

BREAST
C500–C509

Primary Site

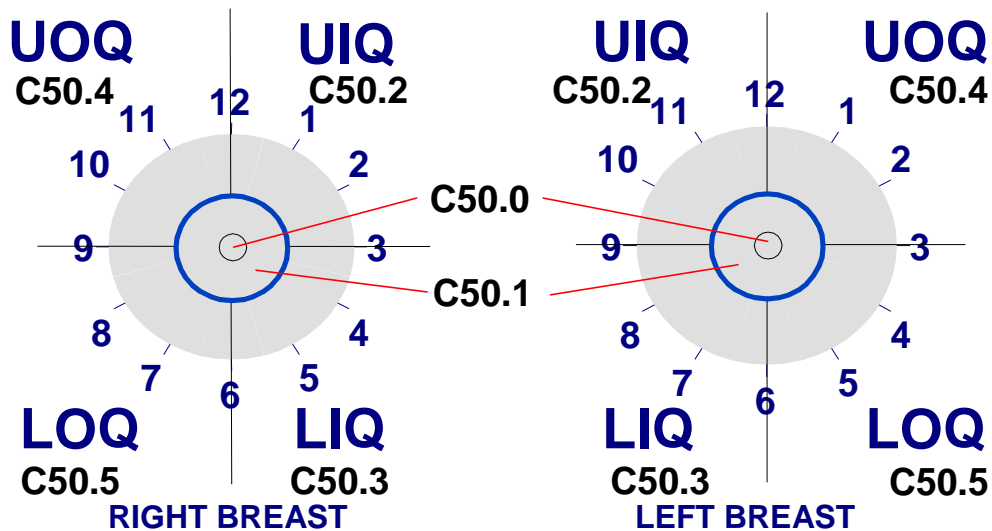
- C500 **Nipple** (areolar)
Paget disease without underlying tumor
- C501 **Central** portion of **breast (subareolar)** area extending 1 cm around areolar complex
Retroareolar
Infraareolar
Next to areola, NOS
Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
Paget disease with underlying tumor
- C502 **Upper inner quadrant** (UIQ) of breast
Superior medial
Upper medial
Superior inner
- C503 **Lower inner quadrant** (LIQ) of breast
Inferior medial
Lower medial
Inferior inner
- C504 **Upper outer quadrant** (UOQ) of breast
Superior lateral
Superior outer
Upper lateral
- C505 **Lower outer quadrant** (LOQ) of breast
Inferior lateral
Inferior outer
Lower lateral
- C506 **Axillary tail** of breast
Tail of breast, NOS
Tail of Spence
- C508 **Overlapping** lesion of breast
Inferior breast, NOS
Inner breast, NOS
Lateral breast, NOS
Lower breast, NOS
Medial breast, NOS
Midline breast NOS
Outer breast NOS
Superior breast, NOS
Upper breast, NOS
3:00, 6:00, 9:00, 12:00 o'clock
- C509 **Breast, NOS**

Entire breast
 Multiple tumors in different subsites within breast
 Inflammatory without palpable mass
 ¾ or more of breast involved with tumor
 Diffuse (tumor size 998)

Additional Subsite Descriptors

The position of the tumor in the breast may be described as the positions on a clock

O'Clock Positions and Codes Quadrants of Breasts



Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

- 1 Pathology report
- 2 Operative report
- 3 Physical examination
- 4 Mammogram, ultrasound

If the pathology proves **invasive** tumor in **one subsite** and **insitu tumor** in all **other** involved subsites, code to the subsite involved with invasive tumor

When to Use Subsites 8 and 9

- A. Code the primary site to C508 when there is a **single tumor** that **overlaps** two or more subsites, and the **subsite** in which the tumor **originated** is **unknown**
- B. Code the primary site to C508 when there is a **single tumor** located at the **12, 3, 6, or 9 o'clock** position on the breast

Code the primary site to C509 when there are **multiple tumors** (two or more) in **at least two quadrants** of the breast

Laterality

Laterality **must** be **coded** for all subsites.

Single Tumor with Complex Histology

If the diagnosis is both **lobular and ductal** (insitu or invasive, or a combination of insitu and invasive) use code 8522

Example 1: Code duct carcinoma and lobular carcinoma insitu to the combination code 8522/3

Example 2: Code LCIS and DCIS to the combination code 8522/2

If the diagnosis is **mixed invasive and insitu**, code the invasive diagnosis

Example 1: Code ductal carcinoma with extensive cribriforming DCIS to the invasive ductal carcinoma (8500/3)

Example 2: Code mucinous carcinoma in a background of ductal carcinoma insitu to the invasive mucinous carcinoma (8480/3)

Example 3: Code infiltrating ductal carcinoma with DCIS, solid, cribriform, and comedo type to the invasive infiltrating ductal carcinoma (8500/3)

Use a **combination code** if the diagnosis is either ductal carcinoma OR lobular carcinoma mixed with another type of carcinoma. Look for the words “and” or “mixed” in the diagnosis.

Code duct carcinoma mixed with another type of carcinoma (excluding lobular) to 8523/_

Example 1: Code duct carcinoma **and** tubular carcinoma to 8523/3

Example 2: Code DCIS **and** cribriform carcinoma insitu to 8523/2

Code lobular carcinoma mixed with another type of carcinoma (excluding ductal) to 8524_

Example 1: Code lobular **and** adenoid cystic carcinoma to 8524/3

Example 2: Code tubular carcinoma **and** lobular carcinoma as 8524/3

Code the **infiltrating ductal subtype** even if the code is numerically lower than infiltrating ductal (8500/_) when the following terms are used

Type: Duct carcinoma, _____ type

Predominantly: Duct carcinoma, predominantly _____

With features of: Duct carcinoma with features of _____

Subtype: Infiltrating ductal, _____ subtype

Variant: Duct carcinoma, _____ variant

Other terms that indicate the majority of tumor

Example 1: Duct carcinoma, tubular type. Code the histology as tubular carcinoma, 8211/3

Example 2: Duct carcinoma with apocrine features. Code the histology as apocrine carcinoma 8401/3

If the diagnosis includes **more than one subtype**, use a combination code

Example 1: Duct carcinoma, cribriform and comedo types. Code the histology to 8523/3

Example 2: Duct carcinoma insitu showing both solid and cribriforming subtypes. Code the histology as 8523/2

Separate Tumors of Different Histologies in One Breast

If different histologies occur in **separate tumors in the same breast**, use the multiple primary rules to determine if there is one or more primaries. If, according to the rules, there are two primaries, abstract and stage separately. If, according to the rules, there is one primary, abstract and stage as one primary. Use a combination code for combinations of duct and lobular or combinations of duct and Paget disease.

Example 1: Lobular carcinoma insitu in the upper inner quadrant of the right breast and duct carcinoma in the lower inner quadrant of the right breast. Code the histology as 8522/3

Example 2: Paget disease of nipple and intraductal carcinoma, upper outer quadrant. Code the histology as 8543/3

Grade

Priority Rules for Grading Breast Cancer

Code the tumor grade using the following priority order:

Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table below)

Bloom Richardson grade (low, intermediate, high)

Nuclear grade only

Terminology

Differentiation (well differentiated, moderately differentiated, etc)

Histologic grade

Grade i, grade ii, grade iii, grade iv

Bloom-Richardson (BR)

BR may **also** be called: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade

BR may be expressed in **scores** (range 3-9)

The score is based on three morphologic features of “invasive no-special-type” breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells)

Use the following table to convert the score into SEER code

BR may be expressed as a **grade** (low, intermediate, high)

BR grade is derived from the BR score

For cases diagnosed 1996 and later, use the following table to convert the BR grade into SEER code (Note that the conversion of low, intermediate, and high is different from the conversion used for all other tumors)

Convert BR Score to SEER Code

Use the table below to convert BR **score** to SEER code.

BR Combined Score	Differentiation	Grade	SEER Code
3, 4, 5	Well differentiated	I	1
6, 7	Moderately differentiated	II	2
8, 9	Poorly differentiated	III	3

Convert BR Grade to SEER Code

Use the table below to convert BR **grade** to SEER code.

BR Grade	Differentiation	Grade	SEER Code
BR low grade	Well differentiated	I	1
BR intermediate grade	Moderately differentiated	II	2
BR high grade	Poorly differentiated	III	3

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table above). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the table below to convert the grade to SEER codes.

Term	Grade	SEER Code
1/3, 1/2	Low grade	2
2/3	Intermediate grade	3
3/3, 2/2	High grade	4

Laterality

Laterality must be coded for all subsites.

Tumor Markers

Estrogen and progesterone receptors (ERA and PRA) are positive in most breast cancers. A positive ERA and PRA indicates a better prognosis and response to estrogen therapy.

Size of Primary Tumor

General Coding Guidelines

If **multiple masses** are present, code the diameter of the **largest invasive mass**. Ignore the insitu even if it is larger than the invasive.

If the patient had **neoadjuvant** treatment, code the **largest** tumor size **documented**, clinical or pathologic.

Tumors That Are Purely Invasive or Purely Insitu

For purely invasive or purely insitu tumors, record the size of tumor based on the following priority of reports.

Priority in which to use Reports to Code Tumor Size

1. **Pathology** report
2. **Operative** report
3. Physical examination
4. Imaging (**mammography**)
5. Imaging (**ultrasound**)

Single Tumors with Both Invasive and Insitu Components

Record the **size** of the **invasive** component, if given.

If **both** an **insitu** and an **invasive** component are present, and the invasive component is measured, record the size of the invasive component even if it is smaller.

Example: Tumor is 37 mm mixed insitu and invasive adenocarcinoma. Pathology documents that 14 mm is invasive. Record tumor size as 014.

General Staging Guidelines

DO NOT USE the following to determine tumor extension:

- A. Dimpling of the skin, tethering, nipple retraction, nipple involvement or skin changes other than those listed in CS extension code 51 (See also CS Extension, Note 1)
- B. **Microscopic** satellite skin nodules
(**macroscopic** or **gross** nodules in skin of primary breast **are** used in staging)
- C. Microscopically proven invasion of lymphatic vessels within the breast

Collaborative Staging Codes

Breast

C50.0-C50.6, C50.8-C50.9

C50.0 Nipple

C50.1 Central portion of breast

C50.2 Upper-inner quadrant of breast

C50.3 Lower-inner quadrant of breast

C50.4 Upper-outer quadrant of breast

C50.5 Lower-outer quadrant of breast

C50.6 Axillary Tail of breast

C50.8 Overlapping lesion of breast

C50.9 Breast, NOS

Note: Laterality must be coded for this site.

CS Tumor Size	CS Site-Specific Factor 1 - Estrogen Receptor Assay (ERA)	The following tables are available at the collaborative staging website: Histologies for Which AJCC Staging is not Generated AJCC Stage for TNM Sites with no stage groupings.
CS Extension	CS Site-Specific Factor 2 - Progesterone Receptor Assay (PRA)	
CS TS/Ext-Eval	CS Site-Specific Factor 3 - Number of Positive Ipsilateral Axillary Lymph Nodes	
CS Lymph Nodes	CS Site-Specific Factor 4 - Immunohistochemistry (IHC) of Regional Lymph Nodes	
CS Lymph Nodes Eval	CS Site-Specific Factor 5 - Molecular Studies of Regional Lymph Nodes	
Reg LN Pos	CS Site-Specific Factor 6 - Size of Tumor--Invasive Component	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Breast

CS Tumor Size

Note 1: For tumor size, some breast cancers cannot be sized pathologically.

Note 2: When coding pathologic size, code the measurement of the invasive component. For example, if there is a large in situ component (e.g., 4 cm) and a small invasive component, see Site-Specific Factor 6 to code more information about the reported tumor size. If the size of invasive component is not given, code the size of the entire tumor and record what it represents in Site-Specific Factor 6.

Note 3: Microinvasion is the extension of cancer cells beyond the basement membrane into the adjacent tissues with no focus more than 0.1 cm in greatest dimension. When there are multiple foci of microinvasion, the size of only the largest focus is used to classify the microinvasion. (Do not use the sum of all the individual foci.)

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microinvasion; microscopic focus or foci only, no size given; described as less than 1 mm
991	Described as less than 1 cm
992	Described as less than 2 cm
993	Described as less than 3 cm
994	Described as less than 4 cm

995	Described as less than 5 cm
996	Mammographic/xerographic diagnosis only, no size given; clinically not palpable
997	Paget's Disease of nipple with no demonstrable tumor
998	Diffuse
999	Unknown; size not stated Not documented in patient record

Breast

CS Extension

Note 1: Changes such as dimpling of the skin, tethering, and nipple retraction are caused by tension on Cooper's ligament(s), not by actual skin involvement. They do not alter the classification.

Note 2: Consider adherence, attachment, fixation, induration, and thickening as clinical evidence of extension to skin or subcutaneous tissue, code '20'.

Note 3: Consider "fixation, NOS" as involvement of pectoralis muscle, code '30'.

Note 4: If extension code is 00, then Behavior code must be 2; if extension code is 05 or 07, then behavior code may be 2 or 3; and, if extension code is 10, then behavior code must be 3.

Note 5: Inflammatory Carcinoma. AJCC includes the following text in the 6th edition Staging Manual (p. 225-6), "Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse erythema and edema (peau d'orange) of the breast, often without an underlying palpable mass. These clinical findings should involve the majority of the skin of the breast. Classically, the skin changes arise quickly in the affected breast. Thus the term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease. On imaging, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor emboli within dermal lymphatics, which may or may not be apparent on skin biopsy. The tumor of inflammatory carcinoma is classified T4d. It is important to remember that inflammatory carcinoma is primarily a clinical diagnosis. Involvement of the dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings. In addition to the clinical picture, however, a biopsy is still necessary to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself."

Note 6: For Collaborative Staging, the abstractor should record a stated diagnosis of inflammatory carcinoma, and also record any clinical statement of the character and extent of skin involvement in the text area. Code 71 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in less than 50% (minority) of the breast. Code 73 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% (majority) of the skin of the breast. Cases with a stated diagnosis of inflammatory carcinoma but no such clinical description should be coded 71. A clinical description of inflammation, erythema, edema, peau d'orange, etc. without a stated diagnosis of inflammatory carcinoma should be coded 51 or 52, depending on described extent of the condition.

Code	Description	TNM	SS77	SS2000
00	In situ: noninfiltrating; intraepithelial Intraductal WITHOUT infiltration Lobular neoplasia	Tis	IS	IS
05	Paget Disease of nipple (WITHOUT underlying tumor)	Tis	**	**
07	Paget Disease of nipple (WITHOUT underlying invasive carcinoma pathologically)	Tis	**	**
10	Confined to breast tissue and fat including nipple and/or areola Localized, NOS	*	L	L

20	Invasion of subcutaneous tissue Local infiltration of dermal lymphatics adjacent to primary tumor involving skin by direct extension Skin infiltration of primary breast including skin of nipple and/or areola	*	RE	RE
30	Attached or fixation to pectoral muscle(s) or underlying tissue Deep fixation Invasion of (or fixation to) pectoral fascia or muscle	*	RE	RE
40	Invasion of (or fixation to): Chest wall Intercostal or serratus anterior muscle(s) Rib(s)	T4a	RE	RE
51	Extensive skin involvement, including: Satellite nodule(s) in skin of primary breast Ulceration of skin of breast Any of the following conditions described as involving not more than 50% of the breast, or amount or percent of involvement not stated: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
52	Any of the following conditions described as involving more than 50% of the breast WITHOUT a stated diagnosis of inflammatory carcinoma: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
61	(40) + (51)	T4c	RE	RE
62	(40) + (52)	T4b	RE	RE
71	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., involving less than 50% of the skin of the breast, or percent of involvement not stated, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS	T4d	RE	RE
72	OBSOLETE Code 72 has been combined with code 71. Any cases coded to 72 should be re-coded to code 71.	T4d	RE	RE
73	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the skin of the breast, WITH or WITHOUT dermal lymphatic infiltration	T4d	RE	RE
95	No evidence of primary tumor	T0	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U
----	---	----	---	---

* For Extension codes 10, 20, and 30 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site.

** For codes 05 and 07 ONLY, summary stage is assigned based on the value of Behavior Code ICD-0-3 as shown in the Extension Behavior Table for this site.

Breast

CS TS/Ext-Eval

SEE STANDARD TABLE

Breast

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field. Use code 60 in the absence of other information about regional nodes.

Note 3: If no lymph nodes were removed surgically, then use only the following codes for clinical evaluation of axillary nodes: 00 - Clinically negative, 50 - Fixed/matted nodes, 60 - Clinically positive axillary nodes, 99 - Unknown/not stated.

Note 4: If pre-surgical therapy was given and there is a clinical evaluation (positive or negative) of lymph nodes, then use only the following codes for clinical evaluation of axillary nodes: 00 - Clinically negative, 50 - Fixed/matted nodes, 60 - Clinically positive axillary nodes, AND Code a '5' in the nodes evaluation field. If there is no clinical evaluation of nodes, use the information from the pathologic evaluation and code a '6' in the nodes evaluation field.

Note 5: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters not greater than 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction). Lymph nodes with ITCs only are not considered positive lymph nodes.

Note 6: Codes 13-50 are used for positive axillary nodes without internal mammary nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement, including ITCs detected by immunohistochemistry or molecular methods ONLY. (See Note 5 and Site-specific Factors 4 and 5.)	*	NONE	NONE
05	Regional lymph node(s) with (ITCs) detected on routine H and E stains. (See Note 5)	N0(i+)	NONE	NONE
13	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected by immunohistochemical (IHC) means ONLY (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm)	N1mi	RN	RN
15	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected or verified on H&E (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm) Micrometastasis, NOS	N1mi	RN	RN
25	Movable axillary lymph node(s), ipsilateral, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm)	**	RN	RN
26	Stated as N1, NOS	**	RN	RN
28	Stated as N2, NOS	**	RN	RN

50	Fixed/matted ipsilateral axillary nodes, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm) Fixed/matted ipsilateral axillary nodes, NOS	**	RN	RN
60	Axillary/regional lymph node(s), NOS Lymph nodes NOS	**	RN	RN
71	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	**	RN	RN
72	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITH axillary lymph node(s), ipsilateral	**	RN	RN
73	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	**	RN	RN
74	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N2b	RN	RN
75	Infraclavicular lymph node(s) (subclavicular)	N3a	D	RN
76	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITH axillary lymph node(s), ipsilateral, codes 15 to 60 WITH or WITHOUT infraclavicular lymph node(s)	N3b	RN	RN
77	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N2b	RN	RN
78	(75) + (77)	N3a	D	RN
79	Stated as N3, NOS	N3NOS	RN	RN
80	Supraclavicular node(s)	N3c	D	D
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For code 00 ONLY, the N category is assigned based on the coding of Site-Specific Factors 4 and 5 using the IHC MOL Table for this site.

**For codes 25, 26, 28, 50, 60, 71, 72, and 73 ONLY, the N category is assigned based on the value of Site-Specific Factor 3, Number of Positive Ipsilateral Axillary Lymph Nodes. See Lymph Nodes Positive Axillary Nodes Table.

Breast

CS Reg Nodes Eval

SEE STANDARD TABLE

Breast**Reg LN Pos**

Note 1: Record this field even if there has been preoperative treatment.

Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are > 0.2mm and code the lymph nodes as positive in this field.

Note 3: Record all positive regional lymph nodes in this field. Record the number of positive regional axillary nodes separately in the appropriate Site-Specific Factor field.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Breast**Reg LN Exam**

SEE STANDARD TABLE

Breast**CS Mets at DX**

Note: Supraclavicular (transverse cervical) is moved to CS Lymph Nodes.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Cervical, NOS Contralateral/bilateral axillary and/or internal mammary Other than above Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
42	Further contiguous extension: Skin over: Axilla Contralateral (opposite) breast Sternum Upper abdomen	M1	D	D

44	Metastasis: Adrenal (suprarenal) gland Bone, other than adjacent rib Contralateral (opposite) breast - if stated as metastatic Lung Ovary Satellite nodule(s) in skin other than primary breast	M1	D	D
50	(10) + any of [(40) to (44)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Breast

CS Mets Eval

SEE STANDARD TABLE

Breast

CS Site-Specific Factor 1 Estrogen Receptor Assay (ERA)

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Breast

CS Site-Specific Factor 2 Progesterone Receptor Assay (PRA)

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline, undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Breast

CS Site-Specific Factor 3 Number of Positive Ipsilateral Axillary Lymph Nodes

Note 1: Record this field even if there has been preoperative treatment.

Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2 mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field.

Note 3: This field is based on pathological information only. If no ipsilateral axillary nodes were removed for examination, or if an ipsilateral axillary lymph node drainage area was removed but no lymph nodes were found, code 098.

Note 4: The general coding instructions in Part I for Regional Nodes Positive also apply to this field (although the codes in Regional Nodes Positive are 2 digits rather than 3). When positive ipsilateral axillary lymph nodes are coded in this field, the number of positive ipsilateral axillary lymph nodes must be less than or equal to the number coded in Regional Nodes Positive (i.e., the number of positive ipsilateral axillary nodes will always be a subset of the number of positive regional nodes.)

Code	Description
000	All ipsilateral axillary nodes examined negative
001-089	1 - 89 nodes positive (code exact number of nodes positive)
090	90 or more nodes positive
095	Positive aspiration of lymph node(s)
097	Positive nodes - number unspecified
098	No axillary nodes examined
099	Unknown if axillary nodes are positive; not applicable Not documented in patient record

Breast

CS Site-Specific Factor 4 Immunohistochemistry (IHC) of Regional Lymph Nodes

Note 1: Use codes 000-009 only to report results of IHC on otherwise histologically negative lymph nodes on routine H and E stains, i.e., only when CS Lymph Nodes is coded 00. Otherwise code 888 in this field.

Note 2: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods (RT-PCR: Reverse Transcriptase Polymerase Chain Reaction) but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction.)

Note 3: If it is unstated whether or not IHC tests were done, assume they were not done.

Code	Description
000	Regional lymph nodes negative on H and E, no IHC studies done or unknown if IHC studies done Nodes clinically negative, not examined pathologically
001	Regional lymph nodes negative on H and E, IHC studies done, negative for tumor
002	Regional lymph nodes negative on H and E, IHC studies done, positive for ITCs (tumor cell clusters not greater than 0.2mm)
009	Regional lymph nodes negative on H and E, positive for tumor detected by IHC, size of tumor cell clusters or metastases not stated
888	Not applicable CS Lymph Nodes not coded 00

Breast

CS Site-Specific Factor 5 Molecular Studies of Regional Lymph Nodes

Note 1: Use codes 000-002 only to report results of molecular studies on otherwise histologically negative lymph nodes on routine H and E stains., i.e., only when CS Lymph Nodes is coded 00. Otherwise code 888 in this field.

Note 2: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters less than or equal to 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods (RT-PCR: Reverse Transcriptase Polymerase Chain Reaction) but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction.)

Note 3: If it is not stated whether molecular tests were done, assume they were not done.

Code	Description
000	Regional lymph nodes negative on H and E, no RT-PCR molecular studies done or unknown if RT-PCR studies done Nodes clinically negative, not examined pathologically
001	Regional lymph nodes negative on H and E, RT-PCR molecular studies done, negative for tumor
002	Regional lymph nodes negative on H and E, RT-PCR molecular studies done, positive for tumor
888	Not applicable CS Lymph Nodes not coded 00

Breast

CS Site-Specific Factor 6 Size of Tumor--Invasive Component

Note 1: Record the code that indicates how the tumor size coded in CS Tumor Size was determined.

Note 2: For this field, "mixed" indicates a tumor with both invasive and in situ components. Such a "mixed" tumor may be a single histology such as mixed infiltrating ductal and ductal carcinoma in situ or combined histology such as mixed infiltrating ductal and lobular carcinoma in situ. "Pure" indicates a tumor that contains only invasive or only in situ tumor.

Note 3: This information is collected for analytic purposes and does not affect the stage grouping algorithm. Different codes in this field may explain differences in outcome for patients in the same T category or stage group. Example: Patient 1 has a "mixed" (see Note 2) tumor measuring 2.5 cm with extensive areas of in situ tumor, and the size of the invasive component is not stated. This would be coded 025 in CS Tumor Size, and would be classified as T2. It would be coded 040 in Site-Specific Factor 6. Patient 2 has a purely invasive tumor measuring 2.5 cm. This would also be coded 025 in CS Tumor Size and would also be classified as T2. However, it would be coded 000 in Site-Specific Factor 6. Patient 1's tumor would probably have a better survival than Patient 2's tumor, since it would more likely be a T1 lesion if the true dimensions of the invasive component were known.

Code	Description
000	Entire tumor reported as invasive (no in situ component reported)
010	Entire tumor reported as in situ (no invasive component reported)
020	Invasive and in situ components present, size of invasive component stated and coded in CS Tumor Size
030	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND in situ described as minimal (less than 25%)
040	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND in situ described as extensive (25% or more)
050	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND proportions of in situ and invasive not known

060	Invasive and in situ components present, unknown size of tumor (CS Tumor Size coded 999)
888	Unknown if invasive and in situ components present, unknown if tumor size represents mixed tumor or a "pure" tumor. (See Note 2.)