

## Conversion and Re-coding Instructions Including Instructions for "OBSOLETE" Codes

From time to time, it is necessary to revise Collaborative Staging (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 being moved from CS Lymph Nodes to CS Mets at DX). Codes in CS tables will not be deleted while users have data coded with those codes. Instead, the codes will be marked as OBSOLETE in their descriptions, and instructions will be provided for handling previously coded data.

In some cases, it may be possible to perform global corrections or conversions on prior data without manual review. In other cases, such as when a code is being split, it will be necessary to manually review abstracts and re-code them. Guidance for handling each instance of such changed or OBSOLETE codes requiring review of prior data will be provided 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 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.

Version 01.02.00 is effective for cases diagnosed on or after **1/1/2005**. Details about the codes made obsolete and other recoding requirements in this version are provided below. Decisions about whether or not to convert or re-code past data should be made based on local needs after reviewing the Comments And Rationales below. Standard setters may also establish requirements or recommendations for converting and recoding cases for their participants, independent of the Collaborative Stage Task Force. In any case, the obsolete codes should no longer be used once Version 01.02.00 is in effect.

Schema Name Table (ID)	Changed and Obsolete Codes and Descriptions	Conversion and Re- coding Instructions	Comments and Rationales
<b>MELANOMA</b> SSF 1 Depth of Invasion (jaa)	<b>990</b> Microinvasion; microscopic focus or foci only; no size given	Convert to 999	Code 990 was mistakenly deleted from an earlier version, when it should have been made obsolete. The code is being added back and shown as obsolete. This ensures that any cases coded with 990 in the past can be handled by the algorithm without causing an error. Any instances of code 990 for these sites can be globally converted to 999, unknown.  For the Melanoma [of skin] schema, SSF1 is only used to determine the T category of AJCC staging. Codes 990 and 999 are treated identically by the algorithm in Version 01.02.00.  For the three eye melanoma schemas, SSF1 does not participate in any of the staging calculations.
<b>MELANOMACONJUNCTIVA</b> SSF 1 Depth of Invasion (jpb)	<b>990</b> Microinvasion; microscopic focus or foci only; no size given	Convert to 999	
<b>MELANOMACHOROID</b> SSF 1 Depth of Invasion (jpb)	<b>990</b> Microinvasion; microscopic focus or foci only; no size given	Convert to 999	
<b>MELANOMAIRISCILIARY</b> SSF 1 Depth of Invasion (jpb)	<b>990</b> Microinvasion; microscopic focus or foci only; no size given	Convert to 999	

Schema Name Table (ID)	Changed and Obsolete Codes and Descriptions	Conversion and Re- coding Instructions	Comments and Rationales
<b>PROSTATE</b> CS Extension-Clinical Extension (bbo)	<b>31</b> Into prostatic apex/arising in prostatic apex, NOS  <b>33</b> Arising in prostatic apex  <b>34</b> Extending into prostatic apex	Re-code to 15, 20, 21, 22, 23, 24 or 30 AND record prostate apex involvement to appropriate code in SSF4	Historically, apex involvement has affected the stage classification, although it does not affect the AJCC 6th edition or SEER Summary Stages 1977 and 2000. The first versions of Collaborative Staging unfortunately assigned codes to apex involvement that took priority over other information about extension within the prostate. As a result, cases with apex involvement coded in the 30 series were always classified as T2NOS. Some of these cases were actually T1 according to the 6th edition of TNM, and others could have been assigned to a more precise subgroup of T2. They were correctly considered localized in SEER Summary Stage 1977 and 2000.
<b>PROSTATE</b> SSF 3 CS Extension- Pathologic (jav)	<b>031</b> Into prostatic apex/arising in prostatic apex, NOS  <b>033</b> Arising in prostatic apex  <b>034</b> Extending into prostatic apex	Re-code to 020, 021, 022, 023, or 030 AND record prostate apex involvement to appropriate code in SSF4	To fix this problem in Version 01.02.00, codes referring to apex involvement in both CS Extension-Clinical and SSF3 CS Extension-Pathologic were made obsolete, and all information about apex involvement was moved to SSF4.  In earlier versions of CS, SSF4 was used for the tumor marker PAP, but this is no longer considered useful information to collect. Since there were no available unused SSF fields for prostate to accommodate apex involvement, it was decided to reuse SSF4.
<b>PROSTATE</b> SSF 4 PAP table (obsolete) renamed to SSF4 Clinical Prostate Apex Involvement (maf)	<b>000</b> Test not done  <b>010</b> Positive/Elevated  <b>020</b> Negative/normal; within normal limits  <b>030</b> Borderline; undetermined whether positive or negative  <b>080</b> Ordered, but results not in chart  <b>999</b> Unknown	Re-coding not applicable. Prostatic Acid Phosphatase is no longer used as a prognostic indicator in staging.	Existing codes in SSF4 that pertained to PAP were marked as obsolete, and new detailed codes were created to describe apex involvement clinically and at prostatectomy.  Re-coding of cases can only be done manually by referring to the original abstract. This is only necessary for those using CS to derive AJCC staging. Those deriving only SEER Summary Stages 1977 and 2000 and who do not collect SSF4 need not review and re-code cases, but they should no longer use the obsolete codes.  Based on SEER data, approximately 16% of all cancers are prostate cancers, and it is estimated that approximately 15% of them would need to be reviewed.

Schema Name Table (ID)	Changed and Obsolete Codes and Descriptions	Conversion and Re- coding Instructions	Comments and Rationales
<b>RENALPELVIS</b> CS Extension (bbn)	<b>62</b> Ureter from pelvis	Re-code to 35, 40, or 60	<p>Extension to ureter from renal pelvis was mapped to T4 for AJCC 6th edition in the first versions of CS. AJCC provided clarification that ureter involvement should be T2. The mapping is being corrected to T2 in CS Version 01.02.00. Mapping to RE for SEER Summary Stages 1977 and 2000 is unchanged. A new code of 35 had to be assigned in order to keep the codes in hierarchical order by increasing T category.</p> <p>Cases coded 62 should be reviewed. If extension to the ureter was the furthest extension, the case can be assigned to new code 35. However, if adjacent connective tissue or kidney parenchyma was also involved, code 40 or 60 will be correct.</p> <p>Re-coding is only necessary for those using CS to derive AJCC staging. Those deriving only SEER Summary Stages 1977 and 2000 need not re-code cases, but they should no longer use the obsolete code.</p> <p>Based on SEER data, less than 0.2% of all cancers are renal pelvis cancers, and it is estimated that approximately 9% of them would need to be reviewed.</p>

Schema Name Table (ID)	Changed and Obsolete Codes and Descriptions	Conversion and Re- coding Instructions	Comments and Rationales
<b>THYROID</b> CS Lymph Nodes (dbr)	<p><b>10 and 11</b>            Ipsilateral regional lymph nodes</p> <p><b>20 and 21</b>            Bilateral, contralateral, and            midline nodes</p> <p><b>30</b>            Tracheoesophageal (posterior            mediastinal)</p> <p><b>31</b>            Mediastinal, NOS            Upper anterior mediastinal</p>	<p>10, 11, 20, and 21:            review and re-code to            appropriate new code in            12-15.</p> <p>30 and 31: convert to 15</p>	<p>Several problems were identified with the coding of lymph nodes for thyroid, affecting both AJCC staging and SEER Summary Staging. Problems included:</p> <ul style="list-style-type: none"> <li>• Mediastinal nodes in multiple codes of CS Lymph Nodes</li> <li>• Unnecessary retention of categories for laterality of lymph nodes that are no longer a part of AJCC staging</li> <li>• Level I nodes in CS Mets at DX, but they should have been in CS Lymph Nodes because they are considered regional by AJCC</li> </ul> <p>To achieve correct assignment of the N category and SEER Summary Stage 1977, manual review of CS Lymph Nodes codes 10 and 11 is required. The cases should be re-coded in 12-15 as appropriate. For SEER Summary Stage 2000 only, no review is required.</p>
<b>THYROID</b> CS Mets at DX (hbf)	<p><b>10</b>            Mandibular nodes</p> <p><b>11</b>            Submandibular (submaxillary)            and submental nodes</p> <p><b>50</b>            (40) + any of [(10) to (12)]            Distant lymph node(s) plus other            distant metastasis</p>	<p>Code 10 and 11 re-code in            CS Lymph Nodes, code 13.</p> <p>Code 50 re-code to 40 or            51 and appropriate code in            CS Lymph Nodes</p>	<p>CS Lymph Nodes codes 30 and 31 can be globally converted to the new code 15. This is necessary only for those deriving SEER Summary Stage 1977. Derivations of AJCC stage and SEER Summary Stage 2000 are unaffected.</p> <p>In CS Mets at DX, the nodes listed in codes 10 and 11 were moved to CS Lymph Nodes. Manual review and recoding of both CS Lymph Nodes and CS Mets at DX for all cases coded 10, 11, or 50 is required for all users to achieve correct staging for AJCC and SEER Summary Stages.</p> <p>Based on SEER data, less than 2% of all cancers are thyroid cancers, and it is estimated that approximately 22% of them would need to be reviewed.</p>

Schema Name Table (ID)	Changed and Obsolete Codes and Descriptions	Conversion and Re- coding Instructions	Comments and Rationales
<p>CS Mets at DX for the following schemas. Except as noted, the schemas use the common table (<b>hpb</b>):</p> <p><b>LIPUPPER</b>  <b>LIPLOWER</b>  <b>OTHLIP</b>  <b>BASETONGUE</b>  <b>ANTTONGUE (hbh)</b>  <b>GUMUPPER</b>  <b>GUMLOWER</b>  <b>OTHGUM</b>  <b>FOM</b>  <b>HARDPALATE</b>  <b>SOFTPALATE</b>  <b>OTHMOUTH</b>  <b>BUCCALMUCOSA</b>  <b>PAROTIDGLAND (hbd)</b>  <b>SUBMANDIBULARGLAND (hbr)</b>  <b>OTHSALIVARY (hbq)</b>  <b>OROPHARYNX</b>  <b>HYPOPHARYNX (hpd)</b>  <b>OTHPHARYNX (hbi)</b>  <b>GLOTTICLARYNX</b>  <b>SUPRALARYNX</b>  <b>SUBLARYNX</b>  <b>OTHLARYNX</b></p>	<p><b>10</b> Distant lymph node(s)</p> <p><b>50</b> (10) + (40) Distant lymph node(s) plus other distant metastases</p>	<p>Review codes 10 and 50, and if supraclavicular nodes are involved, recode to appropriate codes in CS Lymph Nodes and CS Mets at DX.</p>	<p>Supraclavicular and transverse cervical lymph nodes have been moved from CS Mets at DX to CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. No codes were made obsolete to effect this correction. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.</p> <p>The change does not affect SEER Summary Stage 1977 or 2000; in both cases, supraclavicular node involvement continues to result in Distant stage. However, for AJCC TNM staging, recoding may move some cases out of M1 to M0 and into a different N category, resulting in a lesser stage.</p>