SCREENING OR BIOPSY PROCEDURES **Combined Items Length: 4**

First digit:	***Item Name: Biopsy procedure***
	Item Length: (1)
Second digit:	***Item Name: Guidance***
	Item Length: (1)
Third digit:	***Breast: Palpability of primary***
	Prostate: Approach for biopsy of primary (1)
	Item Length: (1)
Fourth digit:	***Breast: First detected by***
	Prostate: Biopsy of other than primary
	Item Length: (1)
	Data Type: Numeric
	Allowable Values: Site Specific
	Required Data Set

"Screening or Biopsy Procedures" are biopsies that do not grossly remove the primary tumor and/or surgical margins were macroscopically involved. Screening and biopsy procedures are collected on two sites, breast and prostate.

If the primary tumor was grossly removed during the biopsy procedure, code all of the screening and biopsy items 0 (not done, not a separate procedure). The biopsy would be coded as cancer-directed surgery.

If the primary site is other than breast or prostate, code all data items 0.

BREAST

Biopsy Procedure (Breast Only)

0 Not done, not a separate procedure
1 Biopsy, NOS
  2 Fine needle aspiration (cytology)
  3 Core biopsy (histology)
  5 Excision of major duct (if procedure removes all gross primary tumor, code as cancer-directed surgery)
9 Unknown if biopsy performed; death certificate only

CODE	DEFINITION (BIOPSY PROCEDURE)
0	No screening or biopsy procedures were done. Biopsy was performed, but was a part of first course surgery (e.g, excisional biopsy). Not a breast or prostate primary
1	A biopsy was done, but the type is unknown.
2	A fine needle aspiration was done and the results were interpreted by cytology.
3	A core needle biopsy was done and the results were interpreted by histology (tissue).
5	A major duct was excised, but this excision did not remove all gross primary tumor.
9	It is unknown if the patient had a biopsy; death certificate only cases.

SCREENING OR BIOPSY PROCEDURES (Continued)

Guidance (Breast Only)

0 Not guided; no biopsy of primary site

1 Guided, NOS
- 2 Radiographic NOS (no dye or dye unknown)
- 3 Mammographic; wire/needle localization
- 4 Stereotactic
- 5 Dye only
- 6 Dye plus (1-3)
- 7 Ultrasound

9 Unknown if guided; biopsy performed; death certificate only

CODE	DEFINITION (GUIDANCE)
0	No biopsy of primary site was done, or the biopsy was part of first course surgery (e.g., excisional biopsy). A biopsy of the primary site was done, none of the guidance techniques listed in codes 1-7 were used. Not a breast or prostate primary.
1	A biopsy was done, it is known that guidance was used, but the type of guidance is not documented/known.
2	A biopsy was done guided by any radiographic technology. No dye was used to localize the tumor or it is unknown if dye was used to localize the tumor.
3	The tumor was localized by needles or wire placed with mammograpic guidance.
4	Stereotactic biopsy was performed, using a fine needle (cytology), or a core needle (histology).
5	Tumor was localized using dye only.
6	Tumor was localized using dye and guided by one of the techniques described in codes 1-3.
7	Biopsy was guided by ultrasound.
9	It is unknown if a biopsy was done. A biopsy was done, it is unknown if a guidance technique was used. Death certificate only case.

SCREENING OR BIOPSY PROCEDURES (Continued)

Palpability of Primary (Breast Only)

0 Not palpable
1 Palpable
9 Palpability not stated; death certificate only

First Detected By (Breast Only)

Record the method by which the breast mass or abnormality was first recognized.

0 Not a breast or prostate primary
1 Patient first felt lump or noted nipple discharge
2 Physician first felt lump
3 Mammography -routine (screening)
4 Occult; incidental finding during other procedure
9 Unknown how first detected

SCREENING OR BIOPSY PROCEDURES (Continued)

PROSTATE

Biopsy Procedure (Prostate Only)

0 Not done, not a separate procedure

1 Incisional biopsy, NOS
- 2 Fine needle aspiration (cytology)
- 3 Needle core biopsy; biopsy gun (histology)
- 4 Sextant biopsy

9 Unknown if biopsy of primary was done; death certificate only

CODE	DEFINITION (BIOPSY PROCEDURE)
0	No screening or biopsy procedures were done. Screening or biopsy procedures were done, but were coded as first course surgery (e.g., TURP). Not a breast or prostate primary.
1	A biopsy was done, but the tumor was not grossly removed during this procedure and/or surgical margins were macroscopically involved, or it is unknown whether it was incisional or a core needle biopsy.
2	A fine needle aspiration was done and the results were interpreted by cytology.
3	A core needle biopsy was done and the results were interpreted by histology (tissue). A biopsy gun was used to get a tissue sample that was interpreted by histology.
4	A biopsy was done using a sextant.
9	It is unknown if the patient had a biopsy; death certificate only cases.

SCREENING OR BIOPSY PROCEDURES (Continued)

Guidance (Prostate Only)

0 Not guided; no biopsy of primary

1 Guided, NOS
2 Radiographic
3 Ultrasound

9 Unknown if guided, biopsy performed; death certificate only

CODE	DEFINITION (GUIDANCE)
0	No biopsy of primary site was done, or the biopsy was part of first course surgery (e.g., TURP). A biopsy of the primary site was done, none of the guidance techniques listed in codes 1–7 were used. Not a breast or prostate primary.
1	A biopsy was done, it is known that guidance was used, but the type of guidance was not documented/known.
2	A biopsy was guided by any radiographic technology. No dye was used to localize the tumor or it is unknown if dye was used to localize the tumor.
3	Biopsy was guided by ultrasound.
9	It is unknown if a biopsy was done. A biopsy was done, it is unknown if a guidance technique was used. Death certificate only case.

SCREENING OR BIOPSY PROCEDURES (Continued)

Approach for Biopsy of Primary (Prostate Only)

0 No biopsy
1 Transrectal
2 Transperineal
3 Transurethral
4 Laparoscopic
5 Open (laparotomy)
9 Unknown approach, but biopsy performed; death certificate only

Biopsy of Other Than Primary (Prostate Only)

0 No biopsy of other than primary

1 Biopsy of seminal vesicle(s), NOS
  2 Unilateral
  3 Bilateral

4 Other than seminal vesicle

5 4 + 1

6 4 + 2

7 4 + 3

9 Unknown if biopsy of other than primary; death certificate only

DATE OF FIRST COURSE TREATMENT (Date Started) **Item Length: 8**

Includes Surgery of Primary Site, Scope of Regional Lymph Node Surgery, and Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s) **Data Type: Numeric Required Data Set**

Date of first course treatment is the month, day, and year (MMDDCCYY) of the first course therapy. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Month	Day	Year
01 January	01	Use four-digit year
02 February	02	9999 year unknown
03 March	03	
04 April	..	
05 May	..	
06 June	30	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		

Examples: Record June as 06
Record December 15, 1996 as 12151996

If the physician decides not to treat the patient, record the date of this decision as the date of initial treatment. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

Example: On February 12, 1996 the physician says that a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) starts to rise. Enter 02121996 as the date of first course treatment.

If the patient refuses treatment, record the date of this decision as the date of initial treatment. Record the date of death for autopsy only cases. If the patient is diagnosed at the reporting facility and no further information is available (patient is lost to follow-up) record the date the patient was last seen at the reporting institution.

Code 99999999 when it is unknown if any treatment was given, or the date is not known, or the case was identified by death certificate only.

If the exact date of the beginning of treatment is not available, recording an approximate date is preferred.

DATE OF DIAGNOSTIC, STAGING, OR PALLIATIVE PROCEDURES

Item Length: 8
Data Type: Numeric
Required Data Set

Collecting dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and treatment to recurrence).

Date of Diagnostic, Staging, or Palliative Procedures is the month, day, and year (MMDDCCYY) that diagnostic, staging, or palliative procedures were performed at any facility. The first two digits are the month, the third and fourth digits are the day and the last four digits are the year.

Month	**Day**	**Year**
01 January	01	Use four-digit year
02 February	02	9999 year unknown
03 March	03	
04 April	..	
05 May	..	
06 June	30	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Examples: Record June as 06.
Record December 15, 1996 as 12151996.

Code 00000000 when no Diagnostic, Staging, or Palliative procedures are performed; as well as for autopsy only cases.

Code 99999999 when it is unknown if any Diagnostic, Staging, or Palliative procedures were performed or the date is not known, or the case was identified by death certificate only.

If the exact date of Diagnostic, Staging, or Palliative procedures is not available, recording an approximate date is preferred.

DIAGNOSTIC, STAGING, OR PALLIATIVE PROCEDURES

Item Length: 2
Data Type: Numeric
Required Data Set

Diagnostic, Staging, or Palliative Procedures

Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are diagnostic, staging, and palliative procedures. Valid codes are 01–07, 09.

Examples of exploratory surgery are:

- Celiotomy
- Laparotomy
- Cystotomy
- Nephrotomy
- Gastrotomy
- Thoracotomy

Examples of palliative bypass surgery are:

- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy
- Urethrostomy

Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Record the type of diagnostic, staging, or palliative procedures performed as part of the initial diagnosis and workup, whether performed at your institution or at other institutions.

DIAGNOSTIC, STAGING, OR PALLIATIVE PROCEDURES (Continued)

Codes:

00 No diagnostic, staging, or palliative surgery

01 Incisional biopsy of other than primary site leaving gross residual disease
(Code microscopic residual disease or no residual disease as Surgery of Other Regional Site[s], Distant Site[s], or Distant Lymph Node[s])
Needle biopsy of other than primary site
Aspiration biopsy of other than primary site

02 Incisional biopsy of primary site leaving gross residual disease
(Code microscopic residual disease or no residual disease as Surgery of Primary Site)
Needle biopsy of primary site
Aspiration biopsy of primary site

03 Exploratory ONLY (no biopsy)

04 Bypass surgery (no biopsy); -ostomy ONLY (no biopsy)

05 Exploratory ONLY and incisional 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 Diagnostic, staging, and palliative surgery, NOS

09 Unknown if diagnostic, staging, and palliative surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01–07 have priority over code 09.
- In the range 01–06, the higher code has priority.
- Codes 01–06 have priority over code 07.

DIAGNOSTIC, STAGING, OR PALLIATIVE PROCEDURES AT THIS FACILITY

Item Length: 2
Data Type: Numeric
Required Data Set

Record the type of diagnostic, staging, or palliative procedures performed at this facility. Do not include procedures done at other facilities.

Codes:

00 No diagnostic, staging, or palliative surgery

01 Incisional biopsy of other than primary site leaving gross residual disease
(Code microscopic residual disease or no residual disease as Surgery of Other Regional Site[s], Distant Site[s], or Distant Lymph Node[s])
Needle biopsy of other than primary site
Aspiration biopsy of other than primary site

02 Incisional biopsy of primary site leaving gross residual disease
(Code microscopic residual disease or no residual disease as Surgery of Primary Site)
Needle biopsy of primary site
Aspiration biopsy of primary site

03 Exploratory ONLY (no biopsy)

04 Bypass surgery (no biopsy); -ostomy ONLY (no biopsy)

05 Exploratory ONLY and incisional 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 Diagnostic, staging, and palliative surgery, NOS

09 Unknown if diagnostic, staging, and palliative surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01–07 have priority over code 09.
- In the range 01–06, the higher code has priority.
- Codes 01–06 have priority over code 07.

DATE OF SURGERY

Item Length: 8
Data Type: Numeric
Required Data Set

Date of surgery is the month, day, and year (MMDDCCYY) that surgery—described as Surgery of Primary Site, Scope of Regional Lymph Node Surgery, or Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)—was performed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting the dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

If your software allows the collection of only one date, record the first date on which the patient had surgery.

Month	**Day**	**Year**
01 January	01	Use four-digit year
02 February	02	9999 year unknown
03 March	03	
04 April	..	
05 May	..	
06 June	30	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		

Example: Record December 15, 1996 as 12151996

Code 00000000 when no surgery of the type described above is performed or for autopsy-only cases.

Code 99999999 when it is unknown if any surgery was performed and the date is unknown, or if the case was identified by death certificate only.

If the exact date of surgery of the types described above is not available, record an approximate date.

DATE OF SURGERY **(Continued)**

If information is limited to a description, use the following:

DESCRIPTIVE TERM USED	DATE CODE
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

SURGICAL APPROACH

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

"Surgical Approach" describes the method used to approach the organ of origin and/or primary tumor. Code the approach for surgery of the primary site only. If no primary site surgical procedure was done ("Surgery of Primary Site" is coded 00), "Surgical Approach" must be coded 0. If the field "Surgery of Primary Site" is 99 (Unknown if surgery performed; death certificate ONLY), code "Surgical Approach" 9 (Unknown; not stated; death certificate ONLY).

"Endoscopy, image guided" is a generic term for guidance provided by any imaging technique include, but not limited to, CT scans, MRI scans, ultrasound, or radiographic imaging.

"Open" is a generic term describing all non scope approaches. Procedures for which "Surgical Approach" would be coded open include, but are not limited to, mastectomy; excision of a melanoma of the skin; glossectomy.

"Open, assisted by endoscopy" means that the scope is being used (present in the body) at the same time the primary tumor is resected. DO NOT CODE a procedure as assisted by endoscopy when the scope is used and removed prior to the resection or when it is inserted and used after the resection of the primary tumor.

Example: Patient with lung cancer is taken to the surgical suite. A bronchoscopy and mediastinoscopy are done to evaluate whether the lesion is resectable. The scopes are removed before the surgeon performs a wedge resection. Code "Surgical Approach" open, **NOT** assisted by endoscopy.

There are differences in how software providers present the surgery codes. Some programs allow only one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If only one field is available for the data item "Surgical Approach" or if a summary treatment field is provided, use the following guidelines.

If the patient has multiple surgeries of the primary site, code the "Surgical Approach" for 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). Since the hemicolectomy is the most invasive, definitive surgery and has the numerically higher code (40), the "Surgical Approach" is coded open, not assisted by endoscopy (5).

SURGERY OF PRIMARY SITE

Item Length: 2
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Only record surgeries 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 as part of a specified code definition or in an **en bloc** resection.

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 pathology finds no nodes in the specimen.

The range of codes from 00-89 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)."

There are differences in how software providers present the surgery codes. Some programs allow only one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If a single field is available for the data item "Surgery of Primary Site" or if a summary treatment field is provided, use the following guidelines:

C If the patient has multiple cancer-directed 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 surgery was done, code 00.

If surgery was previously done, code the total result of that surgery with the current surgery.

Biopsies that remove all gross tumor or leave only microscopic margins should be coded to surgery of the primary site.

SURGERY OF PRIMARY SITE **(Continued)**

If multiple fields are provided to record consecutive surgical events, use the following guidelines.

- Code each consecutive surgery of the primary site.
- If no primary site surgical procedure was done code 00.

Site-Specific Surgery Codes

ICD-O-2 CODE	SITE
C00.0 - C06.9	Lip and oral cavity
C07.9 - C.8.9	Parotid and other unspecified 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 - C21.9	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 - C 41.9, 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, C77.0 - C77.9	Spleen and lymph nodes
C44.0 - C44.9	Skin
C50.0 - C50.9	Breast

SURGERY OF PRIMARY SITE **(Continued)**

ICD-O-2 CODE	SITE
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
C14.1-C14.8, C17.0 - C17.9, C23.9, C24.0 - C24.8, C26.0 - C26.0, C30.0 - C 30.1, C31.0 - C31.9, C33.9, C37.9, C38.0 - C38.8, C39.0 - C39.9, C42.0 - C42.1, C42.3 - C42.4, C48.0 - C48.8, C51.0 - C51.9, C52.9, C57.0 - C57.9, C58.9, C60.0 - C 60.9, C63.0 - C 63.9, C74.0 - C76.8, C80.9	All other sites

Priority of Codes

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

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

Note: The hierarchy of surgery codes for cervix and brain will be corrected in a future ROADS revision.

SURGERY AT THIS FACILITY **Combined Items Length: 6**

Surgery of Primary Site at this Facility: 2
Scope of Regional Lymph Node Surgery at this Facility: 1
Number of Regional Lymph Nodes Removed at this Facility: 2
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at this Facility: 1

Record only Surgery of Primary Site, Scope of Regional Lymph Node Surgery, Number of Regional Lymph Nodes Removed at This Facility, and Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) done at the reporting facility. This includes "excisional" biopsy that has microscopic residual disease or no residual disease.

SURGICAL MARGINS
(RESIDUAL PRIMARY TUMOR FOLLOWING FIRST COURSE SURGERY)

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

This field describes the status of the surgical margins after resection of the primary tumor. DO NOT code margin status from regional lymph node surgery or secondary or metastatic site surgery.

Microscopic involvement cannot be seen by the naked eye. The pathology report usually documents microscopic involvement in the final diagnosis or the microscopic portion of the report.

Macroscopic involvement is gross tumor which is visible to the naked eye. It may be documented in the operative report or in the gross portion of the pathology report.

The code is hierarchical, if two codes describe the margin status, use the numerically higher code.

Example: The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 5) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 5).

There are differences in how software providers present the surgery codes. Some programs will allow one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If a single field is available for the data item "Surgical Margins" or if a summary treatment field is provided, use the following guidelines.

- If the patient has multiple first course surgeries of the primary site (at least two fields "Surgery of Primary Site" are coded in the range 10-89), code the status of the surgical margins after the final or last surgery.

  Example: Patient has an excisional biopsy of a breast lesion. The pathology report describes an infiltrating ductal carcinoma. The margins are microscopically involved. A few weeks later, the patient has a modified radical mastectomy. The pathology report says all margins are free. Code the margin status after the mastectomy, all margins grossly and microscopically negative (0).

- If no first course surgery of the primary site was done ("Surgery of Primary Site" is coded 00), "Surgical Margins" must be coded 8.

If multiple fields are provided to record surgical margins for consecutive surgical events, use the following guidelines.

- Code the margin status for each individual surgical event.

- For each surgical event, if no primary site surgical procedure was done (Surgery of Primary Site is coded 00), surgical margins must be coded 8 (no cancer-directed surgery of primary site).

SCOPE OF REGIONAL LYMPH NODE SURGERY

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

For the majority of sites, "Scope of Regional Lymph Node Surgery" defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. This refers to the farthest regional lymph nodes removed regardless of involvement with disease (e.g., the biopsy of a contralateral lung lymph node). 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 or biopsied, code regional lymph node(s) removed, NOS (1).

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.

For an unknown primary, leukemia, lymphoma, and brain primaries, code 9.

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 D. 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 first course surgical procedure was performed, code 0.

NUMBER OF REGIONAL LYMPH NODES REMOVED

Item Length: 2
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Record the number of regional lymph nodes that were microscopically examined and identified in the pathology report **FOR THIS SURGICAL PROCEDURE ONLY**. **DO NOT** add numbers of nodes removed during 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.

Because this field is not cumulative and not affected by timing, it does not replace or duplicate the field "Regional Lymph Nodes Examined" in the staging section. Do not copy the values from one field to the other.

For an unknown primary (C80.9), code 99.

SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S) OR DISTANT LYMPH NODE(S)

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

"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. This field is for all procedures that do not meet the definitions of Surgery of Primary Site or Scope of Regional Lymph Node(s).

Example: A patient has an excisional biopsy of a hard palate lesion, which is removed from the floor 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 gall bladder. Do not code removal of the gall bladder.

RECONSTRUCTION/RESTORATION - FIRST COURSE

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

"Reconstruction/Restoration - 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 its treatment.

"Reconstruction/Restoration - First Course" is limited to procedures started during the first course of treatment. Some reconstructive/restorative procedures involve several surgical events. Code as "Reconstruction/Restoration - First Course" if the first event occurred during the first course of treatment.

Each site-specific surgery code scheme in Appendix D has either a list of reconstructive/restorative procedures or codes that define specific procedures. Code only those procedures listed under each site.

Reconstructive/restorative procedures may be performed after first course of treatment is complete. Code these procedures in the field "Reconstruction/Restoration-Delayed."

REASON FOR NO SURGERY

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason for no Surgery of Primary Site, Scope of Regional Lymph Node Surgery, and Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Codes 1–2 and 6–9 are valid only when the field Surgery of Primary Site is coded 00, Scope of Regional Lymph Node Surgery is coded 0, and Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) is coded 0.

Codes:

0 Surgery performed
1 Surgery not recommended
2 Surgery contraindicated because of other conditions, autopsy only cases
6 Reason unknown for no surgery
7 Patient or patient's guardian refused surgery
8 Surgery recommended, unknown if done
9 Unknown if surgery recommended or performed, death certificate only cases

REASON FOR NO SURGERY **(Continued)**

Clarification of code definitions:

CODES	DEFINITION	EXAMPLE
0	Surgery was performed. The field "surgery" is coded in the range 10–90.	
1–9	No surgery known to have been performed. The field "Surgery" must be coded 00.	
1	Surgery is not recommended for this stage of disease, histologic type, or site.	Small cell carcinoma of the lung; widely metastatic colon cancer; leukemia
2	Cases in which surgery would have been the treatment of choice, but could not be performed because of comorbid conditions. Cases in which surgery was recommended, but the patient expired before it could be performed. Autopsy only cases (class 5)	Stage I adenocarcinoma of the lung. Patient has severe COPD. Cannot remove any part of the lung because pulmonary function is not adequate.
6	Surgery would have been the treatment of choice; surgery was not performed, but the reason is not given.	
7	Surgery was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused surgical treatment.	
8	Surgery was recommended by a physician; no follow-up information available to confirm if surgery was performed.	
9	No surgery known to have been performed. No confirmation if surgery was recommended or performed (frequently non-analytic cases). Death certificate only cases.	