CANCER THERAPY

Abstractors Training

First Course of Therapy

- Treatment Plan
  - All cancer-directed treatments specified in the physician(s) treatment plan and delivered to the patient after initial diagnosis are *First Course of Therapy*
  - Describes type(s) of treatment(s) intended to modify or control the malignancy
  - Documentation is frequently found in several different sources (Ex: medical record, clinic record, consultation reports, outpatient records)
  - Document treatment plan in your text

Recording/Abstracting Cancer Therapy

- All Kentucky registries and registries that are part of ACoS-accredited cancer programs are required to record complete *first course of therapy* for analytic cases accessioned into CPDMS.net
- Complete reporting of first course of therapy is vital to researchers for determining treatment outcomes and developing more effective treatment and improving outcomes
- Complete reporting of first course of therapy impacts cancer patient survival

Time Period

- All malignancies except leukemia
  - **First course of therapy** includes all cancer-directed treatment planned by the physician(s) during or after the first diagnosis of cancer
  - Planned therapy may include multiple modes of therapy, and may encompass intervals of a year or more
  - *No treatment* or *active surveillance* may be a planned treatment option, and is considered first course of therapy
  - If a treatment plan is not available, evaluate the therapy and the time it started – If the therapy is part of an established protocol or within accepted management guidelines for the disease, it is first course of therapy

Time Period (continued)

- Consult the attending physician (Ex: surgeon, medical oncologist, radiation oncologist) or your registry's physician advisor if protocols or management guidelines are not available
- If there is no treatment plan, established protocol or management guidelines, and you cannot consult with a physician, use the principle, "first course of treatment must begin within four months of the date of initial diagnosis"

Non-Definitive Treatment

- Non-definitive treatment is mainly used for diagnosis of cancer. This can also be used to prolong the patient's life, make the patient comfortable, or prepare the patient for definitive therapy.
  - *Not* cancer-directed – not meant to reduce the size of the tumor or delay the spread of disease
  - Non-definitive procedures include diagnostic procedures and supportive care
  - Generally not used in statistical analysis of treatment

Non-Definitive Treatment (continued)

- *NOTE: For many of the reportable hematopoietic diseases, the principle treatment is either supportive care, observation, or another type of treatment that does not meet the usual definition of treatment that "modifies, controls, removes or destroys proliferating cancer tissue." Such treatments include phlebotomy, aspirin, supportive care and observation.
  - These treatments are recorded as first course *Other Treatment* (code 1) for the hematopoietic diseases ONLY (as directed in the hematopoietic database and coding manual)
  - Record a complete description of the treatment plan in the text field

Non-Definitive Treatment (continued)

- Examples of non-definitive treatment:
  - Surgical procedures:
    - *In*cisional biopsies
    - Exploratory procedures with or without biopsies
  - Supportive care/symptom relief:
    - Pain medication
    - Oxygen
    - Antibiotics administered for an associated infection
    - Transfusions*
    - Intravenous therapy to maintain fluid or nutritional balance
    - Laser therapy directed at relieving symptoms

Definitive Treatment

- Definitive treatment modifies, controls, removes, or destroys proliferating cancer tissue
  - May be directed toward either the primary site or to metastatic sites
  - Administered to minimize the size of the tumor or to delay the spread of disease
  - NOTE: Only definitive therapy should be included in statistical analyses of treatment – Surgery codes 00-07, and ‘Other’ treatment code 0 are not considered definitive therapy and must be excluded from analyses

Palliative Treatment

- Palliative treatment improves the patient's quality of life by preventing or relieving suffering
- May include definitive treatment procedures as well as non-definitive patient care procedures (Ex: Patient diagnosed with stage IV colon cancer with extensive liver metastasis – Patient is unresectable due to advanced stage of disease and advanced age - Begins chemotherapy intended to shrink the metastatic tumor and relieve symptoms – The chemotherapy is palliative because shrank the tumors and relieved symptoms AND the chemotherapy is also definitive therapy because it destroyed proliferating cancer tissue)
  - Record any palliative therapy that modifies or destroys cancer tissue if planned as part of first course definitive therapy

Adjuvant vs Neo-adjuvant Therapy

- Definitive therapy (chemotherapy, radiation therapy, hormone therapy, immunotherapy, etc) given as part of planned first course of therapy ***after*** surgical resection is called **'**adjuvant**'** therapy.
- Definitive therapy (chemotherapy, radiation therapy, hormone therapy, immunotherapy, etc) given as part of planned first course of therapy ***before*** surgical resection is called **'**neo-adjuvant**'** therapy.

Treatment-Related Coding Fields

Treatment Status

- Summarizes whether patient received any treatment or was under active surveillance (watchful waiting)
- This field may be left blank for cases diagnosed prior to 1/1/10
- Treatment administered after a period of active surveillance is considered subsequent therapy and is not coded in this item
- Definition:
  - Code 0 = No treatment given
  - Code 1 = Treatment given
  - Code 2 = Active surveillance (watchful waiting)
  - Code 3 = Unknown if treatment was given

Treatment Status (continued)

- Coding sample:
  1. Patient diagnosed with prostate cancer and chooses to “watch and wait”. Treatment status code?
  2. Patient diagnosed with colon cancer and undergoes a colectomy. Treatment status code?

Systemic Surgery Sequence

- Records sequencing of systemic therapy and surgical procedures given as part of first course of treatment
- Use this data field for cases diagnosed on or after 1/1/06
- Codes:
  - 0 = No systemic therapy ***and/or*** surgical procedures
  - 2 = Systemic therapy ***before*** surgery
  - 3 = Systemic therapy ***after*** surgery
  - 4 = Systemic therapy ***both before and after*** surgery
  - 5 = ***Intraoperative*** systemic therapy
  - 6 = ***Intraoperative*** systemic therapy ***with*** other systemic therapy administered ***before or after*** surgery
  - 9 = Sequence unknown

Radiation/Surgery Sequence

- Records the sequencing of radiation and surgical procedures given as part of first course of treatment
- Codes:
  - 0 = No radiation therapy ***and/or*** surgical procedure
  - 2 = Radiation therapy ***before*** surgery
  - 3 = Radiation therapy ***after*** surgery
  - 4 = Radiation therapy ***both before and after*** surgery
  - 5 = ***Intraoperative*** radiation therapy
  - 6 = ***Intraoperative*** radiation therapy ***with*** other therapy administered ***before or after*** surgery
  - 9 = Sequence unknown

Reason No Non-Definitive Surgery

- Code reason no non-definitive surgical procedure performed as part of initial diagnostic work-up
- If non-definitive surgical specimen is diagnostic of malignancy, **must** create a non-definitive surgical therapy record for the earliest positive non-definitive surgical procedure
- For this field, record only biopsies that obtain *tissue*; fine needle aspirations that obtain only cells (not tissue) for cytology are **not** coded in this field

Reason No Non-Definitive Surgery (continued)

- Definitions of codes:

0 Non-definitive surgery not performed; not applicable; not recommended for this case; autopsy only

1 Non-defininve surgery performed and results diagnostic of malignancy

2 Non-definitive surgery performed and results negative for malignancy

3 Non-definitive surgery performed and results turned out to be definitive therapy (excisional biopsy)

8 No non-definitive surgery **at this hospital**; unknown if non-definitive surgery done elsewhere

9 Unknown if non-definitive surgery performed

Reason No Therapy

- Code reason why treatment not administered as part of first course of therapy
- Includes reason no surgery, no chemotherapy, no radiation therapy, no hormone therapy, no immunotherapy, no other therapy

Reason No Therapy (continued)

- Definition of codes 0 and 1 for surgery:
  - Code 0 for surgery = Surgery **was performed** as part of planned first course of therapy
  - Code 1 for surgery = Surgery **was NOT performed** as part of planned first course of therapy

Reason No Therapy (continued)

- Definition of codes 0 and 1 for chemotherapy, radiation therapy, hormone therapy, immunotherapy and other therapy:
  - Code 0 for chemotherapy, radiation therapy, hormone therapy, immunotherapy and other therapy = **not administered** because it was not part of planned first course therapy – Use code 0 when:
    - There is no information in the patient's medical record about these therapies AND
      - it is known that these therapies are not usually performed for this type and/or stage of cancer OR
      - there is no reason to suspect that the patient would have undergone one of these therapies

Reason No Therapy (continued)

- If the treatment plan offered multiple treatment options and the patient selected treatment that did not include any of these therapies
- Patient elects to pursue no treatment following discussion of these treatments (a discussion does not equal a recommendation)
- Only information available is that the patient was referred to an oncologist (a referral does not equal a recommendation)
- Watchful waiting is the planned course of treatment
- Patient diagnosed at autopsy

- Code 1 for chemotherapy, radiation therapy, hormone therapy, immunotherapy and other therapy = **Therapy administered** as part of first course of therapy

Reason No Therapy (continued)

- Definitions of codes 2 – 9 for ALL therapies:
  - Code 2 = Therapy not recommended/administered because it was contraindicated due to other patient risk factors (co-morbid conditions, advanced age, etc)
  - Code 5 = Therapy not administered because patient died prior to planned or recommended therapy
  - Code 6 = Therapy not administered; was recommended by patient's physician, but was not administered as part of first course of treatment – no reason why noted in the medical record

Reason No Therapy (continued)

- Code 7 = Therapy not administered; was recommended by the patient's physician, but treatment was refused by patient, patient's family member, or patient's guardian – refusal noted in the medical record
- Code 8 = Therapy recommended, but unknown whether it was administered
- Code 9 = Unknown if therapy recommended or administered, or death certificate case only*

*The Kentucky Cancer Registry and the Commission on Cancer (for ACoS-accredited registries) recommend that you utilize all resources to obtain complete first course of therapy information. This may entail obtaining information from outside resources such as physician offices and other facilities. NCCN guidelines are a great resource for identifying usual treatment recommendations by primary site and stage of disease. NCCN guidelines can be found at *www.nccn.org*. The Hematopoietic Database is an excellent resource for identifying usual treatment recommendations for hematopoietic diseases. Consult the attending physician (Ex: surgeon, medical oncologist, radiation oncologist) or your registry's physician advisor if protocols or management guidelines are not available.

Reason No Therapy (continued)

- Coding sample:
  1. Patient undergoes an LAR (lower anterior resection) for a rectosigmoid colon cancer. Reason no surgery code?
  2. Patient is recommended by physician to undergo chemotherapy for colon cancer, but patient refuses. Reason no chemotherapy code?
  3. Patient is diagnosed with rectal cancer at your facility and is discharged. No additional work-up performed at your facility (stage of disease unknown), no treatment at your facility, and no treatment plan documented, and unknown if treatment administered elsewhere. Reason no therapy code(s)?

Reason No Therapy (continued)

4. Patient diagnosed with lymph node positive colon cancer and undergoes hemicolectomy at your facility. There is no information re: adjuvant therapy in the medical record. Per NCCN treatment guidelines, chemotherapy is recommended. Reason no therapy chemotherapy code?

Palliative Care

- Record the type of palliative care provided during the first course of planned therapy
- Given to relieve symptoms and may include surgery, radiation, systemic therapy or other pain management therapy
  - Palliative procedures do not diagnose or stage the primary tumor
  - Palliative surgical procedures, radiation therapy, and systemic therapy that are part of first course of therapy and that also remove or modify primary or secondary malignant tissue are **coded in the palliative care fields AND in the respective therapy fields**

Palliative Care (Continued)

- Codes:
  - Code 0 = No palliative care provided; diagnosed at autopsy only
  - Code 1 = Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
  - Code 2 = Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage or treat the primary tumor is made
  - Code 3 = Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made
  - Code 4 = Patient received or referred for pain management therapy with no other palliative care

Palliative Care (Continued)

- Codes (continued):
  - Code 5 = Any combination of codes 1, 2, and/or 3 WITHOUT code 4
  - Code 6 = Any combination of codes 1, 2, and/or 3 WITH code 4
  - Code 7 = Palliative care was performed or referred, but no information on the type of procedure available in the patient record; palliative care was provided that does not fit the descriptions in codes 1-6 (Ex: stent placement in bile duct for patient with pancreatic cancer)
  - Code 9 = Unknown if palliative care performed or referred; not stated in patient record

Palliative Care (continued)

- Coding sample:
  1. Patient diagnosed with advanced colon cancer undergoes colon bypass surgery with colostomy due to obstruction. Palliative care code?
  2. Patient diagnosed with unresectable, obstructive colon cancer with extensive liver metastases and undergoes chemotherapy to hopefully reduce the tumor burden and relieve symptoms. Palliative care code?

End of Cancer Therapy Presentation

Any questions?

Lets complete the reason no therapy exercises.

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