Therapy Information

Data items 50040-50400

Each type of definitive therapy (surgery, radiation, chemotherapy, etc.) that the patient received should be recorded in detail in data items 50040-50400. These items may be repeated as often as necessary in order to record every type of treatment administered to the patient. If the same type of treatment is given more than once during a course, it only needs to be recorded one time -- UNLESS the procedure code or treatment agents change. Then, items 50040-50400 would have to be repeated in order to record the differences in those item(s). For example, if a patient has both a lumpectomy and a mastectomy, you would have to complete items 50040-50400 for each instance of surgery because the procedure code is different. See special note for radiation treatment below.

Coding Surgery: The CPDMS software uses the same data fields (items 50040-50400) to record both definitive and non-definitive therapies. Non-definitive surgical procedures include incisional biopsies, bypass surgeries, etc., and the codes for these procedures are the same for all types of cancer. Coding non-definitive surgical procedures became required by the ACoS for approved facilities in 1996. Beginning with 2010 diagnoses, KCR requires the first non-definitive surgical procedure which is positive for malignancy to be recorded.

The definitive surgical procedure codes are site specific and they are contained in Appendix G. These surgery codes changed significantly in 1998 with the ACoS ROADS Manual, and again in 2003 with the FORDS Manual. Surgery codes collected prior to 1998 were converted to the 1998 ROADS definitions and are stored in data items 50240-50290. Surgeries coded for cancers diagnosed from 1998 to 2002 are also collected in items 50240-50290 and are defined by the ACoS ROADS Manual. Starting with cancers diagnosed in 2003, the site specific surgery codes are stored in data items 50100-50120 and are defined by the ACoS FORDS Manual. Both sets of codes are included in Appendix G. Be sure to use the correct table based on the diagnosis year of the cancer being abstracted.

Note on Coding Radiation Treatment: (This is for ACoS approved hospitals and pertains to treatment given to patients diagnosed after January 1, 2003.) You should summarize the entire first course of radiation treatment on one radiation therapy segment. Code all eight new radiation fields implemented with FORDS. If you learn of more radiation given after you have abstracted and entered this patient record, then EDIT the EXISTING radiation treatment segment instead of creating a new radiation therapy record segment. This is important for NCDB submissions. They require one summary record of first course radiation treatment. If there are more in your database, only the one with the earliest start date will be sent to NCDB. If palliative radiation is also given, it must also be recorded in the radiation therapy fields. Each data element and the appropriate codes are further explained on the following pages. Follow-up information about subsequent therapies may be recorded in the same manner as the first course of therapy.