

Site-Specific Codes for Neoadjuvant Therapy Treatment Effect

Schema: Lung

Neoadjuvant Therapy--Treatment Effect data item [NAACCR # 1634] is related to the Neoadjuvant Therapy data item [NAACCR #1632]. This data item records the findings from the post neoadjuvant therapy surgical pathology report ONLY when surgery is performed after neoadjuvant therapy. This set of codes applies to the Lung schema.

| Code | Description |
|------|---|
| 0 | Neoadjuvant therapy not given/no known presurgical therapy |
| 1 | No residual invasive carcinoma identified Residual in situ carcinoma only Stated as Complete response (CR) |
| 2 | Less than or equal to 10% residual viable tumor |
| 3 | Greater than 10% of residual viable tumor |
| 4 | Residual viable tumor, percentage not stated Stated as partial response |
| 6 | Neoadjuvant therapy completed and surgical resection performed, response not documented or unknown Cannot be determined |
| 7 | Neoadjuvant therapy completed and planned surgical resection not performed |
| 9 | Unknown if neoadjuvant therapy performed Unknown if planned surgical procedure performed after completion of neoadjuvant therapy Death Certificate only (DCO) |

For purposes of this data item, **neoadjuvant therapy** is defined as systemic treatment (chemotherapy, endocrine/hormone therapy, targeted therapy, immunotherapy, or biological therapy) and/or radiation therapy given to shrink a tumor before surgical resection.

Surgical resection: For purposes of this data item, surgical resection is defined as the most definitive surgical procedure that removes some or all of the primary tumor or site, with or without lymph nodes and/or distant metastasis. For many sites, this would be Surgical Codes 30-80; however, there are some sites where surgical codes less than 30 could be used (for example, code 22 for Breast (excisional biopsy or lumpectomy)).

Note: This data item is **not** the same as AJCC's Post Therapy Path (yp) Pathological Response, which is based on the managing/treating physician's evaluation from the surgical pathology report and clinical evaluation after neoadjuvant therapy. This data item addresses response based on the **surgical pathology report** including the Treatment Effect section of the CAP Cancer Protocol if applicable.

Coding Instructions

Use the *Neoadjuvant Therapy--Treatment Effect* data item [NAACCR # 1634] to record the findings from the post neoadjuvant therapy **surgical pathology report ONLY** including the Treatment Effect section of the CAP Cancer Protocol if applicable.

1. Assign code **0**
 - a. When the patient did not receive neoadjuvant therapy prior to surgical resection
 - b. When the treatment administered is not neoadjuvant therapy (pre-surgical treatment) because surgical resection was not planned
Example: Patient with unresectable lung cancer (no surgical resection planned), chemotherapy and radiation administered.
 - c. It is clear that the patient did not have neoadjuvant therapy based on the sequence of diagnosis and treatment
Example: Patient diagnosed with lung cancer via biopsy, had surgical resection followed by chemotherapy and radiation.
 - d. For autopsy only cases
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 0 or 3.
2. Assign code **1** when
 - a. A complete (total) pathological response (CR) is documented in the surgical pathology report
Note: CR is defined as the absence of all known tumor/lesions and lymph nodes.
 - b. There is residual in situ cancer only
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.
3. Assign code **2** when
 - a. The presence of less than or equal to 10% residual viable tumor is documented in the surgical pathology report
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.
4. Assign code **3** when
 - a. The presence of greater than 10% of residual viable tumor is documented in the surgical pathology report
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.
5. Assign code **4** when
 - a. There is residual viable tumor present; however, the percentage is not documented
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.
6. Assign code **6** when
 - a. Neoadjuvant therapy was completed and there is no documented treatment response in the surgical pathology report
Note: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.
7. Assign code **7** when
 - a. The planned post neoadjuvant surgical resection was not completed for reasons including
 - i. Complete clinical response and planned surgical resection cancelled

- ii. Treatment failure (stable or progressive disease) and planned surgical resection cancelled
- iii. Complications and planned surgical resection cancelled
- iv. Patient refusal of planned surgical resection
- v. Planned surgical resection started but not completed (surgical resection aborted)

Note 1: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 1 or 2.

Note 2: Code the reason for the surgery not done in *Reason for No Surgery* [NAACCR # 1340].

8. Assign code 9 when

- a. It is unknown whether neoadjuvant therapy was administered
 - i. Planned, but unknown if given
 - ii. Death certificate only (DCO)
- b. The only information available is the managing/treating physician's evaluation

Note 1: *Neoadjuvant Therapy* data item [NAACCR # 1632] coded to 9.

Note 2: *Neoadjuvant Therapy--Clinical Response* data item [NAACCR # 1633] coded to 9.

Note 3: Code 9 (unknown) should be used rarely.

Note 4: Use code 0 when it is clear that the patient did not have neoadjuvant therapy based on the sequence of diagnosis and treatment.