Advanced Abstracting: Breast Cancer

TREATMENT

Part 4
Besides recording what types of treatment were provided, the two biggest issues for cancer registries are figuring out which treatments are initial therapy, and how much data to collect. Sometimes it isn’t very clear when treatment becomes subsequent. Sometimes it becomes a matter of setting policies for your registry on how to handle certain ambiguous situations.

Registries always face the problem of how much data to collect. That’s why software vendors put additional data items in their abstract and supply a number of data fields that can be defined by the user.
By definition, first-course therapy is the initial plan for treating a patient after a diagnosis of cancer is made. Treatment in the context of this presentation is therapy directed at removing or modifying an area of proliferating malignant cells. Making a decision not to treat in this context is also a treatment decision. Even palliative care, as collected by cancer registries, usually involves a procedure that targets cancer cells. The exception is pain management, which does not target cancer cells but uses other methods specifically designed for reducing and controlling pain. Pain management procedures would be coded only in the palliative care fields. Other palliative procedures should also be coded in the appropriate treatment fields. For example, radiation for bone mets targets cancer cells for the purpose of reducing pain. This procedure would be coded to palliative radiation in the palliative care fields (not pain management), and would also be coded under radiation therapy in the treatment fields.

The initial plan of therapy is the clinician’s best attempt at cure or long-term survival If this attempt is not thought possible because of the medical condition of the patient or the extent of the cancer, then the first plan may be directed at palliation and quality of life.

Determining first-course therapy used to be simple. Some of you may remember the guideline that first-course therapy was all treatment initiated in the first four months after diagnosis. Now first-course therapy is an algorithm with changes in therapy implemented at every newly-discovered characteristic of the cancer. First-course therapy for breast cancer frequently takes over a year to implement completely. Sometimes a change in hormone therapy is planned after five years of Tamoxifen, meaning changes are taking place six years after diagnosis and are still first-course therapy. For example, National Comprehensive Cancer Network (NCCN) practice guidelines for invasive breast cancer in postmenopausal women recommend approximately five years of Tamoxifen followed by five additional years of Letrozole.
Knowing when first-course therapy ends is an important question, not only for accuracy of data collection, but also because some registries do not collect subsequent therapy at all.

First-course therapy ends when the initial plan of treatment is completed and the cancer has not recurred or progressed. Treatment for breast cancer is often surgery followed by chemotherapy, radiation to the chest wall, and hormone therapy in that order. Once hormone therapy is started, the plan is completed.

First-course therapy ends when the cancer progresses on treatment, but common sense applies. For example, bone mets that progress because a palliative mastectomy was done prior to planned radiation therapy for the bone mets doesn’t mean the radiation is subsequent. However, if bone mets were evident at diagnosis and progressed during chemotherapy, that progression would make any additional treatment subsequent.

First-course therapy is over when the treatment is changed to another type. If the modality wasn’t in the original plan, and especially if the cancer progresses, then the therapy is no longer first course. Changing to a chemo that has a different type of activity than the drug in the original tx plan is also an indication that first-course therapy has ended. The second drug is likely subsequent therapy.
Subsequent therapy begins after first-course of therapy ends. For most breast cancers, the separation between first-course and subsequent therapy is clearly defined. If cancer recurs after a disease-free interval, the therapy for the recurrence is clearly subsequent. However, the lines become blurred, usually in late-stage cases, when subsequent therapy starts before the initial treatment plan is completed or changes in treatment occur, and there’s no documentation that the cancer has progressed.

There are some specific situations to be aware of:

- If the radiation oncologist decides to use electrons instead of photons to radiate the axilla after a lymph node dissection, this is still first course.

- If chemo is changed from one type of chemo drug to another because the cancer didn’t respond to the first drug (Example: change from AC+T regimen to single-agent Capecitabine), this is still first course. Check the SEER*Rx drug-subcategory field for type of chemotherapy. SEER*Rx can be downloaded free from the SEER web page at www.cancer.gov/seerrx.

- If the biopsy says DCIS and a lumpectomy is done, but then, because the DCIS is extensive, a mastectomy is done to get negative margins, then the mastectomy wasn’t specifically planned, but it was always a consideration. This is still first course.

- If a mastectomy is done for a local recurrence to a breast originally treated with a lumpectomy, this is subsequent therapy. Fortunately, the prognosis for a subsequent mastectomy following a first-course lumpectomy is essentially the same as if the mastectomy had been done as first-course.
The amount of treatment data required by state registries differs from state to state. Each state registry may add required data items to the NPCR data set. Facilities must comply, because state laws mandate reporting of cancer in all states. The Commission on Cancer requires additional treatment data defined in FORDS. Collecting only the basic required data sets is fine for facilities that have minimal data needs. The required data sets provide enough data to create statistical graphs and tables that can be interesting and useful to physicians, administrators, and other staff.
Research and teaching health care facilities may extend the required data set with additional data items because of a greater emphasis on outcomes beyond simple end-of-life survival studies. State registries may be involved in patterns of care studies that require additional data items. Some community health care facilities also desire an expanded data set that helps them plan, evaluate and assign resources more effectively. As a cancer registrar, you may identify areas where additional data may be useful to your facility. Sometimes cancer registry data are not requested because no one realizes how much and what types of data are collected.

Some common types of data that are collected in addition to the required data set include the names of chemotherapy regimens, hormone drugs and drugs used in clinical trials. Additional dates are collected for all types of systemic therapy, instead of just one date for the start of systemic therapy, NOS. A simple field for family history of cancer may be collected, or a group of fields may collect more detailed information such as the type of cancer in a family member and their relationship to the patient.
Special data may be collected for a specific purpose or for a limited time. What information does your facility need? What will it need in the future? You may be the person to suggest additional data to your facility.

Is your facility concerned because it is not attracting minority breast cancer patients? Besides collecting race and ethnicity, you may want to collect the county where the patient resided at the time they came to your facility. You may already collect address at diagnosis and current address, but these may be different than where the patient lived when they became a patient at your facility.

Does your facility think it has a unique procedure? Identify that procedure in a user-defined field. Compare numbers of patients having that unique procedure to numbers of patients who previously used a more standard procedure at your facility. If the numbers of patients using the unique procedure show an increase in patient volumes, then you can confirm your facility’s faith in their unique procedure.

Special items may be needed for a study, for example HER2 status. Discontinue collection of special fields when the study is complete. Perhaps your facility wants to know how many patients are using the new mammosite equipment. The radiology department might be able to provide the raw number of patients, but it is doubtful they could sort them by county of residence, gender, stage of disease, and disease-free survival.
Standard therapy for breast cancer usually includes some type of surgical procedure, although some late-stage cases may be treated with non-surgical modalities only. The extent of the surgery depends on the extent of the cancer. A small tumor can be removed with a lumpectomy. A large tumor might require a modified radical mastectomy. If a breast cancer is diagnosed as in situ, NCCN guidelines do not recommend a lymph node bx.

The purpose of the surgery also depends on the extent of the cancer. Most breast cancer is diagnosed at an early stage, and the purpose of surgery is for cure. If the cancer is advanced, then the purpose may be palliation.

Breast cancer treatment is usually multi-modality. Surgery is the foundation, but treatment routinely includes radiation and some type or types of systemic therapy.
There are several levels of surgical procedures for breast cancer. Surgeries of the primary site and regional lymph nodes are fairly routine for most breast cancers treated today.
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Excisional Biopsy (Lumpectomy)

- Grossly removes entire tumor
- Can also be diagnostic
- Margins may have microscopic disease
- Macroscopic disease at margins makes bx incisional no matter the original intent
- Needle biopsies that leave no residual tumor are excisional

You can’t tell if a core needle biopsy is incisional or excisional until the lumpectomy or mastectomy specimen is examined. If no residual cancer is found in the lumpectomy specimen, then the core needle biopsy is coded as an excisional biopsy, and the lumpectomy is coded as a re-excision. The same holds true for a fine needle aspiration biopsy. No residual cancer means the FNA was treatment.

An excisional biopsy or lumpectomy may have microscopically positive margins without affecting its status as excisional. Macroscopic disease at the margins makes the specimen an incisional biopsy even if the original intent was excisional.

If the surgeon removes a palpable malignant lump without first getting a positive biopsy, the lumpectomy serves a diagnostic purpose as well as a therapeutic purpose. The procedure is still coded only in the field “surgery to the primary site.”
Lymph node surgical procedures, even fine needle aspirations, are coded in the site-specific surgical fields, even when there is no surgery of primary site. Frequently the surgical evaluation and treatment procedures are performed in steps as follows:

1) Core needle biopsy,
2) Lumpectomy and sentinel lymph node biopsy,
3) If a sentinel node is found to be positive, then a lymph node dissection may be done as a separate procedure. Registries that code procedures performed on one date separately from procedures done on a different date would code the lymph node dissection in the two surgical fields for regional nodes, and code 00 for surgery to the primary site. Registries that code each date’s procedures cumulatively to create a surgery summary would use the lumpectomy code for surgery to the primary site when coding the lymph node dissection.

Surgeons do not feel the need to take more lymph nodes than necessary. AJCC says one or two sentinel nodes are sufficient for pathological staging. However, if a regional node dissection is done, AJCC suggests there should be six or more nodes in the specimen.

Regional nodes may also be examined by fine needle aspiration (using a needle to extract a few cells), sampling (removing a few single nodes), or a dissection (which removes one or more lymph node chains and their surrounding tissue). An axillary lymph node dissection is sometimes described as removing the axillary contents.
Lymphoscintigraphy, or mapping of sentinel lymph nodes is one of the major advances of the past couple of decades, and has spared countless women the morbidity of an axillary lymph node dissection. NCCN states that it is the preferred method of lymph node staging. But NCCN cautions that the procedure should only be done by an experienced team.

The procedure starts with injecting a slightly radioactive blue dye circumferentially in the area of the tumor or where the tumor was excised. The dye collects in the lymph nodes first encountered, and creates a radioactive hot spot. The hot spot is localized with a needle or spent radioactive seed, then the surgeon cuts down and removes the blue node. It is pathologically examined, usually for ITC's and micromets as well as for frank involvement. If the sentinel node is positive, then the surgeon will probably schedule a full node dissection. If the sentinel node is negative, then the patient will most likely be spared a node dissection and any further surgery.
Sentinel lymph node biopsies have had much the same impact on breast cancer treatment as lumpectomies did years ago. The benefits of sentinel node biopsy over regional node dissection is obvious. The surgery is much less invasive. The patient has a much quicker and easier recovery. Cosmetically the results are much better. The risks of lymphedema and other surgical morbidities are greatly reduced.

The impact on breast cancer staging is almost as dramatic. Fewer nodes are needed for staging, which makes it easier on the patient, the surgeon and the registrar. The down side is that the categories of staging regional nodes for breast cancer have expanded with new “N” categories.
If sentinel node biopsy or physical examination indicates cancer cells may have reached a regional lymph node chain, the procedure for definitive diagnosis and treatment is a dissection. The possibility of regional node involvement can also be indicated by visible nodes on a mammogram or other imaging methods, a large primary tumor, or an aggressive histology, among others.

The three major regional node chains for breast are the axillary, internal mammary and, now in the sixth edition of TNM, supraclavicular. You should become familiar with the names of the regional nodes and with the nearer chains that are distant stage. Good references to review for identifying nodes are your staging manuals.

Per AJCC, a dissection should remove six or more nodes. A dissection is usually done only after a positive sentinel node biopsy. Exceptions include when the nodes are palpable and when the primary tumor is so extensive that nodal involvement is likely.
These are the various general types of mastectomies: subtotal, total, modified radical, palliative, and prophylactic. For more specific surgical types, review the list of mastectomies in the FORDS manual’s site-specific surgeries for breast cancer. One type of subtotal mastectomy, the excisional biopsy, has already been discussed, but there are other types.
A subtotal or partial mastectomy removes the tumor and some of the surrounding tissue, but not all of the breast tissue. The lumpectomy is probably the most common type of subtotal mastectomy. The other types listed are similar but remove a wider margin of normal tissue around the tumor. When the cancer is large, when the breast is small, or when the cancer is multifocal, good cosmetic results sometimes cannot be achieved with a subtotal mastectomy, and a total mastectomy is performed. Sometimes the patient simply wants the security of the more extensive surgery, although research hasn’t shown those fears to be founded.
A simple or total mastectomy removes all the breast tissue, but not the axillary lymph node chains. A skin sparing total mastectomy removes the breast tissue but not the skin in order to facilitate reconstruction and achieve a more natural-looking result. Most cancer surgeons do not consider a skin-sparing total mastectomy to be a good cancer-directed operation.
The modified radical mastectomy removes all breast tissue and the axillary contents. This has been the gold standard of breast cancer surgery for decades, although for early stage tumors, now the most common surgery is lumpectomy and sentinel lymph node biopsy. This slide shows the location of the regional lymph nodes.
The intent of a palliative mastectomy is to relieve symptoms, not to actually treat the breast cancer for cure or even long term survival. A palliative mastectomy is coded in the palliative procedure fields, as well as in the surgical fields. There are some circumstances when a palliative mastectomy is the best choice for care:

The primary cancer in the breast may be large, painful, ulcerated, infected, or cosmetically unattractive. Even though extensive disease might be elsewhere in the body, removing the breast will make the patient more comfortable.

Another situation could be in a very elderly and/or medically frail patient. The cancer may not be extensive, but surgery for cure or adjuvant therapy may be too debilitating for the patient. A simple mastectomy would simply remove the tumor before it progressed.
A prophylactic mastectomy is the removal of an uninvolved breast for the purpose of eliminating the risk of developing cancer in that breast. High-risk patients who are diagnosed with breast cancer will sometimes choose mastectomy for the involved breast and have the contralateral breast removed also. Some women who are at high-risk of developing breast cancer, but have not been diagnosed, choose bilateral prophylactic mastectomies to eliminate their risk of ever getting breast cancer. In either case, prophylactic mastectomies are typically desired by patients who have a genetically high risk for breast cancer, or a very strong family history of breast, colon, or ovarian cancer. Patients with other high risk factors, such as the presence of the BRCA1 and BRCA2 genes, might be other candidates for prophylactic mastectomy.

The situation you will encounter for abstracting is the removal of an uninvolved contralateral breast for a patient who received a mastectomy. Removing the contralateral uninvolved breast is a prophylactic mastectomy. There are specific primary site surgery codes for contralateral mastectomies of uninvolved breasts. If the contralateral breast is involved, it would be abstracted as a second primary. If the involvement is determined to be metastatic from the original breast, the mastectomy would be coded as “surgery to other distant or regional sites”.

Lobular cancer has a high risk of developing a subsequent primary in the contralateral breast. Physicians sometimes advise lobular cancer patients to have the prophylactic mastectomy procedure. Another reason for removal of the uninvolved breast is to facilitate a more attractive breast reconstruction.
Adjuvant and neoadjuvant radiation therapy are terms related to the timing of the radiation procedure. Brachytherapy and primary radiation therapy refer to types of procedures. The terms are not all mutually exclusive. It's not uncommon to have adjuvant brachytherapy. The picture on the slide is of an implant type of brachytherapy.
Radiation therapy is frequently used as adjuvant therapy after surgery. Lumpectomy followed by whole breast beam radiation with a boost to the excision site has been shown to be equivalent to modified radical mastectomy in long term survival. If the tumor is non-invasive, radiation may not be necessary but, if given, the field may not include the lymph nodes. If the tumor is invasive, NCCN recommends that the nodes also be radiated.

The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins is studying partial breast radiation therapy. Because only part of the breast is involved, larger doses can be given to the tumor site for each fraction, which shortens the overall treatment time. The Center found that women were choosing mastectomy over lumpectomy because the course of adjuvant radiation took seven weeks. Partial breast radiation takes about three weeks. So far results have been promising, but it’s the long-term results that will prove the concept.

Following a mastectomy, adjuvant beam radiation to the chest wall and axilla with a boost to the mastectomy scar helps prevent loco-regional recurrence.
Note that adjuvant radiation therapy is performed so frequently for breast cancer that if radiation is not documented in the patient’s medical record, it’s good practice to check with the patient’s physicians to see if she was referred for adjuvant radiation nearer her home. According to NCCN treatment guidelines, the situations where radiation therapy is not specifically recommended are as follows:

- Lobular carcinoma in situ;
- Ductal carcinoma in situ treated with a total mastectomy;
- Invasive breast carcinoma treated with both total mastectomy and surgical lymph node staging and where all nodes are negative, the tumor is less than 5 cm and the surgical margins are greater than 1 mm.

The timing of adjuvant radiation delivery differs according to the extent of the tumor. For in situ lesions, radiation is given after surgery, usually without chemotherapy but possibly concurrent with or prior to hormone therapy.

Adjuvant radiation for an invasive tumor may be given concurrently with chemotherapy or given after chemotherapy is completed. A possible reason radiation may not be documented in the patient’s record is that the patient hasn’t completed her chemotherapy yet. Be aware of the timing factor when you start looking for documentation of adjuvant radiation.
Neoadjuvant radiation is given prior to surgery. The purpose is usually to downstage the tumor and make it more easily resectable. The need for neoadjuvant radiation is infrequent, because breast cancer is usually found early. IBC may require neoadjuvant radiation and chemotherapy, but chemotherapy alone is a more common neoadjuvant therapy overall.
Brachytherapy of the breast is not very common. Needle implants have been tried in the past and may sometimes still be used. Brachytherapy is most often used as a boost after beam radiation. A recently developed brachytherapy technique is mammosite. It is coded as interstitial high dose radiation (HDR), rather than intracavitary HDR. Although it is placed in a cavity in the breast, the cavity is not a natural body cavity, but rather one created when the cancer was removed. Mammosite is given as regional radiation, or as a boost after whole-breast beam radiation. A contraindication for mammosite is if the margin nearest the skin is too thin. The radiation does not penetrate very far, but radiating the skin can cause all kinds of unpleasant complications for the patient.
The mammosite radiation therapy system requires great precision on the part of the surgeon and the radiation therapy team. Some of you may have it at your facility, and already know how it works. If so, you may want to consider identifying it separately in your data base, and pulling some statistics down the road on outcomes comparing mammosite boosts to beam boosts after lumpectomy.

The surgeon creates a round cavity after removing the tumor. A large bore needle (trocar) creates a pathway into the cavity through the skin. The mammosite balloon is inserted through the pathway.
The mammosite balloon is inflated with saline within the tissue cavity. A high-dose rate [HDR] remote afterloader positions an iridium 192 radiation source in the center of the balloon. The radiation source is left in place for about 10 minutes and then removed. The radiation treats a precise margin of tissue around the balloon. Treatment as primary radiation is usually two treatments per day for five days. Boost treatment is usually only 1–2 days. After the final treatment, the mammosite device is deflated and removed.
Radiation therapy is not really used as primary treatment for breast cancer. It is sometimes used for late stage breast cancer that resists neoadjuvant chemotherapy attempts to downstage it enough to be resectable. Even then the radiation is concurrent with other chemotherapy. It may infrequently be used for metastatic sites. But even for bone metastases, one of the distant sites common to breast cancer, the first choice of treatment is chemotherapy. IBC is sometimes treated with radiation, chemotherapy and hormones without surgery, but usually only when surgery is contraindicated.
Chemotherapy has a major role in breast cancer treatment. It is used as adjuvant therapy, neoadjuvant therapy or both for the same primary cancer.

The SEER*Rx interactive drug database is an excellent tool for getting information on coding oncology drugs and regimens. The tool will differentiate among chemotherapies, hormones, biological response modifiers, and ancillary drugs. It’s a valuable resource to keep on your computer desktop for instant access. If you don’t currently have it, you can get it free from the SEER website: http://seer.cancer.gov/tools/seerrx.
Neoadjuvant chemotherapy is used frequently before surgery to downstage large tumors and shrink them to a resectable size. Neoadjuvant chemotherapy can make inoperable tumors surgically resectable. Sometimes tumors fit all the criteria for breast conservation surgery except that they are too large. These cases may be able to avoid mastectomies by using neoadjuvant chemotherapy. Neoadjuvant chemotherapy may also downstage N2 disease.
Adjuvant chemotherapy is given after surgery. Deciding factors for adjuvant therapy include the size and grade of the tumor, lymph-node involvement, and other considerations. If both adjuvant chemotherapy and adjuvant radiation are planned, the chemotherapy is usually given first. The radiation is given once chemotherapy is completed. Occasionally both are given concurrently to intact breasts. The purpose of adjuvant chemotherapy is to eliminate cancer cells that may remain in the body after surgery, and destroy them before they can grow into recurrent tumors.
The medical oncologist has a large number of chemotherapy agents and regimens from which to choose in treating a patient for breast cancer. If the tumor is HER2 positive, a chemotherapy regimen that includes trastuzumab (Herceptin) will most likely be used. Trastuzumab is a monoclonal antibody that has shown to be effective for HER2-positive tumors. Trastuzumab is coded as chemotherapy.
Sometimes chemotherapy is given as neoadjuvant and adjuvant therapy for the same tumor. Occasionally chemotherapy is given concurrent with radiation therapy, especially during the neoadjuvant phase; but usually chemotherapy and radiation are sequential with chemotherapy occurring first.

Neoadjuvant chemotherapy is used to make the tumor more resectable. Once resected, additional chemotherapy is given to reduce the risk of recurrence and metastatic spread. The sequence for neoadjuvant treatment is usually neoadjuvant chemotherapy, with or without radiation, followed by mastectomy and then followed by more chemotherapy. There may be more radiation to the chest wall and scar following the completion of chemotherapy. After all that, the patient will probably start hormone therapy.

Be familiar with the standards of care for breast cancer, so that you know what to look for in the patient’s chart, and so that you can recognize what’s missing. If the expected therapy is not found, look for referrals to radiation oncology and medical oncology. Contact physicians for information on additional treatment that the patient might have received.
Breast cancer is especially receptive to hormone manipulation. Estrogen in the body makes breast cancers grow. Consequently, all tumors are tested for estrogen (ER) and progesterone (PR) receptors. If these are positive, hormone therapy will be effective against these tumors and will be in the treatment plan. There have been indications that even ER and PR negative tumors may benefit from hormone therapy, but the general rule is that the lack of receptors means hormone therapy will not be much help.

Neoadjuvant hormone therapy has been used to downstage tumors too large for breast conservation surgery.

Even non-invasive and very small invasive tumors that seem completely resected benefit from adjuvant hormone therapy. For early stage tumors that don’t get chemotherapy, hormone therapy is usually started soon after surgery. For tumors that do get chemotherapy, hormone therapy is started either concurrent with radiation after chemotherapy is completed, or after radiation is also completed.
Research has shown patients benefit from years of adjuvant hormone therapy. A common regimen is Tamoxifen for five years followed by letrozole for five more years. Which hormone drugs are used is somewhat dependent on the patient’s menopausal status. The medical oncologist has many choices of hormone therapy drugs from which to select.
Breast cancer is commonly treated with multi-modality therapy. Treatment for a typical invasive cancer can take over a year before hormone therapy is initiated. The usual sequence, as mentioned before, is surgery followed by adjuvant chemotherapy, followed by adjuvant radiation therapy, followed by adjuvant hormone therapy. Variations include skipping chemotherapy for low risk tumors, and adding neoadjuvant therapy for large or extensive tumors.

It’s important to know the sequence and the length of time a treatment plan may take. Since registries are required to abstract their cases within six months, breast cancer may be abstracted and reported before initial therapy is completed. Such cases should be revisited at a later point so you can complete the first course of therapy fields. You’ll need to flag these cases at the time of abstracting, so complete treatment information can be added later. If the case has already been reported, send the updated information to the state registry. You may need to contact the state registry regarding procedures for reporting the additional information if there aren’t any already in place.
It’s not often seen in cancer patients’ charts, but ovarian ablation for premenopausal women is still a current treatment option for metastatic breast cancer. Chemotherapy is effective against metastatic breast cancer. So is hormone therapy. Regression of metastatic breast cancer is not uncommon. Bisphosphonates are often used in conjunction with systemic therapy for bone metastases. Its action is to maintain the strength of bones weakened by lytic cancer lesions and loss of calcium. Bisphosphonates are ancillary treatment; don’t try to code them as they are not cancer-directed treatment.
At one time, bone marrow transplants and (later) stem cell transplants were researched as promising tools for treating metastatic breast cancer. However, studies have shown that transplantation has no survival benefit over chemotherapy. Research trials may exist at some facilities for transplantation for breast cancer, but this therapy has been pretty much abandoned. You should not find it being done outside of a clinical trial.
Palliative care is provided when the breast cancer is incurable or the patient is too debilitated to tolerate definitive treatment. The goal of palliative care is optimum quality of life and the comfort of the patient. Most palliative therapies also fall in the categories of surgery, radiation, chemotherapy, and hormone therapy. These treatments, when provided for palliation, must be coded in both palliative care and the appropriate treatment fields. They not only control pain and other symptoms, but they work directly on cancer cells. Pain management procedures that don’t involve these types of palliative, cancer-directed treatments are coded only in palliative care.

Registries might consider collecting hospice care as a special data field for palliative care.

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The findings and conclusions in this presentation are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.
For information about CDC’s Cancer Prevention and Control Programs and the National Program of Cancer Registries

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