - C72.9	Brain and other parts of central nervous system
C73.9	Thyroid

All Other Sites

Surgeries for all other primary cancers should be coded using the general surgery code scheme for All Other Sites at the end of Appendix C. These primaries include:

C14.1 - C14.8	Other and Ill-defined Sites in Lip, Oral Cavity and Pharynx
C17.0 - C17.9	Small Intestine
C23.9	Gallbladder
C24.0 - C24.9	Extrahepatic Bile Duct, Ampulla of Vater; Overlapping Lesion of Biliary Tract, Biliary Tract, NOS
C26.0 - C26.9	Intestinal Tract, NOS, Overlapping Lesion of Digestive System, Gastrointestinal Tract, NOS
C30.0 - C 30.1	Nasal Cavity, Middle Ear
C31.0 - C31.9	Accessory (paranasal) Sinuses
C33.9	Trachea
C37.9	Thymus
C38.0 - C38.8	Heart, Mediastinum, Pleura
C39.0 - C39.9	Other and Ill-defined Sites within Respiratory System and Intrathoracic Organs

All Other Sites, continued

C42.0 - C42.1	Blood, Bone Marrow
C42.3 - C42.4	Reticuloendothelial System, NOS, Hematopoietic System, NOS
C48.0 - C48.8	Retroperitoneum and Peritoneum
C51.0 - C51.9	Vulva
C52.9	Vagina
C57.0 - C57.9	Other and Unspecified Female Genital Organs
C58.9	Placenta
C60.0 - C60.9	Penis
C63.0 - C63.9	Other and Unspecified Male Genital Organs
C68.0 - C68.9	Other and Unspecified Urinary Organs
C69.0 - C69.9	Eye and Adnexa
C74.0 - C75.9	Adrenal Gland, Other Endocrine Glands and Related Structures
C76.0 - C76.8	Other and Ill-defined Sites
C80.9	Unknown Primary Site

Surgery of Primary Site 2003+

Record surgeries only of the primary site. Surgery to remove regional tissue or organs is coded in this field only if the tissue/organs are removed with the primary site in an **en bloc** resection. SEER defines an en bloc resection as the removal of tissues during the same procedure, but not necessarily in a single specimen.

Example When a patient has a modified radical mastectomy, since the breast and axillary contents are removed in one piece (en bloc), surgery of primary site is coded as a modified radical mastectomy ('50') even if the pathologist finds no nodes in the specimen.

Record a non en bloc resection of a secondary or metastatic site in the data field "Surgical Procedure of Other Site."

Site-specific codes for this data item are found in Appendix F (see table on next page for schema).

A single set of fields summarizing surgical treatment during the first course should be reported to SEER. Use the following guideline to determine the priority of codes:

If the patient has multiple surgeries of the primary site, code the most invasive, definitive surgery.

Example Patient has a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report identifies carcinoma extending into the stalk ("Surgery of Primary Site" code '27'). A week later, the patient has a hemicolectomy ("Surgery of Primary Site" code '40'). Code the hemicolectomy since it is the most invasive, definitive surgery.

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

The range of codes from '00' to '84' are NOT NUMERICALLY hierarchical. For codes 00 through 79, the *response positions* are hierarchical; last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00.

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

Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix F.

If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix F for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix F for the correct site-specific code for the procedure.
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 codes; special	Special code. Refer to Appendix F for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Site-Specific Surgery Codes 2003+

Site-Specific Surgery Codes are available in Appendix F for the following sites:

C00.0 - C06.9	Lip and oral cavity
C07.9 - C08.9	Parotid and other unspecified salivary glands
C09.0 - C14.0	Pharynx
C15.0 - C15.9	Esophagus
C16.0 - C16.9	Stomach
C18.0 - C18.9	Colon
C19.9	Rectosigmoid
C20.9	Rectum
C21.0 - C21.8	Anus
C22.0 - C22.1	Liver and intrahepatic bile ducts
C25.0 - C25.9	Pancreas
C32.0 - C32.9	Larynx
C34.0 - C34.9	Lung
C40.0 - C41.9, C47.0 - C47.9, C49.0 - C49.9	Bones, joints , and articular cartilage; peripheral nerves and autonomic nervous system; connective, subcutaneous and other soft tissues
C42.0, C42.1, C42.3, C42.4	Hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative disease*
C42.2	Spleen
C44.0 - C44.9	Skin
C50.0 - C50.9	Breast
C53.0 - C53.9	Cervix uteri
C54.0 - C55.9	Corpus uteri
C56.9	Ovary
C61.9	Prostate
C62.0 - C62.9	Testis
C64.9 - C66.9	Kidney, renal pelvis, and ureter
C67.0 - C67.9	Bladder
C70.0 - C72.9	Brain and other parts of central nervous system
C73.9	Thyroid
C76.0-C76.8, C80.9	Unknown and ill-defined primary sites
C77.0 - C77.9	Lymph nodes

* surgery scheme includes C42.0, C42.1, C42.3, C42.4 with any histology; and histologies 9750, 9760-9764, 9800-9820, 9831-9920, 9931-9964, 9980-9989 of any site

All Other Sites

Surgeries for all other primary cancers should be coded using the general surgery code scheme for All Other Sites at the end of Appendix F. These primaries include:

C14.1 - C14.8	Other and Ill-defined Sites in Lip, Oral Cavity and Pharynx
C17.0 - C17.9	Small Intestine
C23.9	Gallbladder
C24.0 - C24.9	Extrahepatic Bile Duct, Ampulla of Vater; Overlapping Lesion of Biliary Tract, Biliary Tract, NOS
C26.0 - C26.9	Intestinal Tract, NOS, Overlapping Lesion of Digestive System, Gastrointestinal Tract, NOS
C30.0 - C 30.1	Nasal Cavity, Middle Ear
C31.0 - C31.9	Accessory (paranasal) Sinuses
C33.9	Trachea
C37.9	Thymus
C38.0 - C38.8	Heart, Mediastinum, Pleura
C39.0 - C39.9	Other and Ill-defined Sites within Respiratory System and Intrathoracic Organs
C48.0 - C48.8	Retroperitoneum and Peritoneum
C51.0 - C51.9	Vulva
C52.9	Vagina
C57.0 - C57.9	Other and Unspecified Female Genital Organs
C58.9	Placenta
C60.0 - C60.9	Penis
C63.0 - C63.9	Other and Unspecified Male Genital Organs
C68.0 - C68.9	Other and Unspecified Urinary Organs
C69.0 - C69.9	Eye and Adnexa
C74.0 - C75.9	Adrenal Gland, Other Endocrine Glands and Related Structures

| **Scope of Regional Lymph Node Surgery 98-02**

See Appendix C for site-specific codes for this field.

| For the majority of sites, "Scope of Regional Lymph Node Surgery 98-02" defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range of '1' - '5.' If a regional lymph node was aspirated, code to '1,' regional lymph node(s) removed, NOS.

For head and neck sites, this field describes neck dissections. Codes '2' - '5' indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

The codes are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

Example A patient with a head and neck primary has a lymph node biopsy (code '1') followed by a limited neck dissection (code 3). Code the limited neck dissection (code '3').

If a patient has a modified radical neck dissection, record code '4' (modified radical neck dissection) rather than the generic code "neck dissection, NOS" (code '2').

A list identifies the regional lymph nodes for each site in Appendix C. Any other nodes are distant, code in the data field "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)."

If no surgical procedure was performed, code '0.'

Priority of Codes

In the Scope of Regional Lymph Node Surgery codes, the following priorities hold:

- Codes '1' - '8' have priority over code '0' and '9.'
- In the range of codes '1' - '8,' the numerically higher code has priority.

Scope of Regional Lymph Node Surgery 2003+

Effective for SEER revision 1 of 3rd ed codes: All primary sites have the same coding structure for this field.

Code

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 node, NOS [former wording for this code was regional lymph node(s) removed, NOS--see new #3]
Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement of disease.
[SEER guideline (with COC concurrence): for a procedure stated to be a biopsy of a lymph node, use code 1; for a procedure stated to be removal of one lymph node, use code 4. Code 1 was not used prior to 01/01/2003.]

2 Sentinel lymph node biopsy
Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.

3 Number of regional 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 node biopsy.

4 1–3 regional lymph nodes removed
Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

5 4 or more regional lymph nodes removed
Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

6 Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated
Code 2 was performed in a single surgical event with code 3, 4, or 5. Or, code 2 and 3, 4, or 5 were performed,but timing was not stated in patient record.

7 Sentinel node biopsy and code 3, 4, or 5 at different times
Code 2 was followed in a subsequent surgical event by procedure 3, 4, or 5.

9 Unknown or not applicable
It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease.
[SEER guideline: 9 includes "not stated."]

Coding Guidelines

The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.

Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* if it is the first type of treatment the patient receives.

Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

Use code 9 for:

- primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9)
- lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9)
- unknown or ill-defined primary (C76.0–C76.8, C80.9)
- hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)

Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field Surgical Procedure of Other Site.

Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.

Examples:

Code	Reason
0	There was no lymph node surgery **OR** an attempt at regional lymph node dissection or sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	**(C14.0-Pharynx)** Aspiration of regional lymph node to confirm histology of widely metastatic disease.
3	**(C44.5-Skin of Back)** Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
4	**(C61.9-Prostate**) Bilateral pelvic lymph node dissection for prostate cancer.
6	**(C50.3-Breast)** Sentinel lymph node biopsy of right axilla, followed by right axillary lymph node dissection during the same surgical event.
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded prior to 1998 when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. Bear in mind that, for research and data presentation purposes, no inference that one category is preferable to another is intended by the structure of these codes.

Number of Regional Lymph Nodes Examined

This field is uniform across all primary sites. The site-specific schemes in Appendix C also display the codes for this field. Code this field ONLY for cases submitted using the codes of the SEER Program Code Manual, 3rd Edition. For cases submitted using the SEER Program Code Manual, 3rd Edition, revision 1, this field is blank.

Codes
00 No regional lymph nodes examined
01 One regional lymph node examined
02 Two regional lymph nodes examined
..
90 Ninety or more regional lymph nodes examined
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes examined unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes examined unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes examined unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate ONLY

Record the number of regional lymph nodes examined by the pathologist. **DO NOT** add numbers of nodes removed at different surgical events.

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

Since SEER collects only one Number of Regional Lymph Nodes Examined field, record the number of lymph nodes examined from the definitive regional lymph node surgery performed during first course of treatment. For example, if a patient has a cervical node biopsy for diagnosis and later undergoes a radical neck dissection during first course, record the number of lymph nodes examined from the radical neck dissection.

Because this field is not cumulative and not affected by timing issues, it does not replace or duplicate the field "Pathologic Review of Regional Lymph Nodes" in the EOD coding section. Do not copy the values from one field to the other.

Priority of Codes

In the Number of Regional Lymph Nodes Examined codes, the following priorities hold:

- If lymph node surgery is done at the same time as definitive surgery, priority is given to the information connected with the most definitive surgery. Use the priority order listed under "Surgery of Primary Site" to determine the most definitive surgery of primary site.
- If lymph node surgery is done at a different time than the definitive surgery, priority is given to the code connected with the most definitive lymph node surgery. Use the priority order listed under "Scope of Regional Lymph Node Surgery" to determine the most definitive lymph node surgery.

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) 98-02

See Appendix C for site-specific codes for this field.

"Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)" describes the removal of tissue(s) or organ(s) other than the primary tumor or organ of origin. The tissue or organ is not removed in continuity with the primary tumor (not en bloc).

Example: A patient has an excisional biopsy of a hard palate lesion that is removed from the roof of the mouth and a resection of a metastatic lung nodule during the same surgical event. Code the resection of the lung nodule as '6' (distant site).

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

DO NOT CODE the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy. For example: During a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gallbladder. Do not code removal of the gallbladder.

Priority of Codes

In the Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) codes, the following priorities hold:

- Codes '1' - '8' have priority over code '0' and '9.'
- In the range of codes '1' - '8,' the numerically higher code has priority.

Surgical Procedure of Other Site

Effective for SEER revision 1 of 3rd ed codes: All primary sites have the same coding structure for this field. This field records the surgical removal of regional tissues other than nodes, distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.

0 None
No surgical procedure of non-primary site was performed. Diagnosed at autopsy.

1 Non-primary surgical procedure performed
Non-primary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.

2 Non-primary surgical procedure to other regional sites
Resection of regional site.
Note: *for en bloc resection with primary site, see Surgery of Primary Site field. Do not code en bloc resection here.*

3 Non-primary surgical procedure to *distant lymph node(s)*
Resection of *distant lymph node(s)*.

4 Non-primary surgical procedure to distant site
Resection of distant site.

5 Combination of codes
Any combination of surgical procedures 2, 3, or 4.

9 Unknown
It is unknown whether any surgical procedure of a non-primary site was performed.
Death certificate only.

Coding Guidelines
Assign the highest numbered code (1 - 5) that describes the surgical resection of *distant lymph node(s)* and/or regional/distant tissue or organs.

Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."

Examples:

Code	Reason
0	No procedure was performed **OR** **(C18.1—Colon)** The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical biopsy of metastatic lesion from liver; unknown primary.
2	**(C18.3—Colon)** Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	(**C19.9—Rectosigmoid)** Excision of multiple liver metastasis.
4	**(C34.9—Lung)** Removal of solitary brain metastasis.
5	**(C21.0—Anus)** Excision of solitary liver metastasis and one large hilar lymph node.

Reconstruction--First Course

| ***Code this field ONLY for cases submitted using the codes of the SEER Program Code Manual, 3rd Edition. For cases submitted using the SEER Program Code Manual, 3rd Edition, revision 1, this field is blank.***

The SEER Program collects information in this field only for breast cancer, and only for reconstruction begun as part of first course treatment. See the Introduction to Section V for a discussion of the time limitations on first course of treatment.

Code

0 No reconstruction/restoration
1 Reconstruction, NOS (unknown if flap)
    2 Implant; reconstruction WITHOUT flap
    3 Reconstruction WITH flap, NOS
        4 Latissimus dorsi flap
        5 Abdominus recti flap
        6 Flap, NOS plus implant
        7 Latissimus dorsi flap plus implant
        8 Abdominus recti plus implant
9 Unknown; not stated; death certificate only

For all other primary sites, enter a blank in this field.

These codes are repeated in Appendix C.

"Reconstruction--First Course" is a surgical procedure that improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer treatment.

"Reconstruction--First Course" is limited to procedures **started** during the first course of therapy. The insertion of a tissue expander is often the beginning of the reconstructive procedure for breast cancer. Some reconstructive/restorative procedures involve several surgical events. Code as "Reconstruction--First Course" if the first event occurred during the first course of treatment.

Code only those procedures listed above. Other reconstructive/restorative procedures for breast cancer, such as tattooing, should not be coded.

Priority of Codes

In the Reconstruction--First Course codes, the following priorities hold:

- Codes '1' - '8' have priority over code '0' and '9.'
- In the range of codes '1' - '8,' the numerically higher code has priority.

RX Summm--Radiation

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

This field was previously named “Radiation.”

Coding Guidelines
Record any type of radiation therapy in this field regardless of source, field being treated, or intent of treatment (curative or palliative). For cases diagnosed 1/1/1998 and after, include prophylactic radiation to the brain and/or central nervous system in this field.

Code ‘1’ for beam radiation directed to cancer tissue regardless of source of radiation. Included is treatment via Xray, Cobalt, Linear accelerator, Neutron beam, Betatron, Spray radiation, Stereotactic radiosurgery such as gamma knife and proton beam.

Code ‘2’ for all interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive material such as cesium, radium, radon, or radioactive gold.

Code ‘3’ for internal use of radioactive isotopes, such as I-131 or P-32, when given orally, intracavitarily, or by intravenous injection.

For lung and leukemia cases diagnosed before 1998 only, code radiation to the brain and/or central nervous system in the Radiation to the Brain and/or Central Nervous System field. For lung and leukemia diagnosed in 1998 and after, code radiation to the brain and CNS as radiation in this field.

Radiation treatment descriptions will typically be found in the radiation oncologist’s summary letter for the first course of treatment.

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

Note that in some circumstances the boost treatment may precede the regional treatment.

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

Note: For SEER central registries, this field is a composite of two radiation data fields collected in American College of Surgeons Commission on Cancer-approved hospital cancer registries. If data are submitted from COC-approved hospitals in the fields “Regional Treatment Modality” or “Boost Treatment Modality,” they can be translated into the required SEER field RX Summ--Radiation according to the following tables.

Translation of Regional Treatment Modality and/or Boost Treatment Modality Field (*refer to the FORDS manual for definitions of these codes)* **to RX Summ--Radiation**

Code 00 translates to RX Summ--Radiation code 0, none.

Code	**Label**
00	No radiation treatment

Codes 20-43 translate to RX-Summ--Radiation code 1, beam radiation

20	External beam, NOS
21	Orthovoltage
22	Cobalt–60, Cesium–137
23	Photons (2–5 MV)
24	Photons (6–10 MV)
25	Photons (11–19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons, with or without photons/electrons
31	IMRT
32	Conformal or 3–D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma Knife

Codes 50-55 translate to RX Summ--Radiation code 2, radioactive implants

50	Brachytherapy, NOS
51	Brachytherapy, Intracavitary, LDR
52	Brachytherapy, Intracavitary, HDR
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium

Codes 60-62 translate to RX Summ--Radiation code 3, radioisotopes

60	Radioisotopes, NOS
61	Strontium–89
62	Strontium–90

Codes 80, 85 translate to RX Summ-Radiation code 4, Combination of 1 with 2 or 3

80* Combination modality, specified*
85* Combination modality, NOS*

Note: For cases diagnosed prior to 01/01/2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to Volume II, ROADS and DAM rules and **should not** be used to record regional radiation for cases diagnosed on or after 01/01/2003. --FORDS Manual, page 157.

Code 98 translates to RX Summ--Radiation code 5, radiation therapy, NOS, method or source unspecified

98 Other, NOS

Code 99 translates to RX Summ--Radiation code 9, unknown

99 Unknown It is unknown whether radiation therapy was administered.

Conversion Table for FORDS Regional Radiation Therapy Fields to SEER RX SUMM--Radiation

For cases that are received from College approved hospitals, information for RX–Summ Radiation can be derived from Rad – Boost RX Modality, Rad – Regional RX Modality and Reason No Radiation by the following table:

Rad – Boost RX Modality	Rad – Regional RX Modality	RX SUMM--Radiation
00	00, 99	0*
00	20-43	1
00	50-55	2
00	60-62	3
00	80-85	4
00	98	5
20-43	00, 20-43, 98, 99	1
20-43	50-55, 60-62, 80-85	4
50-55	00, 50-55, 98, 99	2
50-55	20-43, 80-85	4
50-55	60-62	3
60-62	00, 50-55, 60-62, 98, 99	3
60-62	20-43, 80-85	4
80-85	00-99	4
98	00, 98, 99	5
98, 99	20-43	1
98, 99	50-55	2
98, 99	60-62	3
98, 99	80-85	4
99	00	0*
99	99	9

* Note: For asterisked items review Reason No Radiation. If Reason No Radiation is 7, RX Summ--Radiation code 0 becomes 7; if Reason No Radiation is 8, RX Summ--Radiation code 0 becomes 8.

Chemotherapy

Note: Effective with cases diagnosed January 1, 2003 and after, this field expanded from one digit to two digits. Cases coded using *SEER Program Code Manual 3rd Edition* must be converted to the two-digit scheme (see next page).

Codes prior to 01/01/2003
0 None
1 Chemotherapy, NOS
2 Chemotherapy, single agent
3 Chemotherapy, multiple agents (combination regimen)
7 Patient or patient's guardian refused chemotherapy
8 Chemotherapy recommended, unknown if administered
9 Unknown

Code any chemical which is administered to treat cancer tissue and which is not considered to achieve its effect through change of the hormone balance. Only the agent, not the method of administration, is to be considered in coding.

Two or more single agents given at separate times during the first course of cancer-directed therapy are considered a combination regimen.

Codes ‘1’ - ‘3’ have priority over codes ‘0,’ ‘7’ - ‘9.’

In the range ‘1’ - ‘3,’ the higher code has priority. Combination chemotherapy containing prednisone (a hormone) should be coded in this field by the number of chemotherapy agents in the combination. For example, if the patient received alkeran and prednisone, the chemotherapy field would be coded to ‘2’ and the hormone therapy field would be coded to ‘1.’ If the regimen contained oncovin, cyclophosphamide and prednisone, the chemotherapy field would be coded to ‘3’ and the hormone field would be coded to ‘1.’

Code ‘8’ means that a physician recommended chemotherapy but there is no indication in the record that the patient started the treatment.

Code ‘9’ means that there is no indication in the record that chemotherapy was recommended or started.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs* if in doubt as to which agents to include.

Chemotherapy
Records the type of chemotherapy administered as first course treatment at all facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Codes after 01/01/2003
Effective for SEER revision 1 of 3rd ed codes

Code	Description
00	None; chemotherapy was not part of the planned first course of therapy
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multi-agent chemotherapy administered as first course 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 patient record.
87	Chemotherapy 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.

Note: Codes 82, 85, and 86 are invalid for cases diagnosed prior to 01/01/2003.

Coding Guidelines

Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include chemotherapy.

If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

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

Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.

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, and *only the original agent or regimen is recorded as first course therapy*.

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

Examples:

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy, however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	Following surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

Chemotherapy Field Conversion Table

SEER Code Manual 3rd Edition Chemotherapy	SEER Code Manual 3rd ed revision 1 Chemotherapy
0	00
1	01
2	02
3	03
7	87
8	88
9	99

Hormone Therapy

Note: Effective with cases diagnosed January 1, 2003 and after, this field expanded from one digit to two digits. Cases coded using *SEER Program Code Manual 3rd Edition* must be converted to the two-digit scheme (see Hormone Therapy Conversion Table).

Codes prior to 01/01/2003
0 None
1 Hormones (including NOS and antihormones)
2 Endocrine surgery and/or endocrine radiation (if cancer is of another site)
3 Combination of 1 and 2
7 Patient or patient's guardian refused hormonal therapy
8 Hormonal therapy recommended, unknown if administered
9 Unknown

This field was formerly called Endocrine (Hormone/Steroid) Therapy.

Code any therapy which is administered to treat cancer tissue and which is considered to achieve its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, or steroids, surgery for hormonal effect on cancer tissue, and radiation for hormonal effect on cancer tissue.

Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs* if in doubt as to which drugs to include. *For example:* leuprolide and flutamide are both agents acting via hormonal mechanisms and should be coded as hormones.

Adrenocorticotrophic hormones (cancer-directed only) are coded for leukemias, lymphomas, multiple myelomas, breast, prostate. Exception: Prednisone given in combination with chemotherapy, e.g., MOPP or COPP, is coded as hormone therapy for any site unless it is specified that prednisone was given for other reasons.

For cases diagnosed prior to 01/01/2003, endocrine surgery or radiation is to be coded in this field for breast and prostate only. For cases diagnosed on or after 01/01/2003, endocrine surgery or radiation is to be coded in the field "Hematologic Transplant/Endocrine Procedures" (see page 139d).

Breast:	Prostate:
oophorectomy	orchiectomy
adrenalectomy	adrenalectomy
hypophysectomy	hypophysectomy

Both glands or the remaining gland of paired glands must be removed or irradiated for the procedure to be considered endocrine surgery or radiation.

Code '8' means that a physician recommended hormone therapy but there is no indication in the record that the patient started the treatment.

Code '9' means that there is no indication in the record that hormone therapy was recommended or started.

Hormone Therapy

Effective for SEER revision 1 of 3rd ed codes. Endocrine surgery and radiation codes are moved to Hematologic Transplant and Endocrine Procedures field.

Codes after 01/01/2003

00	None, hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy administered as first course 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 therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: Codes 82, 85, and 86 are invalid for cases diagnosed prior to 01/01/2003.

Coding Guidelines

Code any therapy which is administered to treat cancer tissue and which is considered to achieve its effect on cancer tissue through change of the hormone balance. Included are the administration of hormones, agents acting via hormonal mechanisms, antihormones, or steroids.

Hormones, agents acting via hormonal mechanisms, and antihormones (cancer-directed only) are to be coded for all sites (primary and metastatic).

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of hormonal agents.

Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

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

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 of first course therapy.

Code 00 if hormone therapy was not administered to the patient, and/or it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include hormone therapy.

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

If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

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

Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Examples:

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

Hormone Therapy Conversion Table

SEER Code Manual 3rd Edition Hormone therapy	SEER Code Manual 3rd ed revision 1 Hormone therapy
0	00
1	01
2	00
3	01
7	87
8	88
9	99

SEER 3rd edition revision 1: information on endocrine surgery and/or endocrine radiation is no longer be collected in this field. See Hematologic Transplant and Endocrine Procedures.

Immunotherapy

| **Note:** Effective with cases diagnosed January 1, 2003 and after, this field expanded from one digit to two
| digits. Cases coded using *SEER Program Code Manual 3rd Edition* must be converted to the two-digit
| scheme (see next page).
|
| Codes prior to 01/01/2003

0 None
1 Biological response modifier
2 Bone marrow transplant - autologous
3 Bone marrow transplant - allogenic
4 Bone marrow transplant, NOS
5 Stem cell transplant
6 Combination of 1 plus 2, 3, 4 or 5
7 Patient or patient's guardian refused biological response modifier
8 Biological response modifier recommended, unknown if administered
9 Unknown

This field was formerly called "Biological Response Modifiers."

`Biological response modifier' is a generic term which covers all chemical or biological agents that alter the immune system or change the host response (defense mechanism) to the cancer. Examples of biological response modifiers (immunotherapy) are:

Allogeneic cells	Interleukin	Pyran copolymer
BCG	LAK cells	Thymosin
C-Parvum	Levamisole	Vaccine therapy
Interferon	MVE2	Virus Therapy

Codes '2' though '6' are effective with cases diagnosed 1/1/96 and after. Code '5' includes both autologous and allogenic transplants.

Code '8' means that a physician recommended immunotherapy but there is no indication in the record that the patient started the treatment.

Code '9' means that there is no indication in the record that immunotherapy was recommended or started.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs* if in doubt as to which drugs to include.

| For cases diagnosed prior to 01/01/2003, transplant procedures and combinations of immunotherapy with
| transplant procedures are to be coded in this field. For cases diagnosed on or after 01/01/2003, transplant
| procedures (codes 2 through 5) are to be coded in the field "Hematologic Transplant/Endocrine Procedures"
| (see page 139d).
|

Immunotherapy

Effective for SEER revision 1 of 3rd ed codes. Bone marrow transplant and stem cell procedures have been moved to Hematologic Transplant and Endocrine Procedures field.

Codes after 01/01/2003

- 00 None, immunotherapy was not part of the planned first course of therapy.
- 01 Immunotherapy administered as first course 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 therapy. 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 an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: Codes 82, 85, and 86 are invalid for cases diagnosed prior to 01/01/2003.

Coding Guidelines

Code 00 if immunotherapy was not administered to the patient, and/or it is known that it is not usually administered for this type and stage of cancer.

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include immunotherapy.

If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

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

Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no indication whether it was recommended or administered.

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a list of immunotherapeutic agents.

Examples:

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

Immunotherapy Conversion Table

SEER Code Manual 3rd Edition Immunotherapy	SEER Code Manual 3rd ed revision 1 Immunotherapy
0	00
1	01
2[1]	00
3[2]	00
4[3]	00
5[4]	00
6[5]	01
7	87
8	88
9	99

[1] Note: bone marrow transplant--autologous has been moved to Hematologic Transplant and Endocrine Procedures code 11.

[2] Note: bone marrow transplant--allogenic has been moved to Hematologic Transplant and Endocrine Procedures code 12.

[3] Note: bone marrow transplant, NOS has been moved to Hematologic Transplant and Endocrine Procedures code 10.

[4] Note: stem cell transplant has been moved to Hematologic Transplant and Endocrine Procedures code 20 and has been renamed “Stem cell harvest.”

[5] Note: combination of biological response modifier and bone marrow transplant or stem cell transplant will be recorded as separate fields. Record biological response modifier in the immunotherapy field and the appropriate bone marrow or transplant procedure in Hematologic Transplant and Endocrine Procedures.

Hematologic Transplant and Endocrine Procedures

Effective for SEER revision 1 of 3rd ed codes: Bone marrow and stem cell procedures are coded in this field. Endocrine surgery or radiation is now coded in this field.

Codes after 01/01/2003

Code	Description
00	No transplant procedure or endocrine therapy was administered as part of first course therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant–autologous.
12	Bone marrow transplant–allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 with 10-20.)
82	Hematologic transplant and/or endocrine surgery/radiation was 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 was 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 of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation 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	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Coding Guidelines

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at all facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

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

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

Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or effect 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.

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

Code 00 if the treatment plan offered multiple options, and the patient selected treatment that did not include a transplant or endocrine procedure.

If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.

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

Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.

Hematologic Transplant and Endocrine Procedures Conversion Table

Conversion from Hormone Therapy and Immunotherapy to Hematologic Transplant and Endocrine Procedures in SEER Program Code Manual		
SEER Program Code Manual 3rd edition		**SEER Program Code Manual 3rd edition, revision 1 Hematologic Transplant and Endocrine Procedures**
Hormone Therapy	**Immunotherapy**	
0, 1, 7, 8	0, 1, 7, 8	00
0, 1, 7, 8, 9	2	11
	3	12
	4, 6	10
	5	20
2, 3	0, 1, 7, 8, 9	30
	2, 3, 4 , 5, 6	40
9	0, 1, 7, 8	00
0, 1, 7, 8	9	00
9	9	99

Note for SEER: After analysis of data, it was decided that codes 7 and 8 in RX Summ - Hormone would be treated as though they only referred to hormonal therapy and not endocrine surgery. Similarly for RX Summ -BRM, codes 7 and 8 would only rarely reflect transplants refused or recommended. Therefore, for SEER, codes 82, 85, 86, 87, and 88 are invalid for cases using this conversion algorithm.