CANCER INFORMATION

DATE OF INITIAL DIAGNOSIS (NAACCR Item #390) (FORDS pgs. 89-90; SEER pg. 88)

Definition
The date of initial diagnosis is the earliest date this primary cancer is diagnosed by a recognized medical practitioner regardless of whether the diagnosis was made at the reporting facility or elsewhere.

Explanation
The date of initial diagnosis is essential in the analysis of staging and treatment of the cancer.

Coding Instructions

- Date format is MMDDCCYY. The first and second digits are the month, the third and fourth digits are the day, the fifth and sixth digits are the century and the seventh and eighth digits are the year.

- The initial diagnosis date may be from a clinical diagnosis e.g., radiologist views chest x-ray and diagnosis is lung carcinoma. If later confirmed by a pathology specimen, the diagnosis date remains the date of the initial clinical diagnosis.

- The date of diagnosis from a pathology report will be the date the specimen was taken, not the date the pathology report was read.

- Refer to the *List of Ambiguous Terms* on page 22 to aid in determining diagnosis.

- If later documentation shows the diagnosis was an earlier date, record the earlier date. Check with your regional office for the appropriate procedure if this case has already been submitted to the TCR.

- The date of death will be the date of initial diagnosis for autopsy-only and death certificate-only cases.

- In the absence of an exact date of initial diagnosis, **make the best approximation.** If the year is known and the month and day are not known, record 9's for the month and day, and record the year of diagnosis. If there is no documentation to make an approximate date of initial diagnosis, record all 9's.

- For vague dates, refer to the table below. Use the date examples on the next page.

DOCUMENTATION	DATE CODE/DESCRIPTION
Spring	Use April (04) for the month
Summer	Use July (07) for the month
Fall	Use October (10) for the month
Winter	Determine if this means the beginning or the end of the year. Use December (12) or January (01) for the month as determined.

DOCUMENTATION	DATE CODE/DESCRIPTION (CONTINUED)
Middle of Year	Use July (07) for the month
Recently	Use the month and year of admission and unknown day (99) for the day. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if a course of treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown.

EXAMPLES:

1. A patient was admitted to your facility on January 15, 2003. The History and Physical states the patient has prostate carcinoma diagnosed approximately two months ago. The date of diagnosis would be recorded as 11992002.

2. A patient was admitted to your facility on September 10, 2003. The History and Physical states the patient has bone and brain metastasis from malignant melanoma diagnosed in the fall, four years ago. The date of diagnosis would be recorded as 10991999.

3. On March 12, 2003 a mammogram reveals a mass in the upper outer quadrant of the patient's right breast. The radiologist's impression states: compatible with carcinoma. On March 20, 2003, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. The date of diagnosis would be recorded as 03122003.

NOTE: Remember to check with your regional office on the appropriate procedure to follow when you have updated information on an abstract you have already submitted to the TCR. Do NOT resubmit the abstract. These cases will result in duplicate records and need manual resolution.

MORPHOLOGY AND BEHAVIOR (NAACCR Item #522, #523) (FORDS pgs. 93-94; SEER pgs. 95-100)

Description
Identifies the histological component of tumor cells and how the tumor behaves.

Explanation
The histological type helps to determine staging and treatment options, and shapes the disease course and prognosis.

Coding Instructions

- **If your facility does not have staff experienced in ICD-O-3 coding, leave this field blank.**

Morphology codes are 5-digit codes. The first 4 digits identify the histological component of the tumor cells. The 5th digit (or behavior code) indicates whether a tumor is malignant, benign, in situ or

uncertain whether malignant or benign.

- Record the morphology code using the Alphabetic Index (ICD-O-3 pgs. 105-218) and the Numerical Index (ICD-O-3 pgs. 69-104). It is important to remember to cross-reference.

- **Adequate text documentation must be provided. Autocoding of the ICD-O-3 code description is not considered adequate text documentation.**

- Use all pathology reports available to code the cell type of the tumor. Generally, the pathology report from a resection or an excision is most representative of the tumor's histology; however, the pathology report from an incisional biopsy is adequate if the tumor is not resected. The microscopic **and** final pathologic diagnosis should be studied for specific information relating to the cell type of the tumor.

- The words **cancer** and **carcinoma** are **not** interchangeable. Record the appropriate histology code from the physician documentation.

Guidelines for coding a single lesion with mixed or multiple morphologies with the same behavior:

Rule 1: Use a combination code if one exists.

EXAMPLES:
1. Predominantly lobular with a ductal component, code to 8522/3
2. Renal cell carcinoma, mixed clear cell and chromophobe types, code to 8255/3
3. Infiltrating duct carcinoma mixed other types of carcinoma, code to 8523/3
4. Infiltrating lobular carcinoma mixed with other types of carcinoma, code to 8524/3
5. Adenocarcinoma with focal mucinous and clear cell differentiation, code to 8255/3
6. Mixed carcinoma with poorly differentiated and small cell neuroendocrine carcinoma, code to 8045/3
7. Mixed alpha cell and beta cell carcinomas of the pancreas, code to 8323/3

For additional instruction on coding complex histologies please refer to page 61 for breast; page 62 for GYN cancers of mixed cell types and renal cell carcinoma subtypes; and page 63 for mixed germ cell tumors.

Rule 2: Use the more specific code if one is not otherwise specified (NOS) and one is more specific.

EXAMPLES:
1. Pathology report states adenocarcinoma, predominately mucin producing. Record the more specific code, mucin-producing adenocarcinoma. Code to 8481/3.
2. Pathology report states invasive carcinoma, probably squamous cell type. Record the more specific code, squamous cell carcinoma. Code to 8070/3.
3. Pathology report states adenocarcinoma with cribriform differentiation. Record the more specific code, cribriform carcinoma. Code to 8201/3.

NOTE: The microscopic description may state mucin producing, papillary, or keratinizing, and the final pathologic diagnosis may simply state carcinoma or adenocarcinoma. Modify the final pathologic diagnosis to include the specific terms such as mucin-producing, papillary, etc.

Rule 3: Use the terms that may or may not indicate a majority of tumor if *Rule 1* or *Rule 2* cannot be applied. Ignore terms that do not indicate a majority of tumor. When both terms are specific (in other words, not NOS) and no combination code exists, code to the majority of the tumor.

MAJORITY TUMOR TERMS	
MAJORITY	**NOT MAJORITY**
Predominantly	With foci of
With features of	Focal/focus of
Major	Areas of
Type	Elements of
With…differentiation	Component

EXAMPLES:
1. Duct carcinoma, **desmoplastic** type, code to 8514/3.
2. Duct carcinoma, predominantly **medullary**, code to 8510/3.
3. Duct carcinoma with features of **comedocarcinoma**, code to 8501/3

- Code the stated type (subtype) even if the code is lower than 8500. Look for the terms "type", "subtype", or variant" or terms that indicate the majority of the tumor.

Rule 4: Code the morphology with the highest code-rule with the lowest priority.

EXAMPLES:
1. Mixed transitional cell carcinoma and squamous cell carcinoma, code to 8120/3.
2. Poorly differentiated carcinoma with squamous and neuroendocrine differentiation, code to 8246/3.
3. Carcinoma was trabecular and acinar pattern, code to 8550/3.
4. The pathology report report states transitional cell epidermoid carcinoma. Transitional cell carcinoma, NOS is coded to 8120/3 and epidermoid carcinoma, NOS is coded to 8070/3. Record the numerically higher code, 8120/3.

NOTE: Code the histology type of a single tumor with two modifying adjectives with different codes to the numerically higher code when there is no combination code available.

Additional coding guidelines for complex histologies.

- **Guidelines for coding complex breast histologies:**

Single breast tumor with complex histology:

- If the diagnosis is both lobular and ductal (in situ or invasive or a combination), use code 8522

EXAMPLES:

1. Duct carcinoma and lobular carcinoma in situ, code to 8522/3.
2. Lobular carcinoma is situ and duct cell in situ, code to 8522/2.

- If the diagnosis is mixed invasive and in situ, code the invasive diagnosis.

EXAMPLES:

1. Ductal carcinoma with extensive cribriforming DCIS, code to 8500/3.
2. Mucinous carcinoma in a background of ductal carcinoma in situ, code to 8480/3.
3. Infiltrating ductal carcinoma with DCIS, solid, cribriform and comedo type, code to 8500/3.

- Use a combination code if the diagnosis is duct carcinoma or lobular carcinoma mixed with another type of carcinoma. Look for "and" or "mixed" in the diagnosis.

- If the diagnosis is duct carcinoma mixed with another type of carcinoma (excluding lobular), use code 8523.

EXAMPLES:

1. Duct carcinoma and tubular carcinoma, code to 8523/3.
2. DCIS and cribriform carcinoma in situ, code to 8523/2.

- If the diagnosis is lobular carcinoma mixed with another type of carcinoma (excluding ductal), use code 8524.

EXAMPLES:

1. Lobular and adenoid cystic carcinoma, code to 8524/3.
2. Tubular carcinoma and lobular carcinoma, code to 8524/3.

- Code the specific type if the diagnosis is

EXAMPLES:

1. Duct carcinoma, tubular type, code to 8211/3.

2. Duct carcinoma with apocrine features, code to 8401/3.

Code the stated type(subtype) even if the code is lower than 85000.

Look for the terms "type," "subtype," or "variant" or terms that indicate the majority of the tumor.

- If the diagnosis includes more than one subtype, use a combination code.

EXAMPLES:

1. Duct carcinoma, cribriform and comedo types, code to 8523/3.
2. Duct carcinoma in situ, showing both solid and cribriforming subtypes, code to 8523/2.

Separate tumors of different histologies in one breast:

- If different histologies occur in separate tumors in the same breast, use a combination code if possible and count the case as a single primary.

EXAMPLES:

1. LCIS UIQ right breast and duct carcinoma, code to 8522/3.
2. Paget disease of nipple and intraductal carcinoma, code to 8543/3.

- **Guidelines for coding GYN cancers of mixed cell types:**

Mixed cell adenocarcinoma of ovary can be any combination of:

a. Serous adenocarcinoma, 8441
b. Mucinous adenocarcinoma, 8480
c. Endometrioid adenocarcinoma, 8380
d. Squamous cell carcinoma, 8070
e. Brenner tumor, 9000

NOTE: If more than one cell type is mentioned in the path report, code to 8323/3 (mixed cell adenocarcinoma).

EXAMPLE:

Endometrium: adenocarcinoma with clear cell, papillary and squamous differentiation, code to 8323/3.

- **Guidelines for coding renal cell carcinoma subtypes:**

EXAMPLES:

1. Renal cell carcinoma (NOS, including hypernephroma[obs]), code to 8312/3.
2. Clear cell, code to 8310/3.

3. Papillary (also called chromophil), code to 8260/3.
4. Chromophobe, code to 8317/3.
5. Sarcomatoid (spindle cell), code to 8318/3.
6. Granular cell, code to 8320/3.
7. Collecting duct carcinoma, code to 8319/3.
8. Malignant renal oncocytoma, code to 8290/3.
9. Cyst-associated renal cell carcinoma, code to 8316/3.

- If more than one subtype is mentioned in the pathology report, code to 8255/3 adenocarcinoma with mixed subtypes.

EXAMPLES:

1. Renal cell carcinoma, mixed clear cell and chromophobe, code to 8255/3.
2. Renal cell carcinoma with mixed granular cell, clear cell and collecting duct differentiation, code to 8255/3.
3. Renal cell carcinoma, mixed granular and clear cell, code to 8255/3.

- **Guidelines for coding mixed germ cell tumors:**

  - Identify the histologies and note which ones are present.

  The following is a list of germ cell tumors in order of prognosis:

  a. Choriocarcinoma, 9100/3.
  b. Yolk sac tumor, 9071/3.
  c. Embryonal cell, 9070/3.
  d. Teratoma, 9080/3.
  e. Seminoma, 9061/3-9064/3.

  EXAMPLES:

  1. Teratoma and choriocarcinoma, code to 9101/3.
  2. Seminoma and teratoma, code to 9081/3.
  3. Embryonal and choriocarcinoma, code to 9101/3.

- **Guidelines for coding specific morphology types:**

  - If one of the cell types is:

  a. Choriocarcinoma, code to 9101.
  b. Embryonal cell, code to 9081.
  c. Teratoma, code to 9081.
  d. Seminoma and other(s) non-seminoma, code to 9085.
  e. None of the germ cell types is seminoma, code to 9065.

EXAMPLES:

1. Mixed embryonal carcinoma and teratoma, code to 9081/3.
2. Mixed germ cell (usually seminoma and something else), code to 9085/3.
3. Choriocarcinoma with other germ cell elements, code to 9101/3.
4. Germ cell tumor, nonseminomatous, code to 9065/3.

- **Guidelines for coding combined small cell and non-small cell carcinoma:**

For single tumors, code 8045/3 should be used for combinations or mixtures of small cell (oat cell) carcinoma and any other type of non-small cell carcinoma. Combinations containing small cell carcinoma and carcinoids, lymphomas, and sarcomas of the lung **cannot** be coded to 8045/3.

Guidelines for coding a single lesion with different behaviors:

- Histologies with different behavior codes are coded to the histology associated with the malignant behavior.

EXCEPTION: *If the histology of the invasive component is an 'NOS' term e.g., carcinoma, adenocarcinoma, melanoma or sarcoma, then use the specific term associated with the in situ component and an invasive behavior code.*

EXAMPLES:

1. The pathology report states squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3). Record to papillary squamous cell carcinoma (8052/3).

2. The pathology report states squamous cell carcinoma in situ (8070/2) with areas of invasive carcinoma (8010/3). Record to squamous cell carcinoma (8070/3).

3. If the fifth digit is **not** the same, select the morphology code with the higher behavior code (the invasive tumor). Refer to the following table.

BEHAVIOR CODE	FIFTH DIGIT TERM	DEFINITION
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease
		Clark's Level for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50._)
2	Synonymous with in situ	Confined to epithelium
		Hutchinson's melanotic freckle, NOS (C44._)
		Intracystic, non-infiltrating
		Intraductal
		Intraepidermal, NOS

BEHAVIOR CODE	FIFTH DIGIT TERM	DEFINITION
		Intraepithelial
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44._)
		Lobular neoplasia (C50._)
		Lobular, non-infiltrating (C50._)
		Non-infiltrating
		Non-invasive
		No stromal involvement
		Papillary, non-infiltrating or intraductal
		Precancerous melanosis Preinvasive
		Queyrat's erythroplasia
3	Invasive	Invasive or microinvasive

- **Guidelines for coding multiple lesions considered a single primary:**
  - One lesion is a 'NOS' term and the second lesion is an associated but more specific term; code to the more specific term.

EXAMPLES:

1. First lesion is carcinoma, NOS and second lesion is large cell carcinoma; code to large cell carcinoma, 8012/3.

2. First lesion is adenocarcinoma, NOS and second lesion is mucinous adenocarcinoma; code to mucinous adenocarcinoma, 8480/3.

3. First lesion is melanoma, NOS and the second lesion is lentigo maligna melanoma; code to lentigo maligna melanoma, 8742/3.

4. First lesion is sarcoma, NOS and the second lesion is spindle cell sarcoma; code to spindle cell sarcoma, 8801/3.

PRIMARY SITE (NAACCR Item #400) (FORDS pg. 91; SEER pgs. 91-92)

Description
Identifies the primary site of the cancer.

Explanation
The primary site helps to determine stage and treatment options, and shapes disease course and prognosis.

Coding Instructions
- **If your facility does not have staff experienced in ICD-O-3 coding, leave this field blank.**

- **Adequate text documentation must be provided**. Auto coding of the ICD-O-3 code description is not considered adequate text documentation.

- Record the code that **most accurately** identifies the anatomical site of the primary neoplasm, the organ, or the tissue of origin.

  NOTE: The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

  EXAMPLE:

  The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical states examination of the right breast reveals a mass in the upper outer quadrant. Code to the more detailed description from the History and Physical, upper outer quadrant of the right breast.

- In the ICD-O-3 book the appropriate site-specific codes are listed in parentheses after morphology terms for neoplasms that usually occur in the same site or tissue e.g. pituitary carcinoma, NOS, **(C75.1).**

  EXAMPLE:

  If documentation in the medical record shows a diagnosis of pituitary carcinoma, NOS with no indication as to the site use the suggested topography code in parenthesis. In this case it would be C75.1.

- In general, when a primary site is preceded by *carcinoma of…,* or *malignancy of…*, code to that primary site.

- If the final diagnosis reflects carcinoma of one of the sites listed, carefully review documentation in the medical record to identify the actual primary site.

  The following is a list of the common metastatic sites:

  1. Bone
  2. CNS Sites (brain, spinal cord, meninges)
  3. Liver
  4. Lymph Nodes (excludes lymphoma)
  5. Pericardium (excludes mesothelioma)
  6. Pleura (excludes mesothelioma)
  7. Peritoneum
  8. Retroperitoneum

- **Guidelines for the four character site codes:**

  - According to ICD-O-3, each four-character site of the colon (C18.0-C18.9); rectum, anus, and anal canal (C19.9, C20.9, C21.0-C21.8); bone (C40.0-C41.9); connective tissue (C49.0-C49.9); peripheral nerves (C47.0-C47.9); and melanoma of the skin (C44.0-44.9), is considered to be a **separate** primary site.

    EXAMPLE:

    Cecum (C18.0) and ascending colon (C18.2) would be considered two separate primaries unless stated to be metastatic from one site to the other.

  - All other four-character site codes are sub-sites of a major site.

    EXAMPLE:

    Upper-inner quadrant of the breast (C50.2) is a sub-site of the breast (C50._).

Additional guidelines for coding primary site:

- Approximately 25% of lymphomas originate in extra-nodal sites such as the stomach, intestine, or breast. A lymphoma primary originating in an organ or extra-nodal site should be coded to the organ or extra-nodal site. The code for the primary site, in some cases, may not be the biopsy site. If a specific lymph node is the primary site, code accordingly.

- Malignant lymphoma of stomach, code to C16.9.

- Two or more lymph node chains and an extra-nodal site are involved; code to C77.8.

- No site is indicated for a lymphoma and it is suspected to be extra-nodal; code to C80.9 (unknown primary site).

- World Health Organization (WHO) diagnosis "B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma" is coded as 9823/3, and cross-referenced to 9670/3, malignant lymphoma, small B lymphocytic. If this WHO term is diagnosed in blood or bone marrow, code to 9823/3; if diagnosed in tissue, lymph nodes or any organ in combination with blood or bone marrow, code to 9670/3.

- Use the site code provided with site associated morphology terms when a site code is not stated in the diagnosis.

- Leukemias and myelomas are coded to bone marrow (C42.1).

- Malignant histiocytosis is coded to bone marrow (C42.1).

- Kaposi's sarcoma is coded to the site in which it originates. If Kaposi's sarcoma originates in skin

and another site simultaneously, code to skin (C44._). If no primary site is stated, code to skin, NOS (C44.9).

- Mycosis fungoides is coded to skin (C44._). If a specific site is stated to be the primary, code accordingly.
- A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.
- Code neuroblastomas of ill-defined sites to the most likely primary site in each case.
- Code to connective, subcutaneous, or other soft tissue NOS (C49.9), if the primary site is unknown.
- Melanoma, NOS is coded to skin, NOS (44.9)

GRADE OF TUMOR (NAACCR Item #440) (FORDS pg. 96) (SEER pgs. 101-104)

Definition
Describes how much or how little the tumor cells resemble normal tissue.

Explanation
The more undifferentiated the tumor, the greater the incidence of metastasis and the more rapid the clinical course. The terms "grade" and "differentiation" are used synonymously.

Coding Instructions
- Code grade/differentiation according to the rules in the ICD-O-3 book, (pp. 30-31 and 67).

CODE	GRADE	DESCRIPTION
1	Grade I	Well differentiated; differentiated, NOS
2	Grade II	Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
3	Grade III	Poorly differentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
4	Grade IV	Undifferentiated; anaplastic, dedifferentiated, high grade NOS
For Leukemias and Lymphomas		
5		T- cell; T--precursor
6		B- cell; pre-B; B-precursor
7		Null cell; non T-non- B
8		NK (natural killer) cell
For use in all histologies		
9		Grade/differentiation not determined, not stated, not applicable; cell type not determined, not stated, not applicable

NOTE: Terms such as "anaplastic," "well differentiated," and "undifferentiated" are used as essential

parts of morphologic terms for neoplasms in ICD-O-3 (as well as those used to describe lymphomas). These morphologies must be reported with the appropriate grade code.

EXAMPLES:

1. 8020/3**4** Carcinoma, undifferentiated
2. 8021/3**4** Carcinoma, anaplastic
3. 8331/3**1** Follicular adenocarcinoma, well differentiated
4. 9082/3**4** Malignant teratoma, undifferentiated
5. 9083/3**2** Malignant teratoma, intermediate type
6. 9401/3**4** Astrocytoma, anaplastic
7. 9451/3**4** Oligodendroglioma, anaplastic
8. 9511/3**1** Retinoblastoma, differentiated
9. 9512/3**4** Retinoblastoma, undifferentiated
10. 9670/3**1** Malignant lymphoma, lymphocytic, well differentiated, diffuse
11. 9714/3**4** Anaplastic large cell lymphoma

- Code the grade/differentiation as stated in the **final** diagnosis of the pathology report. If not stated in the final diagnosis of the pathology report, use the information in the microscopic description or comments.

- Grade is best determined from the specimen obtained at resection of the primary site. If this is unavailable, the grade from a biopsy of the primary site or cytology should be used.

- Code to the highest grade, even if the highest grade is only a focus, when the pathology report states more than one grade/differentiation of tumor (Rule G, ICD-O-3, page 31).

  EXAMPLE:

  The pathology report states moderately differentiated squamous cell carcinoma with poorly differentiated areas, this is coded to grade 3.

  - Code the grade/differentiation for in situ lesions if stated.

  - Code the grade/differentiation from the primary site, not from metastatic sites.

  - When there is no tissue diagnosis, it may be possible to establish the grade/differentiation of a tumor through magnetic resonance imaging (MRI) or positron emission tomography (PET). Code the grade/differentiation based on the information from these reports.

  - Code to 9 when the primary site is unknown.

  Do not use the terms “low grade,” “intermediate grade,” or “high grade” for lymphomas to code grade/differentiation. These terms are categories in the *Working Formulation of Lymphoma Diagnoses* and do not indicate the grade/differentiation.

- Information on T-cell, B-cell, or null cell for lymphomas and leukemia's has precedence over the information on grade/differentiation. If the grade/differentiation is stated (moderately differentiated, poorly differentiated, well differentiated) and the cell type is not, use this information.

- FIGO (International Federation of Obstetrics and Gynecology) grades are not coded.

- Conversion tables used to change a 3-grade system to a 4-grade system:

When described by terms:

CODE	GRADE	TERMINOLOGY
2	I-II	Low grade, partially differentiated
3	II-III	Medium grade
	III	Moderately undifferentiated, relatively undifferentiated
4	III-IV	High grade

When described by numbers:

CODE	NUMBERS
1	I/III or 1/3
2	II/III or 2/3
3	III/IV or 3/4

NOTE: When a grade is written as 2/3 (meaning this is a grade 2 **of** a 3 grade system), record grade 2. When a grade is written as 3-4, (meaning this is grade 3 **to** 4), record the higher grade of 4.

- **Site- specific grade/differentiation codes:**

Prostate

Prostate cancers may be graded using Gleason's Score or Pattern. If only one number is stated and it is less than or equal to 5, assume it is a pattern. If only one number is stated and it is greater than 5, assume it is a score. If two numbers are stated, assume that it is two patterns and add them together to obtain the score.

CODE	GLEASON'S SCORE	GLEASON'S PATTERN	GRADE/DESCRIPTION
1	2, 3, 4	1, 2	I/Well differentiated
2	5, 6,	3	II/ Moderately differentiated
3	7, 8, 9, 10	4, 5	III/Poorly differentiated

NOTE: If not identified as Gleason's score or pattern, assume it is a non-Gleason grade system and code appropriately. If both a non-Gleason's grade and a Gleason's score or patterns are given, **code to the non-Gleason Grade**.

Breast

SEER suggests the use of these guidelines for recording grade or differentiation in the following order:

1. Terminology (differentiation: well, moderately, poorly, moderately-well, etc.; I, II, III, etc.)
2. Histological grade (grade I, grade II, grade III)
3. Bloom-Richardson scores (range 3-9, converted to grade)
4. Bloom-Richardson grade (low, intermediate, high)
5. Nuclear grade only

CODE	GRADE	SCORE	DIFFERENTIATION
1	Low grade	3, 4, 5	Well differentiated
2	Intermediate Grade	6, 7	Moderately differentiated
3	High grade	8, 9	Poorly differentiated

NOTE: Bloom-Richardson score may also be called modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham-Tenovus, or Nottingham grade.

Brain – Astrocytomas

MORPHOLOGY TERM	GRADE
Astrocytoma, anaplastic	4
Astrocytoma, low grade	2
Astrocytoma, grade 1	1
Astrocytoma, grade 2	2
Astrocytoma, grade 3	3
Astrocytoma, grade 4	4

NOTE: Astrocytomas are graded according to ICD-O-3 rules.

LATERALITY (NAACCR Item #410) (FORDS pg. 92; SEER pgs. 93-94)

Description
Identifies the side of a paired organ or the side of the body on which the tumor originated.

Explanation
Aids in staging and extent of disease information, and may indicate the number of primaries.

Coding Instructions
Non-paired sites are coded to 0.

- Unknown sites (C80.9) are coded to 0.
- Midline lesions are coded to 9.
- **Do not** code metastatic sites as bilateral involvement.
- For primaries of in situ behavior, if laterally is not known, code to "3" (only one side involved, right or left origin of primary not indicated). Laterality for in situ behavior cannot be coded to "9" or "4".

CODES	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement; side of origin unknown; stated to be a single primary. Includes: •Both ovaries simultaneously involved with a single histology •Bilateral retinoblastomas •Bilateral Wilms' tumors
9	Unknown site; paired site, lateral origin unknown; midline tumor

- See below for list of paired (bilateral) sites.
- Laterality must be recorded for the following bilateral sites. Only major headings are listed. Laterality should be recorded for all anatomic sub-sites included in ICD-O-3 unless specifically excluded. Such exclusions are coded '0'.

BILATERAL SITES

Laterality codes of "1" - "9" must be used for the following sites.

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Acoustic nerve	C72.4
Adrenal gland [cortex, medulla]	C74.0-C74.9
Breast	C50.0-C50.9
Carotid body	C75.4
Cerebral meninges, NOS	C70.0
Cerebrum	C71.0
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C69.0
Connective, subcutaneous & other soft tissues of lower limb & hip	C49.2
Connective, subcutaneous & other soft tissue of upper limb & shoulder	C49.1

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Cranial nerve, NOS	C72.5
Epididymis	C63.0
Fallopian tube	C57.0
Frontal lobe	C71.1
Frontal Sinus	C31.2
Kidney, NOS	C64.9
Long Bones of Upper Limb, Scapula & associated joints	C40.0
Long Bones of Lower Limb & associated joints	C40.2
Short Bones of Upper Limb & associated joints	C40.1
Short Bones of Lower Limb & associated joints	C40.3
Lung	C34.1-C34.9
Main Bronchus [excluding carina]	C34.0
Maxillary Sinus [antrum]	C31.0
Middle Ear [tympanic cavity]	C30.1
Nasal Cavity [excluding nasal cartilage & nasal septum code “0”]	C30.0
Occipital lobe	C71.4
Olfactory nerve	C72.2
Optic nerve	C72.3
Ovary	C56.9
Overlapping lesion of the eye & adnexa, Eye NOS, Eye and Lacrimal Gland	C69.0-C69.9
Parietal lobe	C71.3
Parotid Gland	C07.9
Pelvic Bones & associated joints [excluding sacrum, coccyx & symphysis pubis - code “0”]	C41.4
Peripheral nerves & autonomic nervous system of lower limb & Hip	C47.2
Peripheral nerves & autonomic nervous system of upper limb & shoulder	C47.1
Pleura	C38.4
Renal Pelvis	C65.9
Rib, Clavicle, & associated joints [excluding sternum - code “0”]	C41.3
Skin of external ear	C44.2
Skin of eyelid	C44.1
Skin of other & unspecified parts of face [midline code “9”]	C44.3
Skin of upper limb & shoulder	C44.6
Skin of lower limb & hip	C44.7
Skin of trunk [midline code “9”] “Back is a bilateral site”	C44.5
Spermatic cord	C63.1
Sublingual Gland	C08.1

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Submandibular Gland	C08.0
Temporal lobe	C71.2
Testis	C62.0-C62.9
Tonsil, NOS and Overlapping of Tonsil	C09.8-C09.9
Tonsillar Fossa	C09.0
Tonsillar Pillar	C09.1
Ureter	C66.9

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3	**PRIMARY SITE**
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8-C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum code “0”)
C30.1	Middle ear (tympanic cavity)
C31.0	Maxillary sinus (antrum)
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb, scapula, and associated joints
C40.1	Short bones of upper limb and associated joints
C40.2	Long bones of lower limb and associated joints
C40.3	Short bones of lower limb and associated joints
C41.3	Rib and clavicle (excluding sternum code “0”)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis code “0”)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (midline code “9”)
C44.5	Skin of trunk (midline code “9”)
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3	**PRIMARY SITE**
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal Pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meningies , NOS
C71.0	Cerebrum
C71.1	Frontal lobe
C71.2	Temporal lobe
C71.3	Parietal lobe
C71.4	Occipital lobe
C72.2	Olfactory nerve
C72.3	Optic nerve
C72.4	Acoustic nerve
C72.5	Cranial nerve, NOS
C74.0-C74.9	Adrenal gland (cortex, medulla)
C75.4	Carotid body

NOTE: All primary Brain and CNS tumors diagnosed prior to 2004 are coded laterally (0), not a paired site.

NOTE: Never use code 4 for bilateral primaries for which separate abstracts are prepared, or when the side of origin is **known** and the tumor has spread to the other side.

EXAMPLE:

1. A left breast primary with metastasis to the right breast is coded to 2 (left). This would not be coded to 4 (bilateral).

NOTE: Sometimes the physician may describe the site of the tumor in an organ as right or left. This is a descriptive term and does not refer to a bilateral site or organ.

EXAMPLE:

1. Patient admitted for surgical resection of tumor in right colon. Code to 0 for "Not a paired site." Do not code to 1. Right colon refers to the ascending colon. The colon is not a paired site.

FINAL DIAGNOSIS – MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (NAACCR ITEM #2580, #2590)

Text information to support morphology/behavior, grade, primary site, and laterality codes **must** be provided.

Documenting Instructions

- Record the morphology/behavior, grade, primary site, and laterality descriptions.

- Do not use the generic ICD-9-CM code statement found on the face/attestation sheet.

EXAMPLES:

1. **Morphology:** Moderately well differentiated mucin-producing adenocarcinoma
   Primary Site: Colon, ascending
2. **Morphology:** Grade 3, infiltrating ductal and lobular carcinoma
   Primary Site: Right breast, upper outer quadrant
3. **Morphology:** Anaplastic astrocytoma
   Primary Site: Brain, temporal parietal lobe
4. **Morphology:** Intermediate grade, large cell carcinoma
   Primary Site: Left lung, lower lobe

DIAGNOSTIC CONFIRMATION (NAACCR ITEM #490) (FORDS pg. 99; SEER pgs. 111-112)

Description
Indicates the most accurate diagnostic method of the reportable tumor being reported at any time in the patient's lifetime.

Explanation
This field does not have a time restriction guideline; it is throughout the patient's lifetime. It is used to calculate the percent of microscopically confirmed cancers. The percentage of cases that are clinically diagnosed is only an indication of whether case finding is including sources outside of pathology reports.

Coding Instructions

- This is a priority series with code "1" having precedence. Each lower number takes priority over higher numbers.

- If diagnosed elsewhere, copies of the previous pathology or radiology reports may be included in the medical record.

- All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review must cover the entire medical history in regard to the primary tumor. The diagnostic confirmation does not have a time frame associated with it. If diagnosed prior to admission to your facility, review the history section to identify information regarding previous diagnostic tests and treatments.

- If the information in the medical record indicates a biopsy or resection of the tumor has been performed, assume the diagnostic confirmation is histological.

- Use code 9 (unknown), **only** if there is no evidence of a definitive diagnostic confirmation.

  NOTE: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, **regardless of time frame**.

Code	Description	Definition
1	Positive histology	Histological confirmation (tissue microscopically examined). Includes positive hematological findings relative to leukemia and bone marrow specimens (including aspiration biopsies). In situ staged cases must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not indicated	Diagnosis is stated to be microscopically confirmed but the method is not specified.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophorectic spike for multiple myeloma. Elevated PSA is non-diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (Adapted from SEER)
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure, with no specimen for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The physician diagnosed the tumor from an imaging technique only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. ***Note:*** Refer to *Ambiguous Terminology List*.
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes Death Certificate Only cases.

EXAMPLES:

1. Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. The correct diagnostic confirmation code is 1.
2. MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained. The diagnostic confirmation code would be changed to 1.
3. A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. The diagnostic confirmation code is 2.

4. CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. The diagnostic confirmation code is 1.

5. Fine needle aspiration (FNA) is performed. The diagnostic confirmation code is 2.

   EXCEPTION: *If an aspiration biopsy of bone marrow is performed for diagnosing leukemia, the diagnostic confirmation code is 1.*

TUMOR SIZE (NAACCR ITEM #780) (FORDS pgs. 100-101; SEER EOD pgs. 3-6; SEER pg. 117)

NOTE: This data field should be coded for cases diagnosed prior to 2004.

Description
The tumor size is the largest dimension or the diameter of the primary tumor recorded in *millimeters*.

Explanation
Tumor size aids in prognosis and treatment decisions.

Coding Instructions
- Record the size of the tumor from the pathology report, if available. Information on tumor size from imaging/radiographic techniques can be used to code size, but should be taken as a low priority.

- Code the exact size of the primary tumor in **millimeters.** To convert centimeters (cm) to millimeters (mm) move the decimal point one digit to the right OR multiply the centimeters by 10.

  EXAMPLE:
  1. A 3.2 **cm** tumor is recorded as 032 mm.

- Code to 001 for tumors less than 1 mm in size.

  EXAMPLE:
  1. A 0.5 **mm** tumor is recorded as 001.

- Round the size of the tumor off to the nearest millimeter.

  EXAMPLES:
  1. A 4.8 mm tumor is recorded as 005.
  2. A 4.2 mm tumor is recorded as 004.

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

EXAMPLES:

1. The colonscopy with biopsy revealed a 1cm tumor. Two days later the pathology report from a sigmoid colon resection described a 3.5 x 2.6 cm lesion. Record the tumor size as 035.
2. The pathology report from an excisional biopsy describes the tumor size as 3 x 4.4 x 2.5 cm. The resection revealed a residual 1.0 cm tumor. Record the tumor size as 044.

- Code the tumor size as stated in the pathology report for true in situ tumors. When a tumor has both an in situ and an invasive component, and each is measured, code to the size of the invasive component, even if it is smaller.

EXAMPLES:

1. The pathology report states an excisional biopsy was performed which contained a 2 mm in situ tumor with clear margins. Record the tumor size as 002.
2. The pathology report describes a breast mass as 2 x 1.5 cm intraductal carcinoma and 1 cm of infiltrating ductal carcinoma. Record the tumor size as 010.

- Guidelines for coding site-specific tumor sizes:

EXAMPLES:

1. For Kaposi's sarcoma, SEER requires information on HIV status instead of tumor size. **The TCR does not collect this information.** *Code the tumor size to 999.*
2. For mycosis fungoides and Sezary disease of skin, vulva, penis, and scrotum, SEER requires information on peripheral blood involvement instead of tumor size. **The TCR does not collect this information.** *Code the tumor size to 999.*
3. **Depth of invasion or thickness of tumor** is recorded instead of size for melanoma of skin, vulva, penis, scrotum, and conjunctiva.

- Code tumor size to 000 if no mass or tumor found.

EXAMPLE:

1. A tumor of a stated primary is not found, but the tumor has metastasized.

EXCEPTION: ***Do not*** *code tumor size to 000 when a tumor is not visible in physical exam or by imaging, however the tumor is found microscopically.*

- Code to 998 when the following terms describe tumor involvement for these specified sites.

a. Esophagus (C15.0-C15.5, C15.8, C15.9): Entire circumference
b. Stomach (C16.0-C16.6, C16.8, C16.9): Diffuse, widespread, 3/4 or more, linitis plastica
c. Colorectal (C18.0-C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis
d. Lung and main stem bronchus (C34.0-C34.3, C34.8, C34.9): Diffuse, entire lobe or lung
e. Breast (C50.0-C50.6, C50.8, C50.9): Inflammatory carcinoma, diffuse, widespread, 3/4 or more of breast

- Code to 999 for the following scenarios.

  a. If only one size is given for a mixed *in situ* **and** an invasive tumor.
  b. If the size of the tumor is unknown or the tumor size is not documented in the medical record.
  c. If only a needle biopsy or incisional biopsy specimen was performed.
  d. For morphologies or sites where size is not applicable: Hematopoietic, reticuloendithelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 and/or M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
  e. Letterer-Siwe disease (M-9754)
  f. Multiple myeloma (M-9732)
  g. Unknown and ill-defined primary (C76.0-C76.8, C80.9)

- **Do not** code the size of polyps, ulcers, cysts, or metastases.

- **Do not a**dd pieces, chips, or slices together to create a whole; they might not be from the same location or might represent only a small portion of a larger tumor.

  EXCEPTION: *If the pathologist states an aggregate or composite size (determined by piecing the tumor together and measuring it), record that size,* ***if*** *the tumor has been completely excised.*

- Code the tumor size if patient received radiation therapy or systemic therapy (chemotherapy, hormone therapy, or immunotherapy) prior to (neoadjuvant) surgery.

CODE	DESCRIPTION
000	No mass or tumor found
001-988	Exact size in millimeters
989	989 millimeters or larger, melanomas greater than or equal to 9.89 mm in depth
990	Microscopic focus or foci only, no size is given
998	Tumor involvement of specified esophageal, stomach, colorectal, lung and mainstem bronchus, and breast primaries (see coding instructions)
999	Unknown; size not stated; not stated in patient record; not applicable

NOTE: The physician or pathologist may describe the tumor size in descriptive terms of an object. The following chart lists examples of some of the most common descriptive terms and the millimeter equivalent:

Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent	Descriptive Term	Millimeter Equivalent
EGG		**MISCELLANEOUS FOOD**		**MISCELLANEOUS ITEMS**	
Bantam	040	Doughnut	090	Ball, golf	040
Goose	070	Lentil	009	Ball, ping-pong	030
Hen	030	Millet	009	Ball, tennis	060
Pigeon	030	**MONEY**		Baseball	070
Robin	020	Dime	010	Eraser on pencil	009
FRUIT		Dollar, half	030	Fist	090
Apple	070	Dollar, silver	040	Marble	010
Apricot	040	Nickel	020	Match head	009
Cherry	020	Quarter	020	Microscopic focus	001
Date	040	Penny	010	**VEGETABLE**	
Fig (dried)	040	**NUTS**		Bean	010
Grape	020	Almond	030	Bean, lima	020
Grapefruit	100	Chestnut	040	Pea	009
Kumquat	050	Chestnut, horse	040	Pea, split	009
Lemon	080	Hazel	020		
Olive	020	Hickory	030		
Orange	090	Peanut	010		
Peach	060	Pecan	030		
Pear	090	Walnut	030		
Plum	030				
Tangerine	060				

REGIONAL LYMPH NODES POSITIVE (NAACCR ITEM #820) (FORDS pg 103)

Description
Describes the total number of regional lymph nodes examined by the pathologist and reported as containing malignant cells.

Explanation
This item is necessary for pathologic staging and helps determine treatment methods.

Coding Instructions
- Record the total number of regional lymph nodes removed (as part of the first course of treatment) and examined and reported as containing malignant cells by the pathologist.

- Code only **regional** lymph nodes in this field. Refer to the SEER Summary Staging Manual 2000 for site-specific identification of regional lymph nodes.

CODE	DESCRIPTION
00	All lymph nodes examined are negative
01-89	1-89 regional lymph nodes are positive (Code exact number of regional lymph nodes positive)
90	90 or more regional lymph nodes are positive
95	Positive aspiration of lymph node(s) was performed
97	Positive regional nodes are documented, but the number not specified
98	No regional nodes were examined
99	It is unknown whether regional lymph nodes are positive or negative; not applicable; not stated in patient record

- The number of regional lymph nodes positive **must be** equal to or less than the number nodes recorded in *Regional Lymph Nodes Examined* (NAACCR Item #830).

- Code to 97 when the lymph nodes are not removed, but cytology or histology from a regional lymph node aspiration is positive for malignant cells.

- Code to 99 for morphologies or sites where regional lymph node examination is not applicable:

    a. Unknown or ill-defined primary (C76.0-C76.8, C80.9)
    b. Brain and cerebral meninges (C70.0, C71.0-C71.9)
    c. Lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9)
    d. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9720, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
    e. Multiple myeloma (M-9732)
    f. Letterer-Siwe disease (M-9754)

    EXCEPTION: *Lymph Nodes Positive are always coded "99" for* ***both*** *nodal and extranodal lymphomas because lymphomas frequently arise in nodal sites.*

REGIONAL LYMPH NODES EXAMINED (NAACCR Item #830) (FORDS pg. 102)

Description
Describes the total number of regional lymph nodes examined by the pathologist.

Explanation
This item is necessary for pathologic staging and helps determine treatment methods.

Coding Instructions

- Record the total number of regional lymph nodes removed (as part of the first course of treatment) and examined by the pathologist.

- Code only **regional** nodes in this field. Refer to the SEER Staging Manual 2000 for site-specific identification of regional lymph nodes.

  NOTE: Removal of the primary tumor and a regional lymph node dissection may or may not be done in one surgical procedure.

CODE	DESCRIPTION
00	No lymph nodes were examined
01-89	1-89 lymph nodes were examined (Code exact number of regional lymph nodes examined)
90	90 or more lymph nodes were examined
95	No regional lymph nodes were removed, but aspiration of regional lymph nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether regional lymph nodes were examined; not applicable; not stated in medical record

- The number of regional lymph nodes examined **must be** equal to or greater than the number of nodes recorded in *Regional Lymph Nodes Positive* (NAACCR Item #820)

- Code to 99 for morphologies or sites where regional lymph node examination is not applicable:

  a. Unknown or ill-defined primary (C76.0-C76.8, C80.9)
  b. Brain and cerebral meninges (C70.0, C71.0-C71.9)
  c. Lymphomas (M-9590-9596, 9650-9719, 9727-9729) with a lymph node primary site (C77.0-C77.9)
  d. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9720, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
  e. Multiple myeloma (M-9732)
  f. Letterer-Siwe disease (M-9754)

- **Do not** code *distant* lymph nodes removed in this field.

Do not record the number of regional lymph nodes examined if the lymph node dissection is performed **after** the first course of therapy.

EXAMPLES:

1. Pathology report states: Right lobectomy and lymph node dissection performed. Nine of twenty-two hilar nodes are positive for metastatic adenocarcinoma.

   Record:
   Regional nodes positive: 09
   Regional nodes examined: 22

2. Physical exam revealed a large lesion in the UOQ of the right breast. Incisional biopsy confirmed infiltrating ductal carcinoma. Patient refused work-up or treatment.

   Record:
   Regional nodes positive: 98
   Regional nodes examined: 00

3. Pathology report states: Moderately differentiated mucinous adenocarcinoma of the colon. Two of 10 pericolic lymph nodes are positive for metastasis.

   Record:
   Regional nodes positive: 02
   Regional nodes examined: 10

4. Pathology report states: All regional nodes examined are negative.

   Record:
   Regional nodes positive: 00
   Regional nodes examined: 98

5. During work-up of a prostate carcinoma, CT of the pelvis revealed probable metastatic iliac lymph nodes.

   Record:
   Regional nodes positive: 98
   Regional nodes examined: 00

6. Patient was diagnosed with multiple myeloma.

Record:
Regional nodes positive: 99
Regional nodes examined: 99