COLLABORATIVE STAGING MANUAL AND CODING INSTRUCTIONS

version 1.0

Collaborative Staging Task Force
of the American Joint Committee on Cancer

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Collaborative Staging (CS) Task Force Members

Member	Representing
Stephen Edge, MD, Chair	American Joint Committee on Cancer
Gayle Clutter, RT, CTR	National Program of Cancer Registries, Centers for Disease Control and Prevention
Lynda Douglas, CTR	American College of Surgeons; Central Registry
April Fritz, BA, RHIT, CTR	Surveillance, Epidemiology, and End Results Program, National Cancer Institute
Missy Jamison	National Program of Cancer Registries, Centers for Disease Control and Prevention
Vencine Kelly, BA, CTR	National Cancer Registrars Association
Karen McCracken, CTR	National Cancer Registrars Association
Tom Rawson	National Program of Cancer Registries, Centers for Disease Control and Prevention
Lynn Ries, MS	Surveillance, Epidemiology, and End Results Program, National Cancer Institute
Nancy Schlag, BS, CTR	North American Association of Central Cancer Registries
Jennifer Seiffert, MLIS, CTR	National Program of Cancer Registries, Centers for Disease Control and Prevention

American Joint Committee on Cancer Staff

Connie Bura
Susan Burkhardt
Valerie Vesich, CTR

Physician Advisors to the Task Force

James Armitage, MD
Mark Arredondo, MD
Laura Fajardo, MD
Gini Fleming, MD
Mary Gospodarowicz, MD
Frederick Greene, MD
Maureen MacIntyre, MD
William MacKillop, MD
David Page, MD
Jatin Shah, MD

Questions regarding this document and Collaborative Staging in general should be directed to:

Valerie Vesich, CTR vvesich@facs.org 312-202-5435
American Joint Committee on Cancer
633 North Saint Clair Street
Chicago, IL 60611

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INTRODUCTION

The Collaborative Staging Task Force, formed in 1998, was convened to address the issue of discrepancies in staging guidelines among the three major staging systems used in the United States. This project is sponsored by the American Joint Committee on Cancer (AJCC) in collaboration with the National Cancer Institute Surveillance, Epidemiology and End Results Program (NCI-SEER); Centers for Disease Control and Prevention National Program of Cancer Registries (CDC/NPCR); National Cancer Registrars Association (NCRA); North American Association of Central Cancer Registries (NAACCR); American College of Surgeons Commission on Cancer (CoC), and Canadian Cancer Society / National Cancer Institute of Canada (CCS-NCIC).

The initial focus of the Task Force was to develop a translation or other method of conversion between the TNM staging system of the AJCC and the SEER Summary Staging System. Such a translation would eliminate duplicate data collection by registrars reporting to clinical (facility-based) and epidemiologic (population-based central) registries, address the concerns of clinicians for more clinically relevant data as well as the public health sector's concerns about data reproducibility over time, and provide a higher degree of compatibility between the systems that would expand data-sharing opportunities.

The Collaborative Staging System is a carefully selected set of data items that describe how far a cancer has spread at the time of diagnosis. Most of the data items have traditionally been collected by cancer registries, including tumor size, extension, lymph node status, and metastatic status. New items were created to collect information necessary for the conversion algorithms, including the evaluation fields that describe how the collected data were determined, and site/histology-specific factors that are necessary to derive the final stage grouping for certain primary cancers. In addition to the items coded by the registrar, this unified data set also includes several data items derived from the computer algorithms that classify each case in multiple staging systems: the sixth edition of the AJCC TNM system (TNM), Summary Stage 1977 (SS77), and SEER Summary Stage 2000 (SS2000).

AJCC TNM staging provides forward flexibility and clinical utility for individual cancer cases. TNM is dynamic and is changed periodically to meet the decision-making needs of clinicians regarding appropriate treatment methods and the evaluation of their results. The AJCC TNM staging system uses three basic descriptors that are then grouped into stage categories. The first component is "T," which describes the extent of the primary tumor. The next component is "N," which describes the absence or presence and extent of regional lymph node metastasis. The third component is "M," which describes the absence or presence of distant metastasis. The final stage groupings (determined by the different permutations of "T," "N," and "M") range from Stage 0 through Stage IV. The stage group is generated when specific criteria are met in the TNM system, for example, prostate cancer stage grouping will only be generated for adenocarcinomas. When a case does not meet the criteria for stage grouping, the result will be reported as Not Applicable. An example of this type of case is leiomyosarcoma of the uterus, which is specifically excluded from TNM staging in both the uterus and the soft tissue sarcoma chapter. The Collaborative Staging System is based on, and compatible with, the terminology and staging in the sixth edition of the *AJCC Cancer Staging Manual*,[1] published in 2002. The general rules of the TNM system have been incorporated into the general rules for Collaborative Staging.

Summary Staging provides a measure for cancer surveillance with longitudinal stability for population-based cancer registries. Summary staging is a single digit system and has only eight categories: in situ, local, regional to lymph nodes, regional by direct extension, both regional lymph nodes and regional extension, regional not otherwise specified, distant, and unknown. It is less complex than other staging systems and was developed for registrars and epidemiologists who want some information on stage but did not wish to collect the more detailed EOD or TNM system. Summary Staging can be useful when a series of cases is so small that only general categories produce enough data for meaningful analysis. The

version of Summary Staging commonly used dates from 1977[2]; the site-specific sections were revised and updated in a new edition published in 2001[3].

The Collaborative Staging System uses a modified EOD format to collect information about each case. The SEER Extent of Disease (EOD)[4] coding system provided longitudinal stability for epidemiological and cancer control studies. More detailed than the Summary Staging System, EOD was developed to assure consistency over time as other staging systems changed. EOD also allows collected data to be collapsed into different and previous staging systems. SEER EOD is a five-field, 10 digit system: tumor size (3 digits), extension of the primary tumor (2 digits), regional lymph node involvement (highest specific lymph node chain involved by tumor) (1 digit), the number of pathologically reviewed regional lymph nodes that are positive (2 digits), and the number of pathologically examined regional lymph nodes (2 digits).

CHANGES IN ABSTRACTING RULES

Note: This introductory discussion refers 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.

Agreement among the participating organizations has resulted in resolution of the rule for timing of data collection and the development of standardized coding rules so that a single format can be used to collect stage information. The timing rule effective 1/1/2004 for Collaborative Staging is: "use all 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, whichever is *longer*." This timing rule change allows the CS Data Set to derive a "best stage" using pathologic data supplemented by clinical data.

Disease progression is defined as further direct extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression is documented should be excluded from the Collaborative Staging fields. Collaborative Staging represents the aggregate information obtained during the period of diagnosis and work-up, not just the initial contact with the patient. For example, within the limits of the timing rule, if further diagnostic tests show more precise extension or a more precise tumor size, this revised information is not considered disease progression. In other words, Collaborative Staging does not consider as disease progression a change from lack of evidence of disease (status unknown) to known status of disease (negative or positive). However, a change from negative status to positive, is disease progression. Take, for example, an asymptomatic patient who is treated surgically. She then develops bone pain and is found to have osseous metastases within a few weeks of surgery. This would be considered disease progression because she was asymptomatic at the time her treatment decisions were made. Furthermore, if the treatment plan is discontinued or changed due to a revised disease status, this is progression of disease and collection of Collaborative Staging information stops at this point.

Other rule modifications have been made and are printed in the site/histology-specific chapters.

In the process of bringing together the principles of Summary Stage, the TNM categories and stage groupings, and the SEER Extent of Disease coding structure, the Collaborative Staging System has also attempted to update abstracting rules to deal with the contemporary health care environment, in which completeness of staging documentation in the medical record has become an issue. In many circumstances, a patient's insurance will not pay for an imaging study or lab test that is expected to be negative but may otherwise be considered part of an 'ideal' cancer staging workup. Similarly, the content of clinician notes has changed over time to simply report any symptomatic, suspicious, or involved areas rather than chronicle every body part that is normal. This change in documentation is a source of

frustration to data collectors who rely on statements of normalcy or negativity to establish the boundaries of how far the cancer has spread.

When clinical practice changes and data collection guidelines do not, the completeness of the data is affected. The implementation of the Collaborative Staging System introduces a paradigm shift in the collection of information documenting the extent of disease, particularly in the collection of information about regional lymph nodes or distant metastases for primary sites 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.

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). The basis for this shift in the approach to information missing from the medical record is that typically the clinician reports positive findings and tends to remain silent on some or all negative findings. This new coding guideline also allows 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 the absence of distant metastasis that would otherwise change the treatment approach.

These guidelines apply primarily to localized or early (T1, T2) stage in the TNM system for inaccessible primary sites such as those mentioned previously. 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. An example would be 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.

By coding regional lymph nodes as negative and/or coding distant metastasis as none rather than coding these fields as unknown, the Collaborative Staging System computer algorithms will be able to derive a stage group that includes the best information.

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 nodes. A statement such as "remainder of examination negative" is sufficient to code regional lymph nodes as clinically negative.

In summary, the developers of the CS model believe that it will improve the quality of data being collected by the cancer registry community. Uniform rules and standardized training will make it easier for cancer registry personnel to complete staging tasks.

HOW THE COLLABORATIVE STAGING SYSTEM WORKS

For each cancer case, the data collector determines the site of origin or general histology for the cancer. The data items specific to that cancer site/histology are extracted from the medical record and coded in the Collaborative Staging System fields. When data collection is complete, the data collector activates the computer algorithms to derive the values for the items in the TNM system and Summary Stage (both 1977 and 2000). These algorithms are provided in portable platform-independent form by the Task Force. The classification or stage of each tumor is actually determined by the computer in a consistent and accurate manner (see Mapping and the Computer Algorithm, below).

Table 1 lists the individual Collaborative Staging data items, both input and derived, together with their NAACCR item number, length and other information, as published in the NAACCR Standards Volume II Version 10.1, Chapter X, Data Descriptor Table (revised November 2003).

Mapping and the Computer Algorithm

Once the data collector has coded all of the Collaborative Staging System elements for a case (the input values), the coded values are passed to a computer program that generates the correct stage for the case in three systems: AJCC TNM, 6th edition; SEER Summary Stage 1977; and SEER Summary Stage 2000. The program returns a set of values for the set of output items included in Table 1. A schematic diagram of the relationship between the inputs and outputs is shown in Figure 1.

The output values are returned as a set of numeric codes designed for storage in the computerized abstract. Each of the numeric codes is also provided with a display value, or English language character string showing the meaning of the code. For example, a returned value of 12 for T means T1a, and a 15 means T1b. Appendix 2 shows all of the output values and their display strings.

The computer algorithm that generates the stages is based on the values in the mapping columns for each of the Collaborative Staging System data elements. Mapping is provided from each code to the appropriate category in TNM and each summary stage. Some schemas require reference to two or more tables to determine the appropriate category. The mapping column either contains the category or a pointer to a further table where the category can be determined. Once each of the categories is determined, a further step is performed to generate the final stage groups. An example of the type of reference table used in this final step is shown in Appendix 3 for converting the results of the individual CS Extension, CS Lymph Nodes and CS Mets at Dx field to Summary Stage 1977 and Summary Stage 2000. For TNM stage grouping, the tables are schema-specific. Although the data collector does not code the stage groups directly, the rules by which the stages are derived are explicit in all of the tables, and the logic that the computer program follows should be fully evident from the tables available to the data collector.

As part of the output of the CS algorithm, two additional fields should be stored by the computer in the CS data base: CS Version 1st and CS Version Latest. CS Version 1st is the number of the version initially used to code CS fields and may be updated if cases are recoded, for example for a special study, using a later version of the Collaborative Staging manual. Depending on the structure of the registry software, CS Version 1st could be stored automatically by the computer or entered manually by the abstractor. The meaning and interpretation of CS Version 1st will be dependent on vendor implementation and local practices. This field should be interpreted with caution in a dataset where the actual coding procedures are unknown. CS Version Latest is the number of the version of the CS algorithm used most recently to derive the CS output fields and should be updated by the computer (rather than manually) every time the CS Derived items are re-computed.

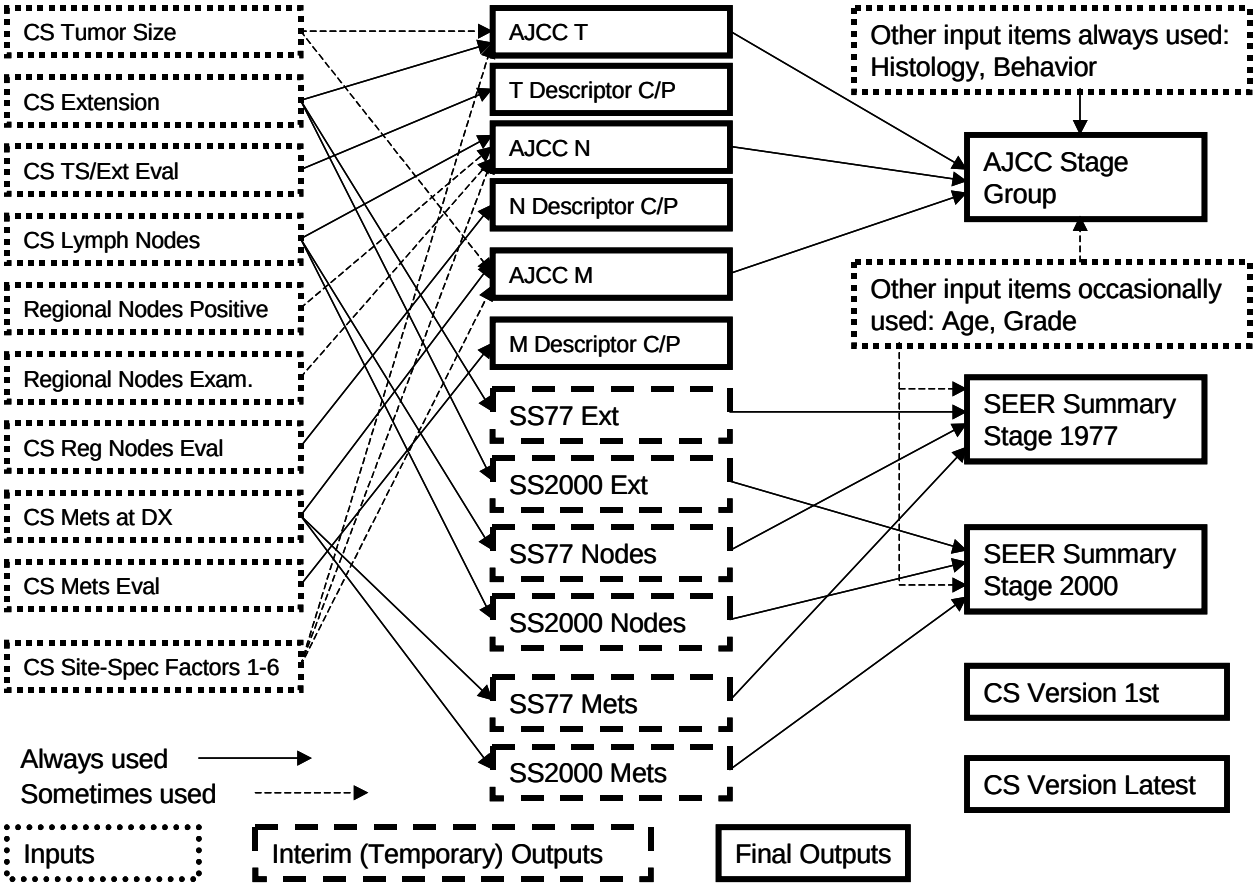
Table 1. Allowable Values and Format for Collaborative Staging Data Items

INPUT ITEMS						
Data Item Name	**NAACCR Data Item Number**	**Char-acter Length**	**Allowable Values (site-specific unless otherwise stated)**	**Right Justified, Zero filled**	**Blanks: Yes or No**	**NAACCR Ver 10.1 Column #**
CS Tumor Size	2800	3	000-999	Yes	No	629-631
CS Extension	2810	2	00-99	Yes	No	632-633
CS Tumor Size/Ext Eval	2820	1	0-9	N/A	No	634-634
CS Lymph Nodes	2830	2	00-99	Yes	No	635-636
CS Reg Nodes Eval	2840	1	0-9	N/A	No	637-637
Regional Nodes Examined	830	2	00-90, 95, 96, 97, 98, 99 (all sites)	Yes	No	541-542
Regional Nodes Positive	820	2	00-90, 95, 97, 98, 99 (all sites)	Yes	No	539-540
CS Mets At Dx	2850	2	00-99	Yes	No	638-639
CS Mets Eval	2860	1	0-9	N/A	No	640-640
CS Site-Specific Factor 1	2880	3	000-999	Yes	No	641-643
CS Site-Specific Factor 2	2890	3	000-999	Yes	No	644-646
CS Site-Specific Factor 3	2900	3	000-999	Yes	No	647-649
CS Site-Specific Factor 4	2910	3	000-999	Yes	No	650-652
CS Site-Specific Factor 5	2920	3	000-999	Yes	No	635-655
CS Site-Specific Factor 6	2930	3	000-999	Yes	No	656-658

Table 1 continued. Allowable Values and Format for Collaborative Staging Data Items						
OUTPUT ITEMS						
Data Item Name	**NAACCR Data Item Number**	**Char-acter Length**	**Allowable Values**	**Right Justified, Zero filled**	**Blanks: Yes or No**	**NAACCR Ver 10.1 Column #**
Derived AJCC T	2940	2	00, 01, 05, 06, 07, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 29, 30, 31, 32, 33, 39, 40, 41, 42, 43, 44, 49, 88, 99	N/A	N/A	659-660
Derived AJCC N	2960	2	00, 01, 02, 03, 04, 09, 10, 11, 12, 13, 18, 19, 20, 21, 22, 23, 29, 30, 31, 32, 33, 39, 88, 99	N/A	N/A	662-663
Derived AJCC M	2980	2	00, 10, 11, 12, 13, 19, 88, 99	N/A	N/A	665-666
Derived AJCC T Descriptor	2950	1	c, p, a, y	N/A	N/A	661-661
Derived AJCC N Descriptor	2970	1	c, p, a, y	N/A	N/A	664-664
Derived AJCC M Descriptor	2990	1	c, p, a, y	N/A	N/A	667-667
Derived AJCC Stage Group	3000	2	00, 01, 02, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 70, 71, 72, 73, 74, 88, 90, 99	N/A	N/A	668-669
Derived AJCC Flag	3030	1	Blank, 1, 2	N/A	Yes	672-672
Derived SS1977	3010	1	Blank, 0, 1, 2, 3, 4, 5, 7, 8, 9	N/A	Yes	670-670
Derived SS1977 Flag	3040	1	Blank, 1, 2	N/A	Yes	673-673
Derived SS2000	3020	1	Blank, 0, 1, 2, 3, 4, 5, 7, 8, 9	N/A	Yes	671-671
Derived SS2000 Flag	3050	1	Blank, 1, 2	N/A	Yes	674-674
CS Version 1st	2935	6	000000-999999	N/A	No	705-710
CS Version Latest	2936	6	000000-999999	N/A	No	711-716

Figure 1

Schematic Diagram of Relationships of Inputs and Outputs for Collaborative Staging



How Mapping Was Determined

The Collaborative Staging Task Force based its codes for the extension, lymph nodes, and metastases fields on SEER's Extent of Disease, which had been designed to accommodate collapsing into TNM 3rd edition and the SEER Summary Stages. Some fundamental restructuring of the EOD codes was necessary to accommodate the sixth edition of TNM with its greater detail and supplementary prognostic information. For example, in EOD, all lymph node involvement (regional and distant) was coded in the lymph nodes field. In Collaborative Staging, regional lymph node involvement is coded in the CS lymph node field, and distant lymph node involvement is coded with other distant metastases. In each table, codes were added or combined where necessary to accommodate the 6th edition of TNM. The following rules and procedures were used to determine the correct mapping to TNM 6th edition:

- **Downstaging rule**. The Collaborative Staging Task Force applied the stated rule from the AJCC manual, "If there is doubt concerning the T, N, or M classification to which a particular case should be assigned, then the lower (less advanced) category should be assigned." When a mapping could be made to more than one classification, for example, T1 or T2, the mapping was always made to the lower or less extensive category. Occasionally this rule did not seem to apply, for example, when a lower category seemed to provide an exclusive list, while the higher category was more general. The downstaging rule was not applied to the assignment of stage group, only to the assignment of T, N, and M classification.

- **Use of NOS.** The Collaborative Staging Task Force added NOS (not otherwise specified) to some of its T, N, M, and stage group categories for clarity and ease of processing. The NOS is added when a further breakdown of the T, N, and M permutations into subsets is available, but the correct subset cannot be determined. NOS can appear in both the descriptions of codes and the mapping. This NOS terminology is not official AJCC usage. The NOS can safely be ignored in reports and analyses when it is not a useful distinction. In addition, the data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

  Example. For glottic larynx, T1 means "Tumor limited to the vocal cord(s) . . ." T1a means tumor limited to one vocal cord, and T1b means tumor involves both vocal cords. In Collaborative Staging, the subgroup of T1 NOS is designated for use when the tumor is known to be limited to the vocal cords, but it cannot be determined whether one or both cords are involved. In Collaborative Staging, the category T1 would be used to mean all of the T1's, including the T1a's, T1b's, and T1 NOS's.

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1. Greene FL, Page DL, Fleming ID et al. *AJCC Cancer Staging Manual, sixth edition.* American Joint Committee on Cancer. New York: Springer-Verlag, 2002.
2. Shambaugh EM and Weiss MA. SEER Summary Staging Guide 1977. Bethesda, MD: National Cancer Institute, NIH Publication Number 98-2313, reprinted December 1997.
3. Young JL, Roffers SD, Ries LAG, Fritz AG, Hurlbut AA (eds). *Summary Staging Manual 2000: Codes and Coding Instructions.* Bethesda, MD: National Cancer Institute, NIH Publication Number 01-4969, 2001
4. Fritz AG and Ries LAG (eds). *SEER Extent of Disease Coding, 1998: Codes and Coding Instructions, Third Edition*. Bethesda, MD: National Cancer Institute, NIH Publication Number 98-1999, April 1998.

General Rules and Instructions

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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 T, N, M, and Stage Group according to the sixth edition of the *AJCC Cancer Staging Manual*; Summary Stage 1977; and SEER Summary Stage 2000.

This manual provides codes and coding instructions for the process of data entry. In order to derive the desired T, N, M, and Stage Group in the TNM system or the Summary Stage(s), the computer algorithms described in the introduction must be used. This manual provides the logic of the computer algorithms in table format for each schema, but is not intended to be used for generating the stages manually, because for some sites, additional tables are necessary to determine T, N, M, or Stage Group. These additional tables are available for review on the Collaborative Staging web site, http://www.cancerstaging.org

These schemas apply to cases diagnosed January 1, 2004 and later. **Do NOT use these schemas for cases diagnosed prior to January 1, 2004**; 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. The diagnostic confirmation field can be used to exclude non-microscopically confirmed cases during analysis as necessary, since the *AJCC Cancer Staging Manual* states that "all cases should be microscopically confirmed. 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. Summary Stage 1977 and Summary Stage 2000 are generated for all sites and histologies. The TNM elements and stage group are only generated for cases that meet the TNM criteria. For example, there is no TNM schema for brain.
   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. Summary Stage 1977 and Summary Stage 2000 are generated for all histologies. The computer algorithms for determining the final TNM stage group take into account any histologies that are excluded from TNM staging. For example, the TNM schema for prostate applies only to adenocarcinomas. For excluded histologies, the computer algorithm returns values representing "Not Applicable," meaning that AJCC T, N, M, and Stage Group are not generated for that site-histology combination.

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. The hierarchies are not the same for the different staging systems, and Collaborative Staging generally follows the hierarchies of the TNM system.
   a. Combination codes (for example, code 35 for "25 plus 30") have been assigned when using the higher number does not result in the appropriate mapping for all three stage groups. Combination codes have been omitted when use of a higher number results in correct mapping for all three staging systems.

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. Appendix 4 lists the names of each site specific factor for each schema.

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

As noted in the introduction, 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 (T1, T2) 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)

Cervix Uteri
- Cervix (Cervix)

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 Scrotum–Melanoma (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 (*iris only*) (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 digestive (OthDigestive)
Middle ear (MiddleEar)
Other sinus (OthSinus)
Trachea (Trachea)
Other respiratory (OthRespiratory)
Other adnexa (OthAdnexa)
Other female genital (OthFemaleGen)
Other male genital (OthMaleGen)
Other urinary (OthUrinary)
Brain (Brain)
Other CNS (OthCNS)
Other endocrine (OthEndocrine)
Other eye (OthEye)
Melanoma of Other Eye (MelanomaOthEye)
Kaposi sarcoma (KS)
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms (HemeRetic)
Other Ill-defined and Unknown Primary 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 Site-Specific Factor 1	888
CS Extension	99	CS Site-Specific Factor 2	888
CS Tumor Size/Ext Eval	9	CS Site-Specific Factor 3	888
CS Lymph Nodes	99	CS Site-Specific Factor 4	888
CS Reg Nodes Eval	9	CS Site-Specific Factor 5	888
Reg LN Pos	99	CS Site-Specific Factor 6	888
Reg LN Exam	99		
CS Mets at DX	99		
CS Mets Eval	9		

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 "p" (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 organ's 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 physiologic 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 adjacent 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

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

** interpreted as involvement of other organ or tissue

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

HOW TO CODE THE COLLABORATIVE STAGING SYSTEM DATA ELEMENTS

A one page summary of how to code using this manual

Note: This procedure focuses on only the Collaborative Staging data fields and assumes other registry operations such as case finding, completion of text fields and other data fields, edit checking and case submission are also being performed appropriately.

1. Before you begin to code using the Collaborative Staging System, read completely 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 the Part II 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 sure 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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Coding Instructions for Collaborative Staging Data Elements

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CS TUMOR SIZE Item Length: 3 NAACCR Item #2800

Description
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.

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)*
Thyroidectomy specimen yields 8 mm carcinoma	*Code as 008*
Prostate needle biopsy shows 0.6 mm carcinoma	*Code as 001 (round up six-tenths of mm)*

For schemas that do not use tumor size:

Code	Description
888	Not applicable

Instructions for Coding
1. Refer to general guidelines for Collaborative Staging for timing rules for data collection.

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

3. Record tumor size information in the following order:
   a. Record tumor size from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

CS Tumor Size, continued

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.*

b. 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.*

c. 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.

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

e. 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.

4. Record the exact size of the primary tumor for all sites/histologies except those for which it is stated to be not applicable. If no size is given, code as 999.

a. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. 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.

b. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

Example A 3.3 cm tumor would be 33 millimeters and would be coded as 033.

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

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

d. 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.*

e. *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.

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

g. Microscopic residual tumor does not affect overall tumor size.

h. 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.

i. 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.

CS Tumor Size, continued

j. 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.

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

5. Special codes

a. 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.

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

c. 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, widespread—¾ 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.

d. 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.

e. Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, the more precise size should be coded in the range 001-989.

f. 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.

g. ***Note:*** 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. It is strongly recommended that the choice of tumor size codes be documented in a related text field on the abstract.

CS EXTENSION Item Length: 2 NAACCR Item #2810

Description
Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field. 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 (clinically).
      Example Patient has rectal mass firmly attached to pelvic wall (clinically T4, 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 (pathologically T3, extension code 40). *Code extension as 60, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.*
   c. In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.
      Example Patient found to have an obstructing central lung tumor very close to the main stem bronchus (clinically T2, extension code 20). Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea (pathologically T4, 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 (clinically T3, 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 (pathologically T2, 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.*

CS Extension, continued

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 guidelines for Collaborative Staging 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 T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) 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. It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.

CS TUMOR SIZE/EXT EVAL Item Length: 1 NAACCR Item #2820

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

Note: This field is used primarily to describe whether the staging basis for the T category in the TNM system is clinical or pathological.

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. Does not meet criteria for AJCC pathologic staging.	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 Meets criteria for AJCC pathologic staging. 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 ***For sites with no TNM schema:*** not applicable	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*.

CS Tumor Size/Ext Eval, continued

Instructions for Coding

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.
   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. 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.

CS Tumor Size/Ext Eval, continued

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 Item Length: 2 NAACCR Item #2830

Description
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 (T1, T2) 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).

CS Lymph Nodes, continued

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.

CS Lymph Nodes, continued

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 NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. 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. It is strongly recommended that the choice of regional lymph node codes be documented in a related text field on the abstract.

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 in each of 7 different levels and other groups defined by AJCC. The definitions of the levels are the same for all applicable head and neck sites. One digit is used to represent lymph nodes of a single level, with the three digits of Site-Specific Factor 3 representing lymph nodes of, respectively, Levels I-III; the digits of Site-Specific Factor 4 representing lymph nodes of Levels IV and V and the retropharyngeal nodes; the digits of Site-Specific Factor 5 representing lymph nodes of Levels VI and VII and the facial nodes; and the digits of Site-Specific Factor 6 representing the remaining Other groups as defined by AJCC. In each digit, a code 1 means Yes, the nodes are involved. See Figure 2a for the layout of Site-Specific Factors 3 through 6 and Figure 2b for the interpretation of a coded example.

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

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

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

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

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

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

CS Lymph Nodes, continued

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

Definitions of Levels for Head and Neck Sites
The definitions of the levels and the lymph node chains included in each level are as follows:

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

Submandibular	Submaxillary	Submental

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

Jugulodigastric (subdigastric)	Upper deep cervical	Upper jugular

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

Middle deep cervical	Mid-jugular

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

Jugulo-omohyoid (supraomohyoid)	Lower deep cervical	Lower jugular

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

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

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

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

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

Upper mediastinal

Other groups

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

CS REG NODES EVAL Item Length: 1 NAACCR Item #2840

Description
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. Does not meet criteria for AJCC pathologic staging.	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 Meets criteria for AJCC pathologic staging.	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), CS Reg Node Eval may be coded 9 (not applicable).

CS Reg Nodes Eval, continued

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 Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled.
      Code CS Reg Node Eval as 3. Staging algorithm would identify information as pathologic (p). According to AJCC, a positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.
      Example Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes.
      Code CS Reg Node Eval as 1. Staging algorithm would identify information as clinical (c).
   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.

REGIONAL NODES POSITIVE Item Length: 2 NAACCR Item #820

Description
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 Item Length: 2 NAACCR Item #830

Description
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 Item Length: 2 NAACCR Item #2850

Description
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 (the TNM M component or distant stage in Summary Staging) at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to a site remote from the primary tumor.

Note: The structure of the CS Mets at Dx field is based on the M category of TNM. In some schemas, there may be additional items in CS Extension or CS Lymph Nodes that map to distant stage in Summary Staging (77 and/or 2000) and there may be some items in CS Mets at Dx that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

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.

CS Mets at Dx, continued

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 NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. 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. It is strongly recommended that the choice of distant lymph nodes and/or distant metastasis codes be documented in a related text field on the abstract.

CS METS EVAL Item Length: 2 NAACCR Item #2860

Description
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. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging of distant metastasis.	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 Meets criteria for AJCC pathologic staging of distant metastasis.	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 ***For sites with no TNM staging***: Not applicable	c

Instructions for Coding
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 (Table 6), 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.

CS Mets Eval, continued

Example Patient has diagnosis of colon cancer by biopsy. CT scan shows liver metastasis.
Code this field as 0. Staging algorithm will indicate information is clinical (c).

Example Lung cancer with endoscopy of contralateral lung showing involvement of contralateral mainstem bronchus.
Code this field as 1. Staging algorithm will indicate information is clinical (c).

Example Prostate cancer with enlarged scalene node confirmed as cancer on needle biopsy.
Code this field as 3. Staging algorithm will indicate information is pathologic (p), since the biopsy of the metastatic site confirms M1 disease.

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.

CS SITE-SPECIFIC FACTOR 1 Item Length: 3 NAACCR Item #2880

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

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

CS Site-Specific Factor 1, continued

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 Item Length: 3 NAACCR Item #2890

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

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

CS Site-Specific Factor 2, continued

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 Item Length: 3 NAACCR Item #2900

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

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

3. Code 000 Not done is used when there is a statement in the record that a test was not performed.
   a. If there is no report of a lab test in the health record, code as 999 Unknown; Not documented in patient record.
   b. For the lymphomas, if the IPI score is not stated in the record, code as 999 Unknown; Not documented in patient record. It is not necessary to calculated the IPI score from other information in the record.

CS Site-Specific Factor 3, continued
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 Item Length: 3 NAACCR Item #2910

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

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

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

CS Site-Specific Factor 4, continued

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 Item Length: 3 NAACCR Item #2920

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

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

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

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

CS Site-Specific Factor 5, continued

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 Item Length: 3 NAACCR Item #2930

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

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

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

CS Site-Specific Factor 6, continued

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.

ADDITIONAL COLLABORATIVE STAGING TABLES

In addition to the tables of codes for each of the Collaborative Staging System data items, it was necessary to develop reference tables that the computer algorithm uses to assure that the output data items (T, N, M, Stage Group, SS77 and SS2000) are accurately derived. These tables are not printed in this manual, usually because of their length. Any reference tables that have been developed for individual schema are listed at the top of the schema in Part II of this manual but are not printed in the manual. They are available for reference on the Collaborative Staging website, www.cancerstaging.org.

AJCC STAGE TABLE

The allowable storage codes for derived T, N, M and Stage Group are shown in Appendix 2 with their output character strings. The AJCC stage tables are site-specific and are not included in this manual due to their length. The data collector or researcher can access the AJCC stage table associated with each schema under the appropriate site-specific section of the Collaborative Staging website, www.cancerstaging.org.

SUMMARY STAGE TABLE

The summary stage conversion table is shown in Appendix 3. This table evaluates the CS Extension, CS Lymph Nodes, and CS Mets at Dx fields to determine the final Summary Stage 77 and Summary Stage 2000 output (Appendix 2e). The Summary Stage Table applies to all schemas and lists all possible combinations, including Not Applicable, Unstagable and Error situations. The algorithm takes the highest (most extensive value) from any of the three input fields as the output value. For example, if the Extension code maps to regional direct extension, the Lymph Nodes code maps to regional lymph nodes, and no distant metastases are coded in the Mets at Dx field, the output value will be RE+RN, regional extension and nodes.

HISTOLOGY EXCLUSION TABLES

It has been previously noted that not all cases will have T, N, M, and Stage Group categories derived by the computer algorithm. This is because certain histologies are excluded from some chapters of the *AJCC Cancer Staging Manual, sixth edition.* In order that the Collaborative Staging System could accurately derive the components of the TNM system only for the histologies allowed in the AJCC manual, tables of allowable and excluded ICD-O-3 histology have been developed with the cooperation of the AJCC. These lists are shown in Appendix 5 of this manual. The nine major categories of cancers are shown with their associated three-digit morphology code ranges.

For example, in TNM staging, carcinoids are specifically excluded from the colon cancer chapter. If a malignant carcinoid case is abstracted, all of the 10 data items for colon should be recorded (9 basic data items plus one site-specific factor for colon). The computer algorithm will look at the recorded ICD-O-3 morphology coded and match it to the exclusions table for colon. Because carcinoid (M-8240/3) is on the exclusions list, the algorithm will not generate a T, N, M or Stage Group, but will generate both Summary Stage 1977 and 2000.

SITE-SPECIFIC EXTRA TABLES

In the introduction to this manual it was noted that some schemas require additional reference tables in order for the computer algorithm to determine the final derived T, N, M, or Stage Group output. The need for these extra tables arises when additional information is needed to differentiate, for example, a T1a from a T1b, or when the tumor size is a significant factor in determining the T category.

For example, it is necessary to combine information from both the tumor size table and the extension table in order to derive the T category for breast cancer. If the tumor extension is purely in situ, the derived T is Tis; if the tumor extension involves the skin or chest wall, the derived T is one of the T4 subcategories. But if the tumor extension is in the range of 10-30, it is necessary to know the exact size of the tumor. The computer algorithm looks at the "Extension Size Table" for breast to determine the correct output. In the table below, if the Extension code is 10 and the tumor size is coded 018 (1.8 cm), the computer algorithm will read the sixth line of the table and output a T1c. If the extension code is 20 and the tumor size is coded 055, the computer algorithm will read the eighth line of the table and output a T3.

Figure 3. Example of "Extension Size Table" for Breast Schema

Note: For Extension codes 10, 20, and 30 ONLY, the T category is assigned based on value of CS Tumor Size, as follows:

From Tumor Size	To Tumor Size	T Code	Comment
000	000	ERROR	Tumor size 000 should only be used with Extension 95.
001	001	T1mic	
002	005	T1a	
006	010	T1b	
011	020	T1c	
021	050	T2	
051	989	T3	
990	990	T1mic	
991	991	T1b	
992	992	T1c	
993	995	T2NOS	
996	996	T1NOS	
997	997	ERROR	Tumor size 997 should only be used with Extension code 05 or 07.
998	998	T3	
999	999	TX	

As another example, the patient's age and histology must be known in order to stage a thyroid cancer. Several additional tables on the thyroid schema are used by the computer algorithm to determine the TNM Stage Group when the patient is under or over age 45 and the histology is papillary/follicular, medullary or anaplastic.

Appendices

1. Determining Descriptive Tumor Size

2. Output Values, Storage Codes, and Display String Descriptions for T, N, M, Stage Group and Summary Stage

3. Summary Stage Conversion Algorithm for All Schemas

4. Site Specific Factors

5. Histology Exclusion Groups

Appendix 1.
Determining Descriptive Tumor Size
Millimeter Equivalents for Descriptive Terms

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

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

Vegetables	
Bean	010
Bean, lima	020
Pea	991
Pea, split	991

Miscellaneous Food	mm
Doughnut	090
Egg	050
Bantam	040
Goose	070
Hen	030
Pigeon	030
Robin	020
Lentil	991
Millet	991

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

Other	
Ball, golf	040
Ball, ping-pong	030
Ball, tennis	060
Baseball	070
Eraser on pencil	991
Fist	090
Marble	010
Matchhead	991
Microscopic focus	990
Described as less than 1 cm.	991
Described as between 1 and 2 cm	992
Described as between 2 and 3 cm	993
Described as between 3 and 4 cm	994
Described as between 4 and 5 cm	995

SIZES IN CENTIMETERS, MILLIMETERS, INCHES

10 millimeters (mm) = 1 centimeter (cm)

1 millimeter (mm) = 1/10 centimeter (cm)

2.5 centimeters (cm) = 1 inch (in)

1 centimeter (cm) = .394 inch (in)

APPENDIX 2. ALLOWABLE VALUES

Appendix 2a. T Allowable Codes

This table shows the allowable values for the generated Collaborative Stage data items. The Storage Code is the value to be stored in the field of a NAACCR record. The Storage Codes are designed for analysis. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings will be clear to the registrar or physician user.

Storage Code	Display String*	Display String Description
99	TX	TX
00	T0	T0
01	Ta	Ta
05	Tis	Tis
06	Tispu	Tispu (Urethra only)
07	Tispd	Tispd (Urethra only)
10	T1	T1
11	T1mic	T1mic
12	T1a	T1a
13	T1a1	T1a1
14	T1a2	T1a2
15	T1b	T1b
16	T1b1	T1b1
17	T1b2	T1b2
18	T1c	T1c
19	T1NOS	T1 NOS
20	T2	T2
29	T2NOS	T2 NOS
21	T2a	T2a
22	T2b	T2b
23	T2c	T2c
30	T3	T3
39	T3NOS	T3 NOS
31	T3a	T3a
32	T3b	T3b
33	T3c	T3c
40	T4	T4
49	T4NOS	T4 NOS
41	T4a	T4a
42	T4b	T4b
43	T4c	T4c
44	T4d	T4d
88	NA	Not applicable

* T_ with no subscript indicates that there is only one choice for that category
T_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 2b. N Allowable Codes

This table shows the allowable values for the generated Collaborative Stage data items. The Storage Code is the value to be stored in the field of a NAACCR record. The Storage Codes are designed for analysis. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings will be clear to the registrar or physician user.

Storage Code	Display String*	Display String Description
99	NX	NX
00	N0	N0
09	N0NOS	N0 NOS
01	N0(i-)	N0(i-)
02	N0(i+)	N0(i+)
03	N0(mol-)	N0(mol-)
04	N0(mol+)	N0(mol+)
10	N1	N1
19	N1NOS	N1 NOS
11	N1a	N1a
12	N1b	N1b
13	N1c	N1c
18	N1mi	N1mi
20	N2	N2
29	N2NOS	N2 NOS
21	N2a	N2a
22	N2b	N2b
23	N2c	N2c
30	N3	N3
39	N3NOS	N3 NOS
31	N3a	N3a
32	N3b	N3b
33	N3c	N3c
88	NA	Not applicable

* N_ with no subscript indicates that there is only one choice for that category
N_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 2c. M Allowable Codes

This table shows the allowable values for the generated Collaborative Stage data items. The Storage Code is the value to be stored in the field of a NAACCR record. The Storage Codes are designed for analysis. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings will be clear to the registrar or physician user.

Storage Code	Display String*	Display String Description
99	MX	MX
00	M0	M0
10	M1	M1
11	M1a	M1a
12	M1b	M1b
13	M1c	M1c
19	M1NOS	M1 NOS
88	NA	Not applicable

* M_ with no subscript indicates that there is only one choice for that category
M_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 2d. Stage Allowable Codes

This table shows the allowable values for the generated Collaborative Stage data items. The Storage Code is the value to be stored in the field of a NAACCR record. The Storage Codes are designed for analysis. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings will be clear to the registrar or physician user.

Storage Code	Display String*	Display String Description
00	0	Stage 0
01	0a	Stage 0a
02	0is	Stage 0is
10	I	Stage I
11	INOS	Stage I NOS
12	IA	Stage IA
13	IA1	Stage IA1
14	IA2	Stage IA2
15	IB	Stage IB
16	IB1	Stage IB1
17	IB2	Stage IB2
18	IC	Stage IC
19	IS	Stage IS
23	ISA	Stage ISA (lymphoma only)
24	ISB	Stage ISB (lymphoma only)
20	IEA	Stage IEA (lymphoma only)
21	IEB	Stage IEB (lymphoma only)
22	IE	Stage IE (lymphoma only)
30	II	Stage II

Appendix 2d continued Storage Code	Display String	Display String Description
31	IINOS	Stage II NOS
32	IIA	Stage IIA
33	IIB	Stage IIB
34	IIC	Stage IIC
35	IIEA	Stage IIEA (lymphoma only)
36	IIEB	Stage IIEB (lymphoma only)
37	IIE	Stage IIE (lymphoma only)
38	IISA	Stage IISA (lymphoma only)
39	IISB	Stage IISB (lymphoma only)
40	IIS	Stage IIS (lymphoma only)
41	IIESA	Stage IIESA (lymphoma only)
42	IIESB	Stage IESB (lymphoma only)
43	IIES	Stage IIES (lymphoma only)
50	III	Stage III
51	IIINOS	Stage III NOS
52	IIIA	Stage IIIA
53	IIIB	Stage IIIB
54	IIIC	Stage IIIC
55	IIIEA	Stage IIIEA (lymphoma only)
56	IIIEB	Stage IIIEB (lymphoma only)
57	IIIE	Stage IIIE (lymphoma only)
58	IIISA	Stage IIISA (lymphoma only)
59	IIISB	Stage IIISB (lymphoma only)
60	IIIS	Stage IIIS (lymphoma only)
61	IIIESA	Stage IIIESA (lymphoma only)
62	IIIESB	Stage IIIESB (lymphoma only)
63	IIIES	Stage IIIES (lymphoma only)
70	IV	Stage IV
71	IVNOS	Stage IV NOS
72	IVA	Stage IVA
73	IVB	Stage IVB
74	IVC	Stage IVC
88	NA	Not applicable
90	OCCULT	Stage Occult
99	UNK	Stage Unknown

* A stage group with no subscript indicates that there is only one choice for that category
A stage group NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 2e. Summary Stage Allowable Codes

This table shows the allowable values for the generated Collaborative Stage data items. The Storage Code is the value to be stored in the field of a NAACCR record. The Storage Codes are designed for analysis. The Display String is the corresponding label that should be displayed on the screen or in a report. The meaning of these strings will be clear to the registrar or physician user.

Storage Code	Display String	Display String Description
	ERROR	Processing error (no storage code needed)
	NONE	None (internal use only, no storage code needed)
0	IS	In situ
1	L	Localized
2	RE	Regional, direct extension
3	RN	Regional, lymph nodes only
4	RE+RN	Regional, extension and nodes
5	RNOS	Regional, NOS
7	D	Distant
8	NA	Not applicable
9	U	Unknown/Unstaged

Appendix 3. Summary Stage Conversion Algorithm for All Schemas

* In situ implies no involvement outside the primary site.

Extension SS77 or SS2000 result	LN SS77 or SS2000 result	Mets SS77 or SS2000 result	Final SS77 or SS2000 result
IS *	NONE	NONE	IS
IS *	NONE	L	ERROR
IS *	NONE	RE	ERROR
IS *	NONE	RN	ERROR
IS *	NONE	RE+RN	ERROR
IS *	NONE	D	ERROR
IS	NONE	NA	IS
IS	NONE	U	IS
IS *	RE	NONE	ERROR
IS *	RE	L	ERROR
IS *	RE	RE	ERROR
IS *	RE	RN	ERROR
IS *	RE	RE+RN	ERROR
IS *	RE	D	ERROR
IS *	RE	NA	ERROR
IS *	RE	U	ERROR
IS *	RN	NONE	ERROR
IS *	RN	L	ERROR
IS *	RN	RE	ERROR
IS *	RN	RN	ERROR
IS *	RN	RE+RN	ERROR
IS *	RN	D	ERROR
IS *	RN	NA	ERROR
IS *	RN	U	ERROR
IS *	RE+RN	NONE	ERROR
IS *	RE+RN	L	ERROR
IS *	RE+RN	RE	ERROR
IS *	RE+RN	RN	ERROR
IS *	RE+RN	RE+RN	ERROR
IS *	RE+RN	D	ERROR
IS *	RE+RN	U	ERROR
IS *	D	NONE	ERROR
IS *	D	L	ERROR
IS *	D	RE	ERROR
IS *	D	RN	ERROR
IS *	D	RE+RN	ERROR
IS *	D	D	ERROR
IS *	D	NA	ERROR
IS *	D	U	ERROR
IS	NA	NONE	IS
IS *	NA	L	ERROR
IS *	NA	RE	ERROR
IS *	NA	RN	ERROR
IS *	NA	RE+RN	ERROR
IS *	NA	D	ERROR
IS	NA	NA	IS
IS	NA	U	IS
IS *	U	NONE	IS
IS *	U	L	ERROR
IS *	U	RE	ERROR
IS *	U	RN	ERROR
IS *	U	RE+RN	ERROR
IS *	U	D	ERROR
IS	U	NA	IS
IS	U	U	IS
L	NONE	NONE	L
L	NONE	L	L
L	NONE	RE	RE
L	NONE	RN	RN
L	NONE	RE+RN	RE+RN
L	NONE	D	D
L	NONE	NA	L
L	NONE	U	L
L	RE	NONE	RE
L	RE	L	RE
L	RE	RE	RE
L	RE	RN	RE+RN
L	RE	RE+RN	RE+RN
L	RE	D	D
L	RE	NA	RE
L	RE	U	RE
L	RN	NONE	RN
L	RN	L	RN
L	RN	RE	RE+RN
L	RN	RN	RN
L	RN	RE+RN	RE+RN
L	RN	D	D
L	RN	NA	RN
L	RN	U	RN
L	RE+RN	NONE	RE+RN
L	RE+RN	L	RE+RN
L	RE+RN	RE	RE+RN
L	RE+RN	RN	RE+RN
L	RE+RN	RE+RN	RE+RN
L	RE+RN	D	D
L	RE+RN	NA	RE+RN
L	RE+RN	U	RE+RN
L	D	NONE	D
L	D	L	D
L	D	RE	D
L	D	RN	D
L	D	RE+RN	D
L	D	D	D
L	D	NA	D
L	D	U	D
L	NA	NONE	L
L	NA	L	L
L	NA	RE	RE
L	NA	RN	RN
L	NA	RE+RN	RE+RN
L	NA	D	D
L	NA	NA	L
L	NA	U	L
L	U	NONE	L
L	U	L	L
L	U	RE	RE
L	U	RN	RN
L	U	RE+RN	RE+RN
L	U	D	D
L	U	NA	L
L	U	U	L

Extension SS77 or SS2000 result	LN SS77 or SS2000 result	Mets SS77 or SS2000 result	Final SS77 or SS2000 result
RE	NONE	NONE	RE
RE	NONE	L	RE
RE	NONE	RE	RE
RE	NONE	RN	RE+RN
RE	NONE	RE+RN	RE+RN
RE	NONE	D	D
RE	NONE	NA	RE
RE	NONE	U	RE
RE	RE	NONE	RE
RE	RE	L	RE
RE	RE	RE	RE
RE	RE	RN	RE+RN
RE	RE	RE+RN	RE+RN
RE	RE	D	D
RE	RE	NA	RE
RE	RE	U	RE
RE	RN	NONE	RE+RN
RE	RN	L	RE+RN
RE	RN	RE	RE+RN
RE	RN	RN	RE+RN
RE	RN	RE+RN	RE+RN
RE	RN	D	D
RE	RN	NA	RE+RN
RE	RN	U	RE+RN
RE	RE+RN	NONE	RE+RN
RE	RE+RN	L	RE+RN
RE	RE+RN	RE	RE+RN
RE	RE+RN	RN	RE+RN
RE	RE+RN	RE+RN	RE+RN
RE	RE+RN	D	D
RE	RE+RN	NA	RE+RN
RE	RE+RN	U	RE+RN
RE	D	NONE	D
RE	D	L	D
RE	D	RE	D
RE	D	RN	D
RE	D	RE+RN	D
RE	D	D	D
RE	D	NA	D
RE	D	U	D
RE	NA	NONE	RE
RE	NA	L	RE
RE	NA	RE	RE
RE	NA	RN	RE+RN
RE	NA	RE+RN	RE+RN
RE	NA	D	D
RE	NA	NA	RE
RE	NA	U	RE
RE	U	NONE	RE
RE	U	L	RE
RE	U	RE	RE
RE	U	RN	RE+RN
RE	U	RE+RN	RE+RN
RE	U	D	D
RE	U	NA	RE
RE	U	U	RE
RNOS	NONE	NONE	RNOS
RNOS	NONE	L	RNOS
RNOS	NONE	RE	RNOS
RNOS	NONE	RN	RNOS
RNOS	NONE	RE+RN	RNOS
RNOS	NONE	D	D
RNOS	NONE	NA	RNOS
RNOS	NONE	U	RNOS
RNOS	RE	NONE	RNOS
RNOS	RE	L	RNOS
RNOS	RE	RE	RNOS
RNOS	RE	RN	RNOS
RNOS	RE	RE+RN	RNOS
RNOS	RE	D	D
RNOS	RE	NA	RNOS
RNOS	RE	U	RNOS
RNOS	RN	NONE	RNOS
RNOS	RN	L	RNOS
RNOS	RN	RE	RNOS
RNOS	RN	RN	RNOS
RNOS	RN	RE+RN	RNOS
RNOS	RN	D	D
RNOS	RN	NA	RNOS
RNOS	RN	U	RNOS
RNOS	RE+RN	NONE	RNOS
RNOS	RE+RN	L	RNOS
RNOS	RE+RN	RE	RNOS
RNOS	RE+RN	RN	RNOS
RNOS	RE+RN	RE+RN	RNOS
RNOS	RE+RN	D	D
RNOS	RE+RN	NA	RNOS
RNOS	RE+RN	U	RNOS
RNOS	D	NONE	D
RNOS	D	L	D
RNOS	D	RE	D
RNOS	D	RN	D
RNOS	D	RE+RN	D
RNOS	D	D	D
RNOS	D	NA	D
RNOS	D	U	D
RNOS	NA	NONE	RNOS
RNOS	NA	L	RNOS
RNOS	NA	RE	RNOS
RNOS	NA	RN	RNOS
RNOS	NA	RE+RN	RNOS
RNOS	NA	D	D
RNOS	NA	NA	RNOS
RNOS	NA	U	RNOS
RNOS	U	NONE	RNOS
RNOS	U	L	RNOS
RNOS	U	RE	RNOS
RNOS	U	RN	RNOS
RNOS	U	RE+RN	RNOS
RNOS	U	D	D
RNOS	U	NA	RNOS
RNOS	U	U	RNOS
D	NONE	NONE	D
D	NONE	L	D
D	NONE	RE	D
D	NONE	RN	D
D	NONE	RE+RN	D
D	NONE	D	D
D	NONE	NA	D
D	NONE	U	D

Extension SS77 or SS2000 result	LN SS77 or SS2000 result	Mets SS77 or SS2000 result	Final SS77 or SS2000 result
D	RE	NONE	D
D	RE	L	D
D	RE	RE	D
D	RE	RN	D
D	RE	RE+RN	D
D	RE	D	D
D	RE	NA	D
D	RE	U	D
D	RN	NONE	D
D	RN	L	D
D	RN	RE	D
D	RN	RN	D
D	RN	RE+RN	D
D	RN	D	D
D	RN	NA	D
D	RN	U	D
D	RE+RN	NONE	D
D	RE+RN	L	D
D	RE+RN	RE	D
D	RE+RN	RN	D
D	RE+RN	RE+RN	D
D	RE+RN	D	D
D	RE+RN	NA	D
D	RE+RN	U	D
D	D	NONE	D
D	D	L	D
D	D	RE	D
D	D	RN	D
D	D	RE+RN	D
D	D	D	D
D	D	NA	D
D	D	U	D
D	NA	NONE	D
D	NA	L	D
D	NA	RE	D
D	NA	RN	D
D	NA	RE+RN	D
D	NA	D	D
D	NA	NA	D
D	NA	U	D
D	U	NONE	D
D	U	L	D
D	U	RE	D
D	U	RN	D
D	U	RE+RN	D
D	U	D	D
D	U	NA	D
D	U	U	D
NA	NONE	NONE	U
NA	NONE	L	L
NA	NONE	RE	RE
NA	NONE	RN	RN
NA	NONE	RE+RN	RE+RN
NA	NONE	D	D
NA	NONE	NA	U
NA	NONE	U	U
NA	RE	NONE	RE
NA	RE	L	RE
NA	RE	RE	RE
NA	RE	RN	RE+RN
NA	RE	RE+RN	RE+RN
NA	RE	D	D
NA	RE	NA	RE
NA	RE	U	RE
NA	RN	NONE	RN
NA	RN	L	RN
NA	RN	RE	RE+RN
NA	RN	RN	RN
NA	RN	RE+RN	RE+RN
NA	RN	D	D
NA	RN	NA	RN
NA	RN	U	RN
NA	RE+RN	NONE	RE+RN
NA	RE+RN	L	RE+RN
NA	RE+RN	RE	RE+RN
NA	RE+RN	RN	RE+RN
NA	RE+RN	RE+RN	RE+RN
NA	RE+RN	D	D
NA	RE+RN	NA	RE+RN
NA	RE+RN	U	RE+RN
NA	D	NONE	D
NA	D	L	D
NA	D	RE	D
NA	D	RN	D
NA	D	RE+RN	D
NA	D	D	D
NA	D	NA	D
NA	D	U	D
NA	NA	NONE	U
NA	NA	L	L
NA	NA	RE	RE
NA	NA	RN	RN
NA	NA	RE+RN	RE+RN
NA	NA	D	D
NA	NA	NA	NA
NA	NA	U	U
NA	U	NONE	U
NA	U	L	L
NA	U	RE	RE
NA	U	RN	RN
NA	U	RE+RN	RE+RN
NA	U	D	D
NA	U	NA	U
NA	U	U	U
U	NONE	NONE	U
U	NONE	L	L
U	NONE	RE	RE
U	NONE	RN	RN
U	NONE	RE+RN	RE+RN
U	NONE	D	D
U	NONE	NA	U
U	NONE	U	U
U	RE	NONE	RE
U	RE	L	RE
U	RE	RE	RE
U	RE	RN	RE+RN
U	RE	RE+RN	RE+RN
U	RE	D	D
U	RE	NA	RE
U	RE	U	RE

Extension SS77 or SS2000 result	LN SS77 or SS2000 result	Mets SS77 or SS2000 result	Final SS77 or SS2000 result
U	RN	NONE	RN
U	RN	L	RN
U	RN	RE	RE+RN
U	RN	RN	RN
U	RN	RE+RN	RE+RN
U	RN	D	D
U	RN	NA	RN
U	RN	U	RN
U	RE+RN	NONE	RE+RN
U	RE+RN	L	RE+RN
U	RE+RN	RE	RE+RN
U	RE+RN	RN	RE+RN
U	RE+RN	RE+RN	RE+RN
U	RE+RN	D	D
U	RE+RN	NA	RE+RN
U	RE+RN	U	RE+RN
U	D	NONE	D
U	D	L	D
U	D	RE	D
U	D	RN	D
U	D	RE+RN	D
U	D	D	D
U	D	NA	D
U	D	U	D
U	NA	NONE	U
U	NA	L	L
U	NA	RE	RE
U	NA	RN	RN
U	NA	RE+RN	RE+RN
U	NA	D	D
U	NA	NA	U
U	NA	U	U
U	U	NONE	U
U	U	L	L
U	U	RE	RE
U	U	RN	RN
U	U	RE+RN	RE+RN
U	U	D	D
U	U	NA	U

Appendix 4. Site Specific Factors

Schema	SSF1	SSF2	SSF3	SSF4	SSF5	SSF6
LipUpper	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
LipLower	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthLip	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
BaseTongue	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
AntTongue	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
GumUpper	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
GumLower	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthGum	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
FOM	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
HardPalate	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
SoftPalate	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthMouth	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
BuccalMucosa	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
ParotidGland	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
Submandibular Gland	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthSalivary	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels

Schema	SSF1	SSF2	SSF3	SSF4	SSF5	SSF6
Oropharynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
AntEpiglottis	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
Nasopharynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
Hypopharynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthPharynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
Esophagus	none					
Stomach	none					
SmallIntestine	none					
Colon	Carcino-embryonic Antigen (CEA)					
Rectosigmoid, Rectum	Carcino-embryonic Antigen (CEA)					
Anus	none					
Liver	Alpha Fetoprotein (AFP)	Fibrosis Score				
Gallbladder	none					
OthBiliary	none					
ExtraHepaticDucts	none					
Ampulla	none					
PancreasHead	none					
PancreasBodyTail	none					
OthPancreas	none					
OthDigestive	none					
NasalCavity	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
MiddleEar	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VII	Otn LN Group Levels
MaxillarySinus	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels

Schema	SSF1	SSF2	SSF3	SSF4	SSF5	SSF6
EthmoidSinus	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthSinus	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
GlotticLarynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
SupraLarynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
SubLarynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
OthLarynx	Size of LNs	Extracaps. Exten. LN for H&N	H&N LN Levels I-III	H&N LN Levels IV-V	H&N LN Levels VI-VIII	Oth LN Group Levels
Trachea	none					
Lung	none					
HeartMediastinum	none					
Pleura	Pleural Effusion					
OthRespiratory	none					
Bone	none					
Skin	none					
SkinEyelid	none					
Melanoma (of Skin, Vulva, Penis, Scrotum)	Measured Thickness (depth) Breslow's	Ulceration	Clinical Status of LN Mets	LDH		
MF	Peripheral Blood Involvement					
SoftTissue	none					
Peritoneum	none					
Breast	ERA	PRA	# Pos. Ipsilat Ax LNs	IHC of LNs	Molecular Studies Reg LNs	Size of Tumor Invasive Component
Vulva	none					
Vagina	none					
Cervix	none					
Corpus	none					
Ovary	CA-125					
FallopianTube	none					

Schema	SSF1	SSF2	SSF3	SSF4	SSF5	SSF6
OthAdnexa	none					
OthFemaleGen	none					
Placenta	Prognostic Scoring Index					
Penis	none					
Prostate	PSA Lab Value	PSA	CS Path Extension	PAP	Gleason's Prim and 2nd Patterns	Gleason's Score
Testis	AFP	HCG	LDH	Radical Orchiectomy	Size of Mets in LNs	
OthMaleGen	none					
Scrotum	none					
Kidney	none					
RenalPelvis	none					
Bladder	none					
Urethra	none					
OthUrinary	none					
Conjunctiva	none					
Melanoma Conjunctiva	Measured Thickness (depth) Breslow's					
OthEye	none					
MelanomaChoroid	Measured Thickness (depth) Breslow's					
MelamonaIrisCiliary	Measured Thickness (depth) Breslow's					
MelanomaOthEye	none					
LacrimalGland	none					
Orbit	none					
Retinoblastoma	Extension Evaluated at Enucleation					
Brain	WHO grade					
OthCNS	WHO grade					
Thyroid	Solitary vs Multifocal					
OthEndocrine	WHO grade					

Schema	SSF1	SSF2	SSF3	SSF4	SSF5	SSF6
KS	Assoc w/ HIV/AIDS					
Lymphoma	Assoc w/ HIV/AIDS	Symptoms at Diagnosis	IPI score			
HemeRetic	none					
OthIllDef	none					

Appendix 5. Histology Exclusion Groups

based on ICD-O-3 Morphology Codes

Histology Code Groupings for Collaborative Staging

Carcinomas	800-823, 825-867; 894
Carcinoids	824
Melanomas	872-879
Sarcomas	871; 880-892; 899; 904; 912-913; 915-925; 937; 954-958
Other specified cancers	868-870; 893; 895-898; 900-903; 906-911; 926-936; 938-953
Mesotheliomas	905
Kaposi sarcoma	914
Lymphomas	959-972
Hematopoietic	973-976; 976; 980-996; 997; 998

In the following table, 'x' in a cell means that category of cancer is excluded from AJCC staging for that site. The CS algorithm will output T-NA, N-NA, M-NA, Stage Group-NA. Conversely, an empty cell means that all histologies in that code grouping will generate (output) T, N, M, and Stage Group. A schema name marked with an asterisk (*) means that there is no TNM staging scheme in the sixth edition. For these sites, all histologies are included and only Summary Stage will be generated.

Schema	Carci-noma	Carci-noid	Mela-noma	Sar-coma	Other specified cancers	Mesothe-lioma	Kaposi sarcoma	Lym-phoma	Hema-topoi-etic	Other exclu-sions
Lip: Upper; Lower; Other		x	x	x	x	x	x	x	x	
Base of Tongue		x	x	x	x	x	x	x	x	
Anterior 2/3 of Tongue		x	x	x	x	x	x	x	x	
Gum: Upper; Lower; NOS		x	x	x	x	x	x	x	x	
Floor of Mouth		x	x	x	x	x	x	x	x	
Hard Palate		x	x	x	x	x	x	x	x	
Soft Palate		x	x	x	x	x	x	x	x	
Other Mouth		x	x	x	x	x	x	x	x	
Buccal Mucosa		x	x	x	x	x	x	x	x	
Parotid Gland		x	x	x	x	x	x	x	x	
Submandibular Gland		x	x	x	x	x	x	x	x	
Other Salivary Gland		x	x	x	x	x	x	x	x	
Tonsil, Oropharynx		x	x	x	x	x	x	x	x	
Anter Surface of Epiglottis		x	x	x	x	x	x	x	x	
Nasopharynx		x	x	x	x	x	x	x	x	
Pyriform Sinus; Hypopharynx		x	x	x	x	x	x	x	x	
Other Pharynx*										
Esophagus		x	x	x	x	x	x	x	x	
Stomach		x	x	x	x	x	x	x	x	
Small Intestine		x	x	x	x	x	x	x	x	
Colon		x	x	x	x	x	x	x	x	
Rectosigmoid; Rectum		x	x	x	x	x	x	x	x	
Anus		x	x	x	x	x	x	x	x	
Liver, intrahepatic ducts		x	x	x	x	x	x	x	x	
Gallbladder		x	x	x	x note 1	x	x	x	x	
Extrahepatic Ducts		x	x	x	x	x	x	x	x	
Ampulla of Vater		x	x	x	x	x	x	x	x	8013; 8041; 8246; 8247; 8574

Schema	Carci-noma	Carci-noid	Mela-noma	Sar-coma	Other specified cancers	Mesothe-lioma	Kaposi sarcoma	Lym-phoma	Hema-topoi-etic	Other exclu-sions
Other Biliary		x	x	x	x	x	x	x	x	
Pancreas: Head		x	x	x	x	x	x	x	x	815_
Pancreas: Body, Tail		x	x	x	x	x	x	x	x	815_
Other Pancreas		x	x	x	x	x	x	x	x	815_
Other Digestive*										
Nasal Cavity		x	x	x	x	x	x	x	x	
Middle Ear*										
Maxillary Sinus		x	x	x	x	x	x	x	x	
Ethmoid Sinus		x	x	x	x	x	x	x	x	
Other Sinus*										
Glottic Larynx		x	x	x	x	x	x	x	x	
Supraglottic Larynx		x	x	x	x	x	x	x	x	
Subglottic Larynx		x	x	x	x	x	x	x	x	
Other Larynx		x	x	x	x	x	x	x	x	
Trachea*										
Lung		x		x	x	x	x	x	x	
Heart, Mediastinum	x	x	x		x	x	x	x	x	
Pleura	x	x	x	x	x		x	x	x	
Other Respiratory*										
Bone	x	x	x		x note 2	x	x	x	x	
Skin (Carcinoma)		x	x	x	x	x	x	x	x	
Eyelid (Carcinoma)		x	x		x	x	x	x	x	
Skin (Melanoma)	x	x		x	x	x	x	x	x	
Mycosis Fungoides	x	x	x	x	x	x	x	x note 3	x	
Soft Tissue	x	x	x		x note 4	x	x	x	x	
Retroperitoneum, Peritoneum	x	x	x		x note 4	x	x	x	x	
Breast		x	x	x	x	x	x	x	x	
Vulva		x	x	x	x	x	x	x	x	
Vagina		x	x	x	x	x	x	x	x	
Cervix		x	x	x	x	x	x	x	x	
Corpus		x	x	x	x note 5	x	x	x	x	
Ovary		x	x	x	x note 6	x	x	x	x	
Fallopian Tube		x	x	x	x	x	x	x	x	
Ligaments, Other Adnexa*										
Other Female Genital*										
Placenta	x	x	x	x	x note 7	x	x	x	x	
Penis		x	x	x	x	x	x	x	x	
Prostate		x	x	x	x	x	x	x	x	813_
Testis	x note 8	x	x	x	x note 8	x	x	x	x	
Other Male Genital*										
Scrotum			x			x	x	x	x	
Kidney		x	x	x	x	x	x	x	x	
Renal pelvis, Ureter		x	x	x	x	x	x	x	x	
Urinary Bladder		x	x	x	x	x	x	x	x	
Urethra		x	x	x	x	x	x	x	x	
Other Urinary*										
Conjunctiva (Carcinoma)		x	x	x	x	x	x	x	x	
Conjunctiva (Melanoma)	x	x		x	x	x	x	x	x	
Melanoma of uvea	x	x		x	x	x	x	x	x	
Other Eye*										
Iris, Ciliary Body (Melanoma)	x	x		x	x	x	x	x	x	
Choroid (Melanoma)	x	x		x	x	x	x	x	x	
Other Eye (Melanoma)	x	x		x	x	x	x	x	x	

Schema	Carci-noma	Carci-noid	Mela-noma	Sar-coma	Other specified cancers	Mesothe-lioma	Kaposi sarcoma	Lym-phoma	Hema-topoi-etic	Other exclu-sions
Lacrimal gland (Carcinoma)		x	x	x	x	x	x	x	x	
Orbit (Sarcoma)	x	x	x		x	x	x	x	x	
Retinoblastoma	x	x	x	x	x note 9	x	x	x	x	
Brain*										
Other CNS*										
Thyroid		x	x	x	x	x	x	x	x	
Other Endocrine*										
Kaposi Sarcoma–all sites*	x	x	x	x	x	x		x	x	
Lymphoma–all sites	x	x	x	x	x	x	x		x	
Hematopoietic, Retic*										
Other, Ill-Defined Sites*										

Note 1: For gallbladder, 8980 is included for TNM Staging.
Note 2: For bone, codes 9260-9342 are included for TNM Staging
Note 3: For mycosis fungoides and Sezary disease, all histologies other than 9700 and 9701 are excluded.
Note 4: For soft tissue and retroperitoneum/peritoneum, codes 8936 and 9473 are included for TNM Staging.
Note 5: For corpus, 8951 is included for TNM Staging.
Note 6: For ovary, morphology codes 906-909 are included for TNM Staging.
Note 7: For placenta, 910 is included for TNM Staging.
Note 8: For testis, 859-865 and 906-909 are included for TNM Staging.
Note 9: For retinoblastoma, all histologies other than 951 are excluded.

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Version 1.0

Part II

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