INTRODUCTION TO COLLABORATIVE STAGING SYSTEM

The majority of instruction and examples for the Collaborative Staging (CS) System have been taken directly from the CS manual to ensure consistency in cancer registration.

The Collaborative Staging (CS) Task Force was formed in 1998 to address the issue of discrepancies in staging guidelines among the three major staging systems (TNM, SEER EOD, and SS). The initial focus was to develop a conversion method between the systems. The CS System is a unified set of data items that describe how far the cancer has spread at the time of diagnosis. The data set also includes several items derived from the computer algorithms that classify each case in multiple staging systems.

CHANGES IN ABSTRACTING RULES

Agreement between the participating organizations resulted in resolution of the timing rule effective January 1, 2004 for data collection and development of standard staging rules so a single format is used to collect staging information. The timing rule for CS is: "use all information gathered through completion of surgery (ies) in first course of treatment or all information available within four months of the diagnosis date in the absence of disease progression, whichever is ***longer***."

Disease progression is defined as further extension or distant metastasis known to have developed after the diagnosis was established. Information about tumor extension, lymph node involvement, or distant metastasis obtained after disease progression should not be documented. CS represents the combined information gathered during the time of diagnosis and work-up, not just the initial contact with the patient. CS ***does not*** consider a change from unknown evidence of disease to known status of disease (negative or positive) as disease progression. However, a change from negative to positive status is considered disease progression. If the treatment plan is discontinued or changed due to a revised disease status, this is disease progression and collection of CS information stops at this point.

EXAMPLE:

1. A patient has been treated surgically and is asymptomatic. During the follow-up exam to surgery, the patient has developed bone pain and is found to have bone metastases. *This is considered disease progression.*

The CS System introduces a change in the collection of information documenting the extent of disease, particularly in the collection of information about regional lymph nodes or distant metastases for primary sites not easily examined by palpation, observation, physical examination, or other clinical methods. The CS System allows the recording of regional lymph nodes as negative (based on clinical evaluation) rather than unknown when there is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration, and the patient receives what would be the usual treatment to the primary site. The primary sites that can be observed, palpated, or examined without instruments should have some description of the regional lymph nodes. **A statement such as "remainder of examination negative" is sufficient to record regional lymph nodes as clinically negative.**

How the Collaborative Staging System Works

The data items specific to that cancer site/histology are extracted from the medical record and coded in the CS System fields. When the data collection is complete, the registrar activates the computer algorithms to derive the values for the items in the TNM and SS systems. The output values are returned as a set of numeric codes designed for storage in the computerized abstract. The CS System schemas consist of the 15 data fields necessary to derive TNM and SS. The CS Manual provides codes and coding instructions for the process of data entry. To derive the desired TNM and SS, the computer algorithms must be used.

SCL will not have the computer algorithms. The stage will be derived once the submission is uploaded into SandCrab. The schemas apply to cases diagnosed January 1, 2004 and later.

***Do not* use the schemas for cases diagnosed prior to January 1, 2004**. Cases diagnosed prior to this date *should* be coded to whatever coding system was in place at the time of diagnosis. Reporting facilities should have the documentation to enable TCR staff to code the appropriate fields.

EXAMPLE:

1. Patient admitted March 17, 2004 for surgery of recurrent colon cancer. Chart states original colon cancer was diagnosed on September7, 2003. Document date of diagnosis is 09/07/2003. This case would be staged according to 2003 guidelines (SSSM2K)
2. Patient admitted April 4, 2004 and diagnosed with ductal carcinoma of the right breast. This case would be staged according to 2004 guidelines (CS).

NOTE: TCR will only collect 6 of the 15 fields collected for the collaborative staging system.

CODES AND GUIDELINES FOR USING THE COLLABORATIVE STAGING SYSTEM

CS 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 fields can be used to exclude non-microscopically confirmed cases during analysis as necessary, since the *AJCC Cancer Manual, 6th edition*, states: "all cases should be microscopically confirmed". Cases not microscopically confirmed should be coded from the schema for the site/histology the clinician considers most likely to be the primary.

All lymphomas are coded according to the lymphoma schema, regardless of the organ in which the lymphoma develops.

EXAMPLE:

1. Patient diagnosed with lymphoma. The CT scan shows multiple lymph node chains involved and a mass in the thyroid. Physician states, "most likely primary is thyroid." The lymphoma schema should be used to stage this case.

TCR staff will code the CS data items for cases submitted by SCL and manual reporters from the documentation required. All staging information available in the medical record should be documented. Both positive and negative findings should be recorded under **STAGING INFORMATION**. Pertinent staging information can be found in the following documents of the medical record. This list is not inclusive.

Pathology Report: Details on morphology, topography, tumor size, and stage of disease.
Surgery Report: Details on stage of disease, tumor size, origin of tumor, and both positive and negative findings observed during the procedure.
Imaging Exams, Lab Tests, Scopes, etc.: Details on tumor size, stage of disease, and both positive and negative findings.
History and Physical Report: Details on other tumors, staging information, primary site, and any prior cancer directed treatment the patient may have had.
Discharge Summary: Supplemental details on diagnosis, morphology, topography, staging and treatment or treatment plan.

GENERAL GUIDELINES

1. All schemas apply to all histologies unless otherwise noted. Derived data fields SS 1977 and SS 2000 are generated for all sites and histologies. The computer algorithms for determining the final TNM elements and Stage Group take into account histologies that are excluded from TNM staging. For excluded histologies, the computer algorithm returns values representing "Not Applicable," meaning the TNM elements and Stage Group are not generated for that site/histology combination.

   EXAMPLE:
   The TNM schema for prostate applies only to adenocarcinomas.

2. ***Timing of Data Collection:*** The data collected in the CS 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 and initial staging was established should be excluded)
   - which ever is ***longer.***

3. Site-specific and histology-specific guidelines take precedence over general guidelines. Always read the notes pertaining to a specific site or histology schema.

4. For each field, code the highest applicable number. 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 CS generally follows the hierarchies of the TNM System.

   EXCEPTION: *Codes for Unknown, Not Applicable, and NOS categories (such as Localized, NOS) do not take priority of more specific codes with lower numbers.*

   NOTE: Combination codes (such as code 35 for "25 plus 30") have been assigned when using the higher number does not result in the appropriate mapping for all three of the stage groups. Combination codes have been omitted when use of a higher number results in correct mapping for all three of the staging systems.

5. For the fields CS Tumor Size, CS Extension, CS Lymph Nodes, and CS Mets at Dx, CS records the greatest extent of disease based on combined clinical and operative/pathological assessment.

   NOTE: 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.

   NOTE: Clinical information should be reviewed carefully to assure accurate recording of CS data set. Information, such as description of skin involvement for breast cancer and size of the primary lesion and distant lymph nodes for any site, can change the stage.

6. When the patient does not receive preoperative treatment and the operative/pathology information disproves the clinical information, code the operative/pathology information.

7. When the patient does not receive preoperative treatment, the greatest extent of disease should be recorded, whether that is determined clinically or postoperatively.

   NOTE: Preoperative 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 the outcome of resection of tumor, or control symptoms before the patient has surgery.

8. The fields Reg LN Pos and Reg LN Exam are based on pathologic (microscopic) information only.

   NOTE: These are not new data fields. The TCR has collected these data fields since 1998.

9. The fields CS Tumor Size/Ext Eval, CS Reg Nodes Eval, and CS Mets Eval document how the most extensive tumor was established, as well as, whether the patient received preoperative treatment.

10. Site-Specific Factors (SSFs) are included in every schema. They are incorporated into the staging algorithms when additional information is necessary to derive the TNM Stage Group, or where the SSF is considered to be of clinical or prognostic importance. Information formerly coded as Tumor Markers is coded in SSFs. For sites/histologies where some or all SSFs are not used, they are coded 888 (not applicable). The TCR will only collect the SSFs for sites required to derive the SS**. SSF 1 will be collected for pleura primaries only and SSF 3 for prostate primaries only.**

11. Metastasis known to have developed after the initial extent of disease was established (disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.

12. Autopsy reports are used in coding the CS System in the same way as pathology reports, applying the same rules for inclusion and exclusion.

13. The extent of disease may be described only in terms of TNM characteristics in the medical record. In such cases, research the medical record for the appropriate staging documentation.

The TNM characteristics do not always translate one to one for SS and does not meet the documentation requirement.

14. 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.

USE OF AUTOPSY INFORMATION IN COLLABORATIVE STAGING

Information obtained from autopsy may be used in the CS System. For facilities deriving the TNM stage, 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 report may be included along with other clinical and pathologic information, if it meets the timing rules for inclusion.

ADJACENT CONNECTIVE TISSUE

Some of the CS System schemas for ill-defined or non-specific sites in this manual contain a code for adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer.

ADJACENT ORGANS

Organs are anatomic structures with specific physiologic functions other than (or in addition to) support and storage.

ADJACENT STRUCTURES

Connective tissues large enough to be given a specific name would be considered adjacent structures.

AMBIGUOUS TERMINOLOGY

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. Refer to the following table for the list of ambiguous terms used in CS.

Consider as Involvement	***Do Not* Consider as Involvement**
adherent	abuts
apparent(ly)	approaching
appears to	approximates
comparable with	attached
compatible with	cannot be excluded/ruled out
consistent with	efface/effacing/effacement
contiguous/continuous with	encased/encasing
encroaching upon*	encompass(ed)
extension to, into, onto, out onto	Entrapped
features of	Equivocal
fixation to another structure**	extension to without invasion/involvement of
fixed**	kiss/kissing
impending perforation of	matted (except for lymph nodes)
impinging upon	possible
impose/imposing on	questionable
incipient invasion	reaching
induration	rule out
infringe/infringing	suggests
into*	very close to
intrude	worrisome
invasion to, into, onto, out onto	* Interpreted as involvement whether the description is clinical or operative/pathological
most likely	
onto*	
overstep	** Interpreted as involvement of other organ(s) or tissue(s)
presumed	
probable	
protruding into (unless encapsulated)	
suspected	
suspicious	
to*	
up to	

TCR REPORTING REQUIREMENTS FOR COLLABORATIVE STAGING

CS DATA FIELDS COLLECTED BY THE TCR

1) CS TUMOR SIZE
2) CS EXTENSION
3) CS LYMPH NODES
4) CS METS AT DX
5) CS SITE-SPECIFIC FACTOR 1, FOR PLEURA PRIMARIES ONLY.
6) CS SITE SPECIFIC FACTOR 3, FOR PROSTATE PRIMARIES ONLY.

1) CS TUMOR SIZE (NAACCR Item # 2800) (CS MANUAL pg. 25)

Description
Records the largest dimension or diameter of the ***primary tumor,*** and is always recorded in millimeters.

> ***NOTE:*** To convert centimeters to millimeters, multiply the dimension by 10. If tumor size is given in tenths of millimeters, round down if between .1 and .4 mm, and round up if between .5 and .9 mm.

Tumor Size General Guidelines

Site/histology specific instructions replace or over-ride general instructions. Where there are no site/histology-specific instructions, general instructions apply.

1. Document tumor size information in the following order:
   a. Document tumor size from the pathology report, if available, when the patient receives no radiation or systemic therapy prior to surgery.

EXAMPLE:
Chest x-ray shows 3.5 cm mass; pathology report from the surgery states the same mass is malignant and measures 2.8 cm. Tumor size should be documented as 2.8 cm and coded as 028.

   b. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy or immunuotherapy) or radiation therapy, document the largest size of tumor prior to treatment.

EXAMPLE:
Patient has a 2.2 cm mass in the oropharynx identified per CT; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. Preop chemo tumor size 0.8 cm; CT: tumor size 2.2 cm should be documented and coded as 022.

c. Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but should be taken as low priority, just above a physical exam.

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

e. In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension.

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

a. Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass", and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

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

EXAMPLE:
Tumor is described as 2.4 x 4.1 x 1.8 cm in size. Tumor should be documented as 4.1 cm and coded as 041.

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. Document invasive tumor size 1.4 cm and should be coded as 014.

e. Additional rule for breast primaries: if the size of the invasive component is not given, document the size of the entire tumor from the surgical report, radiology report of clinical examination.

EXAMPLES:
Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Tumor size should be documented as 2.3 cm and coded as 023.

Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. Document tumor size as 1.9 cm and should be coded as 019.

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

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

h. Do not add pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

i. If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.
j. For an incisional needle biopsy, code tumor size as 999. Do not code the tumor size from a needle biopsy unless no residual tumor is found on further resection.
k. Record tumor size (lateral dimension) for malignant melanoma. Depth of invasion is coded in a site-specific factor.

3. Special codes

a. Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to SSF's for those sites/histologies.
b. If size is not reported, code as 999, which means unknown size, not applicable, or not documented in the patient record.
c. The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following sites:

Esophagus (15.0-C15.5, C15.8-C15.9): Entire circumference
Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse, widespread-3/4 or more, linitis plastica
Colorectal (M8220-8221, with /2 or /3): Familial/multiple polyposis
Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lobe or lung
Breast (C50.0-C50.6, C50.8-C50.9): Inflammatory carcinoma: Diffuse, widespread-3/4 or more of breast.

d. Code 990, microscopic focus or foci only; no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

Note: the terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumors identified microscopically should be coded to 990.

EXAMPLES:

Ovary specimen: extensive cystic disease with focal areas of tumor seeding.
"Focal" should be disregarded and tumor size should be coded to 999.

Cervix conization: severe dysplasia with focal areas of microinvasion.
Tumor size should be coded as 990 microscopic focus, no size given.

e. Codes 991 through 995 are non-specific size descriptions. If a more specific size is given, the more precise size should be coded in the range 001-989.
f. Other special codes in the range 996 to 997 are used on a site-specific basis. See the individual site/histology schemas for further information and definitions.
g. Note: For the following diagnoses and/or primary site, size is not applicable. Record as code 888.

Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma)
Mast cell tumors

Multiple myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases

4. Documentation of the source and tumor size is required in the Staging Documentation" text field.

Code	Description
000	Indicates no mass or no tumor found.
001-988	Exact size in millimeters.
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
991	Described as less than 1 cm.
992	Described as less than 2 cm.
993	Described as less than 3 cm.
994	Described as less than 4 cm.
995	Described as less than 5 cm.
	SITE-SPECIFIC SCHEMA CODES WHERE NEEDED
999	Unknown; size not stated; not stated in patient record.

EXAMPLES:

Tumor of stated primary not found,	*Code as 000*
Evidence of metastasis.	*Code as 000*
Mammogram shows 2.5 cm breast malignancy.	*Code as 025 (2.5 cm = 25 mm)*
CT of chest shows 4 cm mass in RUL	*Code as 040 (4 cm = 40 mm)*
Thyroidectomy specimen yields 8 mm carcinoma	*Code as 008*
Prostate needle biopsy shows 0.6 mm carcinoma	*Code as 001 (round up sixth-tenths)*

DETERMINING DESCRIPTIVE TUMOR SIZE (NAACCR Item #780) (CS MANUAL pg. 62)

NOTE: For cases diagnosed prior to 01/01/2004, use the tumor size chart in the TCR Handbook, page 81.

Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent
EGGS		**MISCELLANEOUS FOODS**		**NUTS**	
Bantam	040	Doughnut	090	Almond	030
Goose	070	Lentil	991	Chestnut	040
Egg	050	Millet	991	Chestnut, horse	040
Hen	030	**MISCELLANEOUS ITEMS**		Hazel	020
Pigeon	030	Ball, golf	040	Hickory	030

Robin	020	Ball, ping-pong	030	Peanut	010
FRUITS		Ball, tennis	060	Pecan	030
Apple	070	Baseball	070	Walnut	030
Apricot	040	Eraser on pencil	009	**OTHER TERMS**	
Cherry	020	Fist	090	Microscopic focus	990
Date	040	Marble	010	Size < 1 cm	991
Fig (dried)	040	Match head	009	Size between 1 and 2 cm	992
Grape	020	**MONEY**		**VEGETABLES**	
Grapefruit	100	Dime	010	Bean	010
Kumquat	050	Dollar, half	030	Bean, lima	020
Lemon	080	Dollar, silver	040	Pea	991
Olive	020	Nickel	020	Pea, split	991
Orange	090	Quarter	020		
Peach	060	Penny	010		
Pear	090				
Plum	030				
Tangerine	060				

* **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)

> ***NOTE:*** Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding. Document the exact tumor size from pathology report, or from imaging or physical exam. Document if size is before or after treatment began. Treatment such as surgery, chemotherapy, or radiation.

2) CS EXTENSION (NAACCR Item # 2810) (CS MANUAL pg. 28)

Description
Identifies contiguous growth (extension) of the primary tumor within the organ or its direct extension into neighboring organs.

> ***NOTE:*** For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field. Refer to site-specific schemas for detailed codes and coding instructions.

CS EXTENSION GENERAL GUIDELINES

1.Document the farthest extension of the primary tumor. Include discontinous metastases to the distant sites.
2.Extension should be coded in the following order:
   a. Extension from the pathology report, if available, when the patient receives no radiation

or systemic treatment prior to surgery.

b. Farthest extension identified prior to treatment if the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy.
c. Farthest extension based on the pathology/operative report after treatment, in the event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after the preoperative treatment as determined by the operative or pathology report.

EXAMPLES:
Patient found to have an obstructing central lung tumor very close to the main stem bronchus. Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea. The tumor was noted to be more extensive after preoperative treatment.

Patient has a 5.5 cm hard, moveable mass in the right breast 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. Chemotherapy shrank the tumor but the residual tumor was found to be more extensive that the clinical extension.

d. Extension from imaging/radiographic techniques can be used to code extension when there is not 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 in the same anatomic area.
f. With the exception of corpus uteri and ovary, extension codes represent direct extension from the site of origin to the organ/structure/tissue.

EXAMPLES:
Carcinoma of the prostate with extension to pubic bone would be coded in the CS Extension data field.

Carcinoma of the prostate with metastases to thoracic spine would be coded in CS Extension data field to the appropriate code for tumor extension and the thoracic metastases would be coded in the CS Mets at DX data field.

3. Distant metastases must be coded in the CS Mets at DX data field.
4. Extension cannot be in situ if there is evidence of nodal or metastatic involvement. The CS Extension data field should be coded Localized, NOS if there is not better information.

EXAMPLE:
Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. Code CS Extension as localized, NOS, because an in situ tumor cannot metastasize and an area of invasion was missed by the pathologist.

5. The presence of microscopic residual disease or positive margins does not increase the extension.
6. Extension and source documentation is required in the Staging Documentation text field.

Code	Description	TNM Mapping	SS 77 Mapping	SS 2000 Mapping
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in medical record	TX	U	U

NOTE: Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding. Document extent of tumor involvement or extent of disease from pathology, surgery, or imaging reports. Be sure to state if information is pre or post treatment.

EXAMPLE:

1. Lung: Tumor in left lower lobe and invades chest wall.
   Document: LLL invasion into chest wall.
2. Rectum: Patient had 3cm rectal mass and received chemo prior to surgery. Pathology report, 1.5 cm mass removed. Tumor invades muscular propria.
   Document: Chemo pre op, tumor invaded muscular propria.

3) CS LYMPH NODES (NAACCR Item #2830) (CS MANUAL pg. 33)

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

CS Lymph Nodes General Guidelines

1. Document the specific regional lymph node chain(s) involved by tumor either clinically or pathologically.
   a. Document involved regional lymph nodes from the pathology report when the patient receives no radiation or systemic treatment prior to surgery.
   b. Pathologic information takes precedence over clinical when there is a discrepancy on the same lymph node chain(s) if no preoperative therapy was administered.

EXAMPLE:

Per physical exam axillary lymph nodes were "suspicious for involvement". After axillary lymph node dissection, all 12 lymph nodes were negative. Document the number of lymph nodes examined and the negative findings (0/12 or number of lymph nodes negative/number of lymph nodes examined).

   c. For patient(s) with primary of inaccessible sites with early or localized disease, receiving usual treatment to the primary site, lymph nodes should be considered negative rather than unknown when there is no mention of regional lymph node involvement in the physical exam, pre-treatment diagnostic testing or surgical exploration.
   d. Document the regional chain involved prior to surgery if patient receives preoperative therapy.

EXAMPLE:
Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on physical examination. 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 to the lymph nodes and the prostatectomy is cancelled. The pelvic lymph node involvement should be documented and coded because the preoperative treatment had not effect on the lymph nodes.

e. Lymph nodes should be considered as not involved for primaries with in situ extension.

2. 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 "lymphadenopathy" 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 considered as involvement for lung primaries only.

b. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes.

c. Regional nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, and ovary. The best information on lymph node involvement will be found on imaging studies or the operative report. If nodes are not mentioned on the imaging reports or operative reports, they are presumed to be negative for inaccessible sites.

d. The terms "homolateral", "ipsilateral", and "same side" are used interchangeably.

e. Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS.

f. Size of the involved regional nodes can be found on the pathology report and should be documented if available.

g. For colon, rectosigmoid, and rectal primaries, if there is a statement about tumor nodule(s) in the pericolic or perirectal fat, use the following guidelines for coding regional lymph node involvement:
Consider regional node involvement if the nodule has a smooth contour
Consider tumor extension if the nodule has an irregular contour.

h. Both positive and negative findings for lymph node involvement should be documented in the Staging Documentation text field.

Code	Description	TNM Mapping	SS 77 Mapping	SS 2000 Mapping
00	None; no regional lymph node involvement.	N0	None	None
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES			
80	Lymph nodes, NOS.	NX	RN	RN
99	Unknown; regional lymph nodes cannot be assessed; not stated in medical record.	NX	U	U

NOTE: Head and neck sites have different levels of lymph nodes according to sites. Refer to CS Manual pgs. 35-38.

NOTE: Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding.

EXAMPLES:

1. Carcinoma base of tongue. Involves bilateral submandibular lymph nodes. Document name of lymph node chain.

4) CS METS AT DX (NAACCR Item #2850) (CS MANUAL pg. 43)

Description

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

CS Mets at DX General Guidelines

1. Document the metastases at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy.
2. Disease progression should not be documented.
3. Assume there are no distant mets when the clinician proceeds with standard treatment of the primary site for localized or early stage disease.
4. All metastatic disease and source of the information should be documented in the Staging Documentation text field.

Code	Description	TNM Mapping	SS 77 Mapping	SS 2000 Mapping
00	None; no regional lymph node involvement.	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastases, except code 10; distant metastasis, NOS; carcinomatosis.	M1	D	D
	SITE/HISTOLOGY SPECIFIC SCHEMA CODES WHERE NEEDED			
50	(40) + (10)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in medical record.	MX	U	U

NOTE: Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding.

EXAMPLE:

1. Breast cancer. Tumor in right upper outer quadrant, 2cm. Mastectomy path report, tumor has skin involvement.
   Document: RT UOQ, 2 cm, skin involvement per path.

5) CS SITE-SPECIFIC FACTOR 1 (NAACCR Item #2880) (CS MANUAL pg. 47)

NOTE: **TCR collects this field for pleura primaries only.** Facilities that collect this information for other sites, refer to CS Manual pg. 47.

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

PLEURA PRIMARY ONLY

Code	Description
000	No pleural effusion
010	Pleural effusion, non-malignant
020	Pleural effusion, malignant
030	Pleural effusion, NOS
999	Unknown if pleural effusion

NOTE: Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding.

EXAMPLE:
1. Biopsy of pleural effusion showed malignant cells.
   Document: Bx pleural fluid pos.

6) CS SITE-SPECIFIC FACTOR 3 (NAACCR Item #2900) (CS MANUAL pg . 51)

NOTE: **TCR collects this field for prostate primaries only.** Facilities that collect this information for other sites, refer to CS Manual pg. 51.

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

CS SITE-SPECIFIC FACTOR 3 CS EXTENSION FOR PROSTATES ONLY - PATHOLOGIC EXTENSION

- **Note 1**: Include information from prostatectomy in this field and not in CS Extension - Clinical Extension. Use all histological information including the prostatectomy if it was done within the first course of treatment. Code 097 if there was no prostatectomy performed within the first course of treatment.
- **Note 2**: Limit information in this field to first course of treatment in the absence of disease progression.
- **Note 3**: Involvement of the prostatic urethra does not alter the extension code.
- **Note 4**: When the apical margin, distal urethral margin, bladder base, or bladder neck margin is involved and there is no extra capsular extension, use code 040.
- **Note 5**: When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found (for example, one lobe, or both lobes, or more).
- **Note 6**: "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 060.
- **Note 7**: AUA stage. Some of the American Urological Association (AUA) stages A-D are provided as guidelines for coding in the absence of more specific information in the medical record. If physician-assigned AUA stage D1-D2 is based on involvement of lymph nodes only, code under CS Lymph Nodes or CS Mets at DX, not CS Extension - Pathologic Extension.
- **Note 8**: For this site, the T category and its associated c, p. y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 3 in order for the algorithm to derive the TNM stage for ACOS facilities. For details, see Note 7 under CS Extension.

NOTE: Documentation is **required** to support coding. Documentation from SCL users is required to determine correct coding.

EXAMPLE:
1. Prostectomy, tumor invaded bladder wall.

PROSTATE PRIMARIES ONLY

CS Site-Specific Factor 3 CS Extension - Pathologic Extension

Code	Description	TNM	SS77	SS2000
000	In situ; non-invasive; intraepithelial	Tis	IS	IS
020	Involvement in one lobe, NOS	T2NOS	L	L
021	Involves one half of one lobe or less	T2a	L	L
022	Involves more than one half of one lobe, but not both lobes	T2b	L	L
023	Involves both lobes	T2c	L	L
030	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Stage B, NOS	T2NOS	L	L
031	Into prostatic apex/arising in prostatic apex, NOS (see also codes 033 and 034)	T2NOS	L	L
032	Invasion into (but not beyond) prostatic capsule	T2NOS	L	L
034	Extending into prostatic apex	T2NOS	L	L
040	No extra capsular extension but margins involved (See Note 4)	T3NOS	L	RE
041	Extension to periprostatic tissue (Stage C1): Extra capsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3a	RE	RE

042	Unilateral extra capsular extension	T3a	RE	RE
043	Bilateral extra capsular extension	T3a	RE	RE
045	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
048	Extra capsular extension and margins involved	T3NOS	RE	RE
050	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
052	Levator muscle Skeletal muscle, NOS Ureter	T4	D	RE
060	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 6)	T4	D	D
070	Further contiguous extension (Stage D2) including to: Bone Penis Sigmoid colon Soft tissue other than periprostatic tissue Other organs	T4	D	D
095	No evidence of primary tumor	T0	U	U
096	Unknown if prostatectomy done	TX	U	U
097	No prostatectomy done within first course of treatment	TX	U	U
098	Prostatectomy was done within first course of treatment, but there was disease progression	TX	U	U
099	Prostatectomy done: Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

TCR DOES NOT COLLECT THE FOLLOWING:

- **CS TUMOR SIZE/EXT EVAL**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 30.

- **REGIONAL NODES EVAL**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 39.

- **REGIONAL NODES POSITIVE (TCR HANDBOOK PG 81) NAACCR ITEM # 820**
  NOTE: TCR DOES NOT COLLECT THIS FIELD FOR CS SYSTEM.
  Regional nodes positive data field is collected for summary stage.
  This is not a new data field for TCR.(Refer to page 106 number 8 of this manual)
  For facilities that collect this information for CS, refer to CS Manual PG # 41.

- **REGIONAL NODES EXAMINED (TCR HANDBOOK PG 82) NAACCR ITEM # 830**
  NOTE: TCR DOES NOT COLLECT THIS FIELD FOR CS SYSTEM.
  Regional nodes examined data field is collected for summary stage.
  This is not a new data field for TCR. (Refer to page 106 number 8 of this manual)
  For facilities that collect this information for CS, refer to CS Manual PG # 42.

- **CS METS EVAL**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 45.

- **CS SITE-SPECIFIC FACTOR 2**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 49.

- **CS SITE-SPECIFIC FACTOR 4**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 53.

- **CS SITE-SPECIFIC FACTOR 5**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 55.

- **CS SITE-SPECIFIC FACTOR 6**
  NOTE: TCR DOES NOT COLLECT THIS FIELD.
  For facilities that collect this information refer to CS Manual PG # 57.