Collaborative Staging Manual and Coding Instructions

Version 01.04.00

National
Cancer Institute
of Canada

Institut national
du cancer
du Canada

COLLABORATIVE STAGING MANUAL AND CODING INSTRUCTIONS

Collaborative Staging Task Force
of the American Joint Committee on Cancer

Part I
Version 01.04.00
incorporating updates through October 31, 2007

NIH Publication Number 04-5496
U.S. Department of Health and Human Services
National Institutes of Health
National Cancer Institute

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Collaborative Staging Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions, version 01.04.00.* Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Publication Number 04-5496. Incorporates updates through September 8, 2006.

Collaborative Staging (CS) Task Force Members (2006-2007)

Member	Representing
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

American Joint Committee on Cancer Staff

Connie Bura, Administrative Director, Cancer Programs, ACoS
Karen Pollitt, AJCC Administrator
Donna Gress, RHIT, CTR, AJCC Technical Specialist

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

Donna Gress, RHIT, CTR dgress@facs.org 312-202-5410
American Joint Committee on Cancer
633 North Saint Clair Street
Chicago, IL 60611

CS Extension, continued

d. Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.
e. If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area.
f. With the exception of corpus uteri and ovary, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.
Example Carcinoma of the prostate with extension to pubic bone would be coded 60. Carcinoma of the prostate with metastases to thoracic spine would be coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine would be coded in the CS Mets at Dx field.

3. Refer to general guidelines for Collaborative Staging for timing rules for data collection.

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

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

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

7. Some site or histology schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

8. Distant metastases must be coded in the CS Mets at Dx field.

9. Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement; use the code for Localized, NOS, if there is no better information.
Example Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. *Code CS Extension as 10, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.*

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

11. It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.

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

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

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

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging.***	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation **OR** surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed 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 ***Meets criteria for AJCC pathologic staging.***	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence	C
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence	Y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	A
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites with no TNM schema:*** not applicable	C

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

CS Tumor Size/Ext Eval, continued

Instructions for Coding

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

   Example Fine needle aspiration biopsy (Eval code 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.*

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

3. For primary sites where both tumor size and extension determine the T category in TNM (see Table 4 in the General Instructions), select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.
   a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

      Example Tumor size for a breast cancer biopsy is 020 (maps to T1). There is ulceration of the skin (extension code 51, maps to T4).
      Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from the physical examination results in a higher T category.
   b. If the patient had no surgery, use code 0, 1, or 9.

      Example Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy.
      Code this field as 0. Staging algorithm would identify information as clinical (c).

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

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

      Exception Lung cancer with mediastinoscopy showing direct extension into mediastinum. *Code this field as 1. Staging algorithm would identify information as pathologic (p), because mediastinoscopy is defined as a pathologic procedure in TNM..*
   c. If the patient had surgery followed by other treatment(s), use code 3 or 9.
   d. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5.
   e. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis.
   f. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. For sites 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 Table 6 in the General Instructions.) 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.

CS Tumor Size/Ext Eval, continued

5. 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.

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

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

8. 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 the tumor size or extension and the Extension field is coded as 99, the registrar still knows what procedures were used to try to determine those fields. In other words, just because the tumor size is coded 999, the Eval field does not have to be coded 9.

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

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

Code	Description	Staging Basis
0	No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No regional lymph nodes removed for examination. Evaluation based on endoscopic examination, diagnostic biopsy including fine needle aspiration of lymph node(s) or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging.***	c
2	No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Regional lymph nodes removed for examination (removal of at least 1 lymph node) WITHOUT pre-surgical systemic treatment or radiation **OR** lymph nodes removed for examination, unknown if pre-surgical systemic treatment or radiation performed ***Meets criteria for AJCC pathologic staging.***	p
5	Regional lymph nodes removed for examination WITH pre-surgical systemic treatment or radiation, and lymph node evaluation based on clinical evidence.	c
6	Regional lymph nodes removed for examination WITH pre-surgical systemic treatment or radiation, BUT lymph node evaluation based on pathologic evidence.	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites that have no TNM staging:*** Not applicable	c

Instructions for Coding

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

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

2. For sites 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 Table 6 in the General Instructions.) For

CS Reg Nodes Eval, continued

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.

3. Select the code that best explains how the information in the CS Lymph Nodes field was determined.
   a. If the patient had no removal of lymph node(s), use code 0, 1, or 9.
      Example Prostate cancer with laparoscopic lymph node biopsy showing involved nodes; radical prostatectomy canceled.
      Code CS Reg Node Eval as 3. Staging algorithm would identify information as pathologic (p). According to AJCC, a positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.
      Example Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes.
      Code CS Reg Node Eval as 0. Staging algorithm would identify information as clinical (c).
   b. If the patient had removal of lymph node(s) surgery followed by other treatment(s), use code 3 or 9.
   c. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of lymph nodes takes precedence (code 5).
   d. If the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is found during lymph node examination after neoadjuvant therapy, use code 6.
   e. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (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.

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

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

7. 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 the tumor size or extension and the Extension field is coded as 99, the registrar still knows what procedures were used to try to determine those fields. In other words, just because the tumor size is coded 999, the Eval field does not have to be coded 9.

CS METS EVAL Item Length: 2 NAACCR Item #2860

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

Code	Description	Staging Basis
0	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No autopsy evidence used. ***Does not meet criteria for AJCC pathologic staging of distant metastasis.***	c
2	No pathologic examination of metastatic tissue done prior to death, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Pathologic examination of metastatic tissue performed WITHOUT pre-surgical systemic treatment or radiation **OR** pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed ***Meets criteria for AJCC pathologic staging of distant metastasis.***	p
5	Pathologic examination of metastatic tissue performed WITH pre-surgical systemic treatment or radiation, and metastasis based on clinical evidence.	c
6	Pathologic examination of metastatic tissue performed WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence.	y
8	Evidence from autopsy AND tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites with no TNM staging***: Not applicable	c

Instructions for Coding

1. One of the uses 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. Coding of the Eval field thus 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. If M0 will be derived (i.e., no distant metastasis are coded), then choose 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.
      Example Cecum carcinoma with negative chest X-ray and negative liver biopsy. CS Mets at DX is coded 00 (None), which maps to M0. CS Mets Eval is coded 1 (Evaluation of distant metastasis based on endoscopic examination or other invasive technique,

CS Mets Eval, continued

including surgical observation without biopsy), which maps to the "c" staging basis.

b. If MX will be derived (i.e., CS Mets at DX is coded 99), then choose an Eval code that will derive a "c" staging basis. The appropriate code might be 9 (Unknown) 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, CS Mets at DX coded 99 (Unknown) which will map to MX. CS Mets Eval is coded 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. CS Mets at DX is coded 99 (Unknown) which maps to MX. CS Mets Eval is coded 0 (imaging), which maps to the "c" staging basis.

c. If M1 will be derived (i.e., there is disease present that is 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. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the M1 disease, select an Eval code that will derive a "c" staging basis.

Example Cecum carcinoma with negative chest X-ray and positive liver biopsy. CS Mets at DX is coded 40 (Distant metastasis except distant nodes), which maps to M1, and there are no subcategories of M for the colon schema. CS Mets Eval is coded 3 (Pathologic examination of metastatic tissue performed WITHOUT pre-surgical systemic treatment or radiation OR pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed), which maps to the "p" staging basis.

Example Cecum carcinoma with positive chest X-ray and negative liver biopsy. CS Mets at DX is coded 40 (Distant metastasis except distant nodes), which maps to M1, and there are no subcategories of M for the colon schema. CS Mets Eval is coded 0 (No pathologic examination of metastatic tissue performed. Evaluation based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No autopsy evidence used), which maps to the "c" staging basis.

d. If a specific subcategory of M1 will be derived (such as M1a, etc.), then 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 Prostate carcinoma with the following:

Involvement	CS Mets at DX Code	TNM
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	Codes 12 + 30 + 40 = Code 55	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. CS Mets at DX is coded 55, which combines the codes for the lymph node, bone, and brain involvement. Code 55

CS Mets Eval, continued

maps to M1c. There is no pathological evidence for the subcategory of M1c (the only pathological evidence is for subcategory M1a). CS Mets Eval is coded 0 (imaging), which maps to the "c" staging basis. The positive lymph node would map to M1a, a lower M subcategory, so do not base the Eval code on that.

Example Prostate carcinoma with positive biopsy of aortic lymph node (distant node), negative bone scan, and negative brain scan. CS Mets at DX is coded 12 (distant lymph node), which maps to M1a. CS Mets Eval is coded 3 (Pathologic examination of metastatic tissue performed WITHOUT pre-surgical systemic treatment or radiation OR pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed), which maps to the "p" staging basis.

2. 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 Table 6 in the General Instructions.) 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.

3. 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. 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. 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.

6. AJCC does not recognize a pathologic M0 category since it is not possible to rule out all possible metastatic sites. Therefore, 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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Appendix 5. Histology Exclusion Groups

based on ICD-O-3 Morphology Codes

Histology Code Groupings for Collaborative Staging

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

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

Schema	Carci-noma	Carcin oid	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	
Pyriform Sinus; Hypopharynx		x	x	x	x	x	x	x	x	
Other Pharynx*										
Esophagus		x	x	x	x	x	x	x	x	
Stomach		x	x	x	x	x	x	x	x	
Small Intestine		x	x	x	x	x	x	x	x	
Colon		x	x	x	x	x	x	x	x	
Rectosigmoid; Rectum		x	x	x	x	x	x	x	x	
Anus		x	x	x	x	x	x	x	x	
Liver, intrahepatic ducts		x	x	x	x	x	x	x	x	
Gallbladder		x	x	x	x note 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

Schema	Carci-noma	Carcinoid	Mela-noma	Sar-coma	Other specified cancers	Mesothe-lioma	Kaposi sarcoma	Lym-phoma	Hema-topoi-etic	Other exclu-sions
Other Biliary		x	x	x	x	x	x	x	x	
Pancreas: Head		x	x	x	x 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	
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	