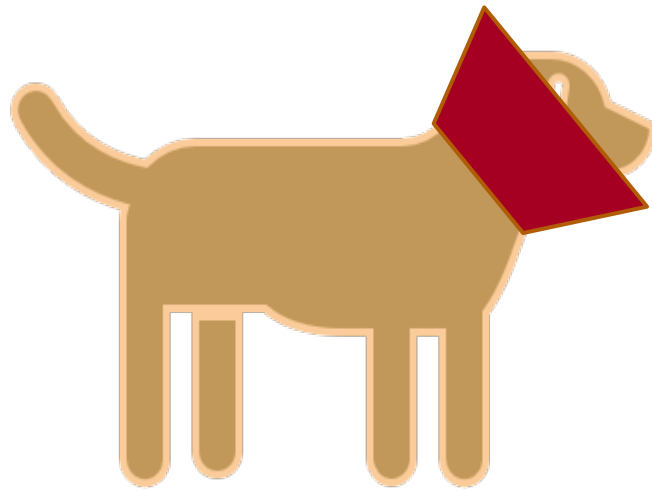# CANCER SURGERY

Treatment Type

KCR #50040

Using the codes below, record the type of therapy the patient received, regardless of where it was given.

Code	Description
N	Non-definitive surgery
S	Surgery
R	Radiotherapy
C	Chemotherapy
H	Hormone therapy
I	Immunotherapy
T	Transplant or Endocrine procedures
O	Other therapy

Other therapy includes: experimental, alternative, complementary, and any other types of therapy not elsewhere listed.

If no definitive therapy was administered to this patient, or you may leave items 50040-50400 blank and record an appropriate code in Reason No Therapy and Date No First Therapy

Obtaining A Diagnosis

- Most cancers are first _biopsied_ in order to determine tumor type.

- **In**cisional biopsies extract small portions of tumor for microscopic examination.

- **Ex**cisional biopsies remove the tumor mass as a whole.

Non-Definitive Surgery

NAACCR #1350

- Create "N" for coding *incisional* biopsies that produce *__malignant tissue__*.

- When therapy type = N, you may record surgical procedures that are *__NOT__* considered treatment in this field. The codes are the same for all sites

Code	Description
01	Incisional biopsy of other than primary site leaving gross residual disease. Needle biopsy of other than primary site
02	Incisional biopsy of primary site leaving gross residual disease. Needle biopsy of primary site
03	Exploratory ONLY (no biopsy)
04	Bypass surgery (no biopsy); - ostomy ONLY (no biopsy)
05	Exploratory ONLY and incisional or needle biopsy of primary site or other sites
06	Bypass surgery and incisional or needle biopsy of primary site or other sites - ostomy ONLY and incisional or needle biopsy of primary site or other sites
07	Non-definitive surgery, NOS

Coding Rules and Guidelines

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.

- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).

- For lymphomas of lymph node primary site (C77._), you may code the excision of a lymph node in this item (code 02) if it is for diagnostic and/or staging purposes.

- The surgical removal of lymph nodes for eradication of the lymphoma would be coded in (Surgical Procedure of Primary Site)

- Do not code surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in this data item.
  - Use the data item to code these procedures (Scope of Regional Lymph Node Surgery)

- Do not code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears).
  - These are not considered surgical procedures.

- Do not code excisional biopsies with clear or microscopic margins in this data item.
  - Use the data item (Surgical Procedure of Primary Site)

- If a needle biopsy precedes an excisional biopsy, even if no tumor is found at the time of surgery, both the needle biopsy and surgery **_must be_** recorded.
  - Code the needle biopsy in the Non-definitive surgery field and code the excision in the (Surgery at Primary Site)

- Surgical margins must be evaluated in order to determine if a biopsy is incisional or excisional and margins cannot be evaluated for a needle biopsy.

- Do not code palliative surgical procedures in this data item.
  - Use the data item (Palliative Procedure)

- Do not record biopsies that are negative for cancer.

Definitive Surgical Therapy

- Create "S" for all definitive cancer surgeries.

- Definitive surgeries remove malignant tumors, although margins may not be negative.

- Excisional biopsy is one example of definitive surgery.

Code	Description
N	Non-definitive surgery
S	Surgery
R	Radiotherapy
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H	Hormone therapy
I	Immunotherapy
T	Transplant or Endocrine procedures
O	Other therapy

Surgery of Primary Site
NAAACCR #1290

Surgery of Primary Site describes a surgical procedure that removes and/or destroys tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy

Use the site-specific coding scheme corresponding to the primary site or histology to code this data variable

Site-specific codes located:

- Appendix C of the SEER Manual

  https://seer.cancer.gov/manuals/2022/appendixc.html

- Appendix A of STORE Manual (page 254)

  https://www.facs.org/media/weqje4pk/store-2022-12102021-final.pdf

- Appendix G of CPDMS Abstractor's Manual

  https://www.kcr.uky.edu/manuals/2021%20Abstractor%20Manual.pdf

Code	Description
00	None; no surgical procedure of primary site; diagnosed at autopsy only
10-19	Site-specific codes. Tumor destruction; no pathologic specimen or unknown whether there is a pathologic specimen
20-80	Site-specific codes. Resection; pathologic specimen
90	Surgery, NOS. A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Special codes for hematopoietic neoplasms; ill-defined sites; and unknown primaries (See site-specific codes for the sites and histologies), except death certificate only
99	Unknown if surgery performed

- Most common codes range from "00" to "79"
- As the code number increases, the invasiveness/extensiveness of the surgery increases
- Codes "80" and "90" are only rarely used when precise information is unavailable
- Use the entire operative report as the primary source document to determine the best surgery of primary site code
- The body of the operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed
- The pathology report may be used to complement the information appearing in the operative report, ***but the operative report takes precedence***

Coding Instructions

Code 00

- No surgery was performed on the primary site
- First course of treatment was active surveillance/watchful waiting
- Case was diagnosed at autopsy

- Assign the code that reflects the cumulative effect of all surgeries to the primary site
  - Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no residual tumor found in the pathologic specimen from the more extensive surgery

- En bloc means, as a whole
  - En bloc procedures resects regional or distant tissue/organs along with the primary site
  - Code the removal of regional or distant tissue/organs when they are resected in continuity with the primary site (en bloc) and that regional organ/tissue is listed in the Surgery of Primary Site codes
  - If the regional or distant tissue and organs are not listed within a site-specific surgery code of the primary site, code as *Surgical Procedure Other Site*

- Incisional biopsies are coded as excisional biopsies when:
  - It remove all tumor/disease **_or_**
  - Removes all gross disease and only leaves microscopic margins
- When previous surgery removes part of primary tumor & additional surgery removes remainder of primary tumor, code "total results"
- Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme for the primary site
  - Do not use the lymph node scheme
- Assign the surgery code(s) that best represents the **_extent_** of the surgical procedure that was **_actually_** carried out when surgery is aborted
  - Code what was done, not what as planned
  - If the procedure was aborted before anything took place, assign code 00.

Course of Treatment

Round 1

First course = "F"

Round 2

Subsequent course = "S"

Subsequent treatments are not REQUIRED to be created, according to the ACoS. If your facility chooses not to create subsequent surgeries, please include subsequent therapy information in the text

Date of Surgery

- Carefully code the exact date on which the first course surgery took place
- Look on the operative/procedure notes
  - Date of procedure
- Look on pathology reports
  - Date the specimen was received by the lab
  - Date specimen was collected

Treatment Facility

Enter the facility name or code where the surgery took place

Facility ID Numbers List

See Appendix F of KCR's Abstractor's Manual

Pages 769-776

Treatment Local Hospital ID

Enter code indicating whether or not this surgery was performed at YOUR facility.

Code	Description
0	Not administered by this facility
<hosp ID>	<HOSPITAL NAME>
9	Valid only for diagnoses before 1/1/2003

This data item is especially important when a healthcare organizations with more than one facility

QUESTIONS?