CAUSE OF DEATH

Column	1388-1391
Length	4
Source of Standard	SEER

Description:

THIS IS A REQUIRED DATA ITEM

Official cause of death as coded from the death certificate in valid **ICD-10 codes.** These codes are to be used for all deaths beginning in 1999.

Rationale:

Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

General Guidelines:

Use the underlying cause of death as coded by the State Health Department even if the code seems to be in error.

Do not record decimal points when copying codes.

The cause of death code is commonly four characters. Do not record a fifth character if present.

If the underlying cause of death code is not available, do not attempt to code the underlying cause of death unless you have a person trained to code ICD-10 available.

Special Codes (in addition to ICD-10 codes)	**Description**
0000	Patient alive at last contact.
7777	State death certificate not available.
7797	State death certificate available but underlying cause of death not coded.

ABSTRACT PLUS:

If the cause of death code is available, type the appropriate **ICD-10** cause of death code in the CURRENT VALUE box.

Click OK or press ENTER.

CLASS OF CASE

Column 440-440
Length 1
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM

For a hospital registry, the class of case divides cases into those included in reports on patient treatment and outcome (analytic) and those that are not included (non-analytic).

Class of Case codes 0-2 are analytic (i.e., The patient was diagnosed and/or received all or part of first course of treatment or had treatment planning at the reporting hospital).

Class of case codes 3-5 and 7- 9 are nonanalytic (i.e., The patient was first diagnosed and received all of first course of therapy at another institution, or was diagnosed at autopsy or by death certificate only).

General Guidelines:

Class 0
Diagnoses at accessioning facility and all of the first course of treatment was performed elsewhere or the the decision no to treat was made at another facility.

- Patients who elect to be treated elsewhere.
- Patients who are referred elsewhere for treatment for any reason. For example, lack of special equipment; proximity of a patient's residence; financial, social or rehabilitative considerations.

Class 1
Diagnosis at the accessioning facility, and all or part of the first course of treatment was performed at the accessioning facility.

- Patients diagnosed at the accessioning facility whose treatment plan is either not to treat or watchful waiting.
- Patients diagnosed at the accessioning facility who refuse treatment.
- Patients diagnosed at the accessioning facility who are not treatable or who were given palliative care only due to age, advanced disease, or other medical conditions.
- Patients diagnosed at the accessioning facility for whom it is unknown whether treatment was recommended or administered.
- Patients diagnosed at the accessioning facility for whom treatment was recommended, but it is unknown whether it was administered.
- Patients diagnosed at a staff physician's office who receive their first course of treatment at the accessioning facility. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.
- Patients diagnosed at the accessioning facility who received all or part of their first course of treatment in a staff physician's office.

Class 2
Diagnosis elsewhere, and all or part of the first course of treatment was performed at the accessioning facility.

- Patient provided palliative care in lieu of first course treatment, or as part of the first course of treatment, at the accessioning facility.

Class 3
Diagnosis and all of first course treatment elsewhere.

- Patient treated or managed at the accessioning facility, but first course of treatment information is unknown.
- Patient for whom the accessioning facility developed a treatment plan or provided "second opinion" services, but the diagnosis and treatment was provided elsewhere.
- Patient treated for a recurrence or progression for a previously diagnosed malignancy.

Class 4
Diagnosis and/ or first course of treatment was performed at the accessioning facility prior to the reference date of the registry.

- Patients for whom the accessioning facility manages or treats a recurrence or progression of disease after the reference date.
- Patients for whom it is unknown whether the accessioning facility delivered the first course of treatment prior to the reference date.

Class 5
Diagnosed at autopsy.

- There is no suspicion of cancer before the autopsy.

Class 6
Diagnosed and all of the first course of treatment completed by a staff physician in the office setting. "Staff physician" refers to any medical staff with admitting privileges at the accessioning facility.

Class 7
Pathology report only. The patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.

Class 8*
Diagnosis established only by death certificate.

Class 9*
Unknown

**NOTE:* Codes 8 and 9 are used in central registries only.

Codes	Description
0	First diagnosed at the reporting institution, since the registry's reference date, and all of first course of therapy elsewhere.
1	First diagnosed and all or part of the first course of therapy was performed at the reporting institution.
2	First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution, after the registry's reference date.

CLASS OF CASE (Cont'd)

Codes (Cont'd)	Description
3	First diagnosed and all of the first course of therapy elsewhere.
4	First diagnosed and/or first course of therapy at the reporting institution before the reference date of the registry.
5	First diagnosed at autopsy.
6	Diagnosed and all of the first course of treatment by staff physician in an office setting. "Staff physician" is any medical staff with admitting privileges at the reporting facility.
7	Pathology report only (excludes cases diagnosed at autopsy).
8	Diagnosis established only by death certificate.*
9	Unknown.*

**Note*: Codes 8 and 9 are used in central registries only

ABSTRACT PLUS:

In the CURRENT VALUE box, type the class of case code.

or

Select the correct Class of Case code from the drop-down table.

Click OK or press ENTER

COC CODING SYSTEM--CURRENT

Column 1200-1201
Length 2
Source of Standard COC

Description:

THIS IS A REQUIRED DATA ITEM

Documents which of the ACoS, COC coding systems is currently used in the record. COC codes may be converted from an earlier version.

Codes	Description
00	No COC coding system.
01	Pre-1988 (Cancer Program Manual Supplement).
02	1988 *Data Acquisition Manual.*
03	1989 *Data Acquisition Manual* Revisions.
04	1990 *Data Acquisition Manual* Revisions.
05	1994 *Data Acquisition Manual* (Interim/Revised).
06	*Registry Operations and Data Standards* (*ROADS*) (effective with cases diagnosed 1996-1997).
07	*ROADS* and 1998 supplement (effective with cases diagnosed 1998-2002).
08	F*acility Oncology Registry Data Standards (FORDS) (*effective with cases diagnosed 2003 and forward).
99	Unknown.

ABSTRACT PLUS:

This data item is generated by the computer software.

COC CODING SYSTEM--ORIGINAL

Column 1202-1203
Length 2
Source of Standard NAACCR

Description:

THIS IS A REQUIRED DATA ITEM.

Documents which of the ACoS, COC coding systems was used to originally code the record.

Codes	Description
00	No COC coding system.
01	Pre-1988 (Cancer Program Manual Supplement).
02	1988 *Data Acquisition Manual.*
03	1989 *Data Acquisition Manual* revisions.
04	1990 *Data Acquisition Manual* revisions.
05	1994 *Data Acquisition Manual* (Interim/Revised).
06	*Registry Operations and Data Standards* (*ROADS*) (effective with cases diagnosed 1996-1997).
07	*ROADS* and 1998 supplement (effective with cases diagnosed 1998-2002).
08	F*acility Oncology Registry Data Standards (FORDS) (*effective with cases diagnosed 2003 and forward).
99	Unknown.

ABSTRACT PLUS:

This data item is generated by the computer software.

COUNTY AT DX

Column 83-85
Length 3
Source of Standard FIPS/SEER

Description:

THIS IS A REQUIRED DATA ITEM

Code for the county of the patient's residence at the time the reportable tumor is diagnosed.

General Guidelines:

For U.S. residents, standard codes are those of the Federal Information Processing Standards (FIPS) Publication, "Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas."

If the patient has more than one tumor, the county codes may be different for each tumor.

Do not update this data item if the patient's county of residence changes.

Use code 998 for Canadian residents and Non-US residents.

See Appendix C for standard FIPS county codes.

Codes (in addition to FIPS)	**Description**
998	Non-US resident; Non-Tennessee resident with a known address but the county code is not known.
999	County unknown.

Note: Code 999 should not be used for Tennessee residents. If unable to locate the FIPS code for a Tennessee resident, please call the Tennessee Cancer Registry for assistance.

Note: If your software supports coding of the FIPS for non-Tennessee residents, please use the correct FIPS code vs 998.

ABSTRACT PLUS:

In the CURRENT VALUE box, type the patient's county of residence at diagnosis or select the code from the drop-down look-up table.

or

COUNTY AT DX (Cont'd)

In the CURRENT VALUE box, begin typing the first letters of the county until the correct county is highlighted.

Click OK or press ENTER.

CS EXTENSION

Column 632-633
Length 2
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents the **contiguous growth** (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. With the exception of a few sites, such as ovary and corpus uteri, discontinuous metastases to distant sites is coded in CS Mets at Dx. See site-specific schemas for detailed codes and coding instructions.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. Code the farthest documented extension of the primary tumor. Do not include discontinuous metastases to distant sites (these are coded in CS Mets at Dx) except for ovary and corpus uteri (see 2e below).

2. Record extension information in the following order:

   a. Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

   b. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest extension identified prior to treatment.

   Example: Patient has rectal mass firmly attached to pelvic wall (extension code 60). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (extension code 40). *Code extension as 60, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.*

   c. In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.

   Example 1: Patient found to have an obstructing central lung tumor very close to the main stem bronchus (extension code 20). Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea (extension code 70). *Code extension as 70, because the tumor was noted to be more extensive after the preoperative treatment.*

CS EXTENSION (Cont'd)

Example 2: Patient has a 5.5 cm hard, moveable mass in the right breast (extension code 10) and receives preoperative chemotherapy. The pathology report from the modified radical mastectomy shows residual 2.8 cm mass with infiltration of the deep subcutaneous tissues over the mass (extension code 20). *Code extension as 20, because although the chemotherapy "shrank" the tumor, the residual tumor was found to be more extensive than the clinical presentation.*

d. Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

e. If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area.

f. <u>With the exception of corpus uteri and ovary, all codes represent </u>contiguous (direct) extension<u> of tumor from the site of origin to the organ/structure/tissue represented in the code.</u>

Example: Carcinoma of the prostate with extension to pubic bone would be coded 60. Carcinoma of the prostate with metastases to thoracic spine would be coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine would be coded in the CS Mets at Dx field.

3. Refer to general instructions for Collaborative Staging in this manual for timing rules for data collection.

4. Refer to the ambiguous terminology section for terms that constitute tumor involvement or extension.

5. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category stated by the physician if he does TNM staging.

6. If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent extension code for that T category.

7. Some site or histology schemas include designations such as Localized, NOS; and other non-specific categories. The data collector should only code to a category such as "Localized, NOS" when a more specific extension cannot be determined.

8. <u>Distant metastases must be coded in the CS Mets at Dx field.</u>

9. Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement; use the code for Localized, NOS, if there is no better information.

Example: Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. *Code CS Extension as 10, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.*

CS EXTENSION (Cont'd)

10. The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

11. In the appropriate text field, document the extension code chosen.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
00	In situ; non-invasive.
--	**SITE/HISTOLOGY-SPECIFIC CODES .**
80	Further contiguous extension.
95	No evidence of primary tumor.
99	Unknown extension; primary tumor cannot be assessed; not stated in patient record.

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display acceptable codes.

Enter the most accurate CS Extension code in the data field.

Click OK or press ENTER.

CS LYMPH NODES

Column 635-636
Length 2
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents the regional lymph nodes involved with cancer at the time of diagnosis.

General Guidelines:

1. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.

   a. Regional lymph nodes are listed for each site/histology. In general, the regional lymph nodes in the chain(s) closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. Record the highest applicable code.

      Exception: The higher codes for 'Regional lymph nodes, NOS'; 'Lymph nodes, NOS'; 'Stated as N1, no other information'; 'Stated a N2a, no other information', and so forth, should only be used when there is no available information as to the name(s) of the regional nodes involved.

      ***Example**:* Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

   b. Record involved regional lymph nodes from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

   c. If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, the pathologic information takes precedence if no preoperative treatment was administered.

      Example: Axillary lymphadenopathy stated as "suspicious *for* involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. *Code CS Lymph Nodes as 0, no regional lymph node involvement.*

   d. For inaccessible sites, primarily for localized or early stage cancers*:* record regional lymph nodes as negative rather than unknown (based on clinical evaluation) when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be usual treatment to the primary site.

   e. If there is direct extension of the primary tumor into a regional lymph node, record the involved node in this field.

f. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery.

Example: Patient has a hard matted mass in the axilla (code 50) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 00). *Code CS Lymph Nodes as 50 because the chemotherapy apparently "sterilized" the lymph nodes.*

g. In the infrequent event that clinically involved regional lymph nodes do not respond to neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Reg Nodes Eval as 6, based on pathology/operative report after treatment.

Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination (Negative, code 00). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 10) to lymph nodes and the prostatectomy is canceled. *Code CS Lymph Nodes as 10 because the preoperative treatment (Lupron) had no effect on the lymph nodes.*

2. Use code 00 for lymph node involvement when the CS Extension is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so lymph nodes can be coded as appropriate for the case.

3. For solid tumors, the terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.

   a. Any other terms, such as "palpable," "enlarged," "visible swelling," "shotty," or "lymph-adenopathy" should be ignored, unless there is a statement of involvement by the clinician.

   Exception: The terms adenopathy, enlargement, and mass in the hilum or mediastinum should be coded as involvement for lung primaries only.

   b. For lymphomas, *any* positive mention of lymph nodes indicates involvement of those lymph nodes.

   c. Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be on imaging studies or in the surgeon's evaluation at the time of exploratory surgery or definitive surgery. If regional lymph nodes for these inaccessible sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative.

   d. The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

   e. Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS.

   f. Where more specific categories are provided, the codes for "regional lymph node(s), NOS"; "lymph nodes, NOS"; and "Stated as N_, no additional information" should be used *only* after an exhaustive search for more specific information.

4. When size of involved regional lymph nodes is required, code from pathology report, if available.

   a. Code the size of the metastasis, not the entire node, unless otherwise stated in site-specific schemas. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes; for example, a single involved node 1.5 cm in size can be coded to "single lymph node $\leq$ 2 cm" because the metastasis cannot be larger than 1.5 cm.

5. If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' C, record the numerically lowest equivalent CS Lymph Nodes code for that N category.

   a. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

   b. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

6. Some site or histology schemas include designations such as N1, NOS; N2, NOS; and other non-specific categories. The "NOS" is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

7. For colon, rectosigmoid and rectum primaries, if there is a statement about tumor nodule(s) in the pericolic or perirectal fat, use the following guidelines for coding regional lymph node involvement:

   Code as regional lymph node involvement if the nodule has a smooth contour.
   Code as tumor extension if the nodule has an irregular contour.

8. In the appropriate text field, document the regional lymph node code chosen.

CODING REGIONAL LYMPH NODES FOR HEAD AND NECK SITES

For head and neck sites, regional lymph node information is coded in several fields. The CS Lymph Nodes field contains information about the nodes involved, their number and laterality. Site-Specific Factors 1 and 2 are used to code the size of involved lymph nodes and the presence of extracapsular extension. Site-Specific Factors 3 through 6 are used to code the presence or absence of lymph node involvement. The definitions of the levels are the same for all applicable head and neck sites. One digit is used to represent lymph nodes of a single level, with the three digits of Site-Specific Factor 3 representing lymph nodes of, respectively, Levels I-III; the digits of Site-Specific Factor 4 representing

lymph nodes of Levels IV and V and the retropharyngeal nodes; the digits of Site-Specific Factor 5 representing lymph nodes of Levels VI and VII and the facial nodes; and the digits of Site-Specific Factor 6 representing the remaining "Other" groups as defined by AJCC. In each digit, a code 1 means Yes, the nodes are involved. See Figure 2a for the layout of Site-Specific Factors 3 through 6 and Figure 2b for the interpretation of a coded example.

Figure 2a. Layout of Site-Specific Factors for Head and Neck Sites

SSF 3	Levels I-III	___ I	___ II	___ III
SSF 4	Levels IV-V, retropharyngeal (RP)	___ IV	___ V	___ RP
SSF 5	Levels VI-VII, Facial (F)	___ VI	___ VII	___ F
SSF 6	Other groups Parapharyngeal (PP), Parotid (PA), Suboccipital (S)	___ PP	___ PA	___ S

Figure 2b. Example and Interpretation of Site-Specific Factors for Head and Neck Sites

Example: Left Radical Neck Dissection: 2 positive parotid node (< 3 cm with extra-capsular extension), 1 positive buccal (facial) node (2 cm), and 1 positive 2 cm submandibular node.

SSF 3	Levels I-III	1 (I)	0 (II)	0 (III)
SSF 4	Levels IV-V, retropharyngeal (RP)	0 (IV)	0 (V)	0 (RP)
SSF 5	Levels VI-VII, Facial (F)	0 (VI)	0 (VII)	1 (F)
SSF 6	Other groups Parapharyngeal (PP), Parotid (PA), Suboccipital (S)	0 (PP)	1 (PA)	0 (S)

Stored in database as		Interpretation
SSF 3	100	Level 1 only
SSF 4	000	All nodes neg
SSF 5	001	Facial nodes only
SSF 6	010	Parotid nodes only

UNKNOWN

In Site-Specific Factors 3-6 for lymph node levels, use code 9 only when it is unknown if lymph nodes are involved. Within each of the Site-Specific Factors 3-6, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

NOS

When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

Example: A carcinoma of the base of tongue involves bilateral submandibular nodes and left upper, mid-, and lower jugular nodes, the largest measuring 4 cm. There is no extracapsular extension. CS Lymph Nodes is coded 40 (bilateral or contralateral nodes). Site-Specific Factor 1 is coded 040 indicating the largest size. Site-Specific Factor 2 is coded 000 for no extracapsular extension. Site-Specific Factor 3 is coded 111, to show that levels I, II, and III are involved. Site-Specific Factor 4 is coded 100 to show that level IV is involved. Site-Specific Factors 5 and 6 are each coded 000, since no other nodes are involved.

Example: Laryngeal biopsy with squamous cell carcinoma, no other information available. CS Lymph Nodes is coded 99. Site-Specific factors 1-6 are each coded 999, since no information is available regarding lymph node involvement.

Example: Patient diagnosed elsewhere with carcinoma of oropharynx with cervical lymph node involvement. No other information available. CS Lymph Nodes is coded 50 (regional nodes, NOS, not stated if ipsilateral, bilateral, or contralateral, or if single or multiple). Site-specific Factors 1 and 2 are each coded 999. Site-Specific Factors 3-6 are each coded 000.

DEFINITIONS OF LEVELS FOR HEAD AND NECK SITES

The definitions of the levels and the lymph node chains included in each level are as follows:

Level I contains the submental and submandibular triangles bounded by the anterior and posterior bellies of the digastric muscle, and the hyoid bone inferiorly, and the body of the mandible superiorly.

Submandibular
Submaxillary
Submental

Level II contains the upper jugular lymph nodes and extends from the level of the skull base superiorly to the hyoid bone inferiorly.

Jugulodigastric (subdigastric)
Upper deep cervical
Upper jugular

Level III contains the middle jugular lymph nodes from the hyoid bone superiorly to the level of the lower border of the cricoid cartilage inferiorly.

Middle deep cervical
Mid-jugular

Level IV contains the lower jugular lymph nodes from the level of the cricoid cartilage superiorly to the clavicle inferiorly.

Jugulo-omohyoid (supraomohyoid)
Lower deep cervical
Lower jugular

Level V contains the lymph nodes in the posterior triangle bounded by the anterior border of the trapezius muscle posteriorly, the posterior border of the sternocleidomastoid muscle anteriorly, and the clavicle inferiorly. For descriptive purposes, Level V may be further subdivided into upper, middle, and lower levels corresponding to the superior and inferior planes that define Levels II, III, and IV.

Posterior cervical
Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower, corresponding to the levels that define upper, middle, and lower jugular nodes)

Level VI contains the lymph nodes of the anterior central compartment from the hyoid bone superiorly to the suprasternal notch inferiorly. On each side, the lateral boundary is formed by the medial border of the carotid sheath.

Anterior deep cervical
Laterotracheal
Paralaryngeal
Paratracheal
Prelaryngeal (Delphian)
Pretracheal
Recurrent laryngeal

Level VII contains the lymph nodes inferior to the suprasternal notch in the superior mediastinum.

Upper mediastinal

Other groups

Buccinator (facial)
Nasolabial
Parapharyngeal
Periparotid and
intraparotid
Preauricular
Retropharyngeal
Sub-occipital

CS LYMPH NODES (Cont'd)

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
00	None; no regional lymph node involvement.
--	**SITE/HISTOLOGY-SPECIFIC CODES**
80	Lymph nodes, NOS
90	Unknown; regional lymph nodes cannot be assessed; not stated in patient record
88	Not applicable (schemas that do not use the CS Lymph Nodes field)

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Lymph Nodes in the data field.

Click OK or press ENTER.

CS METS AT DX

Column 638-639
Length 2
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents the distant site(s) of metastatic involvement at the time of diagnosis.

General Guidelines:

1. This field represents distant metastases at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

2. Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.

3. Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in the CS Mets at Dx field.

4. Record CS Mets at Dx as Code 00 (None) rather than Code 99 (Unknown) when the clinician proceeds with standard treatment of the primary site for localized or early stage disease, since this action presumes that there are no distant metastasis that would otherwise alter the treatment approach. Code 99 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases.

5. If the only indication of extension in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes' D, record the numerically lowest equivalent extension code for that M category. In most cases, this will be 40, Distant metastasis, NOS.

6. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the M category stated by the physician, if this is available.

7. Some site or histology schemas include a designation of M1, NOS. The "NOS" is added when there is further breakdown of the category into subsets (such as M1a, M1b, M1c), but the correct subset cannot be determined. The data collector should only code to a category such as "Stated as M1 NOS" when the appropriate subset (such as M1a or M1b) cannot be determined.

8. In the appropriate text field, document the distant lymph nodes and/or distant metastasis code chosen.

CS METS AT DX (Cont'd)

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
00	No; none.
10	Distant lymph node(s).
40	Distant metastases except code 10; distant metastasis, NOS; carcinomatosis.
--	**SITE/HISTOLOGY-SPECIFIC CODES WHERE NEEDED.**
50	(40) + (10).
99	Unknown; distant metastasis cannot be assessed; not stated in patient record.
88	Not applicable (for schemas that do not use the CS Mets at Dx field).

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Mets at Dx code in the data field.

Click OK or press ENTER.

CS METS EVAL

Column 640-640
Length 1
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents how the code for the item "CS Mets at Dx" was determined based on the diagnostic methods employed.

General Guidelines:

1. Select the CS Mets Eval code that documents the report or procedure from which the information was obtained about metastatic involvement farthest from the primary site; this may not be the numerically highest eval code.

   Example: Liver palpated and reported as normal during laparotomy for stomach cancer (Eval code 1). CT scan of brain shows multiple metastatic nodules (Eval code 0). *Code CS Mets Eval as 0; the brain would be reported as involved but the liver would not be reported as involved..*

2. For primary sites/histologies where there is no TNM schema (See Table 6 in the *Instructions for Using the Collaborative Staging System Codes and Coding Instructions)*, this field may be coded as 9 (not applicable).

3. Select the code that best explains how the information in the CS Metastases field was determined.

   a. If the patient had no examination of metastatic tissue, use code 0, 1, or 9.

   Example : Patient has diagnosis of colon cancer by biopsy. CT scan shows liver metastasis. *Code this field as 0.*

   Example: Lung cancer with endoscopy of contralateral lung showing involvement of contralateral mainstem bronchus. *Code this field as 1.*

   Example: Prostate cancer with enlarged scalene node confirmed as cancer on needle biopsy. *Code this field as 3.*

   b. If the patient had removal of presumed metastatic tissue (even though the pathology report was negative), use code 3.

   c. Code the method of evaluation for the site(s) farthest from the primary.

   Example: Colon cancer patient has CT scan showing normal lungs. During the resection, the surgeon palpates the liver and finds it to be normal. *Code this field as 0, since the CT scan shows that potential metastatic sites outside the surgical field are negative.*

d. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

CS METS EVAL (Cont'd)

4. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of metastases at diagnosis takes precedence (code 5).

5. If the patient has biopsies of some metastases while others are visible only on imaging, use code 6 to indicate if, after preoperative treatment, the biopsy is negative for metastasis but there is still evidence of clinical metastasis.

6. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

7. Any positive biopsy or resection of distant metastasis meets the requirement for pathologic staging basis and should be coded to CS Mets Eval code 3.

8. Code 1 includes endoscopy and observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description	Staging Basis
0	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No autopsy evidence used.	c
2	No pathologic examination of metastatic tissue done prior to death, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Pathologic examination of metastatic tissue performed WITHOUT pre-surgical systemic treatment or radiation **OR** pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed.	p

CS METS EVAL (Cont'd)

Codes (Cont'd)	**Description**	**Staging Basis**
5	Pathologic examination of metastatic tissue performed WITH pre-surgical systemic treatment or radiation, and metastasis based on clinical evidence.	c
6	Pathologic examination of metastatic tissue performed WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence.	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. *For sites with no TNM staging*: Not applicable.	c

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Mets Eval code in the field.

Click OK or press ENTER.

CS REG NODES EVAL

Column 637-637
Length 1
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents how the code for the item "CS Lymph Nodes" was determined, based on the diagnostic methods employed.

General Guidelines:

1. Select the CS Reg Nodes Eval code that documents the report or procedure from which the information about the farthest involved regional lymph nodes was obtained; this may not be the numerically highest eval code.

   ***Example**:* Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (CS Reg LN code 10, Eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (CS Reg LN code 32, Eval code 0). *Code CS Reg Nodes Eval as 0 since the scalene node involvement was determined clinically rather than by examination of tissue.*

2. For sites/histologies where there is no TNM schema (see Table 6 in the *General Instructions for Using the Collaborative Staging System Codes and Coding Instructions*), CS Reg Node Eval may be coded 9 (not applicable).

3. Select the code that best explains how the information in the CS Lymph Nodes field was determined.

   a. If the patient had no removal of lymph node(s), use code 0, 1, or 9.

   ***Example 1**:* Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled. *Code CS Reg Node Eval as 3.*

   Example 2: Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. *Code CS Reg Node Eval as 1.*

   b. If the patient had removal of lymph node(s) surgery followed by other treatment(s), use code 3 or 9.

   c. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of lymph nodes takes precedence (code 5).

   d. If the size, number, or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is during lymph node examination after neoadjuvant therapy, use code 6.

e. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

5. Codes 0-3 are oriented to the AJCC staging basis. Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system. For example, a needle biopsy of an axillary lymph node will document that a lymph node is involved by breast cancer, but does not meet the requirement for removal of a sufficient number of lymph nodes so that the highest N stage can be assessed. Pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, sixth edition*. Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied.

6. Code 3 maps to pathologic staging across all sites. Use code 3 if the lymph node procedure meets the requirements for pathologic staging basis of regional lymph nodes. The requirements vary among sites as to the location and number of lymph nodes involved, the size of the involved nodes, and other characteristics. For prostate cancer, a positive biopsy of a single regional lymph node is sufficient to assign CS Reg Nodes Eval code 3 to the case.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description	Staging Basis
0	No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No regional lymph nodes removed for examination. Evaluation based on endoscopic examination, diagnostic biopsy including fine needle aspiration of lymph node(s) or other invasive techniques. No autopsy evidence used.	c
2	No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p

CS REG NODES EVAL (Cont'd)

Codes (Cont'd)	**Description**	**Staging Basis**
3	Regional lymph nodes removed for examination (removal of at least 1 lymph node) WITHOUT pre-surgical systemic treatment or radiation **OR** lymph nodes removed for examination, unknown if pre-surgical systemic treatment or radiation performed	p
5	Regional lymph nodes removed for examination WITH pre-surgical systemic treatment or radiation, and lymph node evaluation based on clinical evidence.	c
6	Regional lymph nodes removed for examination WITH pre-surgical systemic treatment or radiation, BUT lymph node evaluation based on pathologic evidence.	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes removed for examination. Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. For sites that have no TNM staging: Not applicable.	c

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the applicable codes.

Enter the most accurate CS Reg Nodes Eval code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 1

Column 641-643
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites/histologies use Site Specific Factor 1 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and neck*	Size of Lymph Nodes
Colon	Carcinoembryonic Antigen (CEA)
Rectosigmoid, rectum	Carcinoembryonic Antigen (CEA)
Liver	Alpha Fetoprotein (AFP)
Pleura	Pleural Effusion
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Measured Thickness (Depth), Breslow's Measurement
Mycosis Fungoides	Peripheral Blood Involvement
Breast	Estrogen Receptor Assay (ERA)
Ovary	Carbohydrate Antigen 125 (CA-125)
Placenta	Prognostic Scoring Index
Prostate	Prostate Specific Antigen Laboratory Value (PSA, PSA Lab Value)
Testis	Alpha Fetoprotein (AFP)
Thyroid	Single vs. Multiple Nodules

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

CS SITE-SPECIFIC FACTOR 1 (Cont'd)

Site/Histology	**Factor**
Melanoma of Conjunctiva	Measured Thickness (Depth), Breslow's Measurement
Melanoma of Choroid	Measured Thickness (Depth), Breslow's Measurement
Melanoma of Iris and Ciliary Body	Measured Thickness (Depth), Breslow's Measurement
Retinoblastoma	Extension Evaluated at Enucleation
Brain	WHO Grade
Other CNS	WHO Grade
Thyroid	Solitary vs. Multifocal
Other Endocrine	WHO Grade
Kaposi Sarcoma	Associated with HIV/AIDS
Lymphoma	Associated with HIV/AIDS

3. Code "000 Not done" is used when there is a statement in the record that a test was not performed.

   a. If there is no report of a lab test in the patient record, code as 999 Unknown; Not documented in patient record.

   b. For Kaposi sarcoma, if AIDS status is not documented, code as "999 Unknown" rather than "002, Not Present".

See Appendix E for CS codes and site/histology-specific rules.

Codes	**Description**
000	None.
---	**SITE/HISTOLOGY-SPECIFIC CODES.**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record.

For schemas that do not use this site-specific factor:

Code	**Description**
888	Not applicable for this site.

CS SITE-SPECIFIC FACTOR 1 (Cont'd)

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display acceptable codes.

Enter the most accurate CS Site-Specific Factor 1 code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 2

Column 644-646
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites use Site Specific Factor 2 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and neck*	Extracapsular Extension, Lymph Nodes for Head and Neck
Liver	Fibrosis Score
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Ulceration
Breast	Progesterone Receptor Assay (PRA)
Prostate	Prostate Specific Antigen (PSA)
Testis	Human Chorionic Gonadotropin (HCG)
Hodgkin and non-Hodgkin Lymphoma	Symptoms at Diagnosis

---

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

3. Code “000 Not done” is used when there is a statement in the record that a test was not performed.

   a. If there is no report of a lab test in the health record, code as “999 Unknown; Not documented in patient record”.

CS SITE-SPECIFIC FACTOR 2 (Cont'd)

b. For malignant melanoma of skin, if ulceration is not mentioned in the pathology report, code as "000 No ulceration present".

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
000	None.
---	**SITE/HISTOLOGY-SPECIFIC CODES.**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record.

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site.

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Site-Specific Factor 2 code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 3

Column 647-649
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites use Site Specific Factor 3 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels I-III, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Clinical Status of Lymph Node Mets
Breast	Number of Positive Ipsilateral Axillary Lymph Nodes
Prostate	CS Extension - Pathologic Extension
Testis	LDH (Lactate Dehydrogenase)
Lymphoma	International Prognostic Index (IPI) Score

---

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

3. Code 000 Not done is used when there is a statement in the record that a test was not performed.

   a. If there is no report of a lab test in the health record, code as 999 Unknown; not documented in patient record.
   b. For the lymphomas, if the IPI score is not stated in the record, code as 999 Unknown; not documented in patient record. It is not necessary to calculate the IPI score from other information in the record.

CS SITE-SPECIFIC FACTOR 3 (Cont'd)

FOR HEAD AND NECK SITES ONLY:

4. Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

5. When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

6. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

See Appendix E for CS codes and site/histology-specific rules.

Codes	**Description**
000	None.
---	**SITE/HISTOLOGY-SPECIFIC CODES.**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record.

For schemas that do not use this site-specific factor:

Code	**Description**
888	Not applicable for this site.

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display acceptable codes.

Enter the most accurate CS Site-Specific Factor 3 code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 4

Column 650-652
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites use Site Specific Factor 4 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels IV-V, Lymph Nodes of Head and Neck
Malignant Melanoma of Skin, Vulva, Penis, Scrotum	Lactate Dehydrogenase (LDH)
Breast	Immunohistochemistry (IHC) of Regional Lymph Nodes
Prostate	Prostatic Acid Phosphatase (PAP)
Testis	Radical Orchiectomy Performed

---

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

3. Code 000 Not done is used when there is a statement in the record that a test was not performed.
    a. If there is no report of a lab test in the health record, code as 999 Unknown; not documented in patient record.

FOR HEAD AND NECK SITES ONLY:

4. Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available

about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

5. When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

6. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
000	None.
---	**SITE/HISTOLOGY-SPECIFIC CODES.**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record.

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site.

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display acceptable codes.

Enter the most accurate CS Site-Specific Factor 4 code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 5

Column 653-655
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites use Site Specific Factor 5 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Levels VI-VIII, Lymph Nodes of Head and Neck
Breast	Molecular Studies of Regional Lymph Nodes
Prostate	Gleason's Primary and Secondary Patterns
Testis	Size of Metastasis in Lymph Nodes

---

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

3. Code 000 Not done is used when there is a statement in the record that a test was not performed.
   a. If there is no report of a lab test in the health record, code as 999 Unknown; not documented in patient record.

FOR HEAD AND NECK SITES ONLY:

4. Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

CS SITE-SPECIFIC FACTOR 5 (Cont'd)

5. When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

6. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
000	None.
---	**SITE/HISTOLOGY-SPECIFIC CODES.**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record.

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site.

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Site-Specific Factor 5 code in the data field.

Click OK or press ENTER.

CS SITE-SPECIFIC FACTOR 6

Column 656-658
Length 3
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents additional information needed to generate stage, or prognostic factors that have an effect on stage or survival.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. If there is no site/histology-specific factor for a schema, code 888.

2. The following primary sites use Site Specific Factor 6 to code information. See the site-specific schemas for acceptable codes and their definitions.

Site/Histology	Factor
Head and Neck*	Parapharyngeal, Parotid, Preauricular, and Sub-Occipital Lymph Nodes, Lymph Nodes for Head and Neck
Breast	Size of Tumor--Invasive Component
Prostate	Gleason's Score

---

* Head and neck includes the following schemas: upper lip; lower lip; other lip; base of tongue; anterior tongue; upper gum; lower gum and retromolar trigone; other gum; floor of mouth; hard palate; soft palate/uvula; other mouth; buccal mucosa; parotid gland; submandibular gland; other salivary glands; oropharynx; anterior surface of epiglottis; nasopharynx; pyriform sinus/ hypopharynx; other pharynx; nasal cavity; middle ear; maxillary sinus; ethmoid sinus; other sinus; glottic larynx; supraglottic larynx; subglottic larynx; other larynx

3. Code 000 Not done is used when there is a statement in the record that a test was not performed.
   a. If there is no report of a lab test in the health record, code as 999 Unknown; not documented in patient record.

For Head And Neck Sites Only:

4. Use code 9 only when it is unknown if lymph nodes are involved. Within the Site-Specific Factors, do not code 9 in some positions and 0 or 1 in other positions. If specific information is available about the positive or negative status of some but not all nodes in any one level or group, assume that the rest of the nodes in the same Site-Specific Factor are negative and code accordingly.

CS SITE-SPECIFIC FACTOR 6 (Cont'd)

5. When the only information available is "Regional nodes, NOS" or "Cervical nodes, NOS" or "Internal jugular lymph nodes, NOS" or "Lymph nodes, NOS," code 0 in all digits of Site-Specific Factors 3-6.

    6. See "Coding Regional Lymph Nodes for Head and Neck Sites" under CS Lymph Nodes for further information about the regional nodes of the head and neck, including definitions of the levels.

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
000	None
---	**SITE/HISTOLOGY-SPECIFIC CODES**
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

ABSTRACT PLUS

In the CURRENT VALUE box, press F4 to display the acceptable codes.

Enter the most accurate CS Site-Specific Factor 6 code in the data field.

Click OK or press ENTER.

CS TUMOR SIZE

Column 629-631
Length 3
Source of Standard AJCC

Description:

THIS IS A REQUIRED DATA ITEM

Documents the largest dimension of the **primary tumor**, and is always recorded in millimeters. To convert centimeters to millimeters, multiply the dimension by 10. If tumor size is given in tenths of millimeters, round down if between .1 and .5 mm, and round up if between .6 and .9mm.

Rationale:

Size of tumor is a prognostic indicator for cancer.

When CS data items are coded, a computer algorithm allows generation of SEER Summary Stage 1977, SEER Summary Stage 2000, etc.

General Guidelines:

1. Refer to the *General Instructions for Using the Collaborative Staging System Codes and Coding Instructions* for the timing rules for data collection.

2. Refer to the site/histology-specific instructions for additional information. **Site/histology-specific instructions replace or over-ride the general instructions.** Where there are no site/histology-specific instructions, these general instructions apply.

3. Record tumor size information in the following order:

- Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

  Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028.

- If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the largest size of tumor prior to treatment.

  Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. Record tumor size as 022.

- Information on size from imaging /radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

- If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record.

- In the infrequent event that the tumor does not respond to neoadjuvant treatment and is more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.

4. Record the exact size of the primary tumor for all sites except where stated to be 'not applicable.' If no size is given, code as 999.

- Always code the size of the tumor, not the size of the polyp, ulcer, or cyst or metastases. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

- Record the largest dimension or diameter of tumor, whether it is from a biopsy specimen or the complete resection of the primary tumor.

  ***Example*:** Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as '051'.

- Record in millimeters (tenths of centimeters) as XXX mm. To convert centimeters to millimeters, multiply the dimension by 10.

  Example: A 2 cm tumor x 10 = 20mm; size would be coded as 020.

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

- If both an *in situ* 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 mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014.

- Additional rule for breast primaries*:* If the size of the invasive component is ***not*** given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

  Example: Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023.

  Example: Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. Record tumor size as 019.

  ***Note*:** For breast cancer, document how the size of the tumor was determined in Site Specific Factor field 6. Information from the pathology report can be used to identify in situ versus invasive tumor even if exact size is not given. If tumor size is a clinical measurement only in the range 001-989, Site Specific Factor 6 must be coded as 888.

CS TUMOR SIZE (Cont'd)

- For purely *in situ* lesions, code the size as stated.

- Microscopic residual tumor does not affect overall tumor size.

- Do **not** add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

- If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

- For an incisional needle biopsy, code tumor size as 999. Do not code the tumor size from a needle biopsy unless no residual tumor is found on further resection.

- Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

5. Special codes

    - Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to Site-Specific Factors for those sites/histologies.

    - If size is not reported, code as 999, which means unknown size, not applicable, or not documented in the patient record.

    - The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites:

        Esophagus (C15.0-C15.5, C15.8-C15.9): Entire circumference
        Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse, widespreadC: or more, linitis plastica
        Colorectal (M-8220/8221 with /2 or /3): Familial/multiple polyposis
        Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lobe or lung
        Breast (C50.0-C50.6, C50.8-C50.9): Inflammatory carcinoma; Diffuse, widespread, ¾ or more of breast.

    - Code 990, Microscopic focus or foci only; no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

    Note: the terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded to 990.

    Example: Ovary specimen: extensive cystic disease with focal areas of tumor seeding. Disregard "focal" and code tumor size to 999 unknown.

Example: Cervix conization: severe dysplasia with focal areas of microinvasion.
Code tumor size as 990 microscopic focus, no size given.

- Codes 991 through 995 are non-specific size descriptions. If a specific size is given, the more precise size should be coded in the range 001-989.

- Other special codes in the range 996 to 997 are used on a site-specific basis. See the individual site/histology schemas for further information and definitions.

- For the following diagnoses and/or primary sites, size is not applicable. Record as code 888.

  Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
  Hematopoietic neoplasms
  Immunoproliferative diseases
  Leukemia
  Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma)
  Mast cell tumors
  Multiple myeloma and other plasma cell tumors
  Myelodysplastic syndromes
  Myeloproliferative diseases
  Unknown and ill-defined primary sites (C76.0-C76.5, C76.7-C76.8, C80.9)

h. The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field.

6. In the appropriate text field, document the extension code chosen.

CS TUMOR SIZE (Cont'd)

Determining Descriptive Tumor Size: Millimeter Equivalents for Descriptive Terms

Fruits	mm
Apple	070
Apricot	040
Cherry	020
Date	040
Fig (dried)	040
Grape	020
Grapefruit	100
Kumquat	050
Lemon	080
Olive	020
Orange	090
Peach	060
Pear	090
Plum	030
Tangerine	060

Nuts	mm
Almond	030
Chestnut	040
Chestnut, horse	040
Hazel	020
Hickory	030
Peanut	010
Pecan	030
Walnut	030

Vegetables	mm
Bean	010
Bean, lima	020
Pea	009
Pea, split	009

Miscellaneous Food	mm
Doughnut	090
Egg	050
Bantam	040
Goose	070
Hen	030
Pigeon	030
Robin	020
Lentil	009
Millet	009

Money	mm
Dime	010
Dollar, silver	040
Dollar, half	030
Nickel	020
Quarter	020
Penny	010

Other	mm
Ball, golf	040
Ball, ping-pong	030
Ball, tennis	060
Baseball	070
Eraser on pencil	009
Fist	090
Marble	010
Matchhead	009
Microscopic focus	001

SIZES IN CENTIMETERS, MILLIMETERS, INCHES

10 millimeters (mm) = 1 centimeter (cm)
1 millimeter (mm) = 1/10 centimeter (cm)
2.5 centimeters (cm) = 1 inch (in)
1 centimeter (cm) = .394 inch (in)

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description
000	Indicates no mass or no tumor found; for example, when a tumor of a stated primary site is not found, but the tumor has metastasized.
001-988	Exact size in millimeters.
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
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
---	**SITE-SPECIFIC CODES WHERE NEEDED**
999	Unknown; size not stated; not stated in patient record.

Examples:

Mammogram shows 2.5 cm breast malignancy	Code as 025 (2.5 cm = 25 millimeters)
CT of chest shows 4 cm mass in RUL	Code as 040 (4 cm = 40 mm)
Thyroidectomy specimen yields 8 mm carcinoma	Code as 008
Prostate needle biopsy shows 0.6 mm carcinoma	Code as 001 (round up six-tenths of mm

For schemas that do not use tumor size:

Code	Description
888	Not applicable

ABSTRACT PLUS:

In the CURRENT VALUE box, type the appropriate CS Tumor Size.

Refer to F4 for additional size codes. Click on code.

Click OK or press ENTER.

CS TUMOR SIZE/EXT EVAL

Column 634-634
Length 1
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

Documents how the codes for the two items “CS Tumor Size” and “CS Extension” were determined, based on diagnostic methods employed.

Rationale

CS is a group of data items, designed to provide a single uniform set of codes and rules for coding stage information to meet the needs of all of the participating standard setters.

General Guidelines:

1. Select the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension or size of the primary tumor was obtained; this may not be the numerically highest Eval code.

   Example: Fine needle aspiration biopsy (Eval code 2) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 1) shows tumor extension through the prostatic capsule into adjacent connective tissues. Code CS Tumor Size/Ext Eval as 1 because the CT scan showed more extensive tumor than the biopsy.

2. For primary sites/histologies where tumor size is not a factor in determining the T category in TNM (see Table 5 in the *General Instructions for Using the Collaborative Staging System Codes and Coding Instustuctions*), code CS Tumor Size/Ext Eval on the basis of the CS extension field only.

3. For primary sites where both tumor size and extension determine the T category in TNM (see Table 4 in the *General Instructions for Using the Collaborative Staging System Codes and Coding Instustuctions*), select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

   a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

   Example: Tumor size for a breast cancer biopsy is 020 (maps to T1). There is ulceration of the skin (extension code 50, maps to T4). Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from the physical examination results in a higher T category.

   b. If the patient had no surgery, use code 0, 1, or 9.

   Example: Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. Code this field as 0.

Example : Colon cancer with colonoscopy and biopsy confirming cancer. Code this field as 1.

Example : Endoscopies for cervix or bladder would be coded as 1.

Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. Code this field as 1.

c. If the patient had surgery followed by other treatment(s), use code 3 or 9.

d. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5.

e. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6.

f. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. For sites/histologies where there is no TNM schema, this field may be coded 9, not applicable. (See Table 6 in the *General Instructions for Using the Collaborative Staging System Codes and Coding Instustuctions*.)

5. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography, lymphography, angiography, scintigraphy (nuclear scans), ultrasonography, magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

6. Codes 0-3 are oriented to the AJCC staging basis. In general, Code 1 includes microscopic analysis of tissue that is insufficient to meet the requirements for pathologic staging in the TNM system. However, pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, sixth edition*. For example, a total cystectomy is required to pathologically stage a bladder cancer. Any tissue removed during another procedure, such as a transurethral resection of a bladder tumor, would not meet the requirements for pathologic staging and should be coded to 1 in this field. Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified, where further tumor extension is not biopsied.

7. Code 3 is considered pathologic staging across all sites. Use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. In other words, according to TNM rules, if the biopsy documents the highest T category, the biopsy meets the requirements for pathologic staging basis and the CS Tumor Size/Ext Eval field should be coded to 3. For example, if a prostate cancer patient has a biopsy of the rectum that shows microscopic involvement of the rectal wall (T4), according to the *AJCC Cancer Staging Manual sixth edition,* that patient meets the requirements for pathologic staging in the T category.

CS TUMOR SIZE/EXT EVAL (Cont'd)

See Appendix E for CS codes and site/histology-specific rules.

Codes	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques. No autopsy evidence used.	c
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

ABSTRACT PLUS:

In the CURRENT VALUE box, press F4 to display the acceptable codes. Select the most accurate CS Tumor Size/Ext Eval code.

Click OK or press ENTER.

CS VERSION 1st

Column 705-710
Length 6
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

This item indicates the number of the version used to initially code CS fields. It must be derived by computer algorithm. This version is a 6-digit code.

ABSTRACT PLUS:

This is computer generated.

CS VERSION LATEST

Column 711-716
Length 6
Source of Standard AJCC

Description

THIS IS A REQUIRED DATA ITEM

This item indicates the number of the version of the CS used most recently to derive the CS output fields. It must be derived by computer algorithm. It is a 6-digit code.

ABSTRACT PLUS:

This is computer generated.