

# CODING TIPS, TRICKS & TRAPS

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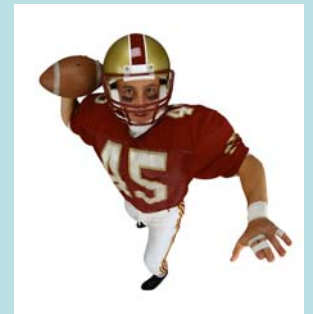
# Patient Identification

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# Accession Number

- If you must delete an abstract, do not reassign the accession number to another patient
  - Source: FORDS 2007, pages 9, 33



Accession numbers are like athlete's jerseys- They are "retired" and not reused!

# Address at Diagnosis

- Never update if patient moves
- May be different for different primaries
- Will usually be unknown for class 3 cases
  - FORDS 2007, pages 8, 42

# Address at Diagnosis

## Ambiguous Residences

Persons with more than one residence (e.g., Winter visitors or “Snowbirds”)

Use the address the patient specifies if a usual residence is not given

Source: FORDS 2007, page 18

## Residents of nursing or convalescent homes

- Use the street address of the nursing or convalescent home
- Enter the name of the resident facility in the “Supplemental” address

Source: FORDS 2007, page 43

# Address at Diagnosis

## A Word About P.O. Boxes...

A P.O. Box should be used as an address if no street address is available.

If patient has both a P.O. box and a street address...

Street address goes first, P.O. box goes in supplemental address field

# Race

## Use of “Unknown Race” code

- If Race 1 is coded in the range 01-98, Race 2 through Race 5 cannot be coded to “99”
- If any race item is coded to “99”, then all race fields must be coded to “99”

# Race/Ethnicity

## Ethnicity

Item used to identify patients of Hispanic origin

## Connection with Race codes

- Persons of Hispanic origin may be of any race
  - Do not code Race 1 to “98” (Other Race) for a person stated to be Hispanic or Latino

Source: Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007 (page 42) (SPCSM)

- If a person is described as Hispanic, but there is no information about race, code Race 1-5 as “99” (Unknown)

# Cancer Identification

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# Class of Case 0 vs. Class 1

- If a patient is diagnosed at your facility, and does not return for any treatment:
  - The case is a class 0 if you know that the patient went elsewhere for treatment
  - The case is a class 1 if you do not know whether treatment was recommended or administered

# Class of Case 0 vs. Class 1

For instance:

I&R 13922

1/13/2005

A patient came to our facility for a urinary tract CT ordered by an outside physician. The CT said, "Large approx 10 cm right kidney lower pole mass suspicious for renal cell carcinoma." If the patient did not return, so it is unknown if they were treated, what is the class of case?

If your facility utilizes radiology as a casefinding source, the case should be accessioned into the cancer registry as a class of case 1.

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# Date of First Contact

Refers to date patient first seen at facility with a diagnosed or suspected cancer.

I & R 22959

7/19/2007

On 12/22/05 a patient was admitted with internal injuries. A chest X-ray 1/3/06 showed a mass in the upper lobe of the right lung. The physician ordered a fine needle biopsy 1/4/06 that was positive for large cell carcinoma.

The date of first contact would be 1/4/06 and the date of diagnosis would be 1/4/06 because the reason for admission was not directed at cancer diagnosis or treatment.

# Primary Site- Lymphomas

A few definitions:\*

- **Lymphatic system**

An umbrella term that includes: lymph nodes, spleen, thymus, tonsils, Waldeyer's ring, and Peyer's patches.

- **Nodal lymphoma**

A lymphoma originating in lymph nodes.

\*Source: SPCSM, page 71

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# Primary Site- Lymphomas

- **Extralymphatic**

- Originating in tissue or an organ that is not a part of the lymphatic system.

- **Extranodal lymphoma**

- Lymphoma originating in tissue or organ other than lymph nodes.
- Lymphatic system organs may be extranodal, e.g., A lymphoma originating in the spleen would be extranodal.

Source: SPCSM, page 71

# Primary Site Coding- Lymphomas

- Do not automatically code to the site that was biopsied.
  - For instance, a patient is seen at your facility for a biopsy of an enlarged cervical node. Histology shows NHL. No further workup is done at your hospital.
    - Do not code site to cervical lymph node (C77.0). Other areas may be involved. Use code C77.9 instead.
- Remember- For lymphomas, *any* positive mention of lymph nodes indicates involvement of those lymph nodes
  - E.g., Lymphadenopathy, enlarged, palpable, etc.
    - Source: Collaborative Staging Manual and Coding Instructions, part I, page I-34

# Primary Site Coding- Lymphomas

## Clarification-

If multiple lymph node chains are involved and the involved chains are in different lymph node regions, code C77.8 (lymph nodes of multiple regions).

Source: SPCSM, page 71

# Lymph Node Regions

- Cervical
- Axillary
- Infraclavicular
- Mediastinal
- Hilar
- Para-aortic
- Mesenteric
- Pelvic
- Inguino-femoral

Source: AJCC Cancer Staging Manual, 6<sup>th</sup> ed., page 396

# Primary Site- Extranodal Lymphomas

- When the lymphoma is extranodal and is confined to the organ of origin:
  - Code the organ of origin.  
For instance,  
Pathology from a stomach resection shows lymphoma. No other pathologic or clinical disease identified. Code the primary site as stomach, NOS (C16.9).

Source: SPCSM, page 71

# Primary Site- Extranodal Lymphomas

When the lymphoma is present in an extranodal site and in that organ/site's regional lymph nodes:

- Code the extranodal organ/site as the primary site.

For example,

Lymphoma is present in the stomach and the gastric lymph nodes. Code the primary site to stomach, NOS (C16.9).

Source: SPCSM, page 71

# Primary Site- Extranodal Lymphomas

Present in extranodal organ(s)/site and non-regional lymph nodes

- Consult physician to determine the primary site.
- If a site cannot be determined, code primary site to Lymph Node, NOS (C77.9).

Source: SPCSM, page 72

# Primary Site Coding- Lymphomas C77.9 vs. C80.9

- If the primary site is unknown, or not specified, code Lymph Nodes, NOS (C77.9)
  - **Exception:** Code unknown primary site (C80.9) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma

Source: SPCSM, page 72

# Primary Site Coding- Lymphomas C77.9 vs. C80.9

## Example

From SEER Inquiry System, #20051015

## Question

Primary Site--Lymphoma: How should this field be coded when a diffuse large B-cell lymphoma is found in the femur and in the soft tissue of the anterior chest wall but all CT scans are negative for lymphadenopathy?

# Primary Site Coding- Lymphomas C77.9 vs. C80.9

## Answer

Code the Primary Site field to C80.9 [Unknown primary site]. The primary site of diffuse large B cell lymphoma can be either nodal or extranodal. The case described above is likely extranodal because there is no evidence of lymph node involvement. Because the extranodal site of origin is unknown, code the Primary Site to C80.9.

# Lymphoma or Leukemia?

## Question

Patient was diagnosed by bx with CLL/SLL (Chronic lymphocytic leukemia/small lymphocytic lymphoma). The physicians on the case refer to CLL throughout the record. Studies demonstrate widespread lymphadenopathy.

How would site and histology be coded?

# Lymphoma or Leukemia?

## Answer

- Consider the case to be small lymphocytic lymphoma (SLL) if there are positive lymph nodes or deposits of lymphoma/leukemia in organs or in other tissue.
- Code the site to the involved tissue (typically lymph nodes, lymphatic structures, breast, and stomach).
  - In this case, lymph nodes of multiple regions (C77.8)
- Code histology to 9670/3 (Malignant lymphoma, small lymphocytic)

Source: SPCSM, page 83

# Lymphoma or Leukemia?

- Consider the case to be chronic lymphocytic leukemia (CLL) if there are no physical manifestations of the disease other than a positive blood study or positive bone marrow.
- Code the primary site to bone marrow (C42.1)
- Code the histology to CLL (9823/3)

Source: SPCSM, page 83

# Primary Site Coding- Blood vs. Bone Marrow

- Site code leukemias to bone marrow (C42.1), not blood (C42.0).

Source: SPCSM, page 70

- Site code Waldenstrom macroglobulinemia to blood (C42.0)

Source: Abstracting and Coding Guide for the Hematopoietic Diseases, page 18

# Meningiomas

Tumors with a meningioma histology (9530-9539)

- Code primary site to meninges (C70.0, C70.1, or C70.9) NOT brain (C71.\_)

Meningiomas originate in the meninges, which are membranes that cover the brain and spinal cord

# III-Defined Site vs. Unknown Primary

- When the medical record does **not** contain **enough information** to assign a primary site:
  - Consult a physician advisor to assign the site code
  - If the physician advisor cannot identify a primary site, use the NOS category for the organ system or the III Defined Sites (C76.0-C76.8)
  - Code Unknown Primary Site (C80.9) if there is not enough information to assign a NOS or III Defined Site category.

Source: SPCSM, page 70

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# Ill-Defined Site vs. Unknown Primary

From SEER Inquiry System, #20061068

## Question

Should the primary site be coded to C80.9 [Unknown primary site] or C76.1 [Thorax, NOS] if the patient died following a limited work-up that included on a cytology on pericardial fluid that was positive for poorly differentiated adenocarcinoma?

# Ill-Defined Site vs. Unknown Primary

From SEER Inquiry System, #20061068

## Answer

Based on the information provided, code the primary site to C80.9 [Unknown primary site]. There is not enough information provided to suggest that the primary site is the thorax or any other location.

# Use of Suggested Site Codes

- Some histologies have site codes associated with them in the ICD-O manual.

For example,

- Non-small cell lung carcinoma has site code for lung (C34.\_\_) beside the histology code of 8046/3 (ICD-O-3, page 182)

# Use of Suggested Site Codes

- Use the suggested site code if:
  - Primary site is unknown, or
  - Documented site is the same as the one suggested in ICD-O-3

For instance,

- Patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The ICD-O-3 histology code for infiltrating duct carcinoma (8500) has a suggested site of breast (C50\_).
  - Code the primary site as breast, NOS (C50.9).

Source: SPCSM, page 70

# Use of Suggested Site Codes

- Code the site as documented in the medical record and ignore the suggested ICD-O-3 site code when a primary site is specified in the medical record.

Source: SPCSM, page 70

# Grade

- If more than one grade is given, go with the highest grade...
  - Even if the highest grade comes from a smaller tumor specimen
  - Even if the highest grade is only a focus
- Code from the final pathologic diagnosis, if available
  - If grade is not stated in the final diagnosis, use the microscopic description.
  - Source: FORDS 2007, page 96

# Grade: Primary Site vs. Mets/Recurrence

- Never code grade:
  - From a metastatic site
  - From a recurrence
- Code only from primary site. For e.g.,  
Liver bx shows poorly-diff. adenoca., c/w lung primary. No lung bx done.

Code grade as “9” (unknown)

Source: FORDS 2007, page 96; SPCSM, page 97

# Grade: Unknown Primaries

Code “9” (unknown) if the primary site is unknown (C80.9)

Source: FORDS 2007, page 96

# Grade: In-Situ Lesions

If the tumor is purely in-situ,  
code the grade if stated

Source: FORDS 2007, page 96

# Grade: In-Situ & Invasive Components

- Lesions with invasive and in-situ components:
  - Code the grade from the invasive portion
  - If the grade from the invasive portion is unknown, then code “9” (unknown)
    - Do not use the grade from the in-situ portion

Source: FORDS 2007, page 96

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# Grade: Lymphomas

- For lymphomas, “grade” refers to the cell of origin:
  - B-cell
  - T-cell
  - Null cell; non-T non-B
  - Natural killer (NK) cell

# Grade: Lymphomas

From SEER Inquiry System, #20000465

Grade, Differentiation--Lymphoma: What code is used when the only grade/differentiation given is "low grade", "intermediate grade" or "high grade"?

Code the Grade, Differentiation field to 9 [cell type not determined, not stated or not applicable]. For lymphomas, do not code the descriptions "high grade," "low grade," and "intermediate grade" in the Grade, Differentiation field. These terms refer to categories in the Working Formulation and not to histologic Grade for lymphoma histologies.

# Stage of Disease at Diagnosis

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# Surgical Diagnostic and Staging Procedure

- Do not code the following procedures in this item:
  - Washings/brushings
  - Cell aspiration
  - Peripheral blood smears
- A procedure must cut or remove tissue in order to be coded in this item.

# Surgical Diagnostic and Staging Procedure

For instance:

Patient had an ERCP. Brushings were obtained from the tumor. The brushings were positive.

Do not code the ERCP in “Surgical Dx/Stage Proc.” Code the “Diagnostic Confirmation” field as “2” (Positive cytology).

# Treatment

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# Biopsy or Surgery?

- Code a biopsy as surgery (i.e., in the Surgical Procedure of Primary Site field) if:
  - It removes all of the tumor or
  - Margins are negative or microscopically positive

Source: FORDS 2007, page 135

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# Biopsy or Surgery?

I&R 21668

3/22/2007

A malignant melanoma was removed with close or transected margins on a punch or shave biopsy. It was followed by a re-excision that showed no residual. Is the punch or shave biopsy coded as a diagnostic procedure and the re-excision coded as the only treatment or is the biopsy coded as part of the surgery treatment?

If the shave or punch biopsy removed all gross tumor (only microscopic margins), then it would be coded as surgery, as per the instructions on page 135 of FORDS.

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# Using “Unknown” Codes for Treatment Items

When coding the following treatment-related fields and their associated dates:

- Surgery of Primary Site
- RX Hosp--Radiation
- Chemotherapy
- Hormone Therapy
- Immunotherapy
- Hematologic Transplant and Endocrine Procedures
- Other Treatment

Continued...

# Using “Unknown” Codes for Treatment Items

If there is no documentation in the record that a treatment was administered, enter 0's.

For instance,

Prostate cancer patient is seen on an outpatient basis for a course of external beam radiation treatments. There is no mention in the record that the patient received Casodex, Lupron, or any other hormonal therapy for the prostate cancer.

Code 0's in the items “Hormone Therapy” and “Date Hormone Therapy Started”

- Do not code 9's (Unknown)
- If it is not in the record, then it was not given

# Using “Unknown” Codes for Treatment Items

Use code “99” (Unknown if performed/administered) in the following situations:

- If the record contains contradictory information about whether a treatment was given
- For a non-analytic case for which there is no information on the treatment

# Using “Unknown” Codes for Treatment Items

## Examples:

- Non-analytic breast cancer case
  - First course of treatment was lumpectomy, radiation, and Tamoxifen (Hormone)
    - Do not use “unknown” codes for chemotherapy, since you have info on treatment
- Non-analytic breast cancer case
  - No mention in record about initial treatment
    - Use “unknown” codes.

# Using “Recommended” Codes for Treatment Items

- Code “8” or “88” (Therapy was recommended, but it is unknown if it was performed/administered) can be used for the following items:
  - Reason for No Surgery of Primary Site
  - Reason for No Radiation
  - Chemotherapy
  - Hormone Therapy
  - Immunotherapy
  - Hematologic Transplant and Endocrine Procedures
  - Other Treatment

# Using “Recommended” Codes for Treatment Items

- Code “8” or “88” is used when a specific treatment is recommended, but it is not known whether it was actually given.
  - A referral, consult, or discussion is not the same as a recommendation!
- Use as a flag to indicate that you need to complete these items

# Using “Recommended” Codes for Treatment Items

## Example:

Nephrectomy is recommended for a newly diagnosed renal cancer, and this recommendation is the most definitive information you have regarding the procedure, use the following codes:

Date of First course treatment = 99/99/9999

Date of First Surgical Procedure = 99/99/9999

Date of Most Definitive Surgical Resection of the Primary Site = 99/99/9999

Surgical Procedure of Primary Site = 99

Surgical Margins of the Primary Site = 9

Scope of Regional Lymph Node Surgery = 9

Surgical Procedure/Other Site = 9

Reason for No Surgery of Primary Site = 8

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# Scope of Regional LN Surgery

This item doesn't refer only to actual LN removal...

- Biopsy or aspiration of node(s) is coded in this field (Codes 1, 2)
- If nodes are removed, use codes in 3-7 range

Source: FORDS 2007, pages 138-39

# Scope of Regional LN Surgery

Record even if surgery to the primary site is not performed

- E.g., mediastinoscopy with LN bx, but no lung resection
  - Record:
    - Number of nodes removed with the mediastinoscopy in the Scope of Regional LN Surgery field
    - Date of mediastinoscopy in the “Date of Surgery” field
    - Code “00” in Surgical Procedure of Primary Site

# Scope of Regional LN Surgery

- Regional node biopsy or removal is considered to be cancer-directed surgery

Therefore,

If a patient has only a biopsy/removal of a regional lymph node at your facility, abstract the case even if the node is negative.

Reference: FORDS 2007, page 27

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# Scope of Regional LN Surgery

Relationship to “Rad/Surg Sequence”  
and “Systemic/Surgery Sequence”

- If no resection of the primary site is performed, but patient undergoes regional LN bx or removal, this is considered to be surgery when coding these 2 items

# Scope of Regional LN Surgery

For instance,

- Mediastinoscopy with removal of 2 mediastinal nodes done 1/7/07
- No lung resection
- Patient began XRT to the chest on 1/29/07

Scope of Regional LN Surgery- Code 4 (1-3 regional LN removed)

Surg/Rad Sequence- Code 3 (XRT after surgery)

# Surgical Procedure/Other Site

Record surgery to regional and/or distant sites, even if surgery to the primary site is not performed

- E.g., patient has resection of solitary brain metastasis for lung cancer. No lung resection performed

Record:

- Code 4 (Nonprimary surgical procedure to distant site) for Surgical Procedure/Other Site
- Date of brain met resection in the “Date of Surgery” field
- Code “00” in Surgical Procedure of Primary Site

# Surgical Procedure/Other Site

- If organ/tissue is removed for reasons other than known/suspected cancer, do not code under Surgical Procedure/Other Site.
  - E.g., incidental removal of appendix or gallbladder to remove right colon cancer.

Source: FORDS 2007, page 142

# Surgical Procedure/Other Site

Note:

An incisional biopsy of a regional or distant site is not coded in the “Surgical Procedure/Other Site” item.

Example:

Patient has a femur bx + for renal cell carcinoma from a known kidney primary. Do not code in this field.

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# Surgical Procedure/Other Site

Note:

Please update the example for code 1 at the bottom of page 142 of FORDS:

1-Surgical biopsy of metastatic lesion from liver; unknown primary.

Update to: “Excisional biopsy of metastatic lesion from liver, unknown primary.”

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# Surgical Procedure/Other Site Unknown/III-Defined Sites

- Use code 1 (Nonprimary surgical procedure performed) for surgical procedures done for tumors of unknown and ill-defined sites (C76.0 – C76.8, C80.9)

E.g., Surgical biopsy of metastatic lesion from liver, unknown primary

Source: FORDS 2007, page 142

Surgical Procedure/Other Site  
Hematopoietic, Reticuloendothelial,  
Immunoproliferative or Myeloproliferative Primaries

Use code 1 (Nonprimary surgical procedure performed) for surgical procedures done for hematopoietic, reticuloendothelial, immuno- or myeloproliferative diseases

E.g., Patient has splenectomy for CLL

Source: FORDS 2007, page 142

# Margin Status

- Obtain this information using pathology report only; never use operative report
- If no surgery of the primary site was performed, code 8 (No primary site surgery)
- A word about TURBs & TURPs
  - Margin status usually not stated; tumor removed in fragments
  - Use code 9 (Unknown) instead of 7 (Not evaluable)

Source: FORDS 2007, page 137

# Palliative Care

- If surgery, radiation, and/or systemic therapy:
  - Is described as palliative
  - Removes or modifies malignant tissue

Then it needs to be double-coded:

- In the applicable treatment fields
- In the Palliative Care field

Source: FORDS 2007, page 189

# Palliative Care- Zometa

- Zometa is a bisphosphonate drug used to slow damage related to bone metastases
- Zometa does not modify, control, or destroy cancer cells, so it is not coded under any of the systemic therapy fields
- Code Zometa in the Palliative Care field using code 3 (Chemo, hormone therapy, or other systemic drugs to alleviate symptoms...),
  - But do not double-code with any of the treatment-related items

# Rad/Surg Sequence

- Use codes 2 thru 6 only if patient had BOTH radiation & cancer-directed surgery
- If patient had:
  - Surgery, but no radiation
  - Radiation, but no surgery
  - Neither radiation nor surgery

Then use code 0

# Rad/Surg Sequence

- Use code 9 if:
  - You know patient underwent both radiation & surgery, but you do not know which came first
  - If it is unknown whether patient underwent radiation and/or surgery

# Rad/Surg Sequence

If patient did not undergo surgery of the primary site, but:

- Scope of Regional Lymph Node Surgery is coded 1-7 and/or
- Surgical Procedure/Other Site is coded 1-5

This is considered to be surgery according to the logic of the Rad/Surg Sequence item

# Rad/Surg Sequence

For instance:

A patient with non-small cell lung carcinoma undergoes resection of a solitary brain met. There was no resection done of the primary site. Patient later receives radiation therapy.

Code Rad/Surg Sequence to 3- Radiation Therapy after surgery

# Embolization

Refer to “Coding Embolization” document for detailed info for all text and examples in the embolization slides (slides 70-76).\*

Coded according to the agent delivered.

- \* The American College of Surgeons (ACoS) Commission on Cancer (CoC), the National Program of Cancer Registries (NPCR) Center for Disease Control (CDC) National Program of Cancer Registries (NPCR), and the National Cancer Institute (NCI) Surveillance, Epidemiology, and End Results (SEER) Program (December 18 2007). Memorandum. Coding Embolization.

# Radioembolization

- Code “Radiation at this Facility” (“Rx-Hosp Radiation”) as “2” (Radioactive implants)
- Code “Regional Treatment Modality” as “50” (Brachytherapy, NOS) if embolization uses radioactive agent or seeds

# Radioembolization- Example

Yttrium-90 microsphere radioembolization is an FDA approved, non-surgical procedure used to treat inoperable liver cancer. With yttrium-90 microsphere radioembolization, a catheter inserted through a tiny incision in the groin and threaded through the arteries until it reaches the hepatic artery. Once the catheter is properly placed in the hepatic artery, millions of tiny beads, or microspheres, which contain the radioactive element yttrium-90, are released into the blood stream. These microspheres lodge into the smaller blood vessels that feed the tumor. In addition to preventing blood flow to the tumor, the microspheres emit radiation that helps destroy the cancerous cells.

Code “2” for Rx Hosp- Radiation

Code “50” for Regional Treatment Modality

Code “88888” for “Regional Dose: cGy” (Not required by ACR)

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# Chemoembolization

- Code as Chemotherapy when the embolizing agent is a chemotherapeutic drug
  - Refer to SEER\*Rx to see if the drug in question is considered to be chemotherapy

# Embolization: Other Therapy

- Code as “Other Therapy” when tumor embolization is performed using alcohol as the embolizing agent.
  - Use code “1”

# Embolization: Other Therapy- Example

For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

# Embolization: Exception

- **Do not code** pre-surgical embolization of hypervascular tumors using particles, coils or alcohol as cancer-directed treatment
  - Typically performed to make the resection of the primary tumor easier
    - E.g., meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

# Systemic/Surgery Sequence

- Code for cases diagnosed 1/1/2006 and later
- Follows same logic as Rad/Surg Sequence
  - Refer to Rad/Surg Sequence slides
- “Systemic” refers to:
  - Chemotherapy
  - Hormone therapy
  - Immunotherapy

# Hormone Therapy- Prednisone

- Prednisone can be considered to be hormonal therapy when administered with chemo agents (Usually for lymphomas)  
Source: FORDS 2007, page 177
- E.g., CHOP (Cyclophosphamide, Doxorubicin, Oncovin, and Prednisone)
  - Code Chemotherapy as 03 (Multiple agents) and Hormone Therapy as 01 (Hormone therapy)

# Hormone Therapy- Thyroid Cancers

- Hormonal therapy administered to thyroid cancer patients after thyroidectomy is considered to be cancer-directed treatment only if:
  - The cancer has a follicular or papillary histology

Source: SPCSM, Appendix C, page C-1023

# Hormone Therapy- Thyroid Cancers

Hormone therapy agents:

Levothyroxine /L-thyroxine  
Liothyronine  
Liotrix  
Methimazole  
Natural Thyroid  
Propylthiouracil / PTU  
Thyrotropin alfa  
Thyroid Drugs Brand Names  
Armour Thyroid  
Cytomel  
Levothroid  
Levoxyl  
Naturethroid  
Synthroid  
Tapazole  
Thyrogen  
Thyrolar  
Unithroid  
Westhroid

Source: SPCSM, Appendix C, page C-1023

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# Questions? Comments? Additions?

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