

GENERAL INSTRUCTIONS FOR USING THE COLLABORATIVE STAGING SYSTEM CODES AND CODING INSTRUCTIONS

The Collaborative Staging System schemas consist of the 15 data fields necessary to derive the Summary Stage 1977, the SEER Summary Stage 2000, and the T, N, M, and Stage Group according to the sixth edition of the *AJCC Cancer Staging Manual*.

These schemas apply to cases diagnosed January 1, 2004 and later. Cases diagnosed prior to 01/01/2004 should be coded to whatever coding system was in effect at the time of diagnosis.

GENERAL GUIDELINES

Note: These general instructions refer to schemas based on primary site when, in fact, some schemas, such as melanoma and lymphoma, are based on histologic type. The schemas are referred to as site-specific for the sake of brevity.

1. Collaborative Staging is collected on all cases regardless of whether they are microscopically confirmed. A description of the type of diagnostic confirmation is collected in a separate data item. Cases not microscopically confirmed should be coded from the schema for the site/histology the clinician considers most likely to be the primary.
2. Collaborative Staging is collected on all sites/histologies.
 - a. The Collaborative Staging System consists of 94 schemas, most of which are site-specific. Some malignancies that can develop in many parts of the body are coded according to the histology of the case. For example, all lymphomas are coded according to the lymphoma schema, regardless of the organ in which the lymphoma develops.
3. All schemas apply to all histologies unless otherwise noted.
4. **Timing of Data Collection:** The data collected in the Collaborative Staging System are limited to
 - * information gathered through completion of surgery(ies) in first course of treatment, OR
 - * all information available within four months of the date of diagnosis in the absence of disease progression (metastasis known to have developed after the diagnosis was established should be excluded)
 - * whichever is *longer*.
5. **Site-specific and histology-specific guidelines take precedence over general guidelines. Always read the notes pertaining to a specific site or histology schema.**
6. For each field, code the highest applicable number. (Exception: codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS do not take priority over more specific codes with lower numbers.) The codes are ordered in a hierarchy so that increasing numbers generally indicate increasing degrees of tumor involvement.

7. For the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at DX, Collaborative Staging records the greatest extent of disease based on combined clinical and operative/pathological assessment.
 - a. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report.
 - b. Clinical information, such as a description of skin involvement for breast cancer and size of the primary lesion and distant lymph nodes for any site, can change the stage. Clinical information should be reviewed carefully to assure accurate recording of the Collaborative Staging data set.
8. When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.
9. When the patient does receive preoperative treatment, the greatest extent of disease prior to the beginning of treatment should be recorded. Preoperative, or neoadjuvant, treatment is defined as systemic (chemotherapy, hormone therapy, or immunotherapy) treatment or radiation therapy that is administered as an attempt to shrink the tumor, improve resectability, or control symptoms before the patient undergoes surgery. In the infrequent situation where post-operative disease is more extensive despite neoadjuvant treatment, this can be coded in the method of evaluation field for extension, regional lymph nodes or metastases at diagnosis.
10. The fields Reg LN Pos and Reg LN Exam are based on pathologic (microscopic) information only.
11. The fields CS Tumor Size/Ext Eval, CS Reg Nodes Eval, and CS Mets Eval document how the most extensive tumor was established as well as whether the patient received preoperative treatment.
12. Site-Specific Factors (SSFs) are included in every schema. They are incorporated into the staging algorithms when additional information is necessary to derive tumor (T), lymph node (N), metastasis (M), or TNM stage group, or where the factor is considered to be of clinical or prognostic importance. Information formerly coded as tumor markers, such as estrogen receptor assay or progesterone receptor assay for breast, is coded in site-specific factors. For sites/histologies where some or all site specific factors are not used, they are coded 888, not applicable. Table 2 lists the schemas that require one or more Site Specific Factors.

Table 2. Site Specific Factors Used For Primary Site/Histology Schemas

SSF	Sites/histologies where used		
1	head and neck* colon rectum liver pleura melanoma	mycosis fungoides breast ovary placenta prostate testis melanoma/conjunctiva melanoma/choroid	melanoma/iris and ciliary body retinoblastoma brain other cns thyroid other endocrine Kaposi sarcoma lymphoma
2	head and neck*, liver, melanoma, breast, prostate, testis, lymphoma		
3	head and neck*, melanoma, breast, prostate, testis, lymphoma		
4	head and neck*, melanoma, breast, prostate, testis		
5	head and neck*, breast, prostate, testis		
6	head and neck*, breast, prostate		

* 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

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13. Metastasis known to have developed after the initial extent of disease was established (in other words, disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.
 14. Autopsy reports are used in coding the Collaborative Staging System in the same way as are pathology reports, applying the same rules for inclusion and exclusion.
 15. The extent of disease may be described only in terms of T (tumor), N (node), and M (metastasis) characteristics. In such cases, assign the code in the appropriate field that corresponds to the TNM information. 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.

STRUCTURE AND FORMAT OF SITE/HISTOLOGY-SPECIFIC CODE SCHEMAS

The schemas in this manual are listed according to the order of the first ICD-O-3 primary site code to which a schema applies. Schemas for which there is no TNM classification are included in ICD-O-3 sequence in the manual. Some of the histology-based schemas appear in site code order (for example, melanoma of the skin is with other skin schemas), and others are at the end of the list. Two indices to the schemas are provided at the end of this manual, one by ICD-O-3 code and the other by common primary site and histology terms.

Within the schemas themselves, the code structures for the various organs, lymph nodes, and other tissues are organized according to the T, N, and M categories (T1, then T2, then T3, for example). As such, they may not be sequential for Summary Stage definitions. Regardless of the relative order of the codes in the schemas, the staging algorithms will properly account for the information.

The categories of TNM are the basis for the CS Extension, CS Lymph Nodes and CS Mets at DX fields. Tissues categorized under T in the TNM system are listed in CS Extension and tissues categorized under M are listed in the CS Mets at DX field. However, for the Summary Staging (1977 and/or 2000) algorithms, there may be codes in the CS Extension field that map to regional direct extension or distant stage, and there may be codes in CS Mets at DX that map to regional or even localized disease. The details of the case should be coded in the fields where they are listed; the computer algorithm is designed to generate the correct stage. It should also be noted that information in fields other than CS Extension may be used to derive the T, N, M and Stage Group, for example tumor size and various site-specific factors.

CODING NONE VS. UNKNOWN IN THE COLLABORATIVE STAGING SYSTEM, TNM AND SUMMARY STAGE

Cancers of certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These ‘inaccessible’ primary sites include, but are not limited to, bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary.

A new coding rule in the Collaborative Staging System applies to these inaccessible sites, primarily for localized or early stage cancers. The Collaborative Staging System allows data collectors to record regional lymph nodes as negative (based on clinical evaluation) rather than unknown 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 (treatment appropriate to the stage of disease as determined by the physician).

This new coding guideline also permits data collectors to record distant metastasis clinically as none rather than unknown (again, based on clinical evaluation) when the clinician proceeds with usual treatment of the primary site, since this action presumes that there are no distant metastasis that would otherwise change the treatment approach.

The code(s) for unknown information can and should be used in situations where there is reasonable doubt that the tumor is no longer localized. For example, when there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (regional direct extension/T3a) and regional lymph node involvement is not mentioned, it would be correct to code lymph node involvement and metastases at diagnosis as unknown in the absence of any specific information regarding nodes or distant metastases.

For accessible primary sites that can be observed, palpated or examined without instruments, such as breast, oral cavity, skin, salivary gland, thyroid, and other organs, there should be some description of the regional lymph node status. A statement such as “remainder of examination negative” is sufficient to code regional lymph nodes as clinically negative.

CHOOSING THE CORRECT CODING SCHEMA FOR A CASE

Most of the Collaborative Staging System schemas apply to cases defined by their primary site codes in ICD-O-3. A few of the schemas apply to cases defined by their histologic type codes in ICD-O-3, and these schemas take precedence over the schema for the site. The histologically defined schemas are shown in Table 3.

TABLE 3. HISTOLOGY-SPECIFIC CODING SCHEMAS

Melanoma (ICD-O-3 morphology codes 8720-8790)
Kaposi sarcoma (9140)
Retinoblastoma (9510-9514)
Lymphoma (9590-9699 and 9702-9729)
Mycosis Fungoides (9700-9701)
Hematopoietic and reticuloendothelial system (9731-9989)

A case with one of these ICD-O-3 histologic types must be coded using the schema for the histologic type group.

Melanomas are further broken down by primary site code, as follows:

Malignant melanoma of the skin, vulva, penis and scrotum (C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.1, C60.8-C60.9, C63.2)
Malignant melanoma of conjunctiva (C69.0)
Malignant melanoma of iris and ciliary body (C69.4)
Malignant melanoma of choroid (C69.3)
Malignant melanoma of other eye (C69.1, C69.2, C69.5, C69.8-C69.9)

For cases with all other histologic types, the correct schema to use is determined by the primary site code.

Each schema clearly states the applicable primary site codes and histologic type codes at the beginning of the schema.

Note: The appropriate site or histology schema to use for coding surgical treatment(s) may be different from the site or histology schema used for coding the Collaborative Staging data set. For example, an extralymphatic lymphoma of the stomach treated surgically would use the lymphoma schema in this manual to code Collaborative Staging, but surgery would be coded using the stomach codes for surgery of primary site. Refer to the treatment coding rules in the SEER Program coding manual or the FORDS manual for more details.

SCHEMAS WHERE TUMOR SIZE IS NECESSARY FOR AJCC STAGING

In order to classify the T category for certain sites/histologies, it is necessary to know the size of the primary tumor, usually for T1 - T3. For the following sites/histologies, the size of the primary tumor must be recorded in order to assign the T category and derive a stage group. Tumor size is not necessary to assign Summary Stage. The name of the Collaborative Staging schema and its website file name (shown in parentheses) are double indented under the **TNM chapter** and *subsite* names. (See Table 4.)

Table 4. Schemas Where Tumor Size Is Necessary For AJCC Staging

Lip and oral cavity

- Lip
- Upper Lip (LipUpper)
- Lower Lip (LipLower)
- Other Lip (OthLip)

Oral Cavity

- Anterior Tongue (AntTongue)
- Upper Gum (GumUpper)
- Lower Gum (GumLower)
- Other Gum (OthGum)
- Floor of Mouth (FOM)
- Hard Palate (HardPalate)
- Buccal Mucosa (BuccalMucosa)
- Other Mouth (OthMouth)

Pharynx

- Oropharynx
- Oropharynx (Oropharynx)
- Base of Tongue (BaseTongue)
- Soft Palate (SoftPalate)
- Hypopharynx
- Hypopharynx (Hypopharynx)

Major Salivary Glands

- Parotid Gland (ParotidGland)
- Submandibular Gland
(SubmandibularGland)
- Other Salivary Gland (OthSalivary)

Thyroid

- Thyroid (Thyroid)

Anal Canal

- Anus (Anus)

Liver including Intrahepatic Bile Ducts

- Liver and intrahepatic bile ducts (Liver)

Exocrine Pancreas

- Pancreas Head (PancreasHead)
- Pancreas Body and Tail
(PancreasBodyTail)
- Other Pancreas (OthPancreas)

Lung

- Lung (Lung)

Bone

- Bone (Bone)

Soft tissue sarcoma

- Heart and Mediastinum
(HeartMediastinum)
- Soft Tissue (SoftTissue)
- Peritoneum (Peritoneum)

Carcinoma of the Skin

- Skin, Vulva, Penis, Scrotum-Carcinoma
(Skin)

Carcinoma of the Eyelid

- Skin of Eyelid-Carcinoma (SkinEyelid)

Breast

- Breast (Breast)

Vulva

- Vulva (Vulva)

Kidney

- Kidney (Kidney)

Carcinoma of the Conjunctiva

- Conjunctiva-Carcinoma
(Conjunctiva)

Malignant Melanoma of the Uvea

- Iris and Ciliary Body-
Melanoma (*ciliary body only*)
(MelanomaIrisCiliary)
- Choroid-Melanoma (MelanomaChoroid)

Carcinoma of the Lacrimal Gland

- Lacrimal gland-Carcinoma
(LacrimalGland)

Sarcoma of the Orbit

- Orbit (Orbit)

SCHEMAS THAT DO NOT USE TUMOR SIZE FOR AJCC STAGING

In order to classify both summary stage and the AJCC T category for certain sites/histologies, it is necessary to know how far the tumor has extended in a contiguous, continuous or direct manner from its point of origin. For the following sites/histologies, the extension of the primary tumor must be recorded in order to assign the T category and derive a stage group. The name of the Collaborative Staging schema and its website file name (in parentheses) are double indented under the **TNM chapter** and *subsite* names. (See Table 5.)

Table 5. Schemas That Do Not Use Tumor Size For AJCC Staging

Pharynx	
Nasopharynx	
Nasopharynx (Nasopharynx)	
Larynx	
Other Larynx (OthLarynx)	
Glottic Larynx	
Glottic Larynx (GlotticLarynx)	
Supraglottic Larynx	
Supraglottic Larynx (SupraLarynx)	
Anterior Surface of Epiglottis (AntEpiglottis)	
Subglottic Larynx	
Subglottic Larynx (SubLarynx)	
Nasal Cavity and Paranasal Sinuses	
Nasal Cavity (NasalCavity)	
Maxillary Sinus (MaxillarySinus)	
Ethmoid Sinus (EthmoidSinus)	
Esophagus	
Esophagus (Esophagus)	
Stomach	
Stomach (Stomach)	
Small Intestine	
Small intestine (SmallIntestine)	
Colon and rectum	
Colon (Colon)	
Rectum (Rectum)	
Gallbladder	
Gallbladder (Gallbladder)	
Extrahepatic bile ducts	
Extrahepatic bile ducts (ExtraHepaticDucts)	
Other Biliary and Biliary, NOS (OthBiliary)	
Ampulla of Vater	
Ampulla (Ampulla)	
Pleural mesothelioma	
Pleura (Pleura)	
Melanoma of the Skin	
Skin, Vulva, Penis ScrotumBMelanoma (Melanoma)	
Vagina	
Vagina (Vagina)	
Corpus uteri	
Corpus uteri (Corpus)	
Ovary	
Ovary (Ovary)	
Fallopian Tube	
Fallopian tube (FallopianTube)	
Gestational trophoblastic tumor	
Placenta (Placenta)	
Penis	
Penis (Penis)	
Prostate	
Prostate (Prostate)	
Testis	
Testis (Testis)	
Renal Pelvis and Ureter	
Renal Pelvis and Ureter (RenalPelvis)	
Urinary Bladder	
Bladder (Bladder)	
Urethra	
Urethra (Urethra)	
Malignant Melanoma of the Conjunctiva	
Conjunctiva-Melanoma (MelanomaConjunctiva)	
Malignant Melanoma of the Uvea	
Iris and Ciliary Body-Melanoma (<i>iris only</i>) (MelanomaIrisCiliary)	
Retinoblastoma	
Retinoblastoma (Retinoblastoma)	
Lymphoid neoplasms	
Mycosis Fungoides (MF)	
Malignant Lymphoma (Lymphoma)	

Table 6. Schemas For Which AJCC Staging Is Not Applicable

For the following schemas, TNM is not applicable. The name of the Collaborative Staging schema and its website file name (in parentheses) are shown below.

Other pharynx (OthPharynx)	Other CNS (OthCNS)
Other digestive (OthDigestive)	Other endocrine (OthEndocrine)
Middle ear (MiddleEar)	Other eye (OthEye)
Other sinus (OthSinus)	Melanoma of Other Eye (MelanomaOthEye)
Trachea (Trachea)	Kaposi sarcoma (KS)
Other respiratory (OthRespiratory)	Hematopoietic, Reticuloendothelial,
Other adnexa (OthAdnexa)	Immunoproliferative and
Other female genital (OthFemaleGen)	Myeloproliferative Neoplasms
Other male genital (OthMaleGen)	(HemeRetic)
Other urinary (OthUrinary)	Other Ill-defined and Unknown Primary
Brain (Brain)	Sites (OthIllDef)

DEATH CERTIFICATE ONLY CASES

Death Certificate **only** cases are coded as unknown (usually 9, 99, 999, etc.) or not applicable (usually 8, 88, 888, etc.) in all Collaborative Staging fields. Although there may be some site/histology-specific exceptions, the usual pattern for coding Death Certificate Only cases is as follows:

CS Tumor Size	999	CS Mets Eval	9
CS Extension	99	CS Site-Specific Factor 1	888
CS Tumor Size/Ext Eval	9	CS Site-Specific Factor 2	888
CS Lymph Nodes	99	CS Site-Specific Factor 3	888
CS Reg Nodes Eval	9	CS Site-Specific Factor 4	888
Reg LN Pos	99	CS Site-Specific Factor 5	888
Reg LN Exam	99	CS Site-Specific Factor 6	888
CS Mets at DX	99		

USE OF AUTOPSY INFORMATION IN COLLABORATIVE STAGING

Information obtained from autopsy may be used in either of two ways in the Collaborative Staging System. The evaluation fields must then be coded correctly to indicate how the autopsy information is to be interpreted. If a patient with a suspected diagnosis of cancer dies and an autopsy is performed, extent of disease information obtained from the autopsy may be included along with other clinical and pathologic information, if it meets the timing rules for inclusion. In this case, the computer algorithm will assign the T, N, or M to Ap@ (pathologic) classification. If cancer is not suspected at the time of autopsy, the extent of disease information from the autopsy is included, but the algorithm will assign the T, N, and M to the autopsy (a) classification of the TNM system rather than to clinical or pathologic evaluation. Each of the evaluation field schemas has appropriate codes to allow this distinction.

DEFINITIONS OF ADJACENT TISSUES, STRUCTURES, AND ORGANS

Adjacent connective tissue

Some of the Collaborative Staging System schemas for ill-defined or non-specific sites in this manual contain a code for adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organs surrounding supportive structures, but has not invaded into larger structures or adjacent organs.

The structures identified in ICD-O-3 as connective tissue include the following: adipose tissue; aponeuroses; arteries; blood vessels; bursa; connective tissue, NOS; fascia; fatty tissue; fibrous tissue; ganglia; ligaments; lymphatic channels (not nodes); muscle; nerves (spinal, sympathetic and peripheral); skeletal muscle; subcutaneous tissue; synovia; tendons; tendon sheaths; veins; and vessels, NOS. In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients. Blood, cartilage, and bone are sometimes considered connective tissues, but in this manual they would be listed separately.

Adjacent organs

Organs are anatomic structures with specific physiological functions other than (or in addition to) support and storage. Continuous tumor growth from one organ into an organ anatomically next to the primary would be coded to the appropriate code for 'adjacent organs/structures' in the Collaborative Staging schemas for ill-defined and non-specific sites.

Adjacent structures

Connective tissues large enough to be given a specific name would be considered adjacent structures. For example, the brachial artery has a name, as does the broad ligament. Continuous tumor growth from one organ into an adjacently named structure would be coded to the appropriate code for 'adjacent organs/structures' in the Collaborative Staging for ill-defined or non-specific sites.

AMBIGUOUS TERMINOLOGY

INTERPRETING AMBIGUOUS TERMINOLOGY FOR COLLABORATIVE STAGING

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Sometimes the clinician is hesitant to commit to a definite statement that a particular organ or tissue is involved by the cancer and uses what data collectors refer to as “ambiguous terminology.” The following lists can generally be used to interpret the intent of the clinician; however, if individual clinicians use these terms differently, the clinician’s definitions and choice of therapy should be recognized. If a term used in a diagnostic statement is not listed below, consult the clinician to determine the intent of the statement.

Consider as involvement

adherent
apparent(ly)
appears to
comparable with
compatible with
consistent with
contiguous/continuous with
encroaching upon*
extension to, into, onto, out onto
features of
fixation to another structure**
fixed**
impending perforation of
impinging upon
impose/imposing on
incipient invasion
induration
infringe/infringing
into*
intrude
invasion to into, onto, out onto
most likely
onto*
overstep
presumed
probable
protruding into (unless encapsulated)
suspected
suspicious
to*
up to

DO NOT Consider as Involvement

abuts
approaching
approximates
attached
cannot be excluded/ruled out
efface/effacing/effacement
encased/encasing
encompass(ed)
entrapped
equivocal
extension to without invasion/
 involvement of
kiss/kissing
matted (except for lymph nodes)
possible
questionable
reaching
rule out
suggests
very close to
worrisome

* interpreted as involvement whether the description is clinical or operative/
pathological

** interpreted as involvement of other organ or tissue

HOW TO CODE THE COLLABORATIVE STAGING SYSTEM DATA ELEMENTS

1. Before you begin to code using the Collaborative Staging System, read all of the general rules in this manual.
2. Read the medical record carefully to determine the primary site and histology and identify the correct ICD-O-3 codes. While you are reviewing the record, make mental notes about the tissues and lymph nodes that are involved by tumor.
3. If the histology is melanoma (8720-8790), Kaposi sarcoma (9140), retinoblastoma (9510-9514), lymphoma (9590-9699 and 9702-9729), mycosis fungoides (9700-9701), or hematopoietic and reticuloendothelial system (9731-9989), use the **histology-specific schema** for the appropriate histology-site combination.
4. Otherwise, turn to the correct site-specific schema in Appendix B of this manual. Schemas are in ICD-O-3 order by the first code that uses the schema. Verify that you are in the correct chapter by confirming that the code is in the list at the beginning of the schema.
5. Begin assigning codes for the 15 fields in the Collaborative Staging System. **Be certain to read the notes and follow the site/histology-specific instructions at the beginning of each data field.** Some schemas may have site-specific factors associated with extension, lymph nodes or metastasis; keep these in mind as you assign the codes.
 - a. Code the tumor size in the CS Tumor Size field.
 - b. Code how far the tumor has **directly** spread in the CS Extension field.
 - c. Code how the farthest tumor spread was determined in the CS Tumor Size/Ext Eval field.
 - d. Code whether regional lymph nodes are involved in the CS Lymph Nodes field.
 - e. Code how the farthest regional node spread was determined in the CS Reg Node Eval field.
 - f. Code the number of positive regional lymph nodes from the pathology report in the Reg Nodes Pos field.
 - g. Code the number of regional lymph nodes examined by the pathologist in the Reg Nodes Exam field.
 - h. Code the farthest distant metastasis (including distant lymph nodes) in the CS Mets at Dx field.
 - i. Code how the distant metastasis was determined in the CS Mets Eval field.
 - j. Code the six site-specific factors. If the first site-specific factor is listed as not applicable, code 888 in all site specific factors. Otherwise, code the specific information requested for each site specific factor. When the next site-specific factor is 888 Not Applicable, all the remaining site-specific factors will also be 888.

Congratulations! You have collected all the facts about the case and the codes are ready for the computer to convert into the T, N, M, Stage Group, Summary Stage 1977 and Summary Stage 2000. Depending on your software system, the final stage information may be derived now, when the case is saved, or prior to exiting the case. Finish the rest of the abstract, edit check it and save it.

When the computer derives the final stage information, the program will check the histology code and other coded information to determine whether T, N, M and Stage Group will be generated for the case. If the histology code is on the computer's exceptions list for that site, the T, N, M, and Stage Group will be reported as "Not Applicable." Summary Stage is generated for every case. The computer algorithm will also record which version of the Collaborative Staging System was used to derive the final stages.

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CS TUMOR SIZE

Records the largest dimension or diameter 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 .4 mm, and round up if between .5 and .9 mm.

Prior to using the table below, refer to the site/histology-specific instructions for additional information. **Site/histology-specific instructions replace or over-ride the general instructions.**

Code	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)
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

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.

- 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.

Determining Descriptive Tumor Size: Millimeter Equivalents for Descriptive Terms

Fruits	mm	Goose	070
Apple	070	Hen	030
Apricot	040	Pigeon	030
Cherry	020	Robin	020
Date	040	Lentil	009
Fig (dried)	040	Millet	009
Grape	020		
Grapefruit	100	Money	mm
Kumquat	050	Dime	010
Lemon	080	Dollar, silver	040
Olive	020	Dollar, half	030
Orange	090	Nickel	020
Peach	060	Quarter	020
Pear	090	Penny	010
Plum	030		
Tangerine	060	Other	mm
		Ball, golf	040
Nuts	mm	Ball, ping-pong	030
Almond	030	Ball, tennis	060
Chestnut	040	Baseball	070
Chestnut, horse	040	Eraser on pencil	009
Hazel	020	Fist	090
Hickory	030	Marble	010
Peanut	010	Matchhead	009
Pecan	030	Microscopic focus	001
Walnut	030		
		SIZES IN CENTIMETERS, MILLIMETERS, INCHES	
Vegetables	mm	10 millimeters (mm) = 1 centimeter (cm)	
Bean	010	1 millimeter (mm) = 1/10 centimeter (cm)	
Bean, lima	020	2.5 centimeters (cm) = 1 inch (in)	
Pea	009	1 centimeter (cm) = .394 inch (in)	
Pea, split	009		
Miscellaneous Food mm			
Doughnut	090		
Egg	050		
Bantam	040		

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CS EXTENSION

Identifies **contiguous growth** (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. **Do not include discontinuous metastases to distant sites** (these are coded in CS Mets at Dx) except for ovary and corpus uteri. See site-specific schemas for detailed codes and coding instructions.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY-SPECIFIC CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in patient record	TX	U	U

INSTRUCTIONS FOR CODING

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 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: 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.*

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

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 Using the for Collaborative Staging System Codes and Coding Instructions* 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.
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. Distant metastases must be coded in the CS Mets at Dx field.

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.*

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.

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CS TUMOR SIZE\EXT EVAL

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

Code	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 <i>For sites with no TNM schema: not applicable.</i>	c

* For some primary sites, code 1 may be a pathologic staging basis, as determined by the site-specific chapter in the *AJCC Cancer Staging Manual, sixth edition*.

INSTRUCTIONS FOR CODING

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 Instructions*), 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 Instructions*), 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 Instructions*.)
 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.
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), 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), 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.

- c. 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. Staging algorithm would identify information as clinical (c).

Example: Colon cancer with colonoscopy and biopsy confirming cancer. Code this field as 1. Staging algorithm would identify information as clinical (c).The biopsy does not meet the criteria for pathologic staging.

Example: Endoscopies for cervix or bladder would be coded as 1 in this field and the staging algorithm would identify the information as clinical (c).

Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. Code this field as 1. Staging algorithm would identify information as pathologic (p), because mediastinoscopy is defined as a pathologic procedure in TNM.

- 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. This code is likely to be used infrequently and maps to the “y” intercurrent treatment staging basis.
 - 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.)
 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 LYMPH NODES

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

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	None; no regional lymph node involvement	N0	None	None
	SITE/HISTOLOGY-SPECIFIC CODES			
80	Lymph nodes, NOS	NX	RN	RN
90	Unknown; regional lymph nodes cannot be assessed; not stated in patient record	NX	U	U

For schemas that do not use the CS Lymph Nodes field:

Code	Description
88	Not applicable

INSTRUCTIONS FOR CODING

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 (see general rules for further discussion).
- 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 # 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	<u>1</u> I	<u>0</u> II	<u>0</u> III
SSF 4	Levels IV-V, retropharyngeal (RP)	<u>0</u> IV	<u>0</u> V	<u>0</u> RP
SSF 5	Levels VI-VII, Facial (F)	<u>0</u> VI	<u>0</u> VII	<u>1</u> F

SSF 6	Other groups	$\frac{0}{PP}$	$\frac{1}{PA}$	$\frac{0}{S}$
	Parapharyngeal (PP),			
	Parotid (PA), Suboccipital (S)			

<u>Stored in database as</u>		<u>Interpretation</u>
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

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

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CS REG NODES EVAL

Records how the code for the item “CS Lymph Nodes” was determined, based on the diagnostic methods employed.

Code	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
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

INSTRUCTIONS FOR CODING

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.

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REGIONAL NODES POSITIVE

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Code	Description
00	All nodes examined are negative.
01-89	1-89 nodes are positive. (Code exact number of nodes positive)
90	90 or more nodes are positive.
95	Positive aspiration of lymph node(s) was performed.
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

INSTRUCTIONS FOR CODING

1. Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the "CS Mets at Dx" field.
2. Rules for coding Regional Nodes Positive are the same for both in situ and invasive cases.
3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 98.
4. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
 - a. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
 - b. This field is to be recorded regardless of whether the patient received preoperative treatment.
5. Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes should be coded to 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.

6. For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99.

Placenta

Brain and Cerebral Meninges

Other Parts of Central Nervous System

Hodgkin and non-Hodgkin Lymphoma

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms

Other and Ill-Defined Primary Sites

Unknown Primary Site

REGIONAL NODES EXAMINED

Records the total number of regional lymph nodes that were removed and examined by the pathologist.

Code	Description
00	No nodes were examined.
01-89	1-89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

INSTRUCTIONS FOR CODING

1. Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the “CS Mets at Dx” field.
2. Rules for coding “Regional Nodes Examined” are the same for in situ and invasive cases.
3. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 00. If it is unknown whether nodes were removed or examined, code as 99.
4. Record the total number of regional lymph nodes removed and examined by the pathologist.
 - a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

- b. If lymph nodes are aspirated and other lymph nodes are removed, use code 98.
 - c. This field is to be recorded regardless of whether the patient received preoperative treatment.
5. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.
6. For the following primary sites and histologies, the “Regional Nodes Examined” field is always coded as 99.

Brain and Cerebral Meninges

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms

Hodgkin and non-Hodgkin Lymphoma

Other and Ill-Defined Primary Sites

Other Parts of Central Nervous System

Placenta

Unknown Primary Site

CS METS AT DX

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

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	No; none	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastases except code 10 Distant metastasis, NOS Carcinomatosis	M1	D	D
	SITE/HISTOLOGY-SPECIFIC CODES WHERE NEEDED			
50	(40) + (10)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in patient record	MX	U	U

For schemas that do not use the CS Mets at Dx field:

Code	Description
88	Not applicable

INSTRUCTIONS FOR CODING

1. This field represents distant metastases. 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 (T1, T2) 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.
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 EVAL

Records how the code for the item “CS Mets at Dx” was determined based on the diagnostic methods employed.

Code	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
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 <i>For sites with no TNM staging:</i> Not applicable	c

INSTRUCTIONS FOR CODING

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.
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.

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CS SITE-SPECIFIC FACTOR 1

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and neck*
Colon
Rectosigmoid, rectum
Liver
Pleura
Malignant Melanoma of Skin,
Vulva, Penis, Scrotum
Mycosis Fungoides
Breast
Ovary
Placenta
Prostate
Testis

Factor

Size of Lymph Nodes
Carcinoembryonic Antigen (CEA)
Carcinoembryonic Antigen (CEA)
Alpha Fetoprotein (AFP)
Pleural Effusion
Measured Thickness (Depth), Breslow's Measurement
Peripheral Blood Involvement
Estrogen Receptor Assay (ERA)
Carbohydrate Antigen 125 (CA-125)
Prognostic Scoring Index
Prostate Specific Antigen Laboratory Value (PSA, PSA Lab Value)
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.

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."

CS SITE-SPECIFIC FACTOR 2

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and neck*

Liver

Malignant Melanoma of Skin,

Vulva, Penis, Scrotum

Breast

Prostate

Testis

Hodgkin and non-Hodgkin Lymphoma

Factor

Extracapsular Extension, Lymph Nodes for
Head and Neck

Fibrosis Score

Ulceration

Progesterone Receptor Assay (PRA)

Prostate Specific Antigen (PSA)

Human Chorionic Gonadotropin (HCG)

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

CS SITE-SPECIFIC FACTOR 3

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and Neck*
Malignant Melanoma of Skin,
 Vulva, Penis, Scrotum
Breast
Prostate
Testis
Lymphoma

Factor

Levels I-III, Lymph Nodes of Head and Neck

Clinical Status of Lymph Node Mets
Number of Positive Ipsilateral Axillary Lymph Nodes
CS Extension - Pathologic Extension
LDH (Lactate Dehydrogenase)
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.

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.

CS SITE-SPECIFIC FACTOR 4

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and Neck*

Malignant Melanoma of Skin,

Vulva, Penis, Scrotum

Breast

Prostate

Testis

Factor

Levels IV-V, Lymph Nodes of Head and Neck

Lactate Dehydrogenase (LDH)

Immunohistochemistry (IHC) of Regional Lymph Nodes

Prostatic Acid Phosphatase (PAP)

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.

CS SITE-SPECIFIC FACTOR 5

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and Neck*
Breast
Prostate
Testis

Factor

Levels VI-VIII, Lymph Nodes of Head and Neck
Molecular Studies of Regional Lymph Nodes
Gleason's Primary and Secondary Patterns
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.
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.

CS SITE-SPECIFIC FACTOR 6

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

Code	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

INSTRUCTIONS FOR CODING

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

Head and Neck*

Breast

Prostate

Factor

Parapharyngeal, Parotid, Preauricular, and Sub-Occipital Lymph Nodes, Lymph Nodes for Head and Neck

Size of Tumor--Invasive Component

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.
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.