



COLLABORATIVE STAGE
DATA COLLECTION SYSTEM

COLLABORATIVE STAGE DATA COLLECTION SYSTEM CODING INSTRUCTIONS



**PART I—SECTION 1:
GENERAL INSTRUCTIONS**

VERSION 02.03.02

EFFECTIVE JANUARY 1, 2011

**Collaborative Stage Data Collection System User Documentation and Coding Instructions
Part I Section 1. General Instructions**

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CSv2 Work Group
CSv2 Project Management Team
CSv2 Education & Training Team
CSv2 Field Study Team
CSv2 I&R Workflow Process Team
CSv2 Informatics Team
CSv2 IT Testing Team
CSv2 Mapping Team
CSv2 New Data Items Team
CSv2 Pre- and Post-Treatment Team
CSv2 Train the Trainers Team
CSv2 User Documentation Team
CSv2 Website Review Team

American Joint Committee on Cancer Staff

Connie Bura, Administrative Director, Cancer Programs, ACoS
Karen Pollitt, Manager, AJCC
Donna Gress, RHIT, CTR, AJCC Technical Specialist
Martin Madera, MA, Education Administrator
Judith Janes, AJCC Coordinator
American Joint Committee on Cancer
633 North Saint Clair Street
Chicago, IL 60611

**Questions regarding this document, the CS computer algorithms,
and the Collaborative Stage Data Collection System in general
should be directed to**

csv2@facs.org

**Specific coding questions should be submitted to the appropriate section of
the CANSwerForum at**

<http://cancerbulletin.facs.org/forums/>

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Acronyms and Abbreviations Used in This Documentation

AJCC	American Joint Committee on Cancer
Collaborative Staging	Same as CS, usually referring to the process of assigning codes in the Collaborative Stage Data Collection System
CS	Collaborative Stage Data Collection System
CSv2	Collaborative Stage Data Collection System, version 2
ICD-O-3	<i>International Classification of Diseases for Oncology, third edition</i>
SSF	Site-Specific Factor
TNM	Tumor-Node-Metastasis staging system promoted by AJCC and UICC
TNM6	Sixth Edition of TNM system
TNM7	Seventh Edition of TNM system
UICC	International Union Against Cancer (promoter of TNM system outside North America)

BACKGROUND

VERSION 1

History of the Collaborative Stage Data Collection System

The Collaborative Stage Data Collection System is a carefully selected, medically relevant 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).

A Collaborative Staging Task Force was convened in 1998 to address the issue of discrepancies in staging guidelines among the three major cancer staging systems used in the United States. This project was 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. What evolved from these efforts was a hybrid or combined system that collects information used by the computer algorithm to derive AJCC TNM, Summary Stage 1977 and Summary Stage 2000.

AJCC TNM Staging

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 rhabdomyosarcoma of the esophagus, which is specifically excluded from TNM staging in both the esophagus and the soft tissue sarcoma chapter. The Collaborative Stage Data Collection 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 Stage.

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Summary Staging (SS)

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 nine categories and codes: in situ (code 0), local (1), regional by direct extension (2), regional to lymph nodes (3), both regional lymph nodes and regional extension (4), regional not otherwise specified (5), distant (7), unknown (9), and not applicable (8). 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 systems. 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 1977²; the site-specific sections were revised and updated in a new edition published in 2001³.

Extent of Disease (EOD)

In CS version 1, the Collaborative Stage Data Collection System used 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 allowed collected data to be collapsed into different and previous staging systems. The SEER Program adopted the CS data format effective with 2004 diagnoses and forward. EOD data is maintained in the SEER Public Use Data for cases diagnosed prior to 2004. In CS version 2, the EOD format was further modified and expanded.

VERSION 2

Revision of the sixth edition of the *AJCC Cancer Staging Manual* began almost as soon as the manual was published in 2002. The seventh edition of the *AJCC Cancer Staging Manual* incorporates advances in the understanding of cancer biology, evidence-based changes in staging criteria, and non-anatomic factors affecting prognosis. The *AJCC Cancer Staging Manual* and CSv2 made a commitment to make staging more relevant for clinicians and registrars by adding better definitions and instructions as well as including more prognostic indicators to the anatomic staging framework of previous editions. This means that more site-specific factors have been added to accommodate the relevant information.

Collaborative Stage has a new name in Version 2: the Collaborative Stage Data Collection System, which is still abbreviated as CS. The new name is intended to show that this is a coding and data collection system, not a new staging system. CS has been revised to correspond to the seventh edition of the *AJCC Cancer Staging Manual*. The various CS version 2 teams began work in February 2008. More than fifty subject matter experts from all of the cancer registry standards setters and numerous outside stakeholders comprise the following teams:

- CSv2 Work Group
- CSv2 User Documentation Team
- CSv2 Project Management Team
- CSv2 Pre- and Post-Treatment Team
- CSv2 New Data Items Team
- CSv2 Mapping Team
- CSv2 Informatics Team
- CSv2 IT Testing Team
- CSv2 Education & Training Team
- CSv2 Train the Trainers Team
- CSv2 Field Study Team
- CSv2 I&R Workflow Process Team
- CSv2 Website Review Team

| See Appendix 8 for the names of the individual work group members.

Effective Dates

Cases with a diagnosis date of 2010 must be coded in a CS version higher than 02.00.

Cases with a diagnosis date of 2011 must be coded in CS version 02.03 or higher.

Version 2 Changes

The CS version 2 Mapping Team had the opportunity to review the seventh edition chapters of the *AJCC Cancer Staging Manual* before it went to press. This allowed the registrars on the Mapping Team to clarify potential staging and coding issues with the chapter authors during the development of the CS schemas. In some instances, the questions to the chapter authors resulted in revisions to the staging manual itself, so the review effort was beneficial to the authors of both manuals.

Among the changes in Version 2 are:

- Development of new CS schemas based on new chapters in TNM, such as malignant melanoma of mucosal head and neck sites, gastrointestinal stromal tumors, adrenal gland, and Merkel cell carcinoma of the skin
- New data fields for lymph-vascular invasion, specific metastatic sites, and grading system
- Expansion of the CS Extension and CS Lymph Nodes fields to three digits
- Expansion of site-specific factors to 25 fields
- Use of one site-specific factor as a “schema discriminator” where needed
- Mapping to AJCC seventh edition as well as AJCC sixth edition, Summary Stage 1977 and Summary Stage 2000
- Inclusion of more non-anatomic factors for prognostic and predictive information in site-specific factors
- Consistency of code structures from site to site
- Addition of more code options for non-specific data, missing information, or summary information, such as when a physician makes a statement that the tumor is T2 with no further description
- Enhanced definitions and coding instructions based on feedback from users of Version 1
- Exclusion of MX as a mapping category in TNM for AJCC 7th edition
- Exclusion of pM0 as a mapping category in TNM for AJCC 7th edition
- Revisions to CS Lymph Nodes code mapping based on more detailed instructions in TNM7 as to whether sentinel nodes are clinical or pathologic

Among the changes in Version 2.03 are:

- Addition of a new schema for multiple myeloma and plasma cell disorders
- Addition of new site-specific factors for post-orchietomy tumor markers for testis
- Addition of new site-specific factors for Kaposi sarcoma
- Replacement of previously allowed “blank” value with 981 or 982 in schema discriminator
- Data validation of the schemas to confirm mapping of CSv2 codes to AJCC7 and AJCC6 staging, Summary Stage 1977 and Summary Stage 2000
- Review of all schemas to reinforce consistency in formatting, wording, code definitions, and code placement
- Table notes reviewed and enhanced

CHANGES AND REVISIONS 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.

Timing Rule

In version 1 of the CS Manual, agreement among the participating organizations 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 Stage 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” or “mixed stage” using pathologic data supplemented by clinical data.

Disease Progression

Disease progression is defined as further direct extension, regional node involvement, 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 CS fields. CS 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, CS 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 known 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 CS information stops at this point. Other rule modifications have been made and are printed in the site/histology-specific chapters.

Documenting Negative Lymph Nodes and Distant Metastases

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 Stage Data Collection 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. Typically, the clinician reports positive findings and tends to remain silent on some or all negative findings but proceeds with usual treatment of the primary site. 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 because in most cases the cancer cannot be completely staged if any of the T, N, or M elements is unknown.

When clinical practice changes and data collection guidelines do not, the completeness of the data is affected. The implementation of Version 1 of the Collaborative Stage Data Collection System introduced

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a paradigm shift in the collection of information documenting the extent of disease, particularly in the collection of information about regional lymph nodes not easily examined by palpation, observation, physical examination, or other clinical methods. The paradigm shift permits registrars to presume that there are no clinically apparent regional lymph nodes or distant metastases when the clinician proceeds with usual or standard treatment to the primary site, since knowledge of such metastases would change the treatment approach. By allowing registrars to code regional lymph nodes as “none” or clinically negative and/or coding distant metastasis as none rather than coding these fields as unknown, the Collaborative Stage Data Collection System computer algorithms are able to derive a stage group that includes the best information. The developers of the CS model believe that this change in the way extent of disease is documented improves the consistency and quality of data being collected by the cancer registry community. Uniform rules and standardized training make it easier for cancer registry personnel to complete staging tasks.

In Version 1, this concept was called the “Inaccessible Sites Rule;” however, it is not the primary site that is inaccessible but rather the lymph nodes themselves. In CS Version 2, this concept has been renamed the “Inaccessible Lymph Nodes Rule.” The details of the Inaccessible Lymph Nodes Rule are discussed later in the General Rules and Instructions.

Elimination of MX

Also in Version 1, if the status of distant metastasis is unknown, the case was mapped to MX. The seventh edition of the *AJCC Cancer Staging Manual* eliminates MX as an option for coding distant metastases for AJCC 7th edition. As a result, even if CS Mets at Dx is coded as 99, the output value will be M0 for AJCC 7th edition. In other words, as of AJCC seventh edition, unless there is evidence of distant metastases either clinically (physical exam, imaging, and so forth) or proven microscopically, the registrar should assume that there are no distant metastases and use code 00 for CS Mets at Dx.

HOW THE COLLABORATIVE STAGE IS DERIVED

Most of the CS schemas apply to cases according to their ICD-O-3 histologic type and primary site codes. Some schemas, however, apply to cases according to additional factors. The applicable primary site codes and histologic type codes are clearly stated at the beginning of each schema. Other characteristics (histology required, tumor size necessary for T, no TNM staging, etc., schema discriminator, number of site-specific factors) of each schema are shown in Appendix 3. It should be noted that, depending on the values of the year of diagnosis, CS Version Original, and the site-histology combination, either TNM7 or TNM6 may not be derived.

CHOOSING THE CORRECT SCHEMA FOR A CASE: THE SCHEMA DISCRIMINATOR

At the start of a cancer case, the abstractor codes the site of origin and general histology for the cancer from the medical record and enters them into the cancer abstracting software. A schema selection algorithm determines which schema is appropriate to each combination of primary site and histology, perhaps taking into account an additional schema discriminator variable, as well. For instance, if the primary site is a segment of the colon, the schema selection algorithm looks at the histology to determine whether the regular (in other words, carcinoma) Colon, GIST Colon, NET (carcinoid) Colon, or Lymphoma schema should be presented to the data collector.

Every site and histology combination plus, in some circumstances, the schema discriminator will go to one and only one schema. Therefore, every reportable case will go to some CS schema. However, not all combinations will have AJCC 7th edition stage. For some primary sites, it may be necessary for the abstractor to select a specific subsite of a topography code in one of the site-specific factors using a

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“schema discrimination factor”. The primary sites where the schema discriminator is needed include esophagus GE junction and stomach; extrahepatic bile ducts; nasopharynx and pharyngeal tonsil; female peritoneum; lacrimal gland and lacrimal sac; and melanomas of the iris and ciliary body of the eye.

As an example, all of the extrahepatic bile ducts have an ICD-O-3 topography code of C24.0. However, within this code, the right, left and common hepatic ducts use the perihilar duct schema, the cystic duct uses a separate cystic duct schema, and the common bile duct and Sphincter of Oddi use the distal bile duct schema. In this situation, in order for the schema selection algorithm to select the correct schema, the abstractor must indicate which of the extrahepatic bile ducts is involved. Using this information, the algorithm will select the correct schema to present on the screen to the abstractor. The abstractor should rely on the schema selection algorithm to select the correct schema based on the facts about the case and not try to force the software to present a particular 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 Stage data set. For example, an extralymphatic lymphoma of the stomach treated surgically would use the lymphoma schema in these coding instructions to code CS, 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.

The data items specific to that cancer site/histology are then abstracted from the medical record and coded in the Collaborative Stage Data Collection System fields. When data collection and coding are complete, the data collector activates the computer algorithms to derive the output values for the items in the seventh and sixth editions of TNM and the Summary Stage (both 1977 and 2000). These algorithms are provided in portable platform-independent form. 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). Appendix 2-1 lists the individual CS input data items, and Appendix 2-2 lists the derived data items, together with their NAACCR item number, effective date, field length, and other information, as published in the NAACCR Standards Volume II Version 12, Chapter X, Data Descriptor Table (revised August 2009).

MAPPING AND THE COMPUTER ALGORITHM

Once the data collector has coded all of the Collaborative Stage data 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 four systems: AJCC TNM seventh edition; TNM sixth 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 Appendix 2-2.

The output values are returned as a set of alphanumeric codes designed for storage in the computerized abstract. Each of the output 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 4 sections a through f show all of the output values and their display strings.

EXTRA TABLES

The computer algorithm that generates the stage is based on the values in the mapping columns for each of the Collaborative Stage Data Collection 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 called “extra tables” to determine the appropriate category. The mapping column contains either the category or a reference to a footnote that describes how the algorithm determines the category.

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Footnotes for sixth edition mapping are identified with asterisks (*); footnotes for seventh edition mapping are identified with carets (^). The footnotes appear at the end of the table. For example, in kidney (renal parenchyma), the difference between T1_ and T2_ is the size of the primary tumor. The kidney CS Extension table has asterisks in the TNM6 Map column and carets in the TNM7 Map column for codes 100 to 360. The asterisks and carets refer to Extension-Size tables for the sixth and seventh edition mapping respectively. The extra tables are in the computer application but are not included in the CS Coding Instructions; however they may be reviewed on the CS Version 2 website at www.cancerstaging.org/cstage. During the mapping process, if CS Extension is coded in the range 100 to 360, the computer algorithm looks at the extra table. If CS Tumor Size is between 1 mm and 4 cm, the derived value is T1a for both sixth and seventh editions. If CS Tumor size is 075, the derived value is T2 in sixth edition and T2a in seventh edition.

Once each of the categories is determined, a further step is performed to generate the stage group for the case. 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.

CS VERSION FIELDS

As part of the output of the CS algorithm, three fields (two CSv1 fields that have been renamed in CSv2 and one new CSv2 field) should be stored by the computer in the data record: CS Version Input Original [NAACCR Item # 2935] (formerly CS Version 1st), CS Version Derived [NAACCR Item #2936] (formerly CS Version Latest), and CS Version Input Current [NAACCR Item #2937]. CS Version Input Original [NAACCR Item # 2935] is the number of the version initially used to code CS fields. Depending on the structure of the registry software, CS Version Input Original [NAACCR Item # 2935] could be stored automatically by the computer or entered manually by the abstractor. The meaning and interpretation of CS Version Input Original 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 Derived [NAACCR Item #2936] 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. CS Version Input Current [NAACCR Item #2937] is the same as CS Version Input Original [NAACCR Item # 2935] until CS input fields are updated or recoded and then it should reflect the CS version in operation when the case is updated. After conversion from CSv1 to CSv2, CS Version Input Current [NAACCR Item #2937] will contain 020000. After conversion from CS v0202 to CS v0203, CS Version Input Current [NAACCR Item #2937] should be either 020300 or 020301. If the case to be converted has CS Version Input Current [NAACCR Item #2937] of 020000 then upon conversion to v0203, CS Version Input Current [NAACCR Item #2937] will be 020300. That is, if the case was originally coded under CSv1, converted to CSv2, and then never updated, CS Version Input Current [NAACCR Item #2937] will be 020300. All other converted cases should have CS Version Input Current [NAACCR Item #2937] of 020301. No 2010+ case should have 020300 because they should have been updated to a version greater than 020000. After implementation of CS v0203, if any case is updated (any CS input item changed using specifications of CS v0203), then CS Version Input Current [NAACCR Item #2937] should be updated to 020302. After implementation of CS v0203, if any new case is abstracted/coded using specifications of CS v0203, then CS Version Input Original [NAACCR Item # 2935] and CS Version Input Current [NAACCR Item #2937] should be 020302.

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OBSOLETE CODES

From time to time, it is necessary to revise CS coding tables by reassigning concepts from one code to another to maintain the underlying structure and rules for code assignment. This can occur when a single code needs to be split into more than one code, or when a structure needs to be moved from one table to another (for example, a lymph node moved from CS Lymph Nodes to CS Mets at Dx). Codes in CS tables are not deleted while users have data coded with those codes. Instead, the codes are marked as OBSOLETE in their descriptions, and instructions are provided for handling previously coded data. Some vendors may provide users the ability to turn off display of obsolete codes.

In some cases, it is possible to perform global changes to prior data without manual review. In other cases, such as when a code is being split, it may be necessary for the registrar to manually review abstracts and recode them. Guidance for handling each instance of OBSOLETE is provided in the form of an implementation guide when the change is published.

The designation of OBSOLETE is an official part of the description of the code, and it should be displayed to users, for example, in pick lists or drop-down menus for coding new data so that the codes are not used into the future, and in translation of codes in displays or printouts of abstracts.

All codes from CS Version 1 have been carried forward, since the coding instructions serve as a reference for data analysts and researchers as well as abstractors. However, as a result of the changes, additions, and revisions in the seventh edition of the AJCC *Cancer Staging Manual*, some codes had to be made obsolete. Be assured that any changes that affect the registry data base, especially those requiring manual review and recoding have been very carefully considered by the Mapping Team and this process is used only when absolutely necessary. Refer to the separate *Conversion Specifications/Release Notes* document and spreadsheet available on www.cancerstaging.org/cstage website for further details about the advantages of reviewing obsolete data and guidelines for recoding.

Obsolete Code Notations

Code descriptions that begin with any of the following notations except CONVERTED AND CODE REUSED V0203 **should not be used for cases diagnosed 2011 and forward or any earlier diagnosed case that is abstracted and/or coded after CSv0203 is implemented** (CS Version Input Original [NAACCR Item #2935] greater than or equal to 020302). **An edit error should occur.**

OBSOLETE Data Tags	Description and Action	TNM 7	TNM 6	SS2000	SS1977
OBSOLETE DATA REVIEWED V0203	Cases should be reviewed and changed according to V0203 guidelines. Review is optional but strongly recommended. AJCC and Summary stage values will be derived.				
OBSOLETE DATA RETAINED AND REVIEWED V0203	Cases should be reviewed and changed according to V0203 guidelines. Review is optional but strongly recommended. AJCC and Summary Stage values will be derived.	ERROR			

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OBSOLETE DATA RETAINED V0203	Review required for specific 2010+ cases listed in Conversion Specifications/Release Notes document	ERROR			
OBSOLETE DATA REVIEWED AND CHANGED V0203	All cases must be reviewed and recoded according to V0203 guidelines; Maps to ERROR for AJCC 6 th and 7 th and Summary Stages.	ERROR	ERROR	ERROR	ERROR
OBSOLETE DATA CONVERTED V0203	All cases converted at implementation of V0203; Maps to ERROR for AJCC 6 th and 7 th and Summary Stages.	ERROR	ERROR	ERROR	ERROR
CONVERTED AND CODE REUSED V0203	Cases coded prior to V0203 have been converted to a new value and original code has been redefined (meaning of code has changed)				

There are a number of reasons a code might become obsolete, and the action resulting from making the code obsolete is provided with the obsolete code and its original description. The following examples demonstrate how various types of obsolete data are handled.

- **OBSOLETE DATA RETAINED AND REVIEWED** (with version number) is the most basic. It means that the code can derive AJCC 6th and 7th sixth edition values. For example, for vagina with CS Lymph Node code 500, nodes for vagina are considered regional or distant based on the location of nodes, pelvic or inguinal, in relation to the location of tumor within the vagina, upper two-thirds or lower third. New cases should use 510, 520, or 530 instead of 500.
- **OBSOLETE DATA REVIEWED AND CHANGED** (with version number) is used for a very limited number of codes that must be changed but first must be manually reviewed and recoded. This notation is used when a code is not sufficient for mapping. For example CS Extension for FloorMouth of 700 needs to be reviewed and changed to codes 535, 635, 735, or 765 or other appropriate code on review of the case.
- **OBSOLETE DATA CONVERTED** (with version number) means that the code is obsolete in CSv2 because the description associated with the code had to be assigned a different code to preserve a natural ordering of rows within the table. All data must be converted to the new codes during the migration to CSv0203. The table should indicate for each OBSOLETE DATA CONVERTED code which new code should be associated with its description. After the computer conversion (no manual case review necessary), the obsolete code should not appear in the data. All mapping columns will show “ERROR,” indicating that the code should **not be used for any case** currently being abstracted. For example, there **was a** global conversion for 888 codes with the description of “Not applicable” to code 988 in an earlier version of CS.

Do not use codes marked with any of the notations beginning with the word ‘OBSOLETE’ for cases abstracted in CS version 0203.

HOW MAPPING WAS DETERMINED

During the development of CS Version 1, the codes for the extension, lymph nodes, and metastases fields were based on SEER's Extent of Disease, which had been designed to accommodate collapsing into the TNM 3rd edition and SEER Summary Stages. Some fundamental restructuring of the EOD codes was necessary to accommodate the sixth and seventh editions of TNM with their 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 CS, 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 sixth edition of TNM. Even more restructuring was necessary to accommodate TNM seventh edition changes. The following rules and procedures were used to determine the correct mapping to TNM:

- **Downstaging principle.** CS has already applied the stated rule from the TNM system, "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 information is insufficient to determine which of two categories is appropriate, such as T1 vs T2, the code is always mapped 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 category. The general rules of CS say to assign the highest applicable code. This is not a contradiction of the TNM downstaging principle. The registrar should not apply the downstaging rule when selecting codes because the TNM downstaging principle had already been applied during the development of the CS code structure.
- **Use of NOS.** NOS (not otherwise specified) was added to some of the CS 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, but is included in CS to avoid loss of data or putting a case into an unknown category. The NOS can safely be ignored in reports and analyses when it is not a useful distinction.

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 CS, the subgroup "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 Stage, 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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General Rules and Instructions

**Collaborative Stage Data Collection System User Documentation and Coding Instructions
Part I Section 1. General Instructions**

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**General Instructions
for Using the Collaborative Stage Data Collection System
Codes and Coding Instructions**

The Collaborative Stage Data Collection System schemas consist of 15 data fields in CS version 1 and 41 data fields in CS version 2. The additional fields in CSv2 consist of 19 new site-specific factors and the new fields for Lymph-Vascular Invasion, Grade Path Value, and Grade Path System, and four specific metastatic site data fields. All data items except for a few that were collected prior to the implementation of CS in 2004 are based on either the sixth or seventh edition of TNM. However, not all of the data fields are used to derive T, N, M, and Stage Group according to the sixth and seventh editions of the *AJCC Cancer Staging Manual* or Summary Stage 1977 and Summary Stage 2000. Most schemas do not use more than a few site-specific factors and therefore will have computer-generated default values for the unused fields.

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 Stage web site, <http://www.cancerstaging.org/cstage>.

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. CS Version 2 must be used for cases diagnosed during 2010 and later and should also be applied to cases diagnosed prior to 2010 that are abstracted after Version 2 is implemented because Version 2 is also designed to map to TNM6. Table 1 shows the effective dates for the various CS versions.

Table 1. CS Versions and Release Dates with Effective Dates

CS Version and release date	Effective Start Date (Cases diagnosed on and after January 1 of [year])	Cannot be used for cases diagnosed after December 31 of [year])
1.00 (version date January 1, 2004)	2004	2004
1.01 (version date August 12, 2004)	2004	2004
1.02 (version date April 25, 2005)	2005*	2006
1.03 (version date September 8, 2006)	2007*	2007
1.04 (version date October 31, 2007)	2008*	2009
2.00.01 (version date January 1, 2010)	2010*	2010
2.01.00 (release date February 2010)	2010*	2010
2.02.00 (release date April 2010)	2010*	2010
2.03.02 (release date December 7, 2010)	2011*	

*Note: Earlier cases may also be coded with this CS version.

GENERAL GUIDELINES

Note: These general instructions refer to schemas based on primary site when, in fact, some schemas, such as melanomas and lymphoma, are based on histologic type or combinations of topographic subsite and histology. Refer to the previous discussion of the schema discriminator for further explanation of the way the computer application selects the schema. In these general instructions, the schemas are referred to as site-specific for the sake of brevity.

1. **Collaborative Stage data 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 confirmed microscopically for classification by TNM (including clinical classification). Rare cases that do not have any biopsy or cytology of the tumor can be staged, but survival should be analyzed separately. These cases should not be included in overall disease survival analyses.” The CS computer algorithm does not make these distinctions.
2. **Collaborative Stage data 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 staging for brain.
 - a. The Collaborative Stage Data Collection System consists of 153 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 (except ocular adnexal lymphoma) are coded according to the lymphoma schema, regardless of the organ in which the lymphoma develops.
 - b. The computer algorithm maps to sixth and seventh editions of the *AJCC Cancer Staging Manual* and to Summary Stage 1977 and Summary Stage 2000. All of these staging systems are intended primarily for adult cancers, although some schemas applicable to pediatric cases, such as retinoblastoma, are included in both TNM and CS. Regardless of the patient’s age, the CS input values are collected, but the computer-derived TNM output values may not be valid for pediatric cases.
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 to all carcinomas. But, for histologies not on the inclusion list, the computer algorithm does not calculate a stage and returns values representing “Not Applicable,” meaning that AJCC T, N, M, and Stage Group are not generated for that site-histology combination. For the purpose of TNM mapping, CS Version 1 used histology exclusion lists for each schema, and Version 2 uses histology inclusion lists, but the concept is the same and does not effect CS coding. Both lists are included as Appendices 6 and 7.
4. **Timing of Data Collection.** CS collects a combined clinical-pathologic or mixed stage. The data collected in the Collaborative Stage Data Collection 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*.As a result, the CSv2 data collection rules are not identical to TNM7.

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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, **assign the highest applicable code number as specifically as possible.** (Exception: codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or “Stated as T1, NOS” do not take priority over more specific codes with lower numbers.)
 - a. 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 Stage generally follows the hierarchies of the TNM system.

Example The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.
 - b. There will be a few situations where it is necessary to review the mapped values (the right-most columns in a table) to determine which code to record.
 - c. Combination codes (for example, code 350 for “250 plus 300”) have been assigned when using the higher of two individual code numbers does not result in the appropriate mapping for all staging systems. Combination codes have been omitted when use of a higher number results in correct mapping for all three staging systems.

7. **Collaborative Stage is a combined clinical-pathologic coding system.** In Versions 1.0x and 2.00, CS records the greatest extent of disease based on combined clinical and operative/pathologic assessment for the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at DX. This is often referred to as “best” or “combined” stage.
 - a. In general, pathologic information about a specific organ or structure takes priority over clinical or imaging information about that structure.

Example Imaging suggests involvement of the visceral pleura for a lung cancer. When that area is resected, there is no involvement of the visceral pleura, only reactive changes. *Select the appropriate “confined to lung” extension code and a pathologic eval code rather than the code for pleural involvement and evaluation by imaging.*
 - b. 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.
 - c. 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 CS data set.
 - d. All information pertaining to the case being coded according to CS rules is collected. This means that extent of disease information may be clinical or pathologic, regardless of any limitations placed on data collection in other staging systems.

Example In the FIGO and TNM systems, staging of cervical cancer is almost entirely clinical. In CS, information from surgical procedures should be coded when there is no preoperative therapy and the Eval fields should accurately reflect how the information was obtained.
 - e. When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.
 - f. 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

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- for extension, regional lymph nodes or metastases at diagnosis.
- g. Reg LN Pos and Reg LN Exam fields are based on pathologic (microscopic) information only.
8. **Eval fields.** CS Tumor Size/Ext Eval, CS Reg Nodes Eval, and CS Mets Eval (referred to collectively as the Eval fields) document how the most extensive tumor was established as well as whether the patient received preoperative treatment. The Eval fields tag the extent of disease data as a staging basis of c (clinical), p (pathologic), y (intercurrent treatment) or a (autopsy) according to the rules of the TNM system. An understanding of the TNM system is essential when coding the Eval fields so that the CS computer algorithm will derive the correct mapping and staging basis.
- a. Assign the Eval field code that describes the diagnostic procedure associated with the corresponding data field. The Eval field code may not be the numerically highest code.
- Example* Patient has a mammogram, core needle biopsy positive for cancer. The lumpectomy shows that the carcinoma is 2.3 cm in greatest dimension and within the margins of excision. *Code the CS Tumor Size/Ext field as 3 because the lumpectomy meets TNM criteria for pathologic staging.*
- b. The Eval field code should correspond to the highest T, N, or M category, not necessarily to the highest code selected in the Tumor Size, Extension, Regional Lymph Nodes or CS Mets at Dx field.
- Example* The workup of a patient with a tonsil lesion includes a positive biopsy of the nasopharynx (Extension code 710, equivalent to T4b) and a CT scan showing involvement of the skull base (Extension code 750, equivalent to T4b). *Code the CS Tumor Size/Ext field as 3 (pathologic) because the imaging documented the highest T value.*
- c. The rules of the TNM system say that if a positive biopsy of a structure documents the highest T, N, or M category, the case meets the criteria for pathologic staging. According to the AJCC, if there is no resection but the highest T or N category can be confirmed microscopically, the case may be classified by pT or pN without resection. Use the appropriate pathologic Eval code when positive biopsy or positive cytology is sufficient for pathologic staging.
- d. Special codes 5 and 6 in the Eval fields indicate when the patient had pre-operative treatment that may have affected the tumor size or extension, involvement of lymph nodes, or the presence of distant metastases. Use these codes when the patient had neoadjuvant therapy followed by a surgical resection.
- e. For further information about the individual Eval fields, refer to the coding rules for individual data fields.
9. **Site-Specific Factors (SSFs)** are included in every schema where they are needed. They are incorporated into the staging algorithms when additional information is necessary to derive tumor (T), lymph node (N), metastasis (M), or AJCC (or Summary) stage group, or where the factor is considered to be of clinical, prognostic, or predictive importance. For example, the number of positive axillary lymph nodes is a site-specific factor necessary for the calculation of the N output value for breast. Other site-specific factors for breast, such as the tumor markers estrogen receptor assay, progesterone receptor assay, and HER-2 status are useful for predicting the response to hormone therapy or the drug Herceptin. For sites/histologies where some or all site specific factors are not used, they are coded as Not Applicable. Appendix 7 lists the names of each site specific factor by schema. Refer to standard setter implementation guidelines to determine which site-specific factors will be required for collection.
10. **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.

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11. **Autopsy reports** are used in coding the Collaborative Stage Data Collection System in the same way as pathology reports, applying the same rules for inclusion and exclusion within the timing rules.
12. **Statement of T, N, or M only.** The extent of disease may be described by the clinician only in terms of T (tumor), N (node), and M (metastasis) categories. In CSv2, many codes have been added to allow coding of T, N, or M information when there is no additional information available in the medical record. Examples include “Stated as T1, NOS,” “Stated as T1a, NOS.” or “Stated as N2b, NOS.”
 - a. When there is no information available to use a more specific code, assign the code in the appropriate field that corresponds to the TNM information. For example, if the clinician reports that the tumor is T3 with no more specific information, use the code for “Stated as T3, NOS.” 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. There will be occasions where there is no information in the medical record to code a specific subcategory of T, N, or M. In such cases, the registrar may use the “Stated as T1, NOS” code if there is not enough information to code T1a or T1b.
13. **Reportable-by-Agreement Cases.** The seventh edition of the AJCC Cancer Staging Manual is a working document for clinicians who treat more than just reportable cancers. Consequently, there are staging systems for a number of neoplasms that may not be reportable to population-based registries. These include terms for in situ cancers that are not included in current reporting regulations in most states, such as high grade dysplasia of the esophagus (the preferred term for in situ carcinoma according to GI pathologists) and pancreatic intraglandular neoplasia (PAIN) of the pancreas, which is also called severe ductal dysplasia. Carcinoid of the appendix is a borderline tumor (/1) in ICD-O-3 but has its own staging schema. The same thing applies to squamous carcinoma of the skin.
 - a. **Follow the instructions of the population-based registry regarding reportability of cases using these terms.** Even though there is a TNM staging system and a CSv2 schema for a site-histology combination, it may not be reportable to a central registry.
 - b. If a case is reportable to the state registry, code the CS data items as instructed in the site-specific schemas. For example, if benign and borderline tumors of the ovary are reportable to a state registry, they are coded as 999 in CS Extension but may be staged using the TNM system.
 - c. Coding of cases that are reportable-by-agreement to a hospital or other facility registry, such as familial adenomatous polyposis of the colon—in other words, cases that will not be reported to a population-based registry, should follow the policies and coding guidelines of the facility.
14. **No forward compatibility.** CS version 2 is not designed to take cases coded in CS version 1 and rerun the conversion algorithm to derive seventh edition TNM. However, in most schemas, a case coded in CSv2 will map to both sixth and seventh edition TNM. Derivation of AJCC 7th edition T, N, M, or stage will not occur for cases diagnosed prior to 2010 even if they are collected under CSv2.
15. **Lymphomas and hematopoietic diseases generally excepted.** The staging rules for solid tumors are not the same as for lymphomas and systemic hematopoietic diseases. Follow the instructions included in the appropriate schema.

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 the 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 listed in the manual after the basic skin schema), 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 ascending values in 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 CS 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.

Schema Format

Each schema follows the same format. The components of each schema are:

- Schema Name, with any exclusions
 - *Example* Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
- ICD-O-3 Codes
 - ICD-O-3 topography codes and descriptions of sites/subsites to which this schema applies
- Schema Notes
 - General notes that apply to this primary site
 - *Example* (Prostate): Note: Transitional cell (urothelial) carcinoma of the prostatic urethra is to be coded to primary site C68.0, Urethra, and assigned Collaborative Stage codes according to the urethra schema.
- CS Master Table
 - Lists every table associated with the schema, including any extra tables in application software but not in CS Manual
- Data Field Tables
 - Notes before table are coding guidelines to assist registrar in selecting the correct code
 - Table with codes, code description, and TNM7, TNM6, SS77 and SS2000 mapping
 - Notes after table explain logic of mapping with references to specific codes and extra tables
 - * indicates TNM6 mapping instructions
 - ^ indicates TNM7 mapping instructions
- Extra Tables
 - Histology inclusions table (seventh Edition)
 - Histology exclusions table (sixth Edition)

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- Additional tables required by computer algorithm to determine mapping of sixth and seventh edition T, N, M and Stage Group
Examples: Extension Size Table, Extension Ulceration Table (melanoma), Lymph Nodes Size Table (head and neck), AJCC Stage
 - Not in manual but available online at www.cancerstaging.org/cstage.

CODING “NONE” VS. “UNKNOWN” IN THE COLLABORATIVE STAGE DATA COLLECTION SYSTEM, TNM AND SUMMARY STAGE

INACCESSIBLE LYMPH NODES RULE

As noted in the introduction, regional lymph nodes for certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated. In other words, these are “inaccessible” lymph nodes. As examples, these are the regional lymph nodes for such primary sites as bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach (this is not an all-inclusive list).

The Collaborative Stage Data Collection System allows data collectors to record regional lymph nodes as code 00 negative (based on clinical evaluation) rather than 99 unknown when three conditions are met:

- There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration.
- The patient has clinically low stage (T1, T2, or localized) disease.
- The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) (or patient is offered usual treatment but refuses it).

These guidelines apply primarily to localized or early (T1, T2) stage in the TNM system for inaccessible lymph nodes. When there is reasonable doubt that the tumor is no longer localized, the code(s) for unknown information can and should be used. For example, when there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (T3a/regional direct extension) and regional lymph node involvement is not mentioned, it would be correct to code lymph node involvement as unknown in the absence of any specific information regarding regional nodes.

For “accessible” lymph nodes that can be observed, palpated or examined without instruments, such as the regional nodes for the breast, oral cavity, skin, salivary gland, thyroid, and other organs, the abstractor should look for 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 (code 000). If there is no documentation regarding accessible lymph nodes, code as 999.

CODING DISTANT METASTASES

This 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. Because there is no longer an MX category in the TNM system, any case where CS Mets at Dx is coded 99 (unknown) will map to clinical M0 in seventh edition, MX in sixth edition, and unknown in Summary Stage 1977 and Summary Stage 2000.

CODING DEATH CERTIFICATE ONLY CASES

Death Certificate **only** (DCO) cases are coded as unknown (usually 9, 99, 999, etc.) or not applicable (usually 8, 98, 988, etc.) in all Collaborative Stage fields. Refer to the schema-specific lists of codes for DCO cases on the CS website for coding instructions for cases that are identified **only** by a diagnosis on a death certificate. True DCO cases are usually identified only at the central registry level. If a hospital finds a case identified through the DCO followback process, it should be coded as completely as possible as an incident case, not using DCO coding rules.

USE OF AUTOPSY INFORMATION IN COLLABORATIVE STAGE

Information obtained from autopsy may be used in either of two ways in the Collaborative Stage Data Collection 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 such cases, the Eval code will be 2 and the computer algorithm will assign the T, N, or M to “p” (pathologic) classification. If cancer is not suspected at the time of autopsy (Eval code 8), 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 CS 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 vessels or 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 CS schemas for ill-defined and non-specific sites.

Adjacent structures

Connective tissues large enough to be given a specific name would be described as 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 CS schemas for ill-defined or non-specific sites.

AMBIGUOUS TERMINOLOGY

Interpreting Ambiguous Terminology for Collaborative Stage

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 if there is no specific statement of involvement in the medical record. 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.

Note: Some schemas interpret certain words as involvement, such as ‘encasing’ the carotid artery for a head and neck site. Terminology in the schema takes priority over this list.

Note: This is not the same list published in Section One of the *Facility Oncology Registry Data Standards* (FORDS) manual to be used for determining reportability. This is not the same list of ambiguous terminology provided for the Multiple Primary and Histology Coding Rules published and maintained by the SEER Program (www.seer.cancer.gov/tools/mphrules).

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 a structure other than primary**
fixed to another structure**
impending perforation of
impinging upon
impose/imposing on
incipient invasion
induration
infringe/infringing
into*
intrude
invasion to into, onto, out onto
most likely
onto*
overstep
presumed
probable
protruding into (unless encapsulated)
suspected
suspicious
to*
up to

DO NOT Consider as Involvement

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

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

** interpreted as involvement of other organ or
tissue

CODING INVOLVEMENT OF REGIONAL AND DISTANT LYMPH NODES

Clinicians describe the characteristics of regional and distant lymph nodes in a variety of ways. In general, for solid tumors, only the terms *fixed*, *matted*, or *mass in the hilum, mediastinum, retroperitoneum, and/or mesentery* (with no specific information as to tissue involved) are considered involvement for the purposes of TNM staging and CS coding. Other descriptions, such as *palpable*, *enlarged*, *visible swelling*, *shotty*, or *lymphadenopathy*, would be considered clinical involvement only when there is an additional comment by the physician that the nodes are, for example, suspicious for malignancy or involvement, or when the physician's TNM staging indicates cN1 or higher. The exceptions are regional lymph nodes of the lung where *mass*, *enlargement*, or *adenopathy* in the hilum or mediastinum is considered involvement of regional nodes; Kaposi sarcoma, and malignant lymphoma, where any mention of any of the terms above is considered lymph node involvement. For lymph nodes of the head and neck, the terms *fixed* and *matted* also imply extranodal extension of metastases in the lymph nodes.

HOW TO CODE THE COLLABORATIVE STAGE DATA COLLECTION SYSTEM DATA ELEMENTS

A brief summary of how to code using this manual

Note: This procedure focuses on only the Collaborative Stage 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 Stage Data Collection 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, lymph nodes, and distant sites that are involved by tumor.
3. The first step is selecting the correct schema. This will usually be done automatically by the software, based on the primary site, histology, and schema discriminator code (if needed) you have entered.
4. Verify that you are in the correct schema by confirming that the primary site and, where relevant, the histology code, are in the list at the beginning of the schema.
5. Begin assigning codes for the fields in the Collaborative Stage Data Collection System according to the data item coding guidelines in this document. Read the notes and follow the schema-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 greatest tumor size and 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 whether there are metastases in the bone, brain, lung and/or liver in the appropriate CS Mets at Dx-Metastatic Site fields.
 - j. Code how any distant metastasis was determined in the CS Mets Eval field.
 - k. Code the site-specific factors for the selected schema as required by your standard-setter(s). Code the specific information requested for each site specific factor. The software may provide default values for undefined or non-required site-specific factors.

Congratulations! You have collected all the facts about the case and the codes are ready for the computer to derive the T, N, M, and Stage Group for the AJCC seventh and sixth editions; 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 AJCC Stage Group will be generated for the

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case. If the histology code is not in the computer's list of stageable morphology codes for that site, the T, N, M, and AJCC Stage Group will be reported as "Not Applicable." Summary Stage is generated for every case. The computer algorithm will also provide which version of the Collaborative Stage Data Collection System was used to derive the final stages. The registry software may display the derived values immediately or may display them when the case is saved; this is vendor-specific. Any error messages or edit warnings displayed by either the CS computer algorithm or the EDITS process must be resolved before the case is ready for transmission to the central registry.

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Coding Instructions for Collaborative Stage Data Elements

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CS TUMOR SIZE

Item Length: 3

NAACCR Item #2800

Description

Record the largest dimension or diameter of the **primary tumor**. Tumor size is always recorded in millimeters. To convert centimeters to millimeters, multiply the dimension by 10.

Code	Description
000	No mass/tumor found
001-988	Exact size in millimeters
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
996-998	SITE-SPECIFIC CODES WHERE NEEDED
999	Unknown; size not stated Not documented in patient record

Examples

Mammogram shows 2.5 cm breast malignancy

CT of chest shows 4 cm mass in RUL

Thyroidectomy specimen yields 8 mm carcinoma

Prostate TURP shows 0.6 mm carcinoma

Lumpectomy shows multiple microscopic foci, no size stated

Clinician reports T1 tongue tumor removed at another facility

Code as

025 (2.5 cm = 25 millimeters)

040 (4 cm = 40 mm)

008

001 (round up tenths of 1 millimeter)

990

992 (Stated as T1 with no other information on size)

Note: Rounding. Round the tumor size only if it is described in fractions of millimeters. If tumor size is less than 1 millimeter, record size as 001 if largest dimension or diameter of tumor is between 0.1 and 0.9 mm (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter.

Examples

Breast cancer described as 6.5 millimeters in size. Code CS Tumor Size as 007.

Cancer in polyp described as 2.3 millimeters in size. Code CS Tumor Size as 002.

Focus of cancer described as 0.5 mm in size. Code as 001.

Focus of cancer described as 1.4 mm in size. Code as 001.

5.2 mm breast cancer. Round down to 5 mm and report as 005; will map to T1a rather than T1b.

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For schemas that do not use tumor size:

Code	Description
988	Not applicable

Instructions for Coding

1. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.
2. **Schema-specific instructions.** Refer to site/histology-specific instructions (notes before the table) for additional information. Schema-specific instructions take priority over general instructions. Where there are no site/histology-specific instructions, the general instructions apply.
3. **Record the largest tumor diameter from reports 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. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the final diagnosis, synoptic report, (also known as CAP protocol or pathology report checklist), microscopic, then gross examination, in that order.
Example Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. *Record tumor size as 032.*
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 neoadjuvant treatment unless the size of tumor is larger at surgery (see 3.e below).**
Example Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. *Record tumor size as 022.*
 - c. **Priority of imaging/radiographic techniques.** 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. **Tumor size discrepancies among reports.** If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record, regardless of which imaging technique reports it.
 - e. **If no response to neoadjuvant treatment.** In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, larger after preoperative treatment as determined by the operative or pathology report, code the greatest tumor size and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.
 - i. If clinical tumor size is unknown but a pathologic tumor size is given after treatment and clinician states there was a response to neoadjuvant, code TS as 999 and TS/Ext Eval as 5.
 - ii. If clinical tumor size is unknown but a pathologic tumor size is given and clinician states no response to treatment, code TS from path report and TS Ext eval as 6.
4. **Record the exact size of the primary tumor** for all sites/histologies except those for which it is stated to be not applicable. Code the exact size in preference to a statement of a T category or a size range (see special codes below). If there is no reference at all about tumor size in the record, code as 999.

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- 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 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 987.
- f. For purely **in situ lesions, code the size as stated.**
- g. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.
- 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. If the clinician gives a size not in agreement with the pathologist or pathology report, the clinician statement must be confirmed with pathology prior to reporting/coding.
- i. **When residual tumor is larger than excisional biopsy.** 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.
- j. **No clinical size but incisional needle biopsy.** Code the size from an incisional needle biopsy only when no residual tumor is found on further resection **or** on the rare occasion when the size of the tumor on incisional needle biopsy is larger than the size of the tumor on resection. If there is no further resection, do not code the size from the incisional needle biopsy; code 999 in the absence of a clinical size.
- k. **Malignant melanoma of skin, mucosal membrane, mucosa of head and neck sites, or eye.** Record tumor size (diameter or lateral dimension) for malignant melanoma. Depth of invasion (tumor thickness) is coded in a site-specific factor.
- l. **Multifocal/multicentric tumors.** If the tumor is multi-focal or there are multiple tumors being reported as a single primary, code the size of the largest tumor.
- m. **Size stated as T_.** If both a T category and exact tumor size are given, code the exact size. If the only information about tumor size given in the medical record is a physician statement of a T category, determine whether the T category is based on tumor size or extension.
 - i. If the T category is based solely on tumor size, use the appropriate “Stated as T_, NOS” code in CS Tumor Size **or** select the appropriate code from the 99_ series (see below for special codes).

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- ii. If the T category is based on extension, use the appropriate “Stated as T_” code in CS Extension.
- iii. If the T category is based on both tumor size and extension, use the appropriate “Stated as T_, NOS” code in CS Extension. Code a specific tumor size as stated in the medical record. If an explicit tumor size is not given but there is a “Stated as T __ value based on size, code the tumor size in the 99__ series in CS Tumor Size. Otherwise, use code 999.

5. Special codes

- a. **Use field for tumor dimension only.** 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. **No size reported.** If size is not reported, code as 999, which means unknown size or not documented in the patient record.
- c. **Use of Code 000.** Code 000 indicates no mass or no tumor was found at the primary site; for example, when a tumor has metastasized but no tumor can be found at the primary site.
- d. **Use of code 990.** Code 990, Microscopic focus or foci only and 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. If the tumor is described as both a microscopic focus and a specific size, code the specific size.

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.*

Example Multicentric microscopic foci in breast, largest is 0.5 millimeters. *Code tumor size as 001.*

- e. **Non-specific size descriptions.** 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, code the more precise size in the range 001-989. If the tumor is described as “greater than 5 cm” and there is not an applicable code in the site-specific schema, record as 051.
- f. **Site-specific special codes.** 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. **Use of code 998.** The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following schemas sites:
 - Esophagus (C15.0-C15.5, C15.8-C15.9): Circumferential
 - EsophagusGEJunction (C16.0-C16.2): Diffuse; widespread: 3/4s or more; linitis plastica
 - Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse; widespread; 3/4s or more; linitis plastica
 - Appendix (C18.1): Familial/multiple polyposis
 - Carcinoid of appendix (C18.1): Familial/multiple polyposis
 - Colon (C18.0, C18.2-C18.9): Familial/multiple polyposis
 - Rectosigmoid and rectum (C19.9, C20.9): Familial/multiple polyposis
 - Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lung or NOS
 - Breast (C50.0-C50.6, C50.8-C50.9): Diffuse
- h. **Size not applicable.** For the following diagnoses and/or primary sites, size is not applicable. *Code as 988:*
 - Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
 - Hematopoietic neoplasms
 - Immunoproliferative diseases
 - Kaposi sarcoma

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Leukemia

Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma) other than ocular adnexal lymphoma

Mast cell tumors

Multiple myeloma and other plasma cell tumors

Myelodysplastic syndromes

Myeloproliferative diseases

Polycythemia vera

Polymorphic Post-Transplant Lymphoproliferative Disorder (PTLD)

Refractory anemias

Other Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (*see HemeRetic schema for a complete list of codes and diagnoses*)

MelanomaChoroid

MelanomaCiliaryBody

MelanomaIris

- i. **Use of CS Tumor Size/Ext Eval field with CS Tumor Size.** The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field when tumor size is the determining factor for the T category.
6. **Document tumor size code in text.** It is strongly recommended that the choice of tumor size codes be documented in a related text field on the abstract.

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CS EXTENSION

Item Length: 3

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	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
000	In situ; non-invasive	Tis	Tis	IS	IS
	SITE/HISTOLOGY-SPECIFIC CODES				
800	Further contiguous extension				
950	No evidence of primary tumor	T0	T0	U	U
999	Unknown; extension not stated Primary tumor cannot be assessed Not documented in patient record	TX	TX	U	U

Instructions for Coding

- 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 corpus uteri, ovary, fallopian tube, and female peritoneum (see 2f below).

Example In the CS Extension table for colon, Note 2 states that codes 600-800 are used for contiguous extension from the site of origin, and discontinuous involvement is coded in CS Mets at Dx. Thus direct tumor extension from the transverse colon onto the surface of the liver would be coded as CS Extension 600, while hematogenous metastases within the liver would be coded as CS Mets at Dx 26.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure involved by direct extension is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

- Record extension information in the following priority order:**
 - No neoadjuvant treatment planned or administered.** Record extension from the pathology report, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.
 - Neoadjuvant treatment planned and administered.** 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 fixed to pelvic wall (clinically T4, extension code 610). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue

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(pathologically T3, extension code 400). *Code extension as 610, because the preoperative treatment apparently “shrank” the tumor away from the pelvic wall.*

- c. **Partial or no response to neoadjuvant treatment.** 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. If response to treatment is unknown, code the farthest clinical extension and code CS Tumor Size/Ext Eval as 5.

Example Patient found to have an obstructing central lung tumor very close to the main stem bronchus (clinically T2, extension code 200). Patient undergoes six weeks of intensive chemotherapy. At resection, tumor was observed directly extending into trachea (pathologically T4, extension code 700). *Code extension as 700, 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 100) 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 200). *Code extension as 200, because although the chemotherapy “shrank” the tumor, the residual tumor was found to be more extensive than the clinical presentation. (Code Tumor Size as 055 because the derived T3 pre-neoadjuvant treatment is greater than the post-treatment T2. Code TS/Ext Eval as 5 {clinical information prior to neoadjuvant treatment} because the tumor size determines the T classification for Extension codes 100, 200, and 300 for breast.)*

- i. If clinical extension is unknown but a pathologic extension is given after treatment and clinician states there was a response to neoadjuvant, code CS Extension as 999 and TS/Ext Eval as 5.
- ii. If clinical extension is unknown but a pathologic extension is given and clinician states no response to treatment, code CS Extension from path report and TS/Ext Eval as 6.
- d. **Priority of imaging/radiographic techniques.** 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. **Involved organ not listed in schema.** 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. **Contiguous (direct) extension only.** With the exception of mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, 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 is coded 600.

Carcinoma of the prostate with metastases to thoracic spine is coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine are coded in the CS Mets at Dx field.

3. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.
4. **Ambiguous terminology.** Refer to the ambiguous terminology section for terms that constitute tumor involvement or extension.
5. **Code the highest applicable specific number.** Codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or “Stated as T1, NOS” do not take priority over more specific codes with lower numbers.

Example The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices

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are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.

6. **Inferring extension code from stated T category or site-specific staging.** 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 or alternative staging system stated by the physician.
 - a. 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, code the appropriate "Stated as T_, NOS" category or record the numerically lowest equivalent extension code for the site-specific staging system.
7. **Use of NOS categories.** Some 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. **Discontinuous or distant metastases.** Distant metastases must be coded in the CS Mets at Dx field. The only exceptions are mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in the CS Extension field.
9. **In situ pathology with nodal or metastatic tumor.** 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 100, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.*
10. **Microscopic residual or positive tumor margins.** The presence of microscopic residual disease or positive tumor margins does not increase the extension code.
11. **Document choice of codes in text.** It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.

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CS TUMOR SIZE/EXT EVAL

Item Length: 1

NAACCR Item #2820

Description

This field is used primarily to derive the staging basis for the T category in the TNM system. In most circumstances it records how the codes for the two items “CS Tumor Size” and “CS Extension” were determined, based on the diagnostic methods employed.

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. <i>See Notes 1 and 2 below.</i>	c
2	Meets criteria for AJCC pathologic staging: No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy). <i>See Note 3 below.</i>	p
3	Either meets criteria for AJCC pathologic staging: Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed AND 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. No surgical resection done. Evaluation based on positive biopsy of highest T classification. <i>See Note 3 below.</i>	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6).	c
6	Meets criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy AND tumor size/extension based on pathologic evidence, because pathologic evidence at surgery is more extensive than clinical evidence before treatment. <i>See Note 4 below.</i>	yp
8	Meets criteria for autopsy (a) staging: Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a

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Code	Description	Staging Basis
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record <i>For sites with no TNM schema: Not applicable. See Note 5 below.</i>	c

- Note 1: For lung, code 1 was pathologic staging basis in CS version 1 and is clinical in CS version 2.
 For liver, code 1 was clinical in CS version 1 and pathologic in CS version 2.
- Note 2: Where sixth and seventh editions differ, there will be separate Staging Basis columns for TNM6 and TNM7.
- Note 3: The codes in this common table do not apply to prostate. See instruction 9 below.
- Note 4: This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.
- Note 5: For primary sites with no TNM schema, code 9 is defined as not applicable and the staging basis is blank.

Instructions for Coding

1. **Document the staging basis for the farthest extension and/or greatest tumor size.** The underlying purpose of this field is to capture the staging basis for the highest T category assigned to the case. In most circumstances, this will be the staging basis for the highest Tumor Size code or Extension code as appropriate to the site. See also instructions 2, 3, and 4.
 - a. Select the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension or largest size of the primary tumor (where applicable) was obtained; this may not be the numerically highest Eval code.

Example 1 Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy.*

Example 2 Patient has elevated PSA, negative digital rectal exam, and clinically inapparent prostate tumor. Needle biopsy identifies adenocarcinoma in right lobe only. *Code CS Tumor Size/Ext Eval as 1 because the needle biopsy, not the clinical examination, established the extent of disease.*

Example 3 Patient has bronchoscopic biopsy (Eval code 1) confirming squamous cell carcinoma of the right upper lobe bronchus. CT scan of chest (Eval code 0) shows that RUL mass extends into mediastinum (Lung Extension code 700). *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed the farthest extension of tumor.*

Example 4 Imaging shows 3.0 cm mass in right upper lobe of lung. Fine needle aspiration biopsy shows adenocarcinoma. *Code CS Tumor Size/Ext Eval as 0 because the imaging documents what is known about the tumor and drives the classification of T, and the FNA simply confirms that the mass is cancer.*

Example 5 Patient has 6 cm mass in left breast with overlying erythema and edema. Core needle biopsy confirms duct carcinoma and the patient receives neoadjuvant chemotherapy followed by a modified radical mastectomy. The pathology report from the surgery shows a 2.5 cm residual carcinoma. *Code the Tumor Size/Ext Eval as 5 (surgical resection after neoadjuvant therapy – size/extension based on clinical information prior to treatment), which maps to clinical staging. (Tumor size would be coded 060.)*

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- b. In the infrequent situation where there is both clinical and pathologic documentation of the same T category, **pathologic information takes priority.**
Example Lung cancer patient has biopsy-proven extension to adjacent trachea (Extension code 700) and radiographic evidence of extension to neural foramina (Extension code 750). *Code CS Extension as 750 and TS/Ext Eval as 3. When both codes map to T4, pathologic staging basis takes priority.*
- c. **Mapping of T subcategories.** Select the CS TS/Ext Eval code that describes how the most advanced subcategory of the derived T was determined.
- i. If a specific subcategory of T will be derived (such as T2a, etc.), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Tumor Size/Ext Eval code that will derive a “p” staging basis.
 - ii. If there was only clinical evidence of the subcategory disease, select a CS Tumor Size/Ext Eval code that will derive a “c” staging basis. In the latter case there may have been pathological evidence of a lower T subcategory, but this is not considered in assigning the Eval code.
Example Cervical carcinoma with bullous edema of bladder (CS Extension code 605, maps to T3a) demonstrated on cystoscopy (CS Tumor Size/Eval code 1). KUB radiography (CS Tumor Size/Eval code 0) shows non-functioning kidney (CS Extension code 635, maps to T3b). *Code CS Tumor Size/Ext Eval as 0 because the imaging documented a higher subcategory of T3 than the cystoscopy.*
- d. **When the only procedure is a polypectomy.** In some situations, an endoscopic procedure may remove the entire tumor, and the TS/Ext Eval must be coded to reflect the correct staging basis for tumor extension.
- i. If there is no tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 3 (pathologic).
 - ii. If there is tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 1 (endoscopic/diagnostic biopsy).
When the patient has further surgery
 - iii. If there is no primary tumor in resection, use extension information from polypectomy and code TS/Ext Eval as 3 (pathologic).
 - iv. If more tumor is found at resection, code farthest extension from polypectomy or resection and code Eval as 3 (pathologic).
2. **When tumor size is the primary factor.** For primary sites where tumor size is the primary factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of how the tumor size was determined.
- Note:* In the CS Extension field, an asterisk (*) in the TNM 6 Map column or a caret (^) in the TNM 7 Map column usually indicates that tumor size is the determining factor in the mapping.
- a. If the tumor size is taken from physical exam or imaging and there was also a needle biopsy or incisional biopsy, code CS Tumor Size/Ext Eval according to which gave the better information about tumor size.
Example On physical examination, patient has a 1.5 cm (T1) lesion in the floor of mouth with mucosal extension onto the gingiva. A biopsy confirms the malignancy and the patient is treated with radiation therapy. *Code the CS Tumor Size/Ext Eval as 0 since the tumor size was determined on physical exam and the biopsy simply confirmed the malignant diagnosis. (Mucosal extension to another structure does not alter the T classification).*
Example Bronchoscopy (Eval code 1) shows blockage in right middle bronchus with no parenchymal extension (Extension code 100). CT scan (Eval code 0) shows tumor size as 2.5 cm (maps to T1b). *Code CS Tumor Size/Ext Eval as 0 because the tumor size determines the difference between T1a, T1b and T2.*

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3. **When tumor size is not a factor.** For primary sites/histologies where tumor size is not a factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of the CS extension field only.
- Note:* For most primary sites, if the tumor is classified as T4 or sometimes even T3, tumor size is no longer a factor.
- Example* CT scan of head and neck (Eval code 0) shows tumor confined to supraglottic larynx (Extension code 100). Panendoscopy (Eval code 1) demonstrates that there is impaired vocal cord mobility (Extension code 250). *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documented a higher Extension code than the CT scan.*
- Example* Sigmoidoscopy and biopsy (Eval code 1) show a 4 cm adenocarcinoma in the upper rectum. Ultrasound (Eval code 0) shows that the carcinoma invades into the perirectal fat. Patient opts for radiation therapy. *Code the CS Tumor Size/Ext Eval field as 0 because the ultrasound showed the depth of invasion, which is the primary factor in classifying the T category for colorectal cancers.*
- Note:* For colon, rectosigmoid and rectum carcinomas, always assign the Tumor Size/Ext Eval code based on extension (depth of invasion). Tumor size is not a factor in classifying colorectal cancers.
4. **When both tumor size and extension determine T category.** For primary sites where both tumor size and extension determine the T category in TNM, 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). On physical exam, there is ulceration of the skin (extension code 512, 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.*
- Note:* For breast, unless there is skin or chest wall involvement, always assign the Tumor Size/Ext Eval code based on size. If there is skin or chest wall involvement or a statement of inflammatory carcinoma (T4 disease), assign Eval code based on extension.
- Example* Panendoscopy and biopsy (Eval code 1) confirm a 3.5 cm lesion on the lateral border of the anterior tongue involving the intrinsic musculature (Extension code 200 with tumor size 035, equivalent to a T2). CT scan of the head and neck (Eval code 0) indicates that the lesion actually involves the extrinsic or deep muscles of the tongue (Extension code 750, equivalent to T4a). *Code CS Tumor Size/Ext Eval as 0 because the CT scan documented a higher stage than the tumor size.*
- 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 will identify information as clinical (c).*
- Example* Colon cancer with colonoscopy and biopsy confirming adenocarcinoma in the submucosa. *Code this field as 1. Staging algorithm will identify information as clinical (c).*
- The biopsy does not meet the criteria for pathologic staging.*
- Example* Information obtained from endoscopies for cervix or bladder showing size or extent of the tumor is coded as 1 in this field and the staging algorithm will identify the information as clinical (c).
- Exception* Lung cancer with mediastinoscopy showing direct extension into mediastinum. *Code this field as 1. The staging algorithm will identify information as pathologic (p) in the sixth edition mapping and clinical (c) in the seventh edition mapping.*
- c. If the patient had surgery followed by other treatment(s), use code 3.

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- d. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5. Cases coded to Tumor Size/Ext Eval code 5 can be analyzed or compared with other cases with a clinical staging basis.
 - 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. Cases coded to Tumor Size/Ext Eval code 6 cannot be analyzed with or compared to any other cases that did not receive neoadjuvant treatment and surgery.
 - f. If the patient had an autopsy and the autopsy information meets the timing rules for determining extension, 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.
5. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Appendix 3.) For any sites and histologies not listed in Table 6, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.
6. **Examples of imaging studies included in Code 0.** Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.
7. **Explanation of Code 1.** Codes 0 – 3 are oriented to the AJCC staging basis. In general, Code 1 includes microscopic analysis of tissue that does not meet the requirements for pathologic staging in the TNM system. Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified and further tumor extension is not biopsied. 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, seventh edition*.
- 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, does not meet the requirements for pathologic staging and should be coded to 1 in this field. This also applies to transurethral resection of the prostate.
- a. If there is a choice between Eval code 0 (physical exam and imaging) and Eval code 1 (needle biopsy), use the Eval code that provides the best information about the tumor size and/or extent of disease. In most situations, the needle biopsy simply confirms the malignancy and the physical exam or imaging provides more information about tumor extension.
- Example* Colposcopic examination and biopsy (Eval code 1) of the cervix shows extensive involvement of the endocervix. Bimanual examination of the pelvis (Eval code 0) indicates that the tumor is fixed to the pelvic sidewall (“frozen pelvis”). *Code CS Tumor Size/Ext Eval as 0 (clinical) because the bimanual examination indicates farther extension than the endoscopy.*
- Example* Patient has nonspecific abdominal symptoms. An Upper GI exam (Eval code 0) shows localized thickening of the stomach wall. Esophagogastrosocopy and biopsy (Eval code 1) confirm diffuse involvement of the upper part of the stomach with extension into the lower esophagus. *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documents more involvement than the imaging.*

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8. **Explanation of Code 3.** For most schemas, Code 3 meets the criteria for pathologic staging. For most schemas, use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. In CSv2, the definition of code 3 has been reworded to include not only surgical resection but also a positive biopsy that confirms the highest T classification. In other words, according to TNM rules, if the highest T category can be confirmed microscopically (positive cytology or tissue), this meets the requirements for pathologic staging basis and the CS Tumor Size/Ext Eval field should be coded to 3.

Example Patient visits doctor complaining of urinary frequency and pain. Pelvic examination shows extensive cervical carcinoma (Eval code 0). Cystoscopic biopsy of bladder shows squamous carcinoma compatible with cervical origin (cervix extension code 700, equivalent to T4). *Code CS Tumor Size/Ext Eval as 3 (pathologic) because biopsy documents highest T category.*

9. **Different code structure for prostate.** The CS Tumor Size/Ext Eval field for prostate is unique. An extra category was inserted between codes 1 and 2 in the common (standard table used for other sites) Tumor Size/Ext Eval table to provide a code for situations where no prostatectomy was performed, but there was a positive biopsy of extraprostatic tissue. This allows assignment of codes in the T3-T4 range (Extension 410-700). Common table code 2 (autopsy of suspected/known cancer) becomes code 3 for prostate, and common table code 3 (pathologic) becomes code 4.

Example A prostate cancer patient has a biopsy of the rectum that shows microscopic involvement of the rectal wall (Extension code 500, equivalent to T4). Code Tumor Size/Ext Eval as 2 (positive biopsy of extraprostatic tissue, which maps to pathologic) because according to the *AJCC Cancer Staging Manual, seventh edition*, the case meets the requirements for pathologic staging in the T category.

Example Patient presents with urinary symptoms and undergoes transurethral resection to improve urinary flow. Adenocarcinoma is found in the chips of tissue removed from the prostate. *Code Tumor Size/Ext Eval as 1 because there was no clinical evidence of cancer and the transurethral resection is an endoscopic procedure that does not meet the criteria for pathologic staging of prostate.*

Example Needle biopsies of the prostate confirm adenocarcinoma. The patient undergoes a radical prostatectomy that shows extensive involvement of the prostate. *Code Tumor Size/Ext Eval as 4 because the prostatectomy meets the criteria for pathologic staging.*

Note: Cryoprostatectomy does not meet pathologic staging criteria because there is no tissue available for the pathologist to examine.

10. **Coding Eval field when tumor size or extension is unknown.** The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or CS Mets at Dx) is unknown. For example, even if it is not possible to determine the tumor size or extension and the Extension field is coded as 999, the registrar still knows what procedures were used to try to determine those fields. In other words, just because the tumor size or extension is coded 999, the Eval field does not have to be coded 9.

11. **Schemas always coded 9.**

AdnexaUterineOther	IntracranialGland
Brain	KaposiSarcoma
CNSOther	MelanomaSinusOther
DigestiveOther	MiddleEar
EndocrineOther	MyelomaPlasmaCellDisorder
EyeOther	PharynxOther
GenitalFemaleOther	RespiratoryOther
GenitalMaleOther	SinusOther
HemeRetic	Trachea
IllDefinedOther	UrinaryOther

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CS LYMPH NODES

Item Length: 3

NAACCR Item #2830

Description

This field identifies the regional lymph nodes involved with cancer at the time of diagnosis. Criteria for involvement are site-specific and may include the location, laterality, size and/or number of involved regional lymph nodes. In general, involved distant lymph nodes are coded in CS Mets at Dx.

Code	Description	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
000	No regional lymph node involvement	N0	N0	None	None
	SITE/HISTOLOGY-SPECIFIC CODES				
999	Unknown; regional lymph nodes not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	NX	U	U

For schemas that do not use the CS Lymph Nodes field (see Rule 10):

Code	Description
988	Not applicable; Information not collected for this schema

Instructions for Coding

- Record the specific involved regional lymph node chain(s) farthest from the primary site.** The lymph nodes may be involved by tumor either clinically or pathologically. Regional lymph nodes are listed for each schema. 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. If a lymph node chain is not listed, check an anatomy book or medical dictionary for a synonym. If the lymph node chain and its synonym are not listed in CS Lymph Nodes, code the involved node in CS Mets at DX. **Record the highest applicable code in the following order: pathology report, imaging, physical exam.**

Exception The higher codes for “Regional lymph nodes, NOS;” “Lymph nodes, NOS;” ”Stated as N1, no other information;” “Stated as N2a, no other information;” and so forth, should be used only when there is no available information regarding the specific regional nodes involved.

Example Patient has a right upper lobe lung cancer, and right hilar lymph nodes are positive on fine needle aspiration biopsy. CT scan shows matted left paratracheal (contralateral mediastinal) nodes, but they are 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.

- If there is no neoadjuvant therapy.** 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.
- Pathologic information takes precedence.** If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, pathologic information takes precedence if no preoperative treatment was administered. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement.

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 000, no regional lymph node involvement.

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- c. **Inaccessible lymph nodes rule for regional lymph nodes.** For inaccessible lymph nodes, record CS Lymph Nodes as Code 000 (None) rather than Code 999 (Unknown) when the following three conditions are met:
1. There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration.
 2. The patient has clinically low stage (T1, T2, or localized) disease.
 3. The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) or is offered usual treatment but refuses it, since this presumes that there are no involved regional lymph nodes that would otherwise alter the treatment approach.

Note: Code 999 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 involved regional lymph nodes. Code 999 should also be used when there is no documentation in the medical record about the status of accessible regional lymph nodes.

Note: If the inaccessible nodes rule applies and the case is coded 000, use code 0 in CS Reg Nodes Eval, as this code documents that criteria were met for a clinical N0.

- d. **Direct tumor extension into lymph node.** If there is direct extension of the primary tumor into a regional lymph node, code the involved node in this field.
- e. **Multiple nodes involved for head and neck primary.** The code structure for CS Lymph Nodes for head and neck cancers varies by primary site, but in general, the following code ranges apply:

000	None
100-190	Single positive ipsilateral node involved
200-290	Multiple positive ipsilateral nodes
300-320	Positive ipsilateral nodes, unknown if 1 or > 1
400-490	Bilateral or contralateral positive nodes
500-520	Regional nodes, NOS, unk. number and laterality
800	Lymph nodes, NOS

If even one involved node is in a higher category, use the appropriate code in the higher category.

Example Patient with hypopharyngeal cancer has two positive ipsilateral level IV nodes and one positive ipsilateral level V node. Level IV nodes are listed in CS Lymph Nodes code 100; level V nodes are listed in CS Lymph Nodes code 120. Because more than one node is involved, the correct code range is 200-290. *Code as 220 because there are multiple lymph nodes involved and at least one of them is in code 120.*

Example Patient with base of tongue cancer has regional lymph nodes involved on both sides of neck. “Regional nodes, NOS” is in code 100, but bilateral nodes are involved. *Code as 400, bilateral lymph nodes listed in 100.*

- f. **Neoadjuvant treatment planned or administered.** 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 510) 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 000). *Code CS Lymph Nodes as 510 because prior to treatment they appeared to be clinically involved and the chemotherapy apparently “sterilized” the lymph nodes.*
- g. **Partial or no response to neoadjuvant treatment.** 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. If response to treatment is not documented, code the clinical status of the lymph nodes and code CS Reg Nodes Eval as 5.

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Example Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on CT scan (Negative, code 000). 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 100) to lymph nodes and the prostatectomy is canceled. *Code CS Lymph Nodes as 100 because the preoperative treatment (Lupron) had no effect on the lymph nodes.*

- i. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated after treatment and clinician states there was a response to neoadjuvant, code CS Lymph Nodes as 999 and CS Reg Nodes Eval as 5.
 - ii. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated and clinician states no response to treatment, code CS Lymph Nodes from path report and CS Reg Nodes Eval as 6.
- h. **Use of Code 800.** The CS Lymph Nodes table for nearly every schema contains a code 800, defined as Lymph nodes, NOS. This code is to be used only when it is not possible to determine whether the involved lymph nodes are regional or distant. Each schema also includes a separate code for “Regional lymph nodes, NOS”. In general, lymph nodes removed during a resection of the primary site are regional and should be coded as such. Occasionally a distant lymph node will be removed separately from the primary site. In the infrequent situation where the involved lymph node is not identified as either regional or distant, use code 800, which will map to N1 category using the TNM downstaging rule applied in the CS computer algorithm.

2. **When CS Extension is coded as in situ/noninvasive.** Use code 000 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 involved lymph nodes can be coded as appropriate for the case. Code the CS Extension field and the behavior code to reflect that the tumor is invasive.
3. **Terms meaning lymph node involvement.** 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.

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. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes. Keep in mind, however, that involved lymph nodes are coded in CS Extension for lymphomas.
 - c. Regional lymph nodes are not palpable for inaccessible lymph nodes sites such as bladder, colon, 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 sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative (code 000) based on the inaccessible lymph nodes rule.
 - 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.

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4. **Coding size of lymph node.** 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 the site-specific schema. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes; for example, a single involved node 1.5 cm in size can be coded to “single lymph node \leq 2 cm” because the metastasis cannot be larger than 1.5 cm.
Example Patient has radical nephroureterectomy for urothelial carcinoma of the renal pelvis. Synoptic pathology list shows three involved nodes, the largest of which is 2 cm in greatest diameter. *Code CS Lymph Nodes as 200 because multiple lymph nodes are involved and no single lymph node or its metastasis is larger than 5 cm in size.*
 - b. If the size of the metastasis in the node is unknown, code the size of the involved node(s) if given.
 - c. Code the clinical size of the involved node(s) in the absence of a pathologic size.
 - d. If the size given is described as a mass, code the size of the mass.
Example Patient presents with 6 cm hard upper jugular (Level II) neck mass. Needle biopsy of mass shows metastatic squamous carcinoma. Panendoscopy finds lesion on soft palate. *Code CS Lymph Nodes as 300 (regional lymph nodes listed in 100 {regional lymph node, NOS}, not stated if single or multiple).*
Code Lymph Nodes Eval as 0 (physical exam).
Code Site-specific Factor 1 (size of lymph node) as 060.
Code Site-specific Factor 2 as 988 (not applicable in CSv2).
Code Site-specific Factor 3 as 010 (level II node involved).
Code Site-specific Factors 4-6 as 000 (no nodes involved).
Code Site-specific Factor 7 as 010 (upper level nodes involved).
Code Site-specific Factor 8 as 010 (nodes involved clinically, no extracapsular extension clinically).
Code Site-specific Factor 9 as 050 (lymph nodes involved pathologically, unknown if extracapsular extension).
The computer algorithm will combine the codes from CS Lymph Nodes, SSF1, and Lymph Nodes Eval and derive a cN2a.
 - e. Information about location, number and size of lymph nodes may be split among the CS Lymph Nodes field and one or more site-specific factors. Code the fields as completely as possible and the computer algorithm will derive the correct N category. Refer to the discussion of head and neck lymph nodes and breast lymph nodes in Section 2 of this manual for further information.
5. **Inferring lymph node involvement from stated N category or site-specific staging.** 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, code the appropriate “Stated as N_, NOS” category or record the numerically lowest equivalent CS Lymph Nodes code for the site-specific staging system. CS Version 2 includes many code choices to accommodate physician statements of N1, N2 NOS, N2a, and so forth.
- 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. **Isolated Tumor Cells (ITCs) in lymph nodes.** Several chapters in the TNM seventh edition refer to isolated tumor cells or ITCs. ITCs are single cells or small clusters of epithelial cells in regional lymph nodes whose metastatic potential is unknown. ITCs are coded according to site-specific guidelines.

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- a. For breast, ITCs are coded as negative lymph nodes (CS Lymph Nodes code 000 or 050, which maps to pN0(i+) or pN0(mol+).
 - b. For cutaneous melanoma, ITCs are coded as positive lymph nodes.
 - c. For Merkel cell carcinoma, ITCs are coded as positive lymph nodes.
7. **Use of NOS categories.** Some 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.
8. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum.** Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. These various aspects are handled in different ways in CS. Furthermore, there are different definitions in the sixth and seventh editions of the *AJCC Cancer Staging Manual* for discontinuous tumor nodules found near the primary site.
- a. In the seventh edition and CSv2, if the primary tumor is localized or maps to T1 or T2, code CS Lymph Nodes as 050 if the only information available is the presence of tumor nodules in pericolic fat. In addition, code the total number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits. If there are tumor deposits and involved regional lymph nodes, code the information on regional lymph nodes in CS Lymph Nodes, the number of positive nodes in Lymph Nodes Positive, and the number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits.
 - b. In the sixth edition of TNM and CS Version 1, tumor nodule(s) present in pericolic or perirectal fat should be coded using the following guidelines:
 - i. Code as regional lymph node involvement if the nodule has a smooth contour.
 - ii. Code as tumor extension if the nodule has an irregular contour.
9. **Sentinel lymph nodes.** Involved nodes found during sentinel lymph node procedures are classified as positive nodes and coded in CS Lymph Nodes. However, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor. For further information, see the coding guidelines for CS Reg Nodes Eval.
10. **For the following primary sites, CS Lymph Nodes is always coded 988, Not applicable.**
- Placenta
 - Brain and Cerebral Meninges
 - Other Parts of Central Nervous System
 - Intracranial Gland
 - Hodgkin and Non-Hodgkin Lymphoma
 - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
 - Other and III-Defined Primary Sites
 - Unknown Primary Site
11. **Document choice of code in text.** It is strongly recommended that the choice of regional lymph node codes be documented in a related text field on the abstract.

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CS LYMPH NODES EVAL

Item Length: 1

NAACCR Item #2840

Description

This field is used primarily to derive the staging basis for the N category in the TNM system. It records how the code for the item “CS Lymph Nodes” was determined, based on the diagnostic methods employed and their intent.

Code	Description	Staging Basis
0	<p>Does not meet criteria for AJCC pathologic staging:</p> <p>No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.</p>	c
1	<p>Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria:</p> <p>No regional lymph nodes removed for examination. Evaluation based on endoscopic examination or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used.</p> <p>OR</p> <p>Fine needle aspiration, incisional or core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup WITHOUT removal of the primary site adequate for pathologic T classification (treatment).</p>	c
2	<p>Meets criteria for AJCC pathologic staging:</p> <p>No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).</p>	p
3	<p>Meets criteria for AJCC pathologic staging based on at least one of the following criteria:</p> <p>Any microscopic assessment of regional nodes (including FNA, incisional or core needle biopsy, excisional biopsy, sentinel node biopsy or node resection) WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category.</p> <p>OR</p> <p>Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.</p>	p
5	<p>Does not meet criteria for AJCC y-pathologic (yp) staging:</p> <p>Regional lymph nodes removed for examination AFTER neoadjuvant therapy and lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant treatment) is more extensive (see code 6).</p>	c

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Code	Description	Staging Basis
6	<p>Meets criteria for AJCC y-pathologic (yp) staging:</p> <p>Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on pathologic evidence, because the pathologic evidence at surgery is more extensive than clinical evidence before treatment. <i>See Note 1.</i></p>	yp
8	<p>Meets criteria for AJCC autopsy (a) staging:</p> <p>Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.</p>	a
9	<p>Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record</p> <p><i>For sites that have no TNM staging:</i> Not applicable; staging basis is displayed as a blank</p>	c

Note 1. This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.

Seventh Edition TNM and CSv2 Changes in Eval Code Definitions

A major change reflecting current medical practice occurred in the rules for clinical and pathologic classification of regional lymph nodes effective with the seventh edition of the *AJCC Cancer Staging Manual*. In CSv2, CS Lymph Nodes Eval is coded as clinical or pathologic based on the intent of the procedure and matching the assessment of the T classification (coded in CS TS/Ext Eval). The intent can be either clinical/diagnostic or therapeutic.

When the lymph node procedure is part of the workup, the staging basis is clinical (CS Lymph Nodes Eval codes 0, 1, 5, 9). If the microscopic assessment (workup) of lymph nodes, such as a regional node biopsy or sentinel lymph node procedure, is intended to help choose the treatment plan, the information obtained is part of clinical staging. In these circumstances, the tumor size and/or extension (T-category) information is also clinical and any resection of the primary site does not meet the criteria for pathologic T classification.

When the intent of the lymph node procedure is therapeutic (treatment), the staging basis is pathologic (CS Reg Nodes Eval codes 2, 3, 6). In these circumstances, there is also a resection of the primary site that meets the criteria for pathologic T classification (also part of the treatment) or there is microscopic confirmation of the highest T category without a surgical resection of the primary site.

Example 1 Breast cancer patient diagnosed by mammography and core needle biopsy; axilla clinically negative. Patient opts for lumpectomy and sentinel node biopsy, which is negative for lymph node metastases. *Code CS Lymph Nodes Eval as 3 because the sentinel node biopsy was part of the treatment.*

Example 2 Large breast mass found to be cancerous on core needle biopsy. Fullness in axilla on physical examination. Sentinel node biopsy shows micrometastasis in one of three nodes. Patient received neoadjuvant chemotherapy followed by modified radical mastectomy. On the mastectomy pathology report, no positive lymph nodes were found. *Code CS Lymph Nodes Eval as 5 because the sentinel node biopsy was performed as part of the workup and the patient received surgical treatment to primary site following neoadjuvant*

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- treatment.*
- Example 3* Patient has hard lump in low neck and an endoscopic paratracheal node biopsy confirms metastatic lung cancer. Patient treated with chemoradiation. *Code CS Lymph Nodes Eval as 1 because the endoscopic biopsy was part of the workup and patient did not have resection of the primary site.*
- Example 4* Sigmoid colon cancer diagnosed by colonoscopy. At the time of resection, 3/15 pericolic lymph nodes were found to contain metastatic cancer. *Code CS Lymph Nodes Eval as 3 because positive nodes were found as part of surgical resection of primary site.*
- Example 5* Patient diagnosed with medullary thyroid carcinoma, and undergoes total thyroidectomy and anterior compartment node dissection. Node dissection finds 2 of 12 lymph nodes contain metastatic carcinoma. *Code CS Lymph Nodes Eval as 3 because the lymph nodes were part of the therapeutic resection of the primary site.*
- Example 6* Patient has malignant melanoma on the forearm confirmed by shave biopsy. Patient has an FNA of an enlarged axillary lymph node that shows no involvement of the axillary lymph node by melanoma. Patient's treatment consists of wide excision of primary site. *Code CS Lymph Nodes Eval as 1 because the sentinel node biopsy was done to determine what type of treatment the patient should have.*

Instructions for Coding

1. Document the farthest involved regional nodes.

- a. Select the CS Lymph Nodes Eval code that identifies the type of 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 LN code 100, Eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (CS LN code 320, Eval code 0). *Code CS Lymph Nodes Eval as 0 because the scalene node involvement was determined clinically rather than by examination of tissue.*

- b. If there is a discrepancy between clinical and pathologic information about the same lymph node chain(s), **pathologic information takes priority**. It is not necessary to biopsy every node in the chain to prove that they are negative.

Example Lung cancer patient has a CT scan showing a mass of lymph nodes in the ipsilateral mediastinum. Biopsies at mediastinoscopy report that two ipsilateral mediastinal lymph nodes are negative for tumor. *Code CS Lymph Nodes as 000 and CS Lymph Nodes Eval as 1 because the mediastinoscopy disproved the clinically suspicious mediastinal nodes.*

- c. **Mapping of N subcategories.** Select the CS Lymph Node Eval code that describes how the most advanced subcategory of the derived N was determined.

- i. If a specific subcategory of N will be derived (such as N2b), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Lymph Node Eval code that will derive a "p" staging basis if the patient also has surgical resection of the primary site.
- ii. If there was only clinical evidence of the subcategory disease, select a CS Lymph Node Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower N subcategory, but this is not considered in assigning the Eval code.

Example Breast cancer patient with 10 of 14 axillary nodes positive at time of modified radical mastectomy (CS Lymph Nodes code 600, Site-specific Factor 3 code 010, maps to pN3a). Patient also has palpable hard supraclavicular node presumed to be involved by the clinician (CS Lymph Nodes code 800, maps to N3c). *Code CS Lymph Node Eval as 0 because the physical examination documented a higher N subcategory than the axillary dissection.*

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2. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. For any sites that have no TNM mapping, code to the value that best identifies the diagnostic methods used, whether or not a stage group is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, for a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.
3. Select the code that best explains how the information in the CS Lymph Nodes field was determined.
 - a. **If no lymph nodes are removed.** 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 microscopically involved nodes; radical prostatectomy canceled.
Code CS Lymph Node Eval as 3. Staging algorithm will 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 Lymph Node Eval as 0. Staging algorithm will identify information as clinical (c).
 - b. **Lymph nodes removed followed by other treatment(s).** If the patient had removal of lymph node(s) surgery together with removal of the primary site that meets the criteria for a pathologic T and these procedures are followed by other treatment(s), use code 3.
 - c. **When there is pre-operative treatment.** 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). If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.
 - d. **When there is more extensive lymph node involvement after preoperative treatment.** Use only code 5 or 6 if the node assessment is performed after neoadjuvant therapy. 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 found during lymph node examination after neoadjuvant therapy, use code 6.
 - e. **Use of autopsy codes 2 and 8.** If the patient had an autopsy and the autopsy information meets the timing rules for determining regional lymph node involvement, 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. **Definition of code 0.** Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Lymph Nodes is coded 000 based on the clinician's impression that there are no involved regional nodes (inaccessible nodes rule), use code 0 to document that met the criteria for a clinical M0.

Examples of imaging studies included in Code 0. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues. According to the *AJCC Cancer Staging Manual* seventh edition, extensive imaging is not necessary to assign a clinical staging basis.
5. **Use of code 1.** 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 contains

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metastases from a 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. For specific classification rules, refer to the *AJCC Cancer Staging Manual, seventh 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. Code 1 is used when the lymph node procedure is part of the patient's workup to determine the course of treatment and the patient does not undergo resection of the primary site sufficient to meet the criteria for a pathologic T category.

6. **Use of code 3.** Code 3 maps to pathologic staging across all sites. Use code 3 when 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 example, for prostate cancer, a positive fine needle aspiration biopsy of a single lymph node is sufficient to code CS Lymph Nodes Eval as code 3, because only one positive node is needed to classify the case as pN1 and there is only one positive N category (N1). In contrast, a fine needle aspiration of a hilar mass (N1) associated with a lung cancer should be coded in CS Lymph Nodes Eval as 1 because by itself it is not sufficient to document the highest N since there are three positive N categories. However, microscopic assessment of the highest N category, for example a supraclavicular node containing metastatic lung cancer, is always pathologic (code 3).

7. **Sentinel nodes.** The coding guidelines for positive sentinel lymph nodes in CS Lymph Nodes Eval are site-specific. In general, however, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor or if the resection of the primary tumor is not adequate for pathologic T.
 - a. When the tumor size and/or extension of the primary tumor meets the criteria for pathologic staging and lymph nodes are biopsied or removed for examination, information on lymph nodes is considered pathologic and it is not necessary to document the highest N category.

Example Patient has a lumpectomy and sentinel lymph node procedure for breast cancer. The margins around the primary tumor are clear, and there is one of three sentinel nodes positive for metastatic duct carcinoma. *Code CS Lymph Nodes Eval as 3 because when the primary tumor procedure meets the criteria for pathologic T and sentinel nodes meet the criteria for pathologic N.*
 - b. When the tumor size and/or extension of the primary tumor does not meet the criteria for pathologic staging, examination of a single lymph node or sentinel nodes is considered clinical.

Example Patient presents with large ulcerated mass in the breast and clinically positive axillary nodes. Core needle biopsies of the breast mass and the axillary node confirm carcinoma. Patient undergoes pre-operative chemotherapy followed by a modified radical mastectomy. *Code CS Lymph Nodes Eval as 5 because when the primary tumor procedure does not meet the criteria for pathologic T, and a core needle biopsy of level I lymph nodes performed prior to neoadjuvant treatment is clinical.*
 - c. If there is a positive biopsy of a lymph node in the highest N category, CS Lymph Nodes Eval should be coded as 3 regardless of whether the primary tumor is clinical or pathologic.

Example Patient presents with a hard supraclavicular mass, which is excised and shows metastatic squamous carcinoma. Further diagnostic workup shows a mass in the left upper lobe of the lung with several satellite nodules. *Code CS Lymph Nodes Eval as 3 because supraclavicular nodes are in the highest N category (N3).*

8. **Coding CS Lymph Nodes Eval when lymph node status is unknown.** The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or Mets at Dx) is unknown. For example, even if it is not possible to determine lymph node involvement and the CS Lymph Nodes field is coded as 999, the registrar still

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knows what procedures were used to try to determine that field. In other words, just because the lymph nodes are coded 999, the Eval field does not have to be coded 9.

9. The following schemas are always coded 9 Not Applicable or Does Not Apply.

AdnexaUterineOther	KaposiSarcoma
Brain	Lymphoma
CNSOther	MelanomaSinusOther
DigestiveOther	MiddleEar
EndocrineOther	MyelomaPlasmaCellDisorder
EyeOther	PharynxOther
GenitalFemaleOther	Placenta
GenitalMaleOther	RespiratoryOther
HemeRetic	SinusOther
IllDefinedOther	Trachea
IntracranialGland	UrinaryOther

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REGIONAL NODES POSITIVE

Item Length: 2

NAACCR Item #820

Description

This field records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. This field is also called Reg LN Pos.

Code	Description
00	All nodes examined negative.
01 - 89	1 to 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s). <i>See Rule 6.</i>
97	Positive nodes – number unspecified. <i>See Rule 7.</i>
98	No nodes examined <i>See Rule 8.</i>
99	Unknown whether nodes are positive; not applicable; not documented in patient record.

Instructions for Coding

1. **Regional lymph nodes only.** 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. This field is **based on pathologic information only.** This field is to be recorded regardless of whether the patient received preoperative treatment.
3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.
4. **Cumulative nodes positive.** 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 remove lymph nodes through the completion of surgeries in the first course of treatment.
 - b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Definition of Code 95 below.

Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

Example Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. *Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.*

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- c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.
Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*
- d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.
Example Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*
5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
6. **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.
Example Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*
b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.
Example Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected. (Code Reg Nodes Eval as 5.)*
7. **Definition of code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
Example Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection “several” of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. *Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.*
Note: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided.
Note: If the aspirated node is the only one that is microscopically positive, use code 95.
Note: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.
8. **Use of code 98.** Code 98 may be used in several situations.
a. When the assessment of lymph nodes is clinical only.
b. When no lymph nodes are removed and examined.

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- c. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
 - d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.
9. **Isolated tumor cells (ITCs) in lymph nodes.** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
- a. **For cutaneous melanoma and Merkel cell carcinoma,** count nodes with ITCs as positive lymph nodes.
10. **Use of code 99.** Use code 99 if it is unknown whether regional lymph nodes are positive.
11. **Primary sites always coded 99.** 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
 - Intracranial Gland
 - Hodgkin and non-Hodgkin Lymphoma
 - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
 - Myeloma and PlasmaCell Disorders
 - Other and Ill-Defined Primary Sites
 - Unknown Primary Site

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REGIONAL NODES EXAMINED

Item Length: 2

NAACCR Item #830

Description

This field records the total number of regional lymph nodes that were removed and examined by the pathologist. This field is also called Reg LN Exam.

Code	Description
00	No nodes examined
01-89	1 to 89 nodes examined (code the exact number of regional lymph nodes examined.)
90	90 or more nodes examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed. <i>See Rule 5.</i>
96	Regional lymph node removal documented as a sampling, and the number of nodes unknown/not stated. <i>See Rule 7.</i>
97	Regional lymph node removal documented as dissection, and the number of nodes unknown/not stated. <i>See Rule 8.</i>
98	Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but the number unknown. <i>See Rule 3e.</i>
99	Unknown whether nodes were examined; not applicable or negative; not documented in patient record.

Instructions for Coding

1. **Regional lymph nodes only.** 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. This field is **based on pathologic information only.** This field is to be recorded regardless of whether the patient received preoperative treatment.
3. **Use of code 00.** Code 00 may be used in several situations.
 - i. When the assessment of lymph nodes is clinical.
 - ii. When no lymph nodes are removed and examined.
 - iii. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
 - iv. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.
4. **Cumulative nodes removed and examined.** 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 with the exception of aspiration or core biopsies coded to 95.

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- b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.
Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*
 - c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.
Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*
 - d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.
Example Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*
 - e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.
5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
 6. **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
Example Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*
 7. **Lymph node biopsy.** 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.
 8. **Definition of “sampling” (code 96).** A lymph node “sampling” is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
 9. **Definition of “dissection” (code 97).** A lymph node “dissection” is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
 10. **Multiple lymph node procedures.** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
 11. **Use of code 99.** If it is unknown whether nodes were removed or examined, code as 99.
 12. **Primary sites always coded 99.** For the following schemas, the Regional Nodes Examined field is always coded as 99.

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Placenta

Brain and Cerebral Meninges

Other Parts of Central Nervous System

Intracranial Gland

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms

Hodgkin and non-Hodgkin Lymphoma

Myeloma and Plasma Cell Disorders

Other and Ill-Defined Primary Sites

Unknown Primary Site

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CS METS AT DX

Item Length: 2

NAACCR Item #2850

Description

This field identifies the distant site(s) of metastatic involvement at time of diagnosis.

Code	Description	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
00	No distant metastasis	M0	M0	None	None
10	Distant lymph node(s)	M1	M1	D	D
	SITE/HISTOLOGY-SPECIFIC CODES WHERE NEEDED				
40	Distant metastases except code 10 Carcinomatosis	M1	M1	D	D
	SITE/HISTOLOGY-SPECIFIC CODES WHERE NEEDED				
50	40 + 10	M1	M1	D	D
60	Distant metastasis, NOS Stated as M1 with no other information on distant metastasis	M1	M1	D	D
99	Unknown; distant metastasis not stated Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

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

Code	Description
98	Not applicable; Information not collected for this schema

Instructions for Coding

- Discontinuous or hematogenous metastases.** This field represents distant metastases (the TNM M component or distant stage in Summary Staging) that are known at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or 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 (1977 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.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure is not

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listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

2. **Use highest applicable code.** 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. Code 40 includes statements of metastases to specific named structures or “carcinomatosis.” Code 60 is nonspecific distant metastases or a statement of M1 with no further information about metastases; code 60 does not take priority over lower codes.
3. **Progression of disease.** 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. **Coding 00 versus 99**
 - a. Record CS Mets at Dx as Code 00 (None) if there is no clinical or pathologic evidence of distant metastases and the patient is not treated as if metastases are present or suspected. This presumes that there are no distant metastases that would otherwise alter the treatment approach.
 - b. Code 99 may be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases. Note that code 99 maps to MX in sixth edition and cM0 in seventh edition.
 - c. Based on the *AJCC Cancer Staging Manual*, seventh edition, determination of the clinical M classification (CS Mets at Dx code 00) only requires history and physical examination. Imaging of distant organ sites is not required to assign cM0 or CS Mets at Dx code 00. In other words, the data collector can infer that there are no distant metastases and code CS Mets at Dx as 00 (cM0) unless distant metastases are identified and classified as cM1 or pM1 (or its equivalents in CS Mets at Dx). Use code 0 in CS Mets Eval as this documents minimal physical examination to support the inference of clinical M0.
5. **No MX classification for AJCC seventh edition.** The category MX has been eliminated from the seventh edition of the TNM staging system. As noted above, if there are no symptoms or other indication of distant metastases, the mapping algorithm takes CS Mets at Dx codes 00 and 99 and maps both to cM0.
6. **Inferring distant metastases from stated M category or site-specific staging.** If the only indication of distant metastases 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, code the appropriate “Stated as M_, NOS” category or record the numerically lowest equivalent CS Mets at Dx code for the site-specific staging system. In most cases, this will be 60, Distant metastasis, NOS.
 - a. 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. **Use of NOS categories.** Some 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. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs).** CTCs and DTCs are small clusters of tumor cells found in distant sites such as bone, circulating blood, or bone marrow having uncertain prognostic significance.

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- a. For breast, code CS Mets at Dx as 05 when a biopsy of a possible metastatic site shows isolated tumor cells or bone marrow micrometastases detected by IHC or molecular techniques. CS Mets at Dx code 05 maps to cM0(i+).
 - b. For other sites, CTCs and DTCs are coded in CS Mets at Dx as 00 and map to cM0.
9. **Primary sites always coded 98.** For the following primary sites and histologies, CS Mets at Dx is always coded as 98.
- Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
 - Hodgkin and non-Hodgkin Lymphoma
 - Kaposi Sarcoma
 - Myeloma and Plasma Cell Disorders
 - Other and Ill-Defined Primary Sites
 - Unknown Primary Site
10. **Document choice of code in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis codes be documented as well as the choice of code in a related text field on the abstract.

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CS METS AT DX-BONE

Item Length: 1

NAACCR Item #2851

Description

This field is a companion to CS Mets at Dx that identifies whether bone is an involved metastatic site. The four CS Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Note: This data item is not officially part of the CSv2 data set but is included in the CSv2 manual and coding instructions because it directly relates to CS Mets at Dx.

Code	Description
0	None; no bone metastases <i>See Note 1.</i>
1	Yes
8	Not applicable
9	Unknown whether bone is involved metastatic site Not documented in patient record

Note 1: If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if bone is not a site of metastasis.

Instructions for Coding

1. **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. This field should not be coded for bone marrow involvement.
 - a. Bone involvement may be single or multiple.
 - b. Information about bone involvement may be clinical or pathologic.
 - c. Code this field whether or not the patient had any preoperative systemic therapy.
 - d. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

2. **Use of codes.** Assign the code that best describes whether the case has bone metastases.
 - a. Use code 0 when the medical record
 - i. indicates that there are no distant (discontinuous) metastases at all
 - ii. includes a clinical or pathologic statement that there are no bone metastases
 - iii. includes imaging reports that are negative for bone metastases
 - iv. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but bone is not mentioned as an involved site. For example, use code 0 when the patient has lung and liver metastases but not bone.
 - b. Use code 1 when the medical record
 - i. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and bone is mentioned as an involved site
 - ii. indicates that bone is the primary site and there are metastases in a different bone or bones
 - c. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site). This includes Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms Hodgkin and non-Hodgkin Lymphoma
 - d. Use code 9 when
 - i. it cannot be determined from the medical record whether the patient specifically has bone

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- metastases; for example, when CS Mets at Dx is coded as carcinomatosis but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.
- ii. CS Mets at Dx is coded 99 (unknown).

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CS METS AT DX-BRAIN

Item Length: 1

NAACCR Item #2852

Description

This field is a companion to CS Mets at Dx that identifies whether brain is an involved metastatic site. The four CS Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Note: This data item is not officially part of the CSv2 data set but is included in the CSv2 manual and coding instructions because it directly relates to CS Mets at Dx.

Code	Description
0	None; no brain metastases <i>See Note 1.</i>
1	Yes
8	Not applicable
9	Unknown whether brain is involved metastatic site Not documented in patient record

Note 1: If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if brain is not a site of metastasis.

Instructions for Coding

1. **Code information about brain metastases only** (discontinuous or distant metastases to brain) known at the time of diagnosis. This field should not be coded for involvement of spinal cord or other parts of the central nervous system.
 - a. Brain involvement may be single or multiple.
 - b. Information about brain involvement may be clinical or pathologic.
 - c. Code this field whether or not the patient had any preoperative systemic therapy.
 - d. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites

2. **Use of codes.** Assign the code that best describes whether the case has brain metastases.
 - a. Use code 0 when the medical record
 - i. indicates that there are no distant (discontinuous) metastases at all
 - ii. includes a clinical or pathologic statement that there are no brain metastases
 - iii. includes imaging reports that are negative for brain metastases
 - iv. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but brain is not mentioned as an involved site. For example, use code 0 when the patient has lung and liver metastases but not brain.
 - b. Use code 1 when the medical record
 - i. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and brain is mentioned as an involved site
 - ii. indicates that brain is the primary site and there are metastases within the brain
 - c. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site). This includes Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms Hodgkin and non-Hodgkin Lymphoma
 - d. Use code 9 when

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- i. it cannot be determined from the medical record whether the patient specifically has brain metastases; for example, when CS Mets at Dx is coded as carcinomatosis but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.
- ii. CS Mets at Dx is coded 99 (unknown).

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CS METS AT DX-LIVER

Item

Length: 1

NAACCR

Item #2853

Description

This field is a companion to CS Mets at Dx that identifies whether liver is an involved metastatic site. The four CS Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Note: This data item is not officially part of the CSv2 data set but is included in the CSv2 manual and coding instructions because it directly relates to CS Mets at Dx.

Code	Description
0	None; no liver metastases <i>See Note 1.</i>
1	Yes
8	Not applicable
9	Unknown whether liver is involved metastatic site Not documented in patient record

Note 1: If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if liver is not a site of metastasis.

Instructions for Coding

1. **Code information about liver metastases only** (discontinuous or distant metastases to liver) known at the time of diagnosis.
 - a. Liver involvement may be single or multiple.
 - b. Information about liver involvement may be clinical or pathologic.
 - c. Code this field whether or not the patient had any preoperative systemic therapy.
 - d. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

2. **Use of codes.** Assign the code that best describes whether the case has liver metastases.
 - a. Use code 0 when the medical record
 - i. indicates that there are no distant (discontinuous) metastases at all
 - ii. includes a clinical or pathologic statement that there are no liver metastases
 - iii. includes imaging reports that are negative for liver metastases
 - iv. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but liver is not mentioned as an involved site. For example, use code 0 when the patient has lung and brain metastases but not liver.
 - b. Use code 1 when the medical record
 - i. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and liver is mentioned as an involved site
 - ii. indicates that liver is the primary site and there are metastases within the liver
 - c. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site). This includes Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms Hodgkin and non-Hodgkin Lymphoma
 - d. Use code 9 when
 - i. it cannot be determined from the medical record whether the patient specifically has liver

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- metastases; for example, when CS Mets at Dx is coded as carcinomatosis but liver is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.
- ii. CS Mets at Dx is coded 99 (unknown).

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CS METS AT DX-LUNG

Item Length: 1

NAACCR Item #2854

Description

This field is a companion to CS Mets at Dx that identifies whether lung is an involved metastatic site. The four CS Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Note: This data item is not officially part of the CSv2 data set but is included in the CSv2 manual and coding instructions because it directly relates to CS Mets at Dx.

Code	Description
0	None; no lung metastases <i>See Note 1.</i>
1	Yes
8	Not applicable
9	Unknown whether lung is involved metastatic site Not documented in patient record

Note 1: If CS Mets at Dx is coded to 00, this field must be coded 0. If CS Mets at Dx is not coded to 00, this field may still be coded to 0 if lung is not a site of metastasis.

Instructions for Coding

1. **Code information about lung metastases only** (discontinuous or distant metastases to lung) known at the time of diagnosis. This field should not be coded for pleural or pleural fluid involvement.
 - a. Lung involvement may be single or multiple.
 - b. Information about lung involvement may be clinical or pathologic.
 - c. Code this field whether or not the patient had any preoperative systemic therapy.
 - d. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.

2. **Use of codes.** Assign the code that best describes whether the case has lung metastases.
 - a. Use code 0 when the medical record
 - i. indicates that there are no distant (discontinuous) metastases at all
 - ii. includes a clinical or pathologic statement that there are no lung metastases
 - iii. includes imaging reports that are negative for lung metastases
 - iv. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) but lung is not mentioned as an involved site. For example, use code 0 when the patient has brain and liver metastases but not lung.
 - b. Use code 1 when the medical record
 - i. indicates that the patient has distant (discontinuous) metastases (in other words, CS Mets at Dx is not coded as 00) and lung is mentioned as an involved site
 - ii. indicates that lung is the primary site and that there are metastases within the lung
 - c. Use code 8 when CS Mets at Dx is coded as 98 (not applicable for this site). This includes Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms Hodgkin and non-Hodgkin Lymphoma
 - d. Use code 9 when
 - i. it cannot be determined from the medical record whether the patient specifically has lung

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- metastases; for example, when CS Mets at Dx is coded as carcinomatosis but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.
- ii. CS Mets at Dx is coded 99 (unknown).

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CS METS EVAL

Item Length: 1

NAACCR Item #2860

Description

This field is used primarily to derive the staging basis for the M category in the TNM system. It records how the code for the item “CS Mets at Dx” was determined based on the diagnostic methods employed.

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastasis performed or pathologic examination was negative.	c
1	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastasis performed or pathologic examination was negative.	c
2	Meets criteria for AJCC pathologic staging of distant metastasis: No pathologic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Meets criteria for AJCC pathologic staging of distant metastasis: Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation OR specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed OR specimen from metastatic site microscopically positive prior to neoadjuvant treatment	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.	c
6	Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence. <i>See Note 1.</i>	yp
8	Meets criteria for AJCC autopsy (a) staging of distant metastasis: Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.	a

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Code	Description	Staging Basis
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record <i>For sites with no TNM staging:</i> Not applicable	c

Note 1. This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.

Instructions for Coding

1. **Document the highest code in CS Mets at Dx.** The primary use of the CS Mets Eval field is to assign a “c” or “p” to the M category derived from the CS Mets at Dx field. Since both clinical and pathologic evidence might be available for assessing distant metastasis, the coding of the Eval field can be confusing. The goal is to assign the Eval code that indicates the best evidence used to determine the M category. In other words, the concept of the Mets Eval field is slightly different from the other Eval fields in that results of the procedure are coded, rather than the type of procedure that provided the information about distant metastasis. Coding of the Eval field therefore requires that the abstractor take note of the M category that will be derived from the code in the CS Mets at Dx field and then use the following guidelines to determine the best Eval code to assign.
 - a. **Deriving M0.** If M0 will be derived (i.e., no distant metastasis are present), select an Eval code that will derive a “c” staging basis. There is no category of pM0, because it is impossible to disprove all possible sites of metastasis pathologically. Therefore, do not assign CS Mets Eval code 2, 3, or 6 when CS Mets at DX is coded 00.

Example Pancreatic carcinoma with negative chest X-ray and negative liver biopsy. Code CS Mets at Dx as 00 (None), which maps to M0. Code CS Mets Eval as 1 to document the liver biopsy, which maps to the “c” staging basis.

Example Chest x-ray negative and surgical observation during hemicolectomy shows no liver metastasis. Code CS Mets Eval as 1, because there was an invasive technique (surgery observation) that yielded a negative result.

Example CT scan indicates thickened stomach wall with normal liver, spleen, lung bases and impression states presumed gastric malignancy. Patient dies 2 days later from chronic renal failure. Autopsy confirms primary gastric adenocarcinoma with all other body systems normal. Code CS Mets Eval as 0 (imaging prior to death) as there is no category of pM0.
 - b. **Mapping of CS Mets at Dx code 99.** If the status of distant metastases is unknown (CS Mets at Dx code 99), choose an Eval code that will derive a “c” staging basis, because code 99 maps to M0 in TNM7, and this category can only be clinical. The appropriate code might be 9 (Unknown) in rare situations or might be another code if workup was done but the results were not definitively positive or negative.

Example Cecum carcinoma abstracted from a pathology report of biopsy only, no clinical data or surgical observations available. Code CS Mets at Dx as 99 (Unknown), which will map to M0 in the seventh edition. Code CS Mets Eval as 9 (Unknown), which maps to the “c” staging basis.

Example Lung cancer diagnosed by imaging. Patient has behavior changes, and brain imaging cannot rule out metastases. Patient is not a surgical candidate. Code CS Mets at Dx as 99 (Unknown), which maps to M0 in the seventh edition. Code CS Mets Eval as 0 (imaging), which maps to the “c” staging basis.

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- c. **Pathologic M1 takes priority.** If M1 will be derived (i.e., there is metastatic disease present and coded in the CS Mets at Dx field) and there are no subcategories of M1, such as M1a and M1b, then determine if there was any pathological evidence for the M1 category.
- i. If there is microscopic confirmation of distant metastases, select an Eval code that will derive a “p” staging basis. In other words, any microscopic confirmation of a distant metastasis meets the criteria for pathologic M1.

Example Patient with perforated stomach cancer. At surgery, peritoneal cytology is positive. CT scan shows multiple liver metastases. Code CS Mets at Dx as 40 for both the liver and peritoneal metastases, which maps to M1. (There are no subcategories of M1 for stomach). Code CS Mets Eval as 3 because any positive microscopic confirmation of distant metastases meets the criteria for pathologic staging of distant metastases.
 - ii. If there was only clinical evidence of the M1 disease, select an Eval code that will derive a “c” staging basis.

Example Patient diagnosed with kidney cancer and discharged to nursing home where she expired within two weeks of diagnosis. Discharge summary states bone metastases from kidney cancer as final diagnosis. There is no supporting documentation for the bone metastases in either the original hospital record or the nursing home record. Code CS Mets Eval as 0 because the physicians’ statement of bone metastases is part of “other non-invasive clinical evidence” in code 0 and maps to a clinical staging basis. Do not use code 9, because the presence of distant metastases was assessed by the clinician.
- d. **Mapping of M1 subcategories.** If a specific subcategory of M1 will be derived (such as M1a), determine if there was any pathological evidence for the specific subcategory. If so, select an Eval code that will derive a “p” staging basis. If there was only clinical evidence of the subcategory disease, select an Eval code that will derive a “c” staging basis. In the latter case there may have been pathological evidence of a lower M subcategory, but this is not considered in assigning the Eval code.

Example 1 Prostate carcinoma with one or more of the following:

Involvement	CS Mets at Dx Code	TNM Map
Positive biopsy of aortic lymph node (distant node)	Code 12	pM1a
Positive bone imaging	Code 30	cM1b
Positive brain imaging	Code 40	cM1c
All of the above	Code 55 (= codes 12 + 30 + 40)	cM1c

To code CS Mets at Dx, follow the general rule to code the highest applicable code, even though there is pathological evidence of metastases. Code CS Mets at Dx as 55, which combines the codes for the lymph node, bone, and brain involvement. Code 55 maps to M1c. There is no pathologic evidence for the subcategory M1c (the only pathological evidence is for subcategory M1a). Code CS Mets Eval as 0 (imaging), which maps to the “c” staging basis. The positive lymph node would map to M1a, a lower M subcategory. Do not base the Eval code on positive microscopic findings for a lower subcategory.

Example 2 Prostate carcinoma with positive biopsy of aortic lymph node (distant node), negative bone scan, and negative brain scan. Code CS Mets at Dx as 12 (distant lymph node), which maps to M1a. Code CS Mets Eval as 3, which maps to the “p” staging basis.

Example 3 Testicular carcinoma patient has a positive pelvic lymph nodes on FNA (CS Mets at Dx code 11, maps to M1a). Patient has CT of brain showing distant metastases (CS Mets at Dx code 40, maps to M1b). Code CS Mets Eval as 0 because the higher M subcategory was established by imaging.

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Example 4 Cecum carcinoma with lung metastases on chest X-ray and positive liver biopsy. CS Mets at Dx is coded 36 (Metastases to more than one distant organ), which maps to M1b. *Code CS Mets Eval as 3, which maps to the “p” staging basis.*

Example 5 Cecum carcinoma with positive chest X-ray and negative liver biopsy. CS Mets at Dx is coded 26 (Metastasis to a single distant organ). *Code CS Mets Eval as 0, which maps to the “c” staging basis.*

2. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Appendix 3.) For any sites and histologies not listed there, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.
3. **When there is neoadjuvant treatment.** 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), unless the pathologic evidence is more extensive (code 6).
4. **Definition of code 0.** Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Mets at Dx is coded 00 based on the clinician’s impression that there are no distant metastases, use code 0 to document that met the criteria for a clinical M0.
Examples of imaging studies included in Code 0. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET), spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.
5. **Definition of Code 1.** 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 as well as biopsies of distant sites that are negative.
6. **Definition of Code 3.** In general, any positive microscopic confirmation of a metastasis meets the criteria for pathologic staging. Therefore, a positive needle biopsy of a metastatic site is Eval Code 3. Complete removal of a metastatic site is not required for pathologic staging.
7. **No pathologic M0.** AJCC does not recognize a pM0 category since it is not possible to microscopically rule out all possible metastatic sites. According to the *AJCC Cancer Staging Manual*, seventh edition, “A case where there are no symptoms or signs of metastases is classified as clinically M0. The only evaluation necessary to classify a case as clinically M0 is history and physical examination. It is not necessary to do extensive imaging studies to classify a case as clinically M0.”
 - a. If there is no mention in the medical record of distant metastases, code CS Mets at Dx as 00 and CS Mets Eval as 0, which maps to cM0.
 - b. If there is evidence of metastases on physical examination, imaging, or exploratory surgery and there is no biopsy of the suspected metastatic site, code CS Mets at Dx appropriately (not 00 or 99) and CS Mets Eval with a code that maps to “c” staging basis. In general, such cases will map to cM1_.
 - c. If the patient has a biopsy or removal of a distant site and the pathology report is negative, generally use Eval code 1, because this does not meet the criteria for pathologic staging.

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8. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs) in metastatic sites.**
CTCs and DTCs, including bone marrow micrometastases, are clinical findings if detected by immunohistochemistry or molecular methods. The significance of these small clusters of tumor cells in distant sites is indeterminate. When identified, CTCs and DTCs are coded in CS Mets at Dx as 00 and CS Mets Eval should be assigned a code that maps to “c” staging basis. In general, such cases will map to cM0 or cM0(i+).

9. **Schemas always coded 9 Not Applicable.**

AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland

KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
RespiratoryOther
SinusOther
Trachea
UrinaryOther

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CS SITE-SPECIFIC FACTORS 1 - 25

Item Length: 3

NAACCR Item #: *see below*

ITEM NAME	NAACCR Item #
CS Site-Specific Factor 1	2880
CS Site-Specific Factor 2	2890
CS Site-Specific Factor 3	2900
CS Site-Specific Factor 4	2910
CS Site-Specific Factor 5	2920
CS Site-Specific Factor 6	2930
CS Site-Specific Factor 7	2861
CS Site-Specific Factor 8	2862
CS Site-Specific Factor 9	2863
CS Site-Specific Factor10	2864
CS Site-Specific Factor11	2865
CS Site-Specific Factor12	2866
CS Site-Specific Factor13	2867
CS Site-Specific Factor14	2868
CS Site-Specific Factor15	2869
CS Site-Specific Factor16	2870
CS Site-Specific Factor17	2871
CS Site-Specific Factor18	2872
CS Site-Specific Factor19	2873
CS Site-Specific Factor20	2874
CS Site-Specific Factor21	2875
CS Site-Specific Factor22	2876
CS Site-Specific Factor23	2877
CS Site-Specific Factor24	2878
CS Site-Specific Factor25	2879

Description

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

Site-specific factors (SSFs) serve a variety of purposes in CS.

- **Required to support TNM mapping.** Some SSFs provide additional information beyond the 9 core CS fields and are necessary for mapping to T, N, M, or stage group. Examples are the number of positive axillary lymph nodes for breast, extracapsular extension for head and neck sites, and the thickness of a malignant melanoma of the skin or mucous membrane. In general, these will be required by COC facilities and SEER.
- **Tumor Markers and Lab Values.** Some SSFs are tumor markers or lab values of prognostic significance for various sites, such as CA-125 for ovary, CA 19-9 for GI sites, alpha fetoprotein and hCG for testis, KRAS for colon and rectum, and Ki-67 for CNS and various eye sites.
- **Prognostic/Predictive Items.** A number of SSFs are included because of their prognostic or predictive value, such as the Gleason tertiary pattern for prostate, and the various international prognostic indices for lymphoma, such as the IPI for aggressive lymphomas, FLIPI for follicular lymphomas, and the IPS for Hodgkin lymphoma.
- **Special Interest/Future Research.** As part of the effort to be clinically relevant, the seventh edition

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chapter authors included items of special interest for future research, such as the presence of microsatellite instability for GI cancers and tumor infiltrating lymphocytes (TIL) for Merkel cell carcinoma of the skin.

- **Other Clinically Significant Information.** Some data items pertain to the patient’s history of other diseases, such as Sjogren’s syndrome for ocular lymphoma, a history of asbestos exposure for pleural mesothelioma, and a particular gene mutation present in many retinoblastoma cases.

Note: North American Standards Setters have determined which site-specific factors are required to be reported by their participating registries. Appendix 7 lists the site-specific factors. Refer to the CSV2 Implementation Guidelines posted on the CSV2 website for the lists of which site-specific factors are required by each standards setter.

Because so many types of information are collected, there are a variety of templates used in CSV2. These different templates use different codes to represent negative values, test not performed, and so forth. However, to the greatest extent possible, similar types of information (such as lab values) in different site-specific schemas use the same template.

The following table shows the general format and codes used for different types of information collected. The specifics of individual site-specific factors are discussed in the next section of this manual.

EXAMPLES OF TEMPLATE FORMATS FOR CSV2 SITE-SPECIFIC FACTORS

Code	Lab values or measurements (except size)	Positive/Negative	Ranges	Sizes	Grades	Things that are counted	Conditions of Involvement
000	000 value			No [mass/ tumor, nodes, whatever is measured] found		None counted	Condition not present
001	1 or less per unit of measure			Codes 001-980 for specific size (cm, mm or other)		1 unit	
002	Codes 002-979 for specific values per unit of measure					2 units	
003						3 units	
004						4 units	
010		Positive/elevated			Grade 1		Condition present (use codes in 010, 020, 030 series)
020		Negative/normal; WNL	Negative/normal; WNL		Grade 2		
030		Border-line, undetermined if pos or neg			Grade 3		
040			Positive Range 1		Grade 4		
050			Positive Range 2				

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Code	Lab values or measurements (except size)	Positive/Negative	Ranges	Sizes	Grades	Things that are counted	Conditions of Involvement
060			Positive Range 3				
...							
888	<i>See Note 1.</i>	Obsolete (if over-lying an SSF 1-6 only)	Obsolete (if over-lying an SSF 1-6 only)				
980	Highest available code (980 units or greater)			980 upper limit of size			
985				Diffuse			
988	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
989							
990				Microscopic focus or foci only [or related terms as needed for specific sites]			
991	991-996, Special codes if needed			Described as < 1 [unit]			
992				Described as < 2 [unit], > 1 [unit], or between 1 and 2 [unit]			
993				Described as < 3 [unit], >2 [unit], or between 2 and 3 [unit]			
994				Described as < 4 [unit], >3 [unit], or between 3 and 4 [unit]			
995				Described as < 5 [unit], >4 [unit], or between 4 and 5 [unit]			
996				Described as < 6 [unit], >5 [unit], or between 5 and 6 [unit]			
997	<i>See Note 2.</i> (if code needed)	<i>See Note 2.</i>	<i>See Note 2.</i>	Described as > 6 [unit]			
998	<i>See Note 3.</i>	<i>See Note 3.</i>	<i>See Note 3.</i>				No histologic examination of prim site.

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Code	Lab values or measurements (except size)	Positive/Negative	Ranges	Sizes	Grades	Things that are counted	Conditions of Involvement
999	See Note 4.	See Note 4.	See Note 4.	Unknown; size not stated; Not documented in patient record	Clinically diagnosed/grade unknown Not documented in patient record; Grade unknown, NOS	Unknown; Insufficient information; Not documented in patient record	

Note 1: Not Applicable (for new unused SSFs 7-24), or Obsolete (if overlaying in SSF 1-6 only), or Value of 988 for new SSFs 7-24 with actual lab values

Note 2: Test ordered, results not in chart

Note 3: Test not done (test was not ordered and was not performed)

Note 4: Unknown or no information; Not documented in patient record

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

Code	Description
988	Not applicable for this site

In addition to varying codes and definitions, the sequencing of SSFs within a site-specific schema varies. This was also done to maintain consistency of SSFs among sites. For most site-specific schemas, the SSFs are presented sequentially, starting with SSF1. For other schemas, particularly those where a CSv2 schema was created from a schema in CS version 1, new SSFs start in the first position available after any items used in the original schema, so as to avoid having a site-specific factor with two different meanings over time. For example, when GIST of stomach was created from the previous stomach schema (now used only for carcinomas), SSF 1 (Clinical assessment of regional nodes) was made obsolete because it is not pertinent to GIST, and the five new GIST SSFs begin at SSF6. Appendix 7 shows the names and positions of each site-specific factor in each schema.

Instructions for Coding

1. The code structure is the same for each site-specific factor (SSF), although the meaning of the codes for each SSF varies on the type of test or measurement being collected. **Select the best code that applies to the case.**
2. **Number of SSFs used.** The number of SSFs used varies by schema. See Appendix 7 for the names of each site-specific factor used in each schema, and refer to the SSF tables in each site/histology schema for the list of codes. For detailed coding instructions on specific SSFs, refer to the next section of this manual.
3. **Use of code for Not Applicable.** If the specific factor is not defined for a schema, code as 988, not applicable. For some schemas there may be unused SSFs between defined site-specific factors to align items for consistency across schemas to make it easier for data analysis. For example, there are three schemas for colon: carcinoma and NOS, GIST, and NET. SSF1 is used for carcinoma but not GIST or NET. SSF2 is the same for NET and carcinoma but is no longer used for GIST. SSFs 3-10 are used only for carcinoma. SSF11 is used for GIST and NET but not carcinoma. SSFs 12-15 are used for GIST only, and 16-17 for NET only. Any SSF not used for a schema, such as 3-10 for GIST and 18-25 for all three schemas, is coded 988.

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4. **Test not done.** Depending on the format of the site-specific factor template, code 000 or some other code may be used when there is a statement in the record that a test was not performed, when the SSF instructions say to code “Not done” when there is nothing in the record, or when the test is negative or normal. The SSF may also provide coding guidelines for situations where the information is not available in the medical record. Follow the instructions provided for the site-specific factor.

Example For malignant melanoma of skin SSF2, note 2 says “If there is no documentation or no mention of ulceration in the pathology report, assume ulceration is not present and code 000.”

5. **Coding lab tests.** Each site-specific factor includes instructions how it is to be coded.
- a. Follow the instructions for the SSF to record the correct lab value, such as highest, lowest, pre-treatment, immediately post-operative, closest to diagnosis, and so forth.
 - b. If there is an indication that the lab test was completed but the results are not in the record, code as Ordered, results not in chart. For most types of SSFs, this is code 997.
 - c. **Rounding.** Follow the instructions for the SSF in coding the lab value, as units of measurements vary. If there is an implied decimal point, round values of 1-4 down to the nearest number and round values of 5-9 up to the next number.

Example Prostate SSF 1 PSA Value. Physician reports PSA of 4.35. *Round the .35 up to .4 and code as 044.*

6. **Priority for Coding Lab Test Interpretation Information.** The results of many tumor markers and laboratory tests vary according to the laboratory conducting the test. The normal reference range and notes are included in the tumor marker comments as background information *only*. The following instructions provide the priority order for coding information about the interpretation of the lab test. These instructions are repeated at the beginning of Part I Section 2 with extensive examples.

- a. Whenever possible, code the clinician’s/pathologist’s interpretation of the lab test. This would include statements of “abnormal”, “elevated”, “normal”, “equivocal”, “present”, “absent”, and so forth. In addition, the physician’s statement of a T, N, or M value or stage group for the case would constitute an implied interpretation of any lab value used to determine the TNM classification.

Note: If the pathologist uses the term “indeterminate,” code as 030 (borderline; undetermined if positive or negative) if that code exists in the site-specific factor. If code 030 does not exist, code as 999.

- b. In the absence of a physician’s interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.
- c. When there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record the registrar should code 999 (not documented, unknown) to code the SSF. Do not code the lab value interpretation based on background information provided in this manual for the SSF.

Note: There will be some cases where an interpretation may be inferred from the background information in the CS User Documentation because the lab result is extremely abnormal. In such cases, common sense would dictate that the case should be coded as 010 (elevated) rather than 999.

7. **Use of 999.** Use code 999 if the tumor marker, prognostic score, predictive value or other SSF is not in the medical record. Use code 999 in the following circumstances, unless different instructions are provided in the SSF:

- a. The facility does not offer the test.

Note: The data collector should determine whether the facility offers the test, perhaps under a different name. For example, not every hospital will test for chromosome 18q loss of heterozygosity for appendiceal carcinoma.

- b. The facility does not offer the test but sends it out and there is no report in the patient record.

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- c. The facility does offer the test and there is no information in the medical record.
- d. There is no report of the lab test in the patient record. **It is not the responsibility of the data collector to track down test results if they are not in the patient record.**
- e. For Kaposi sarcoma SSF1, if AIDS status is not documented, code as 999 rather than 002, Not Present.
- f. For lymphoma SSF3, if the IPI score is not stated in the record. It is not necessary to calculate the IPI score from other information in the record.

LYMPH-VASCULAR INVASION

Length: 1

NAACCR Item #1182

Description

This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. The presence of lymph-vascular invasion may affect the patient’s prognosis.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System. Lymph-vascular invasion is an item of interest to both pathologists and clinicians and is mentioned in many chapters of the AJCC Cancer Staging Manual, seventh edition.

Note: This field is *required* for mapping of T in some sites, such as testis and penis.

Code	Description
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present Indeterminate

Definition

Lymph-vascular invasion is defined as the presence of tumor cells found inside small blood vessels or lymphatic channels within the tumor and surrounding tissues in the primary site. The tumor cells have broken free of the primary tumor and now have the capability to float throughout the body. Other names for lymph-vascular invasion are LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels; LVI cells are not attached to or growing into the wall of the blood vessel. Lymphatic invasion is not the same as involvement of regional lymph nodes. Lymph-vascular invasion does not include perineural invasion.

Instructions for Coding

1. **Code from pathology report(s).** Code the absence or presence of lymph-vascular invasion as described in the medical record.
 - a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician’s statement, in that order.
 - b. Do not code perineural invasion in this field.
 - c. Information to code this field can be taken from any specimen from the primary tumor.
 - d. If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.

2. **Use of codes.**
 - a. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

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- b. Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.
- c. Use code 8 for the following primary sites.
 - Hodgkin and Non-Hodgkin lymphoma
 - Leukemias
 - Hematopoietic and reticuloendothelial disorders
 - Myelodysplastic syndromes including refractory anemias and refractory cytopenias
 - Myeloproliferative disorders
- d. Use code 9 when
 - i. there is no microscopic examination of a primary tissue specimen
 - ii. the primary site specimen is cytology only or a fine needle aspiration
 - iii. the biopsy is only a very small tissue sample
 - iv. it is not possible to determine whether lymph-vascular invasion is present
 - v. the pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
 - vi. lymph-vascular invasion is not mentioned in the pathology report

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GRADE PATH VALUE

Length: 1

NAACCR Item #441

Description

This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System.

Code	Description
1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 grade system available Unknown

Instructions for Coding

1. **Code the histologic grade** or differentiation reported in the pathology report or a physician's statement in the medical record, in that order. Do not convert the grade described in the pathology report or medical record.
 - a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.

Note: Follow the guidelines for coding Grade/Differentiation in the Commission on Cancer's *Facility Oncology Registry Data Standards* (FORDS) manual or the appropriate standards setter's coding manual. For example, code grade only from the primary site, not a metastatic site.
 - b. Do not convert the terms *well*, *moderately*, or *poorly differentiated*, *low/high*, or *anaplastic* into codes in this field.
 - c. Code the histologic grade/differentiation in priority over a nuclear or architectural grade.
 - d. If grade is described in the medical record as a fraction (x/y), this data field is the numerator. In other words, this field is the first or upper number of a grade expressed in two parts.

Examples Synoptic report states grade ii of iii. *Code Grade Path Value as 2.*
 Final pathologic diagnosis listed as grade 1/4. *Code Grade Path Value as 1.*
 Microscopic description reports high grade III of III. *Code Grade Path Value as 3.*
 - e. Do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field. These grading systems are coded in a site-specific factor in their respective schemas.
 - f. The code in this field cannot be greater than the corresponding code in Grade Path System.
 - g. For lymphomas and hematopoietic malignancies, this field is blank.

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GRADE PATH SYSTEM

Length: 1

NAACCR Item #449

Description

This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

Note: This data item is separate from the CS data items but is included in this manual because of its relationship to the Collaborative Stage Data Collection System.

Code	Description
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 grade system available Unknown

Instructions for Coding

1. **Code the grading system** reported in the medical record. Do not convert the grade described in the pathology report.
 - a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (Grade/Differentiation). This field identifies how the original grade of the tumor was described.
Note: Follow the guidelines for coding Grade/Differentiation in the Commission on Cancer's *Facility Oncology Registry Data Standards* (FORDS) manual or the appropriate standards setter's coding manual. For example, code grade only from the primary site, not a metastatic site.
 - b. If grade is described in the medical record as a fraction (x/y), this data field is the denominator. In other words, this field is the second or lower number of a grade expressed in two parts.
Examples Synoptic report states grade ii of iii. *Code Grade Path System as 3.*
Final pathologic diagnosis listed as grade 1/4. *Code Grade Path System as 4.*
Microscopic description reports high grade III of III. *Code Grade Path System as 3.*
 - c. Leave this field blank if another grading system is used in the pathology report. For example, do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field. These grading systems are coded in a site-specific factor in their respective schemas.
 - d. For lymphomas and hematopoietic malignancies, this field is blank.

ADDITIONAL COLLABORATIVE STAGE TABLES

In addition to the tables of codes for each of the Collaborative Stage Data Collection 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 included 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 Stage website, www.cancerstaging.org/cstage.

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 Stage website, www.cancerstaging.org/cstage.

SUMMARY STAGE TABLE

The summary stage conversion table is shown in Appendix 5. This table evaluates the CS Extension, CS Lymph Nodes, and CS Mets at Dx fields to determine the final Summary Stage 1977 and Summary Stage 2000 output (Appendix 2f). The Summary Stage Table applies to all schemas and lists all possible combinations, including Not Applicable, Unstageable 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 CS Mets at Dx field, the output value will be RE+RN, regional extension and nodes.

HISTOLOGY 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 only certain histologies are included in some of the *AJCC Cancer Staging Manual, seventh edition* chapters. In order that the Collaborative Stage Data Collection System can 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. Appendix 6 is the Histology Exclusion Table for AJCC sixth edition. This table was used in CS version 1 and continues to be used to for sixth edition mapping in CS version 2. It contains the list of ICD-O-3 histologies for which the CSv2 algorithm *does not* derive AJCC6 staging values.

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.

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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

This table documents the coding of AJCC-6 T and AJCC-7 T based on CS Extension and CS Tumor Size. When the appropriate extension code is 100, 200, or 300, the T category is assigned based on value of tumor size, as follows:

Tumor Size	T Code	Comment
000	ERROR	Tumor size 000 should only be used with Extension 950.
001	T1mi	
002-005	T1a	
006-010	T1b	
011-020	T1c	
021-050	T2	
051-989	T3	
990	T1mi	
991	T1b	
992	T1NOS	
993-995	T2	
996	T1NOS	Per downstaging rule
997	ERROR	Tumor size 997 should only be used with Extension code 050 or 070.
998	T3	
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.

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SECTION 2. SITE-SPECIFIC INFORMATION

**See separate document at
www.cancerstaging.org/cstage.**

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Appendices

1. Determining Descriptive Tumor Size
2. Effective Dates, Allowable Values, and Format for CS Data Items—Input and Output
3. Schema Names, Site Codes, and Other Characteristics of CS Schemas
4. Output Values, Storage Codes, and Display String Descriptions for T, N, M, Stage Group, AJCC Descriptors, and Summary Stage
5. Summary Stage Conversion Algorithm for All Schemas
6. Histology Exclusion Groups (CS version 1 and Sixth Edition in CS version 2)
7. Site-Specific Factors Table for CS version 2
8. CSv2 Team Members

Appendix 1. Determining Descriptive Tumor Size

Millimeter Equivalents for Descriptive Terms

Fruits	mm	Miscellaneous Food	mm
Apple	070	Doughnut	090
Apricot	040	Egg	050
Cherry	020	Bantam	040
Date	040	Goose	070
Fig (dried)	040	Hen	030
Grape	020	Pigeon	030
Grapefruit	100	Robin	020
Kumquat	050	Lentil	991
Lemon	080	Millet	991
Olive	020		
Orange	090	Money	mm
Peach	060	Dime	010
Pear	090	Dollar, half	030
Plum	030	Dollar, silver	040
Tangerine	060	Nickel	020
		Penny	010
Nuts	mm	Quarter	020
Almond	030		
Chestnut	040	Other	mm
Chestnut, horse	040	Ball, golf	040
Hazel	020	Ball, ping-pong	030
Hickory	030	Ball, tennis	060
Peanut	010	Baseball	070
Pecan	030	Eraser on pencil	991
Walnut	030	Fist	090
		Marble	010
Vegetables	mm	Matchhead	991
Bean	010	Microscopic focus	990
Bean, lima	020		
Pea	991		
Pea, split	991		

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)

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Appendix 2. Effective Dates, Allowable Values, and Format for CS Data Items

Reference: Thornton M, O'Connor L (eds). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12*, 14th ed. Springfield, Ill.: North American Association of Central Cancer Registries, February 2009, rev. August 2009.
http://www.naaccr.org/filesystem/pdf/Standards_Volume_II_Version_12_Revised.pdf

Table 2-1. Effective Dates, Allowable Values and Format for CS Data Items – Input Items							
Data Item Name	NAACCR Data Item Number	Effective Date	Character Length	Allowable Values (site-specific unless otherwise stated)	Right Justified, Zero filled	Blanks: Yes or No	NAACCR Version 12 Column #
Grade Path Value	441	2010	1	1-4	N/A	Yes	556-556
Grade Path System	449	2010	1	2-4	N/A	Yes	557-557
Regional Nodes Examined	830	2004	2	00-90, 95, 96, 97, 98, 99 (all sites)	Yes	No	914-915
Regional Nodes Positive	820	2004	2	00-90, 95, 97, 98, 99 (all sites)	Yes	No	916-917
Lymph-vascular Invasion	1182	2010	1	0,1,8,9 (all sites)	N/A	No	984-984
CS Tumor Size	2800	2004	3	000-999	Yes	No	985-987
CS Extension	2810	2004	3	000-999	Yes	No	988-990
CS Tumor Size/Ext Eval	2820	2004	1	0-9	N/A	No	991-991
CS Lymph Nodes	2830	2004	3	000-999	Yes	No	992-994
CS Lymph Nodes Eval	2840	2004	1	0-9	N/A	No	995-995
CS Mets At Dx	2850	2004	2	00-99	Yes	No	996-997
CS Mets Eval	2860	2004	1	0-9	N/A	No	998-998
CS Mets at Dx-Bone	2851	2010	1	0-9	N/A	No	999-999
CS Mets at Dx-Brain	2852	2010	1	0-9	N/A	No	1000-1000
CS Mets at Dx-Liver	2853	2010	1	0-9	N/A	No	1001-1001
CS Mets at Dx-Lung	2854	2010	1	0-9	N/A	No	1002-1002
CS Site-Specific Factor 1	2880	2004	3	000-999	Yes	No	1003-1005
CS Site-Specific Factor 2	2890	2004	3	000-999	Yes	No	1006-1008
CS Site-Specific Factor 3	2900	2004	3	000-999	Yes	No	1009-1011
CS Site-Specific Factor 4	2910	2004	3	000-999	Yes	No	1012-1014
CS Site-Specific Factor 5	2920	2004	3	000-999	Yes	No	1015-1017
CS Site-Specific Factor 6	2930	2004	3	000-999	Yes	No	1018-1020
CS Site-Specific Factor 7	2861	2010	3	000-999	Yes	No	1021-1023
CS Site-Specific Factor 8	2862	2010	3	000-999	Yes	No	1024-1026
CS Site-Specific Factor 9	2863	2010	3	000-999	Yes	No	1027-1029
CS Site-Specific Factor 10	2864	2010	3	000-999	Yes	No	1030-1032
CS Site-Specific Factor 11	2865	2010	3	000-999	Yes	No	1033-1035
CS Site-Specific Factor 12	2866	2010	3	000-999	Yes	No	1036-1038
CS Site-Specific Factor 13	2867	2010	3	000-999	Yes	No	1039-1041
CS Site-Specific Factor 14	2868	2010	3	000-999	Yes	No	1042-1044
CS Site-Specific Factor 15	2869	2010	3	000-999	Yes	No	1045-1047
CS Site-Specific Factor 16	2870	2010	3	000-999	Yes	No	1048-1050
CS Site-Specific Factor 17	2871	2010	3	000-999	Yes	No	1051-1053

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Data Item Name	NAACCR Data Item Number	Effective Date	Character Length	Allowable Values (site-specific unless otherwise stated)	Right Justified, Zero filled	Blanks: Yes or No	NAACCR Version 12 Column #
CS Site-Specific Factor 18	2872	2010	3	000-999	Yes	No	1054-1056
CS Site-Specific Factor 19	2873	2010	3	000-999	Yes	No	1057-1059
CS Site-Specific Factor 20	2874	2010	3	000-999	Yes	No	1060-1062
CS Site-Specific Factor 21	2875	2010	3	000-999	Yes	No	1063-1065
CS Site-Specific Factor 22	2876	2010	3	000-999	Yes	No	1066-1068
CS Site-Specific Factor 23	2877	2010	3	000-999	Yes	No	1069-1071
CS Site-Specific Factor 24	2878	2010	3	000-999	Yes	No	1072-1074
CS Site-Specific Factor 25	2879	2010	3	000-999	Yes	No	1075-1077
CS PreRx Tumor Size	2730	2011	3	000-999	No	No	1078-1080
CS PreRx Extension	2735	2011	3	000-999	No	Yes*	1081-1083
CS PreRx Tum Sz/Ext Eval	2740	2011	1	0-9	N/A	Yes*	1084-1084
CS PreRx Lymph Nodes	2750	2011	3	000-999	No	Yes*	1085-1087
CS PreRx Reg Nodes Eval	2755	2011	1	0-9	N/A	Yes*	1088-1088
CS PreRx Mets at DX	2760	2011	2	00-99	No	Yes*	1089-1090
CS PreRx Mets Eval	2765	2011	1	0-9	N/A	Yes*	1091-1091
CS PostRx Tumor Size	2770	2011	3	000-999	No	Yes*	1092-1094
CS PostRx Extension	2775	2011	3	000-999	No	Yes*	1095-1097
CS Post Rx Lymph Nodes	2780	2011	3	000-999	No	Yes*	1098-1100
CS PostRx Mets at DX	2785	2011	2	00-99	No	Yes*	1101-1102

* Blanks are allowed until this field is defined and implemented.

Data Item Name	NAACCR Data Item Number	Effective Date	Character Length	Allowable Values (site-specific unless otherwise stated)	Right Justified, Zero filled	Blanks: Yes or No	NAACCR Version 12 Column #
Derived AJCC-6 T	2940	2004	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	Yes	1103-1104
Derived AJCC-6 T Descript	2950	2004	1	c, p, a, y, N	N/A	Yes	1105-1105
Derived AJCC-6 N	2960	2004	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	Yes	1106-1107
Derived AJCC-6 N Descript	2970	2004	1	c, p, a, y, N	N/A	Yes	1108-1108
Derived AJCC-6 M	2980	2004	2	00, 10, 11, 12, 13, 19, 88, 99	N/A	Yes	1109-1110
Derived AJCC-6 M Descript	2990	2004	1	c, p, a, y, N	N/A	Yes	1111-1111
Derived AJCC-6 Stage Grp	3000	2004	2	00, 01, 02, 10, 11, 12, 13, 14, 15, 16,	N/A	Yes	1112-1113

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Table 2-2. Effective Dates, Allowable Values and Format for CS Data Items–Output Items

Data Item Name	NAACCR Data Item Number	Effective Date	Character Length	Allowable Values (site-specific unless otherwise stated)	Right Justified, Zero filled	Blanks: Yes or No	NAACCR Version 12 Column #
				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			
Derived AJCC-7 T	3400	2010	3	000-999	N/A	Yes	1114-1116
Derived AJCC-7 T Descript	3402	2010	1	c, p, a, y, N	N/A	Yes	1117-1117
Derived AJCC-7 N	3410	2010	3	000-999	N/A	Yes	1118-1120
Derived AJCC-7 N Descript	3412	2010	1	c, p, a, y, N	N/A	Yes	1121-1121
Derived AJCC-7 M	3420	2010	3	000-999	N/A	Yes	1122-1124
Derived AJCC-7 M Descript	3422	2010	1	c, p, a, y, N	N/A	Yes	1125-1125
Derived AJCC-7 Stage Grp	3430	2010	3	000-999	N/A	Yes	1126-1128
Derived PreRx-7 T	3440	2011	3	000-999	N/A	Yes	1129-1131
Derived PreRx-7 T Descrip	3442	2011	1	c, N	N/A	Yes	1132-1132
Derived PreRx-7 N	3450	2011	3	000-999	N/A	Yes	1133-1135
Derived PreRx-7 N Descrip	3452	2011	1	c, N	N/A	Yes	1136-1136
Derived PreRx-7 M	3460	2011	3	000-999	N/A	Yes	1137-1139
Derived PreRx-7 M Descrip	3462	2011	1	c, N	N/A	Yes	1140-1140
Derived PreRx-7 Stage Grp	3470	2011	3	000-999	N/A	Yes	1141-1143
Derived PostRx-7 T	3480	2011	3	000-999	N/A	Yes	1144-1146
Derived PostRx-7 N	3482	2011	3	000-999	N/A	Yes	1147-1149
Derived PostRx-7 M	3490	2011	2	00-99	N/A	Yes	1150-1151
Derived PostRx-7 Stage Grp	3492	2011	3	000-999	N/A	Yes	1152-1154
Derived SS1977	3010	2004	1	0-5, 7, 8, 9	N/A	Yes	1155-1155
Derived SS2000	3020	2004	1	0-5, 7, 8, 9	N/A	Yes	1156-1156
Derived Neoadjuv Rx Flag	3600	2011	1	0, 1	N/A	Yes	1157-1157
Derived AJCC Flag	3030	2004	1	1, 2	N/A	Yes	1158-1158
Derived SS1977 Flag	3040	2004	1	1, 2	N/A	Yes	1159-1159
Derived SS2000 Flag	3050	2004	1	1, 2	N/A	Yes	1160-1160
CS Version Input Current	2937	2010	6	000000-999999	N/A	Yes	1161-1166
CS Version Original	2935	2004	6	000000-999999	N/A	Yes	1167-1172
CS Version Derived	2936	2004	6	000000-999999	N/A	Yes	1173-1178

Appendix 3. Schema Names, Site Codes, and Other Characteristics of CS Schemas

Column Ddefinitions:

ICD-O Codes – Topography codes for which schema is applicable

Schema Name – Name of schema in computer algorithm

No TNM Mapping – Schemas which have no mapping to T, N, M and/or Stage Group, by TNM edition

Histology Specific – Schemas for which ICD-O morphology code is important

Size necessary for T – Schemas for which tumor size is a critical part of correct mapping of T (Tumor) category in TNM

Number of SSFs – Number of site-specific factors used in CSv2; does not include SSFs made obsolete. For list of SSFs by schema and name, see Appendix 7.

ICD-O Codes	Schema Name	No TNM Mapping	Histology Specific	Size necessary for T	Number of SSFs
		6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C00.0, C00.3	LipUpper		Y	Y	10
C00.0, C00.3	MelanomaLipUpper	6	Y		10
C00.1, C00.4, C00.6	LipLower		Y	Y	10
C00.1, C00.4, C00.6	MelanomaLipLower	6	Y		10
C00.2, C00.5, C00.8-C00.9	LipOther		Y	Y	10
C00.2, C00.5, C00.8-C00.9	MelanomaLipOther	6	Y		10
C01.9, C02.4	TongueBase			Y	9
C01.9, C02.4	MelanomaTongueBase	6	Y		10
C02.0-C02.3, C02.8-C02.9	TongueAnterior		Y	Y	10
C02.0-C02.3, C02.8-C02.9	MelanomaTongueAnterior	6	Y		10
C03.0	GumUpper		Y	Y	10
C03.0	MelanomaGumUpper	6	Y		10
C03.1, C06.2	GumLower		Y	Y	9
C03.1, C06.2	MelanomaGumLower	6	Y		10
C03.9	GumOther		Y	Y	10
C03.9	MelanomaGumOther	6	Y		10
C04.0-C04.1, C04.8-C04.9	FloorMouth		Y	Y	10
C04.0-C04.1, C04.8-C04.9	MelanomaFloorMouth	6	Y		10
C05.0	PalateHard		Y	Y	10
C05.0	MelanomaPalateHard	6	Y		10
C05.1-C05.2	PalateSoft		Y	Y	9
C05.1-C05.2	MelanomaPalateSoft	6	Y		10
C05.8-C05.9, C06.8-C06.9	MouthOther		Y	Y	10
C05.8-C05.9, C06.8-C06.9	MelanomaMouthOther	6	Y		10

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ICD-O Codes	Schema Name	No TNM Mapping	Histology Specific	Size necessary for T	Number of SSFs
		6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C06.0-C06.1	BuccalMucosa		Y	Y	10
C06.0-C06.1	MelanomaBuccalMucosa	6	Y		10
C07.9	ParotidGland			Y	8
C08.0	SubmandibularGland		Y	Y	8
C08.1, C08.8-C08.9	SalivaryGlandOther			Y	8
C09.0-C09.1, C09.8-C09.9, C10.0, C10.2-C10.4, C10.8-C10.9	Oropharynx		Y	Y	9
C09.0-C09.1, C09.8-C09.9, C10.0, C10.2-C10.4, C10.8-C10.9	MelanomaOropharynx	6	Y		10
C10.1	EpiglottisAnterior		Y		9
C10.1	MelanomaEpiglottisAnterior	6	Y		10
C11.0-C11.3, C11.8-C11.9	Nasopharynx*		Y		9
C11.0-C11.3, C11.8-C11.9	MelanomaNasopharynx	6	Y		10
C11.1	PharyngealTonsil*		Y	Y	9
C12.9, C13.0-C13.2, C13.8-C13.9	Hypopharynx		Y	Y	9
C12.9, C13.0-C13.2, C13.8-C13.9	MelanomaHypopharynx	6	Y		10
C14.0, C14.2, C14.8	PharynxOther	X	Y		9
C14.0, C14.2-C14.8	MelanomaPharynxOther	6	Y		10
C15.0-C15.5, C15.8-C15.9	Esophagus		Y		5
C15.0-C15.5, C15.8-C15.9	GISTEsophagus	6	Y	Y	5
C16.0, C16.1, C16.2	EsophagusGEJunction*		Y		4
C16.1-C16.6, C16.8-C16.9	Stomach*		Y		5
C16.0-C16.6, C16.8-C16.9	GISTStomach	6	Y	Y	5
C16.0-C16.6, C16.8-C16.9	NETStomach		Y	Y	3
C17.0-C17.3, C17.8-C17.9	SmallIntestine		Y		5
C17.0-C17.3, C17.8-C17.9	GISTSmallIntestine	6	Y	Y	5
C17.0-C17.3, C17.8-C17.9	NETSmallIntestine		Y	Y	3
C18.0, C18.2-C18.9	Colon		Y		10
C18.0, C18.2-C18.9	GISTColon	6	Y	Y	5
C18.0, C18.2-C18.9	NETColon		Y	Y	4
C18.1	Appendix		Y		8
C18.1	CarcinoidAppendix		Y	Y	2

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ICD-O Codes	Schema Name	No TNM Mapping	Histology Specific	Size necessary for T	Number of SSFs
		6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C18.1	GISTAppendix	6	Y	Y	5
C19.9, C20.9	Rectum		Y		10
C19.9, C20.9	GISTRectum	6	Y	Y	5
C19.9, C20.9	NETRectum		Y	Y	4
C21.0-C21.2, C21.8	Anus			Y	1
C22.0	Liver		Y	Y	8
C22.1	BileDuctsIntraHepat		Y	6	6
C23.9	Gallbladder				1
C24.0	BileDuctsPerihilar*	6			5
C24.0	CysticDuct*	6			0
C24.0	BileDuctsDistal*	6			3
C24.1	AmpullaVater				3
C24.1	NETAmpulla		Y	Y	3
C24.8-C24.9	BiliaryOther	7			0
C25.0	PancreasHead			Y	3
C25.1-C25.2	PancreasBodyTail			Y	3
C25.3-C25.4, C25.7-C25.9	PancreasOther			Y	3
C26.0, C26.8-C26.9	DigestiveOther	X			0
C30.0	NasalCavity		Y		10
C30.0	MelanomaNasalCavity	6	Y		10
C30.1	MiddleEar	X			9
C31.0	SinusMaxillary		Y		10
C31.0	MelanomaSinusMaxillary	6	Y		10
C31.1	SinusEthmoid		Y		10
C31.1	MelanomaSinusEthmoid	6	Y		10
C31.2-C31.3, C31.8-C31.9	SinusOther	X	Y		10
C31.2-C31.3, C31.8-C31.9	MelanomaSinusOther	X	Y		10
C32.0	LarynxGlottic		Y		9
C32.0	MelanomaLarynxGlottic	6	Y		10
C32.1	LarynxSupraglottic		Y		9
C32.1	MelanomaLarynxSupra-glottic	6	Y		10
C32.2	LarynxSubglottic		Y		9
C32.2	MelanomaLarynxSubglottic	6	Y		10
C32.3, C32.8-C32.9	LarynxOther		Y		9
C32.0, C32.8-C32.9	MelanomaLarynxOther	6	Y		10
C33.9	Trachea	X			0
C34.0-C34.3, C34.8-C34.9	Lung			Y	2
C38.4	Pleura		Y		5
C38.0-C38.3, C38.8	HeartMediastinum			Y	4
C39.0, C39.8-C39.9	RespiratoryOther	X			0
C40.0-C40.3, C40.8-C40.9, C41.0-C41.4, C41.8-C41.9	Bone			Y	4

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		6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C44.0, C44.2-C44.9	Skin			Y	5
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MelanomaSkin	6	Y		9
C44.1	SkinEyelid		Y	Y	16
C44.0, C44.2-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MerkelCellSkin		Y	Y	9
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2	MycosisFungoides		Y		1
C47.0-C47.6, C47.8-C47.9, C49.0-C49.6, C49.8-C49.9	SoftTissue		Y	Y	4
C48.0	Retroperitoneum	6	Y	Y	4
C48.1-C48.2, C48.8	Peritoneum*		Y	Y	4
C48.0-C48.2, C48.8	GISTPeritoneum*	6	Y	Y	5
C50.0-C50.6, C50.8-C50.9	Breast			Y	24
C51.0-C51.2, C51.8-C51.9	Vulva			Y	6
C51.0-C51.2, C51.8-C51.9	MerkelCellVulva		Y	Y	10
C52.9	Vagina				7
C53.0-C53.1, C53.8-C53.9	Cervix			Y	9
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusCarcinoma		Y		8
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusAdenosarcoma		Y		8
C54.0-C54.3, C54.8-C54.9, C55.9	CorpusSarcoma		Y	Y	8
C56.9	Ovary				5
C57.0	FallopianTube				7
C57.1-C57.4	AdnexaUterineOther	X			0
C57.7-C57.9	GenitalFemaleOther	X			0
C58.9	Placenta		Y		2
C48.0-C48.2, C48.8	PeritoneumFemaleGen*		Note 1	Y	5
C60.0-C60.2, C60.8-C60.9	Penis		Y		5
C60.0-C60.2, C60.8-C60.9	MerkelCellPenis		Y	Y	9
C61.9	Prostate		Note 1		13
C62.0-C62.1, C62.9	Testis				12

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		6-6th ed only 7-7th ed only X-both 6th and 7th eds		6-6th ed only 7-7th ed only Y-both 6th and 7th eds	
C63.0-C63.1, C63.7-C63.9	GenitalMaleOther	X			0
C63.2	Scrotum		Y	Y	5
C63.2	MerkelCellScrotum		Y	Y	9
C64.9	KidneyParenchyma			Y	8
C65.9, C66.9	KidneyRenalPelvis				2
C67.0-C67.9	Bladder				3
C68.0	Urethra				1
C68.1, C68.8-C68.9	UrinaryOther	X			0
C69.0	Conjunctiva		Y	Y	2
C69.0	MelanomaConjunctiva		Y		3
C69.1-C69.4, C69.8-C69.9	EyeOther	X			0
C69.1, C69.2, C69.5, C69.8-C69.9	MelanomaEyeOther	X	Y		0
C69.4	MelanomaChoroid		Y	Y	13
C69.4	MelanomaCiliaryBody*		Y	Y	13
C69.4	MelanomaIris*		Y		13
C69.5	LacrimalGland*			Y	8
C69.5	LacrimalSac*	7		Y	0
C69.6	Orbit			Y	0
C69.0-C69.6, C69.8-C69.9	Retinoblastoma		Y		6
C44.1, C69.0, C69.5-C69.6	LymphomaOcularAdnexa	7	Y		13
C70.0, C71.0-C71.9 C70.1, C70.9, C72.0-C72.5, C72.8-C72.9	Brain	X			8
C72.0-C72.5, C72.8-C72.9	CNSOther	X			8
C75.1-C75.3	IntracranialGland	X			1
C73.9	Thyroid		Y	Y	1
C74.0-C74.1, C74.9 C37.9, C75.0-C75.5, C75.8-C75.9	AdrenalGland	6	Note 1	7	2
EndocrineOther		X			0
--	KaposiSarcoma	X	Y		4
--	Lymphoma		Y		5
--	HemeRetic	X	Y		1
-- (except C44.1, C69.0, C69.5- C69.6)	MyelomaPlasmaCell Disorder	X	Y		2
C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9	IIIDefinedOther	X			0

Note 1. All histologies are coded, but only a specific subset of histologies is used to derive TNM.

Appendix 4. Output Values, Storage Codes, and Display String Descriptions for T, N, M, Stage Group, Descriptors, and Summary Stage

Appendix 4a. Allowable T 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 for sixth or seventh edition of TNM. 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. A blank may indicate either that the calculation was not performed or that the calculation resulted in an error.

Display String	AJCC6 Storage Code	AJCC7 Storage Code	Comments and Notes
TX	99	999	TX
T0	00	000	T0
Ta	01	010	Ta
Tis	05	050	Tis
Tispu	06	060	Tispu (Urethra only)
Tispd	07	070	Tispd (Urethra only)
T1	10	100	T1
T1mi	11	110	T1mi
T1NOS	19	199	T1 NOS
T1a	12	120	T1a
T1a1	13	130	T1a1
T1a2	14	140	T1a2
T1b	15	150	T1b
T1b1	16	160	T1b1
T1b2	17	170	T1b2
T1c	18	180	T1c
T1d		181	T1d
T2	20	200	T2
T2NOS	29	299	T2 NOS
T2a	21	210	T2a
T2a1		211	T2a1
T2a2		212	T2a2
T2aNOS		213	T2a NOS
T2b	22	220	T2b
T2c	23	230	T2c
T2d		240	T2d
T3	30	300	T3
T3NOS	39	399	T3 NOS
T3a	31	310	T3a
T3b	32	320	T3b
T3c	33	330	T3c
T3d		340	T3d
T4	40	400	T4
T4NOS	49	499	T4 NOS
T4a	41	410	T4a
T4b	42	420	T4b
T4c	43	430	T4c
T4d	44	440	T4d
T4e		450	T4e

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T1aNOS	80	800	T1a NOS
T1bNOS	81	810	T1b NOS
NA	88	888	Not applicable

T_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 4b. Allowable N 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 for sixth or seventh edition of TNM. 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. A blank may indicate either that the calculation was not performed or that the calculation resulted in an error. Code N0NOS was defined in CSv1 but never used. It has been removed in CSv2.

Display String	AJCC6 Storage Code	AJCC7 Storage Code	Comments
NX	99	999	NX
N0	00	000	N0
N0(i-)	01	010	N0(i-)
N0(i+)	02	020	N0(i+)
N0(mol-)	03	030	N0(mol-)
N0(mol+)	04	040	N0(mol+)
N1	10	100	N1
N1NOS	19	199	N1 NOS
N1a	11	110	N1a
N1b	12	120	N1b
N1c	13	130	N1c
N1mi	18	180	N1mi
N2	20	200	N2
N2NOS	29	299	N2 NOS
N2a	21	210	N2a
N2b	22	220	N2b
N2c	23	230	N2c
N3	30	300	N3
N3NOS	39	399	N3 NOS
N3a	31	310	N3a
N3b	32	320	N3b
N3c	33	330	N3c
N4		400	N4
NA	88	888	Not applicable

N_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

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Appendix 4c. AllowableM 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 for sixth or seventh edition of TNM. 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. A blank may indicate either that the calculation was not performed or that the calculation resulted in an error.

Display String	AJCC6 Storage Code	AJCC7 Storage Code	Comments
MX	99	999	MX
M0	00	000	M0
M0(i+)		010	M0(i+)
M1	10	100	M1
M1a	11	110	M1a
M1b	12	120	M1b
M1c	13	130	M1c
M1d		140	M1d
M1e		150	M1e
M1NOS	19	199	M1 NOS
NA	88	888	Not applicable

M_ NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

Appendix 4d. Allowable Stage 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. A blank may indicate either that the calculation was not performed or that the calculation resulted in an error.

Display String	AJCC6 Storage Code	AJCC7 Storage Code	Comments
0	00	000	Stage 0
0a	01	010	Stage 0a
0is	02	020	Stage 0is
I	10	100	Stage I
INOS	11	110	Stage I NOS
IA	12	120	Stage IA
IA1	13	130	Stage IA1
IA2	14	140	Stage IA2
IANOS		121	Stage IA NOS
IB	15	150	Stage IB
IB1	16	160	Stage IB1
IB2	17	170	Stage IB2
IBNOS		151	Stage IB NOS
IC	18	180	Stage IC
IS	19	190	Stage IS
ISA	23	230	Stage ISA (lymphoma only)
ISB	24	240	Stage ISB (lymphoma only)
IEA	20	200	Stage IEA (lymphoma only)
IEB	21	210	Stage IEB (lymphoma only)

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IE	22	220	Stage IE (lymphoma only)
II	30	300	Stage II
IINOS	31	310	Stage II NOS
IIA	32	320	Stage IIA
IIANOS		321	Stage IIA NOS
IIA1		322	Stage IIA1
IIA2		323	Stage IIA2
IIB	33	330	Stage IIB
IIC	34	340	Stage IIC
IIEA	35	350	Stage IIEA (lymphoma only)
IIEB	36	360	Stage IIEB (lymphoma only)
IIE	37	370	Stage IIE (lymphoma only)
IISA	38	380	Stage IISA (lymphoma only)
IISB	39	390	Stage IISB (lymphoma only)
IIS	40	400	Stage IIS (lymphoma only)
IIESA	41	410	Stage IIESA (lymphoma only)
IIESB	42	420	Stage IIESB (lymphoma only)
IIES	43	430	Stage IIES (lymphoma only)
III	50	500	Stage III
IIINOS	51	510	Stage III NOS
IIIA	52	520	Stage IIIA
IIIB	53	530	Stage IIIB
IIIC	54	540	Stage IIIC
IIIC1		541	Stage IIIC1
IIIC2		542	Stage IIIC2
IIIEA	55	550	Stage IIIEA (lymphoma only)
IIIEB	56	560	Stage IIIEB (lymphoma only)
IIIE	57	570	Stage IIIE (lymphoma only)
IIISA	58	580	Stage IIISA (lymphoma only)
IIISB	59	590	Stage IIISB (lymphoma only)
IIIS	60	600	Stage IIIS (lymphoma only)
IIIESA	61	610	Stage IIIESA (lymphoma only)
IIIESB	62	620	Stage IIIESB (lymphoma only)
IIIES	63	630	Stage IIIES (lymphoma only)
IV	70	700	Stage IV
IVNOS	71	710	Stage IV NOS
IVA	72	720	Stage IVA
IVA1		721	Stage IVA1
IVA2		722	Stage IVA2
IVB	73	730	Stage IVB
IVC	74	740	Stage IVC
NA	88	888	Not applicable
OCCULT	90	900	Stage Occult
UNK	99	999	Stage Unknown

A stage group NOS indicates that there are additional choices for the category but a more specific code cannot be determined.

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Appendix 4e. Allowable Derived AJCC Descriptor Codes

This table shows the allowable values for the derived Collaborative Stage data items Derived AJCC T Descriptor, Derived AJCC N Descriptor, and Derived AJCC M Descriptor. 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.

Note 1: A blank of length 1 may indicate either that the calculation was not performed or that the calculation resulted in an error.

Note 2: These descriptors are considered to be modifiers of the derived T, N, and M codes. If the T, N, or M code is absent, there will be nothing to modify and the descriptor should not be displayed or stored.

Note 3: In CS Version 2, display strings can have different lengths. For example, the display string for 'y' is 'yp'. The display string for 'c' is 'c'. The display string for 'N' is ' ', a blank of length 0.

Display String	Storage Code	Comments
c	c	
p	p	
a	a	
yp	y	
	N	Display String is blank of length 0.

Appendix 4f. Allowable Summary Stage 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. A blank may indicate either that the calculation was not performed or that the calculation resulted in an error.

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

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Appendix 5. 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	Extension SS77 or SS2000 result	LN SS77 or SS2000 result	Mets SS77 or SS2000 result	Final SS77 or SS2000 result	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*	NA	L	ERROR	L	RE+RN	RE	RE+RN
IS*	NONE	L	ERROR	IS*	NA	RE	ERROR	L	RE+RN	RN	RE+RN
IS*	NONE	RE	ERROR	IS*	NA	RN	ERROR	L	RE+RN	RE+RN	RE+RN
IS*	NONE	RN	ERROR	IS*	NA	RE+RN	ERROR	L	RE+RN	D	D
IS*	NONE	RE+RN	ERROR	IS*	NA	D	ERROR	L	RE+RN	NA	RE+RN
IS*	NONE	D	ERROR	IS	NA	NA	IS	L	RE+RN	U	RE+RN
IS	NONE	NA	IS	IS	NA	U	IS	L	D	NONE	D
IS	NONE	U	IS	IS*	U	NONE	IS	L	D	L	D
IS*	RE	NONE	ERROR	IS*	U	L	ERROR	L	D	RE	D
IS*	RE	L	ERROR	IS*	U	RE	ERROR	L	D	RN	D
IS*	RE	RE	ERROR	IS*	U	RN	ERROR	L	D	RE+RN	D
IS*	RE	RN	ERROR	IS*	U	RE+RN	ERROR	L	D	D	D
IS*	RE	RE+RN	ERROR	IS*	U	D	ERROR	L	D	NA	D
IS*	RE	D	ERROR	IS	U	NA	IS	L	D	U	D
IS*	RE	NA	ERROR	IS	U	U	IS	L	NA	NONE	L
IS*	RE	U	ERROR					L	NA	L	L
IS*	RN	NONE	ERROR	L	NONE	NONE	L	L	NA	RE	RE
IS*	RN	L	ERROR	L	NONE	L	L	L	NA	RN	RN
IS*	RN	RE	ERROR	L	NONE	RE	RE	L	NA	RE+RN	RE+RN
IS*	RN	RN	ERROR	L	NONE	RN	RN	L	NA	D	D
IS*	RN	RE+RN	ERROR	L	NONE	RE+RN	RE+RN	L	NA	NA	L
IS*	RN	D	ERROR	L	NONE	D	D	L	NA	U	L
IS*	RN	NA	ERROR	L	NONE	NA	L	L	U	NONE	L
IS*	RN	U	ERROR	L	RE	NONE	RE	L	U	L	L
IS*	RE+RN	NONE	ERROR	L	RE	L	RE	L	U	RE	RE
IS*	RE+RN	L	ERROR	L	RE	RE	RE	L	U	RN	RN
IS*	RE+RN	RE	ERROR	L	RE	RE	RE	L	U	RE+RN	RE+RN
IS*	RE+RN	RN	ERROR	L	RE	RN	RE+RN	L	U	D	D
IS*	RE+RN	RE+RN	ERROR	L	RE	RE+RN	RE+RN	L	U	NA	L
IS*	RE+RN	D	ERROR	L	RE	D	D	L	U	U	L
IS*	RE+RN	U	ERROR	L	RE	NA	RE				
IS*	D	NONE	ERROR	L	RE	U	RE	RE	NONE	NONE	RE
IS*	D	L	ERROR	L	RN	NONE	RN	RE	NONE	L	RE
IS*	D	RE	ERROR	L	RN	L	RN	RE	NONE	RE	RE
IS*	D	RN	ERROR	L	RN	RE	RE+RN	RE	NONE	RN	RE+RN
IS*	D	RE+RN	ERROR	L	RN	RN	RN	RE	NONE	RE+RN	RE+RN
IS*	D	D	ERROR	L	RN	RE+RN	RE+RN	RE	NONE	D	D
IS*	D	NA	ERROR	L	RN	D	D	RE	NONE	NA	RE
IS*	D	U	ERROR	L	RN	NA	RN	RE	NONE	U	RE
				L	RN	U	RN	RE	RE	NONE	RE
				L	RE+RN	NONE	RE+RN	RE	RE	RE	RE
IS	NA	NONE	IS	L	RE+RN	L	RE+RN	RE	RE	RN	RE+RN

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

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

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**Appendix 6. Histology Exclusion Groups
(CS Version 1 and Sixth Edition in Version 2)**

based on ICD-O-3 Morphology Codes

Histology Code Groupings for Collaborative Stage version 1

Carcinomas	800-823, 8244, 8245, 8246, 8247; 825-867; 894
Carcinoids	8240, 8241, 8242, 8243, 8248, 8249
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; 980-996; 997; 998

* There is overlap between lymphomas and hematopoietic disorders. Primary site has to be taken into account for the lymphoma/leukemias -- for example 9823, which can be chronic lymphocytic leukemia in blood and bone marrow, or small lymphocytic lymphoma in other tissues.

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 NA, for the derived T, N, M and AJCC 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.

Note: The first column supplies a primary site name. This is not the same as the schema name in CS version 1 and not the same as the schema name in CS version 2. It is simply an identifier for the primary site.

Primary Site	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 note 1	x	x	x	x	
Submandibular Gland		x	x	x	x note 1	x	x	x	x	
Other Salivary Gland		x	x	x	x note 1	x	x	x	x	
Tonsil, Oropharynx		x	x	x	x	x	x	x	x	
Anterior Surface of Epiglottis		x	x	x	x	x	x	x	x	
Nasopharynx		x	x	x	x	x	x	x	x	
Pyriiform 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	

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Primary Site	Carci- noma	Carci- noid	Mela- noma	Sar- coma	Other specified cancers	Mesothe- lioma	Kaposi sarcoma	Lym- phoma	Hema- topoi- etic	Other exclu- sions
Liver, intrahepatic ducts		x	x	x	x	x	x	x	x	
Gallbladder		x	x	x	x note 2	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
Other Biliary		x	x	x	x	x	x	x	x	
Pancreas: Head		x	x	x	x note 3	x	x	x	x	815_
Pancreas: Body, Tail		x	x	x	x note 3	x	x	x	x	815_
Other Pancreas		x	x	x	x note 3	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 4	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 5	x	
Soft Tissue	x	x	x		x note 6	x	x	x	x	
Retroperitoneum, Peritoneum	x	x	x		x note 6	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 7	x	x	x	x	
Ovary		x	x	x	x note 8	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 9	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 10	x	x	x	x note 10	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	

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Primary Site	Carci- noma	Carci- noid	Mela- noma	Sar- coma	Other specified cancers	Mesothe- lioma	Kaposi sarcoma	Lym- phoma	Hema- topoi- etic	Other exclu- sions
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	
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 11	x	x	x	x	
Brain*										
Other CNS*										
Thyroid		x	x	x	x	x	x	x	x	
Other Endocrine*										
Kaposi SarcomaBall sites*	x	x	x	x	x	x		x	x	
LymphomaBall sites	x	x	x	x	x	x	x		x	
Hematopoietic, Retic*										
Other, Ill-Defined Sites*										

Note 1:For parotid gland, submandibular gland and other salivary gland, 8982 is included for TNM Staging.

Note 2:For gallbladder, 8980 is included for TNM Staging.

Note 3:For Pancreas (head, body, tail, other) 8971 is included for TNM Staging

Note 4:For bone, codes 9260-9342 are included for TNM Staging

Note 5:For mycosis fungoides and Sezary disease, all histologies other than 9700 and 9701 are excluded.

Note 6:For soft tissue and retroperitoneum/peritoneum, codes 8936 and 9473 are included for TNM Staging.

Note 7:For corpus, 8950 and 8951 are included for TNM Staging.

Note 8:For ovary, morphology codes 906-909 are included for TNM Staging.

Note 9:For placenta, 910 is included for TNM Staging.

Note 10:For testis, 859-865 and 906-910 are included for TNM Staging.

Note 11:For retinoblastoma, all histologies other than 951 are excluded.

Appendix 7. Site-Specific Factors Table for CS Version 2

<http://www.cancerstaging.org/cstage/manuals/appendix.html>

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Appendix 8. CS Version 2 and CS Version 1 Team Members

EDUCATION AND TRAINING TEAM

CYNTHIA BOUDREAUX, LPN, CTR – Team
Leader
Independent Consultant
Raceland, LA

ELAINE COLLINS, RHIA, CTR
Minnesota Cancer Surveillance System
St. Paul, MN

ANNA DELEV, RHIT, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

LYNDA DOUGLAS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

MICHELLE ESTERLY, RHIA, CTR
Pennsylvania Cancer Registry
Harrisburg, PA

APRIL FRITZ, RHIT, CTR
A. Fritz and Associates
Reno, NV

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

LILLY GROSSMAN
National Cancer Registrars Association
Alexandria, VA

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

GEMMA LEE
Cancer Care Ontario
Toronto, ON Canada

MARTIN MADERA
American Joint Committee on Cancer
Chicago, IL

HERMAN MENCK, MBA, FACE
Los Angeles Cancer Surveillance Program
Marina del Ray, CA

JOAN PHILLIPS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

JENNIFER RUHL, RHIT, CCS, CTR
National Cancer Institute
Bethesda, MD

LOUISE SCHUMAN, MA, CTR
Clinical Data Systems
Fountain Valley, CA

KAREN STARRATT
Nova Scotia Surveillance and Epidemiology
Unit
Halifax, NS Canada

SHANNON VANN, CTR
North American Association of Central Cancer
Registries
Springfield, IL

JOHN YOUNG, PhD, CTR
Emory University
Atlanta, GA

FIELD STUDY TEAM

LYNDA DOUGLAS, CTR – Team Leader
Centers for Disease Control and Prevention
Atlanta, GA

BRENDA EDWARDS, PhD
National Cancer Institute
Bethesda, MD

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

**Collaborative Staging Manual and Coding Instructions Part I
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GEMMA LEE
Cancer Care Ontario
Toronto, ON Canada

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

GARY LEVIN, CTR
University of Miami, Miller School of Medicine
Miami, FL

JENNIFER RUHL, RHIT, CCS, CTR
National Cancer Institute
Bethesda, MD

MARTIN MADERA
American Joint Committee on Cancer
Chicago, IL

ANDREW STEWART
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

STEVEN PEACE, BS, CTR
University of Miami, Miller School of Medicine
Miami, FL

JERRI LINN PHILLIPS, MA, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

IMPLEMENTATION ISSUES TEAM

SUZANNA HOYLER, BS, CTR, Team Leader
Consultant
Austin, TX

ALAN HOUSER
C/NET Solutions
Berkeley, CA

PEGGY ADAMO, RHIT, CTR
National Cancer Institute
Bethesda, MD

CAROL JOHNSON, CTR
National Cancer Institute
Bethesda, MD

KIMBERLEY BOYUK, MA
Statistics Canada
Ottawa, ON Canada

PETER KIM
Centers for Disease Control and Prevention
Atlanta, GA

SUSAN CAPRON
Consultant
Chicago, IL

GARY M. LEVIN, CTR
University of Miami, Miller School of Medicine
Miami, FL

ELAINE COLLINS, RHIA, CTR
Minnesota Cancer Surveillance System
St. Paul, MN

MARY LEWIS
Centers for Disease Control and Prevention
Atlanta, GA

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

MARY NIGHTINGALE
Canadian Cancer Registry
Ottawa, ON Canada

LORI HAVENER, CTR
North American Association of Central Cancer
Registries
Springfield, IL

Collaborative Staging Manual and Coding Instructions Part I
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JERRI LINN PHILLIPS, MA, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

JOAN PHILLIPS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

LYNN RIES, MS
National Cancer Institute
Bethesda, MD

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

FRANCES ROSS, CTR
Kentucky Cancer Registry
Lexington, KY

JENNIFER SEIFFERT, MLIS, CTR
Northrop Grumman Health Solutions
Warsaw, IN

ANDREW STEWART
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

DAVID STINCHCOMB
National Cancer Institute
Bethesda, MD

CASTINE VERRILL, MS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

REDA WILSON, CTR
Centers for Disease Control and Prevention
Atlanta, GA

INFORMATICS TEAM

DAVID RONEY – Team Leader
Information Management Services, Inc.
Silver Spring, MD

JIM BANASIAK
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

KIMBERLEY BOYUK, MA
Statistics Canada
Ottawa, ON Canada

SUSAN CAPRON
Consultant
Chicago, IL

BARRY GORDON, PhD
C/NET Solutions
Berkeley, CA

DON GREEN
IMS, Inc.
Silver Spring, MD

PETER KIM
Centers for Disease Control and Prevention
Atlanta, GA

GARY LEVIN, CTR
University of Miami, Miller School of Medicine
Miami, FL

ANDREA MACLEAN
Canadian Partnership Against Cancer
Toronto, ON Canada

CHUCK MAY
IMS, Inc.
Silver Spring, MD

HERMAN MENCK, MBA, FACE
Los Angeles Surveillance Program
Marina del Ray, CA

MARY MROSZCZYK, CTR
Massachusetts Cancer Registry
Boston, MA

MARY NIGHTINGALE
Canadian Cancer Registry
Ottawa, ON Canada

**Collaborative Staging Manual and Coding Instructions Part I
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TOM RAWSON

Centers for Disease Control and Prevention
Atlanta, GA

LYNN RIES, MS

National Cancer Institute
Bethesda, MD

JOSEPH ROGERS

Centers for Disease Control and Prevention
Atlanta, GA

PETER SCHAD, PhD

National Cancer Institute
Bethesda, MD

WENDY SCHARBER, RHIT, CTR

Registry Widgets
Brooklyn Park, MN

JENNIFER SEIFFERT, MLIS, CTR

Northrop Grumman Health Solutions
Warsaw, IN

DAVID STINCHCOMB

National Cancer Institute
Bethesda, MD

I&R WORK FLOW PROCESS TEAM

PEGGY ADAMO, RHIT, CTR – Team Leader

National Cancer Institute
Bethesda, MD

APRIL FRITZ, RHIT, CTR

A. Fritz and Associates
Reno, NV

CYNTHIA BOUDREAUX, LPN, CTR

Independent Consultant
Raceland, LA

DONNA GRESS, RHIT, CTR

American Joint Committee on Cancer
Chicago, IL

CONNIE BURA

American College of Surgeons, Commission on
Cancer
Chicago, IL

SUZANNA HOYLER, BS, CTR

Consultant
Austin, TX

ELAINE COLLINS, RHIA, CTR

Minnesota Cancer Surveillance System
St. Paul, MN

JOAN PHILLIPS, CTR

Centers for Disease Control and Prevention
Atlanta, GA

ANNA DELEV, RHIT, CTR

National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

KAREN POLLITT

American Joint Committee on Cancer
Chicago, IL

DEBORAH ETHERIDGE, CTR

American College of Surgeons, Commission on
Cancer
Chicago, IL

JENNIFER RUHL, RHIT, CCS, CTR

National Cancer Institute
Bethesda, MD

**Collaborative Staging Manual and Coding Instructions Part I
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IT TESTING TEAM

DAVID RONEY– Team Leader
Information Management Services, Inc.
Silver Spring, MD

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

LYNDA DOUGLAS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

ALAN HOUSER
C/NET Solutions
Berkeley, CA

BARRY GORDON, PhD
C/NET Solutions
Berkeley, CA

JERRI LINN PHILLIPS, MA, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

DON GREEN
IMS, Inc.
Silver Spring, MD

LYNN RIES, MS
National Cancer Institute
Bethesda, MD

MAPPING TEAM

JENNIFER SEIFFERT, MLIS, CTR – Team
Leader
Northrop Grumman Health Solutions
Warsaw, IN

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

IRIS CHILTON, CHIM, CTR
Cross Cancer Institute
Edmonton, AB Canada

LYNN RIES, MS
National Cancer Institute
Bethesda, MD

ELAINE COLLINS, RHIA, CTR
Minnesota Cancer Surveillance System
St. Paul, MN

JENNIFER RUHL, RHIT, CCS, CTR
National Cancer Institute
Bethesda, MD

MICHELLE ESTERLY, RHIA, CTR
Pennsylvania Cancer Registry
Harrisburg, PA

COLLEEN SHERMAN, RHIA, CTR
New York State Cancer Registry
Albany, NY

APRIL FRITZ, RHIT, CTR
A. Fritz and Associates
Reno, NV

KAREN STARRATT
Nova Scotia Surveillance and Epidemiology
Unit
Halifax, NS Canada

DON GREEN
IMS, Inc.
Silver Spring, MD

LEON SUN, MD, PhD
National Cancer Institute
Bethesda, MD

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

**Collaborative Staging Manual and Coding Instructions Part I
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NEW DATA ITEM TEAM

DONNA GRESS, RHIT, CTR – Team Leader
American Joint Committee on Cancer
Chicago, IL

MARY KENNEDY, MPH
College of American Pathologists
Northfield, IL

CYNTHIA BOUDREAU, LPN, CTR
Independent Consultant
Raceland, LA

JERRI LINN PHILLIPS, MA, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

SUSAN CAPRON
Consultant
Chicago, IL

JOAN PHILLIPS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

BRENDA EDWARDS, PhD
National Cancer Institute
Bethesda, MD

LYNN RIES, MS
National Cancer Institute
Bethesda, MD

LORI HAVENER, CTR
North American Association of Central Cancer
Registries
Springfield, IL

WENDY SCHARBER, RHIT, CTR
Registry Widgets
Brooklyn Park, MN

PRE/POST SPECIFICATIONS TEAM

FREDERICK GREENE, MD, FACS – Team
Leader
Carolinas Medical Center
Charlotte, NC

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

JAMES BRIERLEY, BSc, MB, BS, FRCP,
FRCR, FRCPC
Princess Margaret Hospital
Toronto, ON Canada

JIM HOFFERKAMP, BA, CTR
North American Association of Central Cancer
Registries
Springfield, IL

DAVID BYRD, MD, FACS
University of Washington School of Medicine
Seattle, WA

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

ELAINE COLLINS, RHIA, CTR
Minnesota Cancer Surveillance System
St. Paul, MN

PETER KIM
Centers for Disease Control and Prevention
Atlanta, GA

STEPHEN EDGE, MD, FACS
Roswell Park Cancer Institute
Buffalo, NY

JERRI LINN PHILLIPS, MA CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

MARY GOSPODAROWICZ, MD, FRCPC,
FRCR
Princess Margaret Hospital
Toronto, ON Canada

JOAN PHILLIPS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

**Collaborative Staging Manual and Coding Instructions Part I
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KAREN POLLITT
American Joint Committee on Cancer
Chicago, IL

LESLIE SOBIN, MD
International Union for Cancer Control
Washington, DC

LYNN RIES, MS
National Cancer Institute
Bethesda, MD

ANDREW STEWART
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

WENDY SCHARBER, RHIT, CTR
Registry Widgets
Brooklyn Park, MN

PROJECT MANAGEMENT TEAM

CONNIE BURA – Team Leader
American College of Surgeons, Commission on
Cancer
Chicago, IL

APRIL FRITZ, RHIT, CTR
A. Fritz and Associates
Reno, NV

CYNTHIA BOUDREAUX, LPN, CTR
Independent Consultant
Raceland, LA

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

KIMBERLEY BOYUK, MA
Statistics Canada
Ottawa, ON Canada

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

LYNDA DOUGLAS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

BETSY KOHLER, MPH, CTR
North American Association of Central Cancer
Registries
Springfield, IL

STEPHEN EDGE, MD, FACS
Roswell Park Cancer Institute
Buffalo, NY

STEVEN PEACE, BS, CTR (2009)
University of Miami, Miller School of Medicine
Miami, FL

BRENDA EDWARDS, PhD
National Cancer Institute
Bethesda, MD

KAREN POLLITT
American Joint Committee on Cancer
Chicago, IL

CHRISTIE EHEMAN, PhD
Centers for Disease Control and Prevention
Atlanta, GA

JOSEPH ROGERS
Centers for Disease Control and Prevention
Atlanta, GA

INEZ EVANS, BS, RHIT, CTR
Wake Forest University Baptist Medical Center
Wake Forest, NC

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

**Collaborative Staging Manual and Coding Instructions Part I
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MARIA SCHYMURA, PhD
New York State Department of Health
Albany, NY

LORI SWAIN, MS
National Cancer Registrars Association
Alexandria, VA

JENNIFER SEIFFERT, MLIS, CTR
Northrop Grumman Health Solutions
Warsaw, IN

ELIZABETH WARD, PhD
American Cancer Society
Atlanta, GA

TRAIN THE TRAINERS TEAM

CYNTHIA BOUDREAUX, LPN, CTR -Team
Leader
Independent Consultant
Raceland, LA

CAROL JOHNSON, CTR
National Cancer Institute
Bethesda, MD

PEGGY ADAMO, RHIT, CTR
National Cancer Institute
Bethesda, MD

GEMMA LEE
Cancer Care Ontario
Toronto, ON Canada

CONNIE BURA
American College of Surgeons, Commission on
Cancer
Chicago, IL

KAREN POLLITT
American Joint Committee on Cancer
Chicago, IL

LYNDA DOUGLAS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

ANTOINETTE PERCY-LAURRY
National Cancer Institute
Bethesda, MD

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

JOAN PHILLIPS, CTR
Centers for Disease Control and Prevention
Atlanta, GA

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

JENNIFER RUHL, RHIT, CCS, CTR
National Cancer Institute
Bethesda, MD

**Collaborative Staging Manual and Coding Instructions Part I
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USER DOCUMENTATION TEAM

SUSAN CAPRON
Consultant
Chicago, IL

APRIL FRITZ, RHIT, CTR
A. Fritz and Associates
Reno, NV

SUZANNA HOYLER, BS, CTR
Consultant
Austin, TX

KAREN POLLITT
American Joint Committee on Cancer
Chicago, IL

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

JENNIFER SEIFFERT, MLIS, CTR
Northrup Grumman Health Solutions
Warsaw, IN

JENNIFER STEVENS
Information Management Services, Inc.
Silver Spring, MD

WEBSITE REVIEW TEAM

SUZANNA HOYLER, BS, CTR - Team Leader
Consultant
Austin, TX

GINGER CARTER
Information Management Services, Inc.
Silver Spring, MD

ELAINE COLLINS, RHIA, CTR
Minnesota Cancer Surveillance System
St. Paul, MN

APRIL FRITZ, RHIT, CTR
A. Fritz and Associates
Reno, NV

DONNA GRESS, RHIT, CTR
American Joint Committee on Cancer
Chicago, IL

DAVID HACKER
Information Management Services, Inc.
Silver Spring, MD

MARTIN MADERA
American Joint Committee on Cancer
Chicago, IL

MARY MROSZCZYK, CTR
Massachusetts Cancer Registry
Boston, MA

JERRI LINN PHILLIPS, MA, CTR
National Cancer Data Base
American College of Surgeons, Commission on
Cancer
Chicago, IL

KAREN POLLITT
American Joint Committee on Cancer
Chicago, IL

DAVID RONEY
Information Management Services, Inc.
Silver Spring, MD

JENNIFER RUHL, RHIT, CCS, CTR
National Cancer Institute
Bethesda, MD

PETER SCHAD, PhD
National Cancer Institute
Bethesda, MD

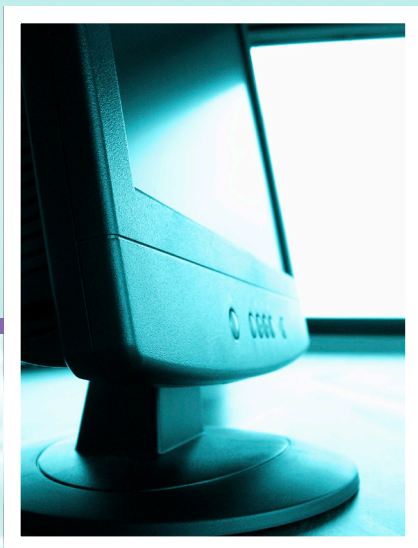
LOUISE SCHUMAN, MA, CTR
Clinical Data Systems
Fountain Valley, CA

JOSHUA WHITLEY
North American Association of Central Cancer
Registries
Springfield, IL

**Collaborative Staging Manual and Coding Instructions Part I
Part I Section 1. Appendices**

Collaborative Staging (CS) Work Group Members (CS Version 1, 2006-2007)

<u>Member</u>	<u>Representing</u>
Stephen Edge, MD, Chair	American Joint Committee on Cancer
Cynthia Boudreaux, LPN, CTR	National Cancer Registrars Association
Gayle Clutter, RT, CTR	National Program of Cancer Registries, Centers for Disease Control and Prevention
Ingrid Friesen, HRT	Statistics Canada
April Fritz, BA, RHIT, CTR	Member-at-Large
Frederick L. Greene, MD, FACS	Ex-officio member, former Chair, AJCC
David L. Page, MD, FCAP	Chair, AJCC
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
Colleen Sherman, RHIA, CTR	North American Association of Central Cancer Registries
Jennifer Seiffert, MLIS, CTR	National Program of Cancer Registries, Centers for Disease Control and Prevention
Valerie Vesich, RHIT, CTR	Member-at-Large



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American Joint Committee on Cancer Staff

Connie Bura
Administrative Director, Cancer Programs, ACoS

Karen Pollitt
Manager, AJCC

Donna Gress, RHIT, CTR
AJCC Technical Specialist

Martin Madera, MA
Education Administrator

Judith Janes
AJCC Coordinator

Questions regarding this document and the Collaborative Stage Data Collection System in general should be directed to:

CSv2@facs.org

American Joint Committee on Cancer
633 N. Saint Clair St.
Chicago, IL 60611