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APPENDICES AVAILABLE ON THE WEB at: http://www.dshs.state.tx.us/tcr/default.shtm

TEXAS CANCER REGISTRY

PREFACE

It is estimated that 95,310 Texans will be newly diagnosed with cancer in 2007 and another 34,170 will die of the disease. The data submitted by cancer reporters and maintained by the Texas Cancer Registry (TCR) are a vital part of these efforts to reduce the burden of cancer in Texas.

With original authorization from the *1979 Texas Cancer Control Act* and, most recently, the *Texas Cancer Incidence Reporting Act, (Chapter 82, Health and Safety Code, amended September, 2001)* (*Appendix B*), the TCR collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities and clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. *Chapter 91 of the Texas Administrative Code* (amended July 2006) outlines the rules necessary to implement this act (*Appendix B*). The laws and rules may be accessed at the following web site: www.dshs.state.tx.us/tcr/lawrules.shtm#law.

The TCR is a population-based statewide cancer incidence reporting system that collects, analyzes, and disseminates information on all new cases of cancer. A statewide cancer registry is the foundation for cancer prevention and control. This central repository of information is a valuable and essential tool for identifying populations at high risk for cancer, monitoring of cancer incidence trends and mortality, facilitating studies related to cancer prevention, evaluating cancer control initiatives, planning health care delivery systems, and developing educational awareness programs. It is dependent on complete, timely and accurate reporting.

The *Texas Cancer Registry Cancer Reporting Handbook, 2006 Edition, revised April 2007,* serves as the instruction manual providing rules and guidelines to assure the consistent collection and coding of relevant cancer case information. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC); North American Association of Central Cancer Registries (NAACCR); Surveillance, Epidemiology, and End Results Program (SEER) of the National Cancer Institute (NCI); and the American College of Surgeons (ACoS).

The Handbook has been revised to include reporting requirements for 2007 cases in additional to those applicable for 2006 cases. Also, feedback from hospital registrars and others has resulted in further modifications and clarifications to this document.

This manual can be downloaded from the TCR's web site: www.dshs.state.tx.us/tcr/.

HANDBOOK SOURCES

The following sources were used in the preparation of this handbook:

- *The SEER Program Coding and Staging Manual 2004, 4th Edition.* National Cancer Institute, NIH Pub. No. 04-55812004, Bethesda, MD, 2004.
- *SEER Summary Staging Manual – 2000: Codes and Coding Instructions.* National Cancer Institute, NIH Pub. No. 01-4969, Bethesda, MD, 2001.
- *Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS).* Chicago: American College of Surgeons Commission on Cancer, January 2003, revised for 2007.
- *NAACCR Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Eleventh Edition, Record Layout Version 11.1.*
- *Cancer Reporting in California: Abstracting and Coding Procedures for Hospitals, Volume I, 5th Edition.* California Cancer Registry, Public Health Institute.
- *SEER Extent of Disease—1988 Codes and Coding Instructions, 3rd Edition.* National Cancer Institute, NIH Pub. No. 98-1999, Bethesda, MD, 1998.
- *International Classification of Diseases for Oncology. 3rd Edition (ICD-O-3).* Geneva: World Health Organization, 2000.
- Texas Cancer Incidence Reporting Law (Amended July 2006), Chapter 82, Health and Safety Code and Rules, Title 25, Health Services, Part I. Texas Department of Health, Chapter 91. Cancer, Subchapter A. Cancer Registry (Effective April 24, 2003).
- *SEER*Rx Version 1.1.1. The Cancer Registrar's Interactive Antineoplastic Drug Database.* U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, Bethesda, MD, 2005 (applicable for cases diagnosed January 1, 2005 forward).
- Collaborative Staging Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions, version 01.03.00.* Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Pub. No. 04-5496. Incorporates updates through September 8, 2006.
- *Abstracting and Coding Guide for the Hematopoietic Diseases*, National Cancer Institute, NIH Pub. No. 02-5146, with errata Pub. No. 03-5146, Bethesda, MD.
- *Data Collection of Primary Central Nervous Tumors National Program of Cancer Registries Training Materials 2004,* U.S. Department of Health and Human Services, CDC.
- *SEER Inquiry System and Resolved Questions*, web site www.seer.cancer.gov/seerinquiry.
- *Multiple Primary and Histology Coding Rules.* (January 1, 2007), National Cancer Institute. Bethesda, MD.

ACKNOWLEDGMENT

We wish to acknowledge that some information presented here was taken verbatim from *The SEER Program Coding and Staging Manual 2004, Fourth Edition, Johnson CH (ed.). National Cancer Institute, NIH Publication number 04-5581, Bethesda, MD 2004*. Appendix O is the complete manual for the 2007 Multiple Primary and Histology Rules by the National Cancer Institute's SEER Program.

ACRONYMS

- ACS American Cancer Society
- ACoS American College of Surgeons
- AJCC American Joint Committee on Cancer
- CDC Centers for Disease Control and Prevention
- CESB Cancer Epidemiology and Surveillance Branch
- CNS Central Nervous System
- CoC Commission on Cancer
- CRH *Cancer Reporting Handbook*
- CS Collaborative Stage
- FIPS Federal Information Processing Standards
- FORDS *Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data* (Manual of the ACoS)
- ICD-O-3 *International Classification of Diseases for Oncology,* 3rd *Edition*
- ICD-O-2 *International Classification of Diseases for Oncology,* 2nd *Edition*
- I&R Inquiry and Response System, web site: www.web.facs.org/coc
- MP/H Multiple Primary and Histology Coding Rules
- NAACCR North American Association of Central Cancer Registries
- NPCR National Program of Cancer Registries, CDC
- HSR Health Service Region
- SC SANDCRAB – Statewide Algorithm and Database for Cancer Registration and Abatement, the TCR's database system
- SCL SANDCRAB LITE-cancer reporting software program provided by TCR for use by facilities
- SEER Surveillance, Epidemiology, and End Results Program, NCI
- SEER EOD SEER Extent of Disease
- SINQ SEER Inquiry System, web site: www.seer.cancer.gov/seerinquiry
- SSSM2K *SEER Summary Staging Manual – 2000: Codes and Coding Instructions*
- TCR Texas Cancer Registry
- WHO World Health Organization
- VSU Vital Statistics Unit

OVERVIEW OF REPORTING CHANGES

NAACCR RECORD LAYOUT VERSION(S)

The TCR requires all reporting to be submitted in version 11 or later versions.

DIAGNOSIS/ADMISSION YEAR	NAACCR VERSION
2004 – 2006	11.0 Accepted
2007 and forward	11.1 Required

Note: *Version 11 may be used to submit data for years prior to 2006. Version 11 submissions must follow version 11 guidelines and codes regardless of date of diagnosis.*

DATA FIELD CHANGES

Effective with 2006 and 2007 Cases:

Due to new national cancer reporting standards, changes will be implemented for cases diagnosed on or after January 1, 2006. There also are some additions for 2007 cases as shown below. The following table lists new data items to be reported and also some that the TCR will no longer require.

NAACCR DATA ITEM DESCRIPTION	NAACCR DATA ITEM #	NEW DATA ITEM	DATA ITEM NO LONGER REQUIRED
Tumor Record Number	60		√
Primary Payer at Diagnosis (effective 1/1/2007)	630	√	
Date of Initial RX—SEER	1260		√
RX Summ—Reg LN Examined	1296		√
Reason for No Surgery	1340	√	
RX Summ—Surg/Rad Seq	1380	√	
RX Summ—Systemic Sur Seq	1639	√	
Name- Alias (effective 1/1/2007)	2280	√	
Address at DX—Supplemental	2335	√	
Physician—Managing	2460	√	
Physician—Follow Up	2470	√	
Text for Chemo	2640	√	
Text for Hormone	2650	√	
Text for BRM	2660	√	
Text for Other	2670	√	

***Note:** Facilities will no longer be responsible for reporting Tumor Record Number. Date of Initial RX-SEER and RX Summ-Reg LN Examined will be populated by coded treatment data items.*

Effective with 2004 Cases and Forward:

As a reminder, effective with cases diagnosed on or after January 1, 2004 selected collaborative stage fields are required.

ITEM/FIELD	NAACCR ITEM NUMBER
CS Tumor Size	2800
CS Extension	2810
CS Lymph Nodes	2830
Regional Lymph Nodes Positive	820
Regional Lymph Nodes Examined	830
CS Mets at DX	2850
CS Site Specific Factor 1 For pleura (C384) primaries only	2880
CS Site Specific Factor 3 For prostate (C619) primaries only	2900

***Note:** Only 8 of the 15 Collaborative Stage Fields are required for 2004 and later cases. These are the fields necessary to derive SEER Summary Stage.*

CODING CANCER CASES

For cancer coding, all cases **must** use the correct ICD-O version according to the year in which the cancer case was diagnosed, or if the diagnosis year is unknown, the year in which the case was accessioned. Otherwise, the cancer case will fail required edits and not be accepted by the TCR.

The *International Classification of Diseases for Oncology, 3rd Edition* (ICD-O-3) **must** be used to code the primary cancer site (topography) and the cell type (morphology, behavior, and grade) of tumor information for all cases diagnosed/admitted on January 1, 2001 and forward.

For all cases diagnosed on January 1, 1992–December 31, 2000, the *International Classification of Diseases for Oncology, 2nd Edition* (ICD-O-2) **must** be used.

STAGING CANCER CASES

For staging cancer cases, all cases must be staged and corresponding stage data fields completed according to the correct staging guidelines for the year in which the cancer was diagnosed. If the diagnosis year is unknown, the correct guidelines for the year in which the case is accessioned must

be used. Otherwise, the cancer case will fail required edits and not be accepted by the TCR.

The *Collaborative Staging Manual and Coding Instructions, Version 01.03.00* must be used for cases diagnosed January 1, 2004 and forward. The SEER Summary Stage 2000 will be derived from the CS data elements.

The *SEER Summary Staging Manual 2000 (SSSM2K)* must be used for cases diagnosed from January 1, 2001 through December 31, 2003. Every site has a staging scheme. The *SSSM2K* has detailed information regarding adjacent sites, and includes site-specific notes, coding guidelines, and anatomic drawings. For cases diagnosed prior to 2001, refer to the *SEER April 1977 Summary Staging Guide.*

Note: *Both Collaborative and Summary Stage schemas use all information (both clinical and pathological assessments) available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer.*

TCR CODING AND STAGING REQUIREMENT SUMMARY

CODING AND STAGING SCHEMA	DIAGNOSIS YEAR
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 – forward
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995 – 2000*
Collaborative Staging Manual and Coding Instructions, Version 01.03.00	2004 – forward
SEER Summary Staging Manual 2000 (SSSMK2)	2001 – 2003
SEER April 1977 Summary Staging Guide	1995 – 2000*

**The TCR no longer requires reporting of non-analytic cases diagnosed prior to 1995.*

ACOS FACILITY INSTRUCTION MANUAL AND DATE IMPLEMENTATION

MANUAL/GUIDELINES	IMPLEMENTED
DAM	1995
ROADS	1996 – 2002
FORDS	2003
Collaborative Staging (CS)	2004
Central Nervous System (CNS)	2004
Multiple Primary and Histology Coding Rules (MP/H)	2007

Note: *Per SEER, the new coding and staging instructions/guidelines replace the old for respective time periods.*

COMPLIANCE

To assure timely and complete cancer case reporting in Texas, the TCR monitors compliance with the Texas Cancer Incidence Reporting Act. The TCR health service regions routinely monitor facility submissions of case reports. If submissions are not received fully and in a timely manner according to our current law and rules, the facility registrar/reporter will be contacted regarding the delinquent reporting status. Further action, which may include cost recovery procedures, will be instituted if submissions continue to be delinquent. These actions are necessary to meet the state and national requirements for timely cancer data.

To be compliant with the law, **all records for 2006 cases and forward must be submitted within 6 months of initial diagnosis, or admission with active disease, or treatment for cancer at your facility.** Cancer reporting rules effective April 24, 2003, require quarterly submissions from health care facilities with an annual caseload of 400 or less, and monthly submissions for health care facilities with an annual caseload greater than 400. Monthly reporting is recommended for all reporters.

Case Submission Requirements:

CASELOAD	SUBMISSION
Equal to or <400	Quarterly
>400	Monthly

Facilities with a Cancer Caseload of 100 or Less:

To facilitate complete, accurate, and timely cancer reporting in healthcare facilities with a cancer caseload of 100 or less, the TCR offers funding for contracted services by Certified Tumor Registrars to perform casefinding and data collection.

Note: *Any questions regarding a facility's compliance should be directed to the facility's health service region.* *Refer to page 12 for the appropriate regional contact information.*

REPORTING TOOLS

ELECTRONIC REPORTING

Effective January 1, 2007, manual (paper) cancer reporting forms and modem submissions will **no** longer be allowed. All cancer reports must be submitted electronically either via an FTP data submission process (**F**ile **T**ransfer **P**rotocol, used to transfer files over the Internet), or by sending an encrypted, password protected data file saved on a diskette or CD.

Note: *Also, effective January 1, 2007, all data submissions must clear TCR required edits at the time of submission. For SCL users, current edits are automatically maintained. For information on incorporating and/or using TCR edits in facility-specific or vendor software, contact the Central TCR Office in Austin at 1-800-252-8059 or (512) 458-7523.*

CRESS

The TCR has developed the Cancer Registry Electronic Submission System (CRESS), to support web-based FTP submissions of data files. The CRESS website is a secured site and cannot be accessed by anyone without a valid user id and password. With this system, all data submissions will become encrypted, password protected and sent to the DSHS secured server. The encryption is done within the CRESS system and is accomplished without any additional effort from the user.

If you are using SCL, follow the instructions in the *SCL User's Guide* or if you are using commercial or your own facility software, please follow the instructions provided at: www.dshs.state.tx.us/tcr/.

For more information about the CRESS application, please refer to *Appendix N* at: www.dshs.state.tx.us/tcr/reporting.shtm#reportHB, contact the CRESS helpdesk at 1-800-252-8059, or at CRESS@Exch.dshs.state.tx.us.

Note*: Facilities with an annual caseload greater than 400 must submit via CRESS using TCR or other acceptable software.*

Note: *All CRESS submissions must include a completed Transmittal Form. SCL users will no longer be required to fax transmittal forms. CRESS users must immediately fax transmittal forms after transmissions to (512) 458-7681.*

MAILING DISKETTES AND CDS FOR DATA SUBMISSION

We strongly recommend facilities to submit their data via the Internet (CRESS or SCL-FTP). This process better assures the security of confidential patient case information during submission to our office. When confidential patient data are submitted on diskette or CD through the mail, they can be lost and/or more readily accessed by unauthorized personnel.

If data files are sent in the mail, they should be sent so that the mailer is tracked, the file should be zipped, encrypted, and password protected, and the password should **never** be sent with the diskette/CD. Please either call the TCR Central Office at 1-800-252-8059 or (512) 458-7523 to provide your password or include it on a faxed copy of the transmittal form (not in the diskette/CD mailer).

Note: *A Texas Cancer Registry Transmittal Form (TCR #2), regardless of the reporting format used, must accompany all submissions. Please refer to www.dshs.state.tx.us/tcr for instructions on completing this form.*

REPORTING SOFTWARE

SANDCRAB Lite (SCL):

SCL, a cancer abstract reporting software developed for reporters, is available from the TCR free of charge. SCL meets TCR reporting requirements, but does not meet all requirements for an ACoS approved cancer program. Cases are entered directly into the computer and submitted to the TCR via an FTP process, thus eliminating the need for paper abstract forms.

The SCL system requirements, registration, software, and *User's Manual* are available at: www.dshs.state.tx.us/tcr/reporting.shtm#SCL. SCL can be downloaded from the TCR website at www.dshs.state.tx.us/tcr/FormSL.shtm by selecting "Register to Download SCL." If you have questions, need assistance with the installation of SCL, or require a CD of the software, contact the Central TCR Office in Austin at 1-800-252-8059 or (512) 458-7523.

SCL System Requirements:

- A 300 MHz Intel-based personal computer
- 64 MB or more RAM for Windows 98
- 128 MB or more of RAM for Windows 2000, Windows NT, Windows ME, Windows XP, and Windows Vista
- CD-ROM Drive or CD-RW (optional)
- 1.44 MB 3 ½" floppy drive (optional)
- Approximately 185 MB (185,000,000 bytes) or more Free Hard Disk Space is needed to install the SCL program. Additional disk space will be needed as records are added to the database.
- Internet and/or network connectivity (recommended for software/table updates)

COMMERCIAL VENDOR OR FACILITY SOFTWARE

All commercial or facility software must fully comply with TCR reporting requirements, including the correct NAACCR format standards and TCR edits. If you have questions, or need assistance in determining if your software meets TCR standards, contact the Central TCR Office in Austin at 1-800-252-8059 or (512) 458-7523.

FORMAT STANDARDS

Note to SCL Users: *Reporters submitting data using SCL should disregard this paragraph.*

The layout and coding scheme for reporting with commercial vendor or facility software should follow the "NAACCR Data Exchange Record Layout." Please refer to the *NAACCR Standard for Cancer Registries, Volume II,* for a description of the layout. All columns not requiring data must be blank.

Facilities with an ACoS approved program must utilize the *FORDS* manual as well as the TCR's *Cancer Reporting Handbook* to ensure reporting compliance with both entities, as the data sets for the TCR and ACoS are different. Refer to *Appendix H* for a comparison of data sets for the ACoS, NAACCR, SEER, and TCR requirements.

Note: *Submissions in an incorrect format, with missing or incomplete data, and/or errors* ***will be rejected****. Effective January 1, 2007, rejected reports must be resubmitted within 30 days. If cases are rejected, they will not count towards your compliance.*

NAACCR Version Submission Format:

DIAGNOSIS/ADMISSION YEAR	NAACCR VERSION
2004 - 2006	11.0 Accepted
2007 and forward	11.1 Required

Note: *When using commercial registry software, follow the coding instructions specific to that software.* ***Do not*** *mix codes from one software with another. Any alteration or deviation from the codes specified in the software instructions will create errors in reporting.*

TIMELINESS OF DATA SUBMISSION

Timeliness of case reporting is important, however, data quality and completeness must be assured as well. Researchers, epidemiologists, health planners, clinicians, and laypersons benefit from speedy access to the most current information. Due to reporting requirements of CDC and TCR, all reports of cases shall be submitted to the TCR within six months of initial diagnosis or admission at their facility with active disease and/or treatment of cancer. This information is referenced in *Section 91.5(a) (When to Report)* of the *Texas Cancer Incidence Reporting Rules*. Refer to *Appendix B* at www.dshs.state.tx.us/tcr/lawrules.shtm#law for more information regarding when to report.

Submission Schedule:

ADMISSION MONTH	SUBMIT TO TCR BY THE FOLLOWING MONTH
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

Representatives from your regional office are available to provide training on appropriate reporting procedures.

***Note**: If cases are abstracted at the time patients are discharged from your facility, all or part of the first course of treatment may be missed. A procedure should be implemented to check patient readmissions for additional first course of treatment information before submitting to the TCR.*

DATA SUBMISSION PROCEDURES FOR OTHER NON-FACILITY REPORTERS

Independent Clinical Laboratories are required to submit reports at least bi-annually. Electronic submission is required.

Health care practitioners are required to furnish data or provide record access to the TCR if the same data or records are not reported by a health care facility or clinical laboratory. Health care practitioners initially diagnosing a patient with cancer and performing in-house pathological tests for that patient should report on a quarterly basis and include cases diagnosed within six (6) months. Otherwise, health care practitioners should submit data within four (4) months of the TCR's request for specific patient information.

***Note:** The reporting by health care practitioners is being implemented in phases as resources allow.*

REGIONAL CONTACTS

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STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

Data obtained under the *Texas Cancer Incidence Reporting Act* are for the confidential use of the Texas Department of State Health Services, including persons, public or private entities that are necessary to carry out the public health interests of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the individual identity of any patient. All reporting entities that comply with the Act are immune from liability for furnishing the required information.

DISCLOSURE OF DATA

All data reported to the TCR are available for use in aggregate form for analysis by registry staff, cancer researchers, and the public. Reports of the incidence of cancer for the state can be generated. Public access to aggregate data is available through published reports, or through the TCR, if in accordance with its data release policies and procedures.

The TCR **may** exchange patient-specific data with the reporting facility, any other cancer-control agency, or clinical facility, pathology laboratories, physician's offices for the purpose of obtaining information necessary to complete the abstract or follow-up information, provided that these agencies and facilities comply with the TCR's confidentiality policies. However, no facility-specific patient information can be released unless authorized under law. The TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law.

To achieve complete case ascertainment, the TCR **may** exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

The TCR **may** grant researchers access to confidential information concerning individual cancer patients, provided that those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of State Health Services Institutional Review Board.

QUALITY ASSURANCE

The TCR implements an extensive series of quality assurance procedures that are based on the SEER Program, CDC recommendations and NAACCR standards. These procedures, which consist of both internal and external processes, ensure the reliability, completeness, consistency and comparability of TCR data.

INTERNAL PROCESS

Submission Review:

All abstracts are reviewed for possible duplicate records and multiple primaries. As cases are uploaded into the system, they are intensely scrutinized for identification of:

- Possible duplicate submission of existing records.
- Unacceptable codes for any field or inter-field inconsistencies.
- Invalid or unusual site/sex, age/site, age/morphology or site/morphology combinations.

The TCR's data upload system currently checks all submitted records for errors. Records returned to the facility for correction do not count towards compliance. All records with errors will be rejected for correction of the specified errors and subsequent re-submission. The error-free records retained will be counted towards reporting compliance.

***Note:** Facilities **must** run their data through the appropriate NAACCR and TCR edits and make necessary corrections before submitting a file to the TCR.*

EXTERNAL PROCESS

Facility Training:

TCR staff provides continuing education and training for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the appropriate TCR Regional Office.

Casefinding Data Quality Audits:

TCR staff or a TCR representative review casefinding sources such as disease indices, pathology reports (including cytology and autopsy reports), outpatient records, radiation therapy logs, and appropriate oncology logs for missing cases. Periodically, facilities are randomly selected for a casefinding audit. A casefinding audit is a systematic method of reviewing the facility's casefinding procedures and identifying all reportable cases in order to assess completeness and timeliness. The audit is a tool to improve a facility's casefinding process and is not a punitive measure. Sometimes chart review may be performed on records identified from the audit to determine case reportability. Casefinding procedures are located in the *Casefinding Section* beginning on page 16. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits:

TCR staff, or a TCR representative, performs complete re-abstracting of a sample of reported cases without reference to the original abstract. If discrepancies are identified, they are used to assess the quality of the facility's cancer case reporting and training needs.

DEATH CLEARANCE

TCR staff performs additional checks of reporting completeness through the death clearance process. Each year the TCR electronically matches existing incidence cases in the cancer master file against the Vital Statistics Unit (VSU) death certificate records for that year. If a match is found, the date of death is updated for that record in the TCR's database and the underlying cause of death added. For non-matches, queries to facilities are made for patients who have a diagnosis of cancer on the death certificate and expired at a reporting facility but were not reported to the TCR. Facilities are required to submit abstracts for all missed cases. In some instances, there may not be evidence of active cancer. If there is no documented evidence of a reportable diagnosis on a queried case, please notify the Vital Statistics Specialist at the TCR central office, or your TCR regional office.

CASE FINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding is a system for identifying all eligible cases. Facility sources used to identify cases are disease indices, pathology and laboratory reports, patient logs, and similar resources. Refer to the Casefinding sources list on page 18. Every inpatient and/or outpatient admission with active disease and/or receiving cancer-directed therapy must be reported to the TCR regardless of the patient's state or country of residence.

Note: *Facilities that submit at least 95% of their cancer reports to the TCR are considered to be compliant.*

REPORTABLE CANCER CASES

Cases of cancer to be reported to the TCR include:

1. All neoplasms with a **behavior code** of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology 3rd Edition (ICD-O-3)*, with some exceptions (see page 22).

Note*: Non-analytic* ***cases diagnosed*** *prior to 1995* ***are no longer required to be reported.***

2. All primary tumors with a **behavior code** of /0 (benign), /1 (borderline), or /3 (malignant) occurring in any of the following sites:

    a. Brain (C710–C719), meninges (C700–C709), spinal cord (720), cauda equina (C721), cranial nerve or nerves (C722–C725), or any other part of the central nervous system (C728–C729)

    b. Pituitary gland (C751), pineal gland (C753), or craniopharyngeal duct (C752)

Note: *A non-malignant reportable CNS diagnosis can include the term* ***neoplasm*** *or* ***tumor****.*

Note: *All tumors and neoplasms of the brain and CNS must have the morphology term and code listed in ICD-O-3. If the morphology term and code are not in the ICD-O-3, then it is not reportable.*

Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors:

GENERAL TERM	SPECIFIC SITES	ICD-O-3 TOPOGRAPHY CODE
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note: Benign and borderline tumors of the cranial bones (C410) are ***not reportable.***

CASES DIAGNOSED CLINICALLY ARE REPORTABLE

In the absence of a histologic or cytologic confirmation of a reportable diagnosis, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner says the patient has a cancer or carcinoma). A clinical diagnosis may be recorded in the final diagnosis on the face sheet or in other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a biopsy that disproves the clinical diagnosis the case is not reportable.

EXCEPTION: *If the physician treats a patient for cancer in spite of the negative biopsy, accession the case.*

EXCEPTION: *If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology report, and the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be 6 months or more.*

CASEFINDING METHODS

There are two types of casefinding methods—*active and passive:*

1. **Active casefinding:** The personnel responsible for reporting obtain and review all sources for eligible cases.

2. **Passive casefinding:** The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases.

Active casefinding is more comprehensive and precise. **Passive casefinding** has a greater potential for missed cases. A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. Casefinding procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

1. Medical records department
   a. Disease indices
   b. Admission and discharge reports
2. Pathology department
   a. Histology reports
   b. Cytology reports
   c. Hematology reports
   d. Autopsy reports
3. Surgery department
4. Outpatient departments
5. Medical and diagnostic imaging
6. Radiation oncology
7. Medical oncology
8. Emergency Room reports

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources, for example, rural health clinics, surgery centers across town or off campus.

A disease index including both **inpatient and outpatient** admissions should be obtained after medical records are completed and coded (monthly or quarterly). The index should be sorted

alphabetically by last name and should include the following: **last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-9 diagnosis codes and admission type.** *Attachment A (*page 31) is an example of a disease index that can be modified for individual facilities.

The following list includes some helpful hints for the casefinding process:

- Review the disease index for reportable cancer codes to insure the facility has reported all of its reportable cases to the TCR.
- Request a TCR Facility Data Report from the regional office. A Facility Data Report is a complete listing of cases submitted by the facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: *If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. Insure that the ICD-9-CM codes used are the most current for the reporting year. This disease index is then checked against the cancer registry database to insure that all cases were either reported or clearly documented as non-reportable and why. After reviewing, the disease index and non-reportable list along with the casefinding check-list (Attachment C, page 33) should be sent to the facility's health service region.*

The following lists are intended to assist the cancer data reporter in identifying the reportable neoplasms.

REPORTABLE NEOPLASMS

- Malignant neoplasms *(exclusions noted below)*
- Benign and borderline neoplasms of central nervous system
- Pituitary adenomas diagnosed as of 2003
- Carcinoma in-situ (*exclusions noted below)*
- Carcinoid, NOS ***(excluding Appendix, unless stated to be malignant)***
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3 per ICD-O-3 errata
- Squamous intraepithelial neoplasia grade III (8077/2) of vulva **[VIN]**, vagina **[VAIN]**, and anus **[AIN] beginning with 2001 cases**

Note: *All tumors and neoplasms of the brain and other CNS sites must have a morphology*

term and code in ICD-O-3. If there is no morphology term and code, it is not reportable. Tumors and neoplasms diagnosed prior to 2001 must have a morphology term and code in ICD-O-2 to be reportable.

Notes:

1. Malignant neoplasms of the skin of genital sites **are reportable**. These sites include: vagina (C529), clitoris (C512), vulva (C519), prepuce (C600), penis (C609), and scrotum (C632).

2. Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor **must be reported regardless of site**. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

NON-REPORTABLE NEOPLASMS

- Basal cell carcinoma (8090–8110) of the skin (C44.0-C44.9) **except genital sites**
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C44.5)
- Epithelial carcinomas (8010–8045) of the skin (C44.0-C44.9)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C44.0-C44.9) **except genital sites**
- Malignant neoplasms, NOS (8000–8004) of the skin (C44.0-C44.9)
- In situ neoplasms of cervix regardless of histology (behavior of /2; C53.9)
- Intraepithelial neoplasms of the cervix (8077/2; C53.9)) or prostate (8148/2; C61.9)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C56.9) with behavior code 1 are **not** collected as of January 01, 2001
- Cyst of brain or CNS tumor diagnosed January 01, 2004 or later and does not have an ICD-O-3 morphology code listed in ICD-O-3

Example:

On 04/12/2004, a patient was diagnosed with cholesteatoma in the cerebral meninges. This is not a reportable CNS case.

COMPREHENSIVE REPORTABLE LISTS

The following are intended to aid appropriate staff (e.g. Information Services, Data Management) in creating the disease index with the required reportable neoplasms and other ICD-9-CM codes.

The reporter should review all admissions (inpatient and outpatient) with the following diagnosis codes for reportability:

ICD-9-CM CODE	DIAGNOSIS
CODE RANGES	**PREFERRED ICD-O-3 TERMINOLOGY**
140.0–208.9	Malignant neoplasms
225.0–225.9	Benign and borderline neoplasms of central nervous system
230.0–234.9	Carcinoma in-situ
235.0–238.9	Neoplasms of uncertain behavior
239.0–239.9	Neoplasms of unspecified behavior
INDIVIDUAL CODES	**PREFERRED ICD-O-3 TERMINOLOGY**
042.	AIDS (review records for AIDS-related malignancies)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
227.3	Benign neoplasm of pituitary (body, fossa, gland, lobe)
227.3	Benign neoplasm of craniopharyngeal (duct, pouch)
227.4	Benign neoplasm of pineal (body, gland)
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.79	Chronic myeloproliferative disease (9960/3)
238.76	Myelosclerosis with myeloid metaplasia (9961/3)
238.71	Essential thrombocythemia (9962/3)
238.72	Refractory cytopenia with multilineage dysplasia (9985/3)
238.73	Myelodysplastic syndrome with 5q-syndrome (9986/3)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
238.75	Myelodysplastic syndrome, unspecified (9989/3)
238.72	Refractory anemia (9980/3)
238.72	Refractory anemia with ringed sideroblasts (9982/3)
238.73	Refractory anemia with excess blasts (9983/3)
238.73	Refractory anemia with excess blasts in transformation (9984/3)
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9931/3)

Admissions with the following procedure codes must be screened for reportable neoplasms:

ICD-9-CM CODES	PROCEDURE DESCRIPTION
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.4 (previously V07.8)*	Other specified prophylactic measure
V10.0–V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, subsequent treatment and diagnosis date)
V58.0	Admission for radiotherapy
V58.11 (previously V58.1)*	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasm

* Revised October 1, 2005

The following are **exclusions** and **do not** need to be reported to the TCR:

MORPHOLOGY CODES	DIAGNOSIS/TERMINOLOGY
8000–8004	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix **beginning with 1996 cases**
8010–8045	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases; CIN**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia

For cases diagnosed January 01, 2001 and forward, the following tables are terms that changed behavior codes from borderline to malignant, and malignant to borderline in the ICD-O-3.

These terms/codes **are reportable** starting with 01/01/2001and forward diagnoses:

ICD-O-2 CODE	TERM AS IT APPEARS IN ICD-O-3	ICD-O-3 CODE
89311	Endometrial stromal sarcoma, low grade (C541)	89313
89311	Endolymphatic stromal myosis (C541)	89313
89311	Endometrial stromatosis (C541)	89313
89311	Stromal endometriosis (C541)	89313
89311	Stromal myosis, NOS (C541)	89313
93931	Papillary ependymoma (C71_)	93933
95381	Papillary meningioma	95383
99501	Polycythemia vera	99503
99501	Polycythemia rubra vera	99503
99601	Chronic myeloproliferative disease, NOS	99603
99601	Chronic myeloproliferative disorder	99603
99611	Myelosclerosis with myeloid metaplasia	99613
99611	Megakaryocytic myelosclerosis	99613
99611	Myelofibrosis with myeloid metaplasia	99613
99621	Idiopathic thrombocythemia	99623
99621	Essential thrombocythemia	99623
99621	Essential hemorrhagic thrombocythemia	99623
99621	Idiopathic hemorrhagic thrombocythemia	99623
99801	Refractory anemia, NOS	99803
99801	Refractory anemia without sideroblasts	99803
99821	Refractory anemia with sideroblasts	99823
99821	Refractory anemia with ringed sideroblasts	99823
99831	Refractory anemia with excess blasts	99833
99841	Refractory anemia with excess blasts in transformation	99843
99891	Myelodysplastic syndrome, NOS	99893
99891	Preleukemia	99893
99891	Preleukemia syndrome	99893

These terms/codes **are no longer reportable** starting with diagnosis date 01/01/2001 and forward diagnoses:

ICD-O-2 CODE	TERM AS IT APPEARS IN ICD-O-3	ICD-O-3 CODE
84423	Serous cystadenoma, borderline malignancy (C569)	84421
84423	Serous tumor, NOS, of low malignant potential (C569)	84421
84513	Papillary cystadenoma, borderline malignancy (C569)	84511
84623	Serous papillary cystic tumor of borderline malignancy (C569)	84621
84623	Papillary serous cystadenoma, borderline malignancy (C569)	84621
84623	Papillary serous tumor of low malignant potential (C569)	84621
84623	Atypical proliferative papillary serous tumor (C569)	84621
84723	Mucinous cystic tumor borderline malignancy (C569)	84721
84723	Mucinous cystadenoma, borderline malignancy (C569)	84721
84723	Pseudomucinous cystadenoma, borderline malignancy (C569)	84721
84723	Mucinous tumor, NOS, of low malignant potential (C569)	84721
84733	Papillary mucinous cystadenoma, borderline malignancy (C569)	84731
84733	Papillary pseudomucinous cystadenoma, borderline malignancy (C569)	84731
84733	Papillary mucinous tumor of low malignant potential (C569)	84731

OTHER METHODS

Other methods for identifying reportable cancer cases can be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting. These charts could be stamped and placed on a shelf marked for Tumor Registry review.

The pathology department reports must be routinely checked. The best procedure is to have a copy of ALL pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments. Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases.
Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency

room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 21. Upon review of the disease index, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (173.0-9), and CIN of the cervix (233.1). A list of these cases should be kept each year because the TCR needs to review the disease index and the non-reportable list when it conducts casefinding audits after facilities should have completed reporting for a given year (see page 14). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 32) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used. If cases are abstracted and reported using SCL v.10, a non-reportable log may be kept. Please refer to the *SCL User's Guide* for instructions.

Examples:

a. The ICD-9-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. This case is not reportable, unless the physician states the patient has active, metastatic, or recurrent disease.

b. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. This case is not reportable.

c. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. This case is not reportable.

d. A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. This case is not reportable.

e. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2006, the patient was admitted and diagnosed with small cell carcinoma of the lung. The 2006 case is reportable.

f. Discharge summary diagnosis states cancer and the ICD-9-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. This case is reportable.

g. A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. This case is reportable.

h. A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. The lung case is reportable.

i. A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. This documentation indicates the patient has active disease. This case is reportable.

j. Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. This case is reportable because the wide excision is considered treatment for the melanoma.

Note: Refer to Appendix O to determine reportability for cases diagnosed on or after 1/1/2007.

Note: *In most cases, the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, there will be times when a physician is not certain or the documented language is not definitive.*

Rules concerning the usage of ambiguous terminology (vague or inconclusive diagnostic language) for cases diagnosed **prior to 2007** are as follows:

AMBIGUOUS TERMS GUIDELINES	
***DO* INDICATE A DIAGNOSIS OF CANCER**	***DO NOT* INDICATE A DIAGNOSIS OF CANCER**
Adherent	*Report these cases only if cancer-directed therapy is planned or given*
Apparently	Approaching
Appears to	Cannot be ruled out
Comparable with	Equivocal
Compatible with	May be
Consistent with	Possible
Favor(s)	Potentially malignant
Malignant appearing	Questionable
Neoplasm **(CNS Only)**	Rule out
Most likely	Suggests
Presumed	Very close to
Probable	Worrisome
Suspect(ed)	
Suspicious (for)	
Tumor **(CNS Only)**	
Typical (of/for)	

Note: *The above terms are not all-inclusive. The entire medical record should be reviewed before basing reportability on one of these terms. If an ambiguous term that is not included in the above list is given contact the state health region for clarification.* ***Do not use the above table for cases diagnosed on or after 1/1/2007, refer to Appendix O.***

EXCEPTION: *If cytology is reported as "suspicious for neoplasm" do not interpret this as a diagnosis of cancer. Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.*

Note: *When phrases such as strongly suspicious or highly questionable are used, disregard the modifying term and refer to the guidelines above regarding the primary term. A patient stated to have "known" cancer should be reported to the TCR.*

Note: *If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a non-reportable term such as "cannot be ruled out," accept the reportable term and accession the case.*

Note: *Cases in which the disease is* ***no longer active*** *should only be reported if the patient is still receiving cancer-directed therapy, i.e., leukemia in remission receiving chemotherapy.*

Example:

A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

***Note:** Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information.*

***Note:** Do not submit a report for each admission; submit one per primary tumor.*

Examples:

a. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one report that includes all first course treatment is to be submitted.

b. Your facility reported a patient diagnosed with breast cancer in 2002. She is now admitted in 2006 with metastatic bone cancer. Do not submit a new report for the metastatic bone cancer.

ADDITIONAL GUIDELINES FOR CASE REPORTING

- There are many instances when it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases **should be included** in the facility's caseload **when**:
  a. The clinic is owned by the facility
  b. The facility is legally responsible for the medical charts in the clinic
  c. The facility receives revenue from the medical charts at the clinic
  d. The clinical charts are filed in the same location as the facility charts, or
  e. The facility pays the physicians to work in the clinic
- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed. *Stable disease indicates active disease.*
- Cases diagnosed at autopsy are reportable.
- Patients with active cancer coming into a facility for "consultation only" should be reported.
- Patients with a history of cancer, **with no evidence of active disease**, should **not** be reported unless they are still receiving cancer-directed therapy.

Note: Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine

if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call the TCR health service region.

Examples:

a. A patient comes to Facility A for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. ***This case is not reportable for Facility A.***

b. A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. ***This case is not reportable.***

c. A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer diagnosis; the patient is only being treated for the broken wrist. ***This case is reportable.***

d. A patient is admitted to Facility A with a breast lump. The history/physical states that the patient was diagnosed elsewhere with breast cancer five years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred to Facility A for a mastectomy. ***This case is reportable by Facility A due to active disease.***

e. A patient comes to your facility for lab work. The face sheet states "cancer". The only other information available is the lab results. ***This case would not be reportable.*** A physician must state the patient has active disease, recurrence, or metastatic disease to make this case reportable.

Note: *Every effort should be made to identify multiple primary tumors. See Appendices D–E.*

To prevent reporting the same patient with the same primary twice, compare the patient name and primary cancer site from the registry database (accession list or SCL facility data report) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Complete cancer reporting is an important element in a cancer registry quality assurance program. The TCR performs casefinding audits on a regular basis to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR's data quality procedures and are necessary both to assure complete and accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility. **The percentage of missed reportable cases identified from a casefinding audit should not exceed 5%.**

HELPFUL HINTS TO CONDUCT CASEFINDING:

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.
- When reporting by the facility is complete for a given year, check the *Yes* column on the "*All Forms Submitted For the Year*" section on the transmittal form.
- **Send the disease index (see *Attachment A*), casefinding checklist (see *Attachment C*), non-reportable list (see *Attachment B*) to the TCR state health region when reporting is complete for a given year. Mail these items by *certified mail* in double envelopes marked "confidential".**

Contact your state health region for an assessment of your casefinding procedures. This will better prepare you for an audit.

ATTACHMENT A

Sample Facility
Disease Index
2005 Cancer Cases

RUN DATE: 08/03/2005 Case Mix/Abstracting Page 40
RUN TIME: 0855

MR #	Name	Unit #	DOB	SS #	SX	PT Class/Type	Admit Date	Dischg Date	*Diagnoses/Description "Include secondary dx"
Dillydally V01644608	Dillydally, Fred. W.	V323436	02/03/29	455-66-9090	M	IN.MCR	05/02/05	05/10/05	162.9 Mal Neo Bronch/Lung NOS
Dixey									
V00853788	Dixey, Charles	V174297	05/05/18	422-23-2323	M	IN.MCR	04/05/05	04/07/05	V58.1 Encounter For Chemo
V00923847	Dixey, Charles	V174297	05/05/18	422-23-2323	M	SCD.MCR	05/11/05	05/11/05	189.1 Malig Neo Renal Pelvis
V01782648	Dixey, Charles	V174297	05/05/18	422-23-2323	M	IN.MCR	09/06/05	09/14/05	198.3 Sec Mal Neo Brain/Spine
Dixey V02548046	Dixey, Ray	V416004	02/25/52	566-66-6666	M	IN.OTH	10/16/05	10/20/05	185 Mal Neo Prostate
Doblio									
V00817429	Doblio, Beth	V197988	06/05/29	500-00-5000	F	CLI.MCR	03/22/06	03/22/05	217 Benign Neo Breast
V00952770	Doblio, Beth	V197988	06/05/29	500-00-5000	F	IN.MCR	05/29/06	06/02/05	174.4 Mal Neo Breast Up-Outer
V00978817	Doblio, Elizabeth	V197988	06/05/29	500-00-5000	F	IN.MCR	05/29/06	06/02/05	196.3 Mal Neo Lymph-Axlla/Arm
V08797666	Doblio, Beth	V197988	06/05/29	500-00-5000	F	RCR.MCR	07/13/06	07/13/05	V58.0 Encounter For Radiotherapy

ATTACHMENT B

Non-Reportable List

Facility Name:_____Facility ID#___Reviewed by:____ Telephone: _____

Patient Name	Med Rec #	Admit Date	Date of Birth	SS#	Casefinding Source	N/R Code

***KEEP A COPY FOR YOUR RECORDS**

N/R CODES:
01 – Benign
02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)
03 – NED (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)
04 – Cancer Not Proven
05 – Duplicate Case (This Cancer has already been reported to TCR)
06 – In situ Cancer of Cervix, CINIII
07 – No Cancer Mentioned in Record
08 – Diagnosed prior to 1995
09 – Lab only diagnosis
10 – Other (Include Explanation)

ATTACHMENT C

A checklist that can be used to document all sources utilized to achieve complete casefinding. Upon completion of abstracting for each year, the casefinding checklist should be completed and mailed to your regional TCR office. ***Keep a copy for your records.**

Facility Name :	**Facility ID#:**	**Expected # Cases:**	**Year:**
Casefinding Source	**Available Y/N or NA**	**Reviewed Y/N or NA**	**Comments**
Accession Register			
Ambulatory Setting			
Day Surgery			
Diagnostic Radiology & Oncology			
Emergency Room			
Free-standing facility			
Hematology Clinic			
Hospice			
Medical Records Disease Index			
Nuclear Medicine			
Outpatient Department			
Pathology Department			
Autopsy Reports			
Bone Marrow Biopsies			
Cytology			
Hematology			
Histology			
Physician's Office			
Radiation Oncology Dept.			
Daily Appointment Book			
Treatment Card			
Treatment Summary			

Reviewed by:_____ Date_____

Mailed to Texas Cancer Registry on:_____ Telephone_____

DEMOGRAPHICS AND PATIENT INFORMATION

***Note to SCL Users**: The selection pop-up boxes in SCL are in an easy pull down menu format. Underlined fields contain pop-up boxes. If data must be entered in a field before an abstract can be added to the database, the selection pop-up box will automatically be displayed when tabbing through the field. To activate the selection pop-up box, right click using your mouse in the appropriate box. SCL users are ensuring the highest level of quality edit checks by activating the various selection pop-up boxes. For specific detailed instructions for SCL refer to the User's Guide.*

DATE OF FIRST CONTACT (NAACCR ITEM #580) (FORDS pg. 87)

Description
The date the patient was first admitted to your facility (outpatient or inpatient) with a diagnosis of **active** cancer or on cancer therapy.

Explanation
This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

   Example:

   Record the admit date of January 22, 2006 as 01222006.

2. Enter the date (month, day, century and year) of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

3. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test at your facility with active cancer.

4. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.

5. For "read only" or "pathology only" cases use the date the specimen was collected. These are cases where a specimen is sent over to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is **NOT** a free standing entity. The class of case should be coded to 7 and the reporting source would be 3.

Note: Document in your Policy and Procedure Manual if you have an agreement with any facilities sending their specimens to your pathology department as "read only," but they are still responsible for reporting those cases to the TCR.

Examples:

a. A patient has an outpatient mammography on February 12, 2006 at the reporting facility. The radiologist reads it as suspicious for malignancy. The patient then has an excisional biopsy on February 14, 2006 and a radical surgical procedure on February 16, 2006. Record the date of first contact as 02122006.

b. A patient has a biopsy in a staff physician's office on March 17, 2006 and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2006 for a wide re-excision. Record the date of first contact as 03172006.

c. A patient has a lymph node biopsy at a small hospital on May 15, 2006. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b-cell lymphoma. The patient never enters your hospital. Record 05152006 as date of first contact.

REGISTRY NUMBER (NAACCR ITEM #550) (FORDS pg. 33)

Description
A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Explanation
This data item serves as a reference number to protect the identity of the patient.

Coding Instructions

1. The first four digits identify the calendar year of the admission the patient was first seen at the facility for a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

   Example:

   200600001 would indicate the first 2006 case reported from a facility.

2. SCL automatically assigns a registry number according to the year of admission. This field can be edited to assign the correct registry number.
   Note: *If your facility begins using SCL after submitting cases on the paper form, contact the appropriate TCR regional registry for the correct registry number. This will alleviate duplicate registry numbers being assigned to different patients. The registry number for each individual patient remains the same regardless of the number of* ***reportable diagnoses*** *for that patient from your facility.*

3. **Do not** assign a new registry number to a patient previously reported to the TCR with a new primary cancer. SCL users will need to refer to the *SCL User's Guide* for instructions on entering multiple primaries.

REPORTING FACILITY NUMBER (NAACCR ITEM #540) (FORDS pg. 208)

Description
Identifies the facility or institution reporting the case.

Explanation
This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

1. Enter the three-digit facility number assigned by the TCR.

2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin.

REPORTING SOURCE (NAACCR ITEM #500) (SEER pgs. 31–32)

Description
This data item identifies the source documents used to abstract the case being reported. This will not necessarily be the document that identified the case but the document that provided the best information.

Explanation
This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only or diagnosed by death certificate only.

Coding Instructions

1. Enter the code for the source of the facility and/or documents used to abstract the case.

CODE	DEFINITION OF REPORTING SOURCES
1	Facility Only (Inpatient, Outpatient, ER, or Clinic)
2	Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3	Laboratory Only (Facility or Private)
4	Physician's Office/Private Medical Practitioner
5	Nursing/Convalescent Homes, Hospice
6	Autopsy Only
7	Death Certificate Only
8	Other hospital outpatient units/surgery centers

***Note:** Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6, 7 if more than one source is used.*

Examples:

a. A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed and cancer is found in the lung. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.

b. A patient is admitted to your facility and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

MEDICAL RECORD NUMBER (NAACCR ITEM #2300) (FORDS pg. 36)

Description
The number assigned to a patient's medical record by the reporting facility.

Explanation
This number identifies the individual patients within a reporting facility. It allows a reporting facility to easily locate a patient's health information. This health information is referenced when abstracting or updating a cancer case or to help identify multiple reports and primaries on the same patient.

Coding Instructions

1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.

2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP in this field. See the list below for other optional medical record identifiers.
3. Optional medical record identifiers:

CODE	DEFINITION
RT	Radiation Therapy department patient without a medical record number
SU	One-day surgery clinic patient without a medical record number
UNK	Medical record number unknown

CLASS OF CASE (NAACCR ITEM #610) (FORDS pgs. 5–6 or 83–84)

Description
Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Explanation
This data item divides case records into analytic and non-analytic categories. Class of case has ten categories 0–9. The class of case determines which cases should be included in the analysis of the facility's cancer experience. The analytical cases (classes 0, 1 and 2) are those cases that were first diagnosed and/or treated at the facility. They are analyzed because the facility was involved in the diagnostic and therapeutic decision-making. Non-analytical cases (classes 3–7) are usually excluded from a facility's routine treatment or survival statistics.

Coding Instructions

1. *Analytical cases (classes 0, 1, and 2):* Diagnosed at the reporting facility and/or received any of the first course of treatment at the reporting facility. Abstracting for class of case 0 and 1 is to be completed within six months of diagnosis. This allows for treatment information to be documented in the patient's medical record. Abstracting for class of case 2 is to be completed within six months of first contact with the reporting facility.

   Note: *A facility network clinic or outpatient center belonging to the facility is considered part of the facility.*

2. *Non-analytical cases (classes 3, 4, 5, 6, 7):* Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility.

   Note: *Per TCR reporting guidelines, non-analytical cases are reportable by all facilities*

if the case was not diagnosed prior to 1995, and there is documentation of active cancer or if the patient received cancer directed therapy.

Note: *Non-analytical cases (classes 8 and 9) are to be used solely by the central registry.*

Class of Case Definitions:

ANALYTIC CASES	
Class 0	**Diagnosed at the reporting facility and all of first course of treatment was performed elsewhere.** *Cases include:* • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, social or rehabilitative considerations, etc.
Class 1	**Diagnosed at the reporting facility and had all or part of the first course of treatment at the reporting facility or was never treated at all.** *Cases include:* • Patients whose treatment plan is watchful waiting. • Patients refused any treatment or for whom no treatment is planned. • Patients who were untreatable due to age, advanced disease, or other medical conditions. • Specific therapy was recommended but not received at the reporting facility and it is unknown if therapy was ever administered. • It is unknown if therapy was recommended or administered. • Patients diagnosed but not treated at the reporting facility and all or part of the first course of treatment was received at a staff physician's office. "**Staff physician**" refers to any physician with admitting privileges at the reporting facility. • Patients diagnosed in a staff physician's office and then treated at the reporting facility. • Patients diagnosed and treatment plan developed and documented at the reporting facility. Therapy was delivered elsewhere in accordance with the treatment plan. ***Note:*** *ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.*

ANALYTIC CASES	
Class 2	**First diagnosed elsewhere and all or part of the first course of treatment given at the reporting facility.** *Cases include:* • The reporting facility administered all or part of the first course of treatment. • The reporting facility administered palliative care in lieu of, or as part of, first course treatment.

NON-ANALYTIC CASES	
Class 3	**First diagnosed and all of the first course of treatment administered elsewhere. Patients are seen at the reporting facility for additional therapy or management, and have active disease and/or are on cancer treatment.** *Cases include:* • No information on first course of treatment. The patient is treated or managed at the reporting facility for an unrelated condition and has active disease and/or on cancer treatment. • The reporting facility developed a treatment plan or provided a "second opinion" , but the diagnosis and treatment was provided elsewhere. • The reporting facility is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy. ***Note:*** *If your facility does not deliver any of the first course of treatment. Class of case is coded to 3.* ***Do not*** *code to 9.*
Class 4	**Patients who were first diagnosed and received their first course of therapy at the reporting facility *before* the registry's reference date. The reporting facility manages or treats a recurrence or progression of that cancer *after* the registry's reference date.** *Cases include:* • Patients for whom the reporting facility manages or treats a recurrence or progression of disease after the reference date. • Patients for whom it is unknown whether the reporting facility delivered the first course of treatment prior to the reference date. ***Note:*** *This class applies to ACoS facilities and/or facilities with a cancer program and reference date* ***only****.*
Class 5	**First diagnosed at autopsy**. Prior to autopsy, no suspicion or diagnosis of cancer.
Class 6	**Diagnosed and entire first course of treatment completed in a staff physician's office. Staff physician** refers to any physician with admitting privileges at the reporting facility.

NON-ANALYTIC CASES	
Class 7	**Pathology report only**. Patient does not enter the reporting facility at any time for diagnosis or treatment. ***Note:*** *This category excludes cases diagnosed at autopsy.*
Class 8	**Diagnosis established only by death certificate.** ***Note:*** *Used by central registries* ***only****.*
Class 9	**Unknown**. Sufficient detail for determining class of case is not stated in medical record. *Cases include:* • Unknown if previously diagnosed or treated. • Previously diagnosed, date unknown. ***Note:*** *Used by central registries* ***only.***

Class of Case Examples:

CODE	REASON
0	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to hospital B for treatment for lung cancer with brain metastasis.
1	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility.
2	Patient was diagnosed and treated at another facility for primary breast cancer. The patient then comes to the reporting facility for radiation.
3	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer.
5	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
7	Reporting facility pathology department receives a tissue sample for evaluation which is positive for malignant melanoma. The patient was never seen/admitted at reporting facility.

LAST NAME (NAACCR ITEM #2230) (FORDS pg. 39)

Description
Identifies the last name of the patient.

Explanation
This data item is used as a patient identifier.

Coding Instructions

1. Enter the last name of the patient in **CAPITAL LETTERS.** Blanks, spaces, hyphens, apostrophes, and punctuation marks **are** allowed.

   Examples:

   a. Record De Leon with space as DE LEON

   b. Record O'Hara with apostrophe as O'HARA

   c. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

2. Do not leave blank. If the patient's last name is not known, enter UNKNOWN in this field.

   *Note: Document in **TEXT REMARKS - OTHER PERTINENT INFORMATION:** last name unknown*

FIRST NAME (NAACCR ITEM #2240) (FORDS pg. 40)

Description
Identifies the first name of the patient.

Explanation
This data item is used to differentiate between patients with the same last name.

Coding Instructions

1. Enter the first name of the patient in **CAPITAL LETTERS.**

2. Do not use punctuation.

3. If the patient's first name is unknown, enter UNKNOWN. Do not leave blank.

   *Note: Document in **TEXT REMARKS - OTHER PERTINENT INFORMATION:** first name unknown.*

MIDDLE NAME (NAACCR ITEM #2250) (FORDS pg. 41)

Description
Identifies the middle name or middle initial of the patient.

Explanation
This data item is used to differentiate between patients with identical first and last names.

Coding Instructions

1. Enter the middle initial if the complete middle name is not provided.
2. Do not use punctuation.
3. If the patient does not have a middle name or initial, or it is unknown, leave blank.

MAIDEN NAME (NAACCR ITEM #2390)

Description
Identifies the female patients who are or have been married.

Explanation
This data item is useful for matching multiple records for the same patient.

Coding Instructions

1. Enter the maiden name of female patients who are or have been married if the information is available. Blanks, spaces, hyphens, apostrophes, and punctuation marks **ARE** allowed.
2. If the patient does not have a maiden name, or it is unknown, leave blank.

ALIAS NAME (NAACCR Item #2280)

Note: Name--Alias** will be collected for patients diagnosed **on or after January 1, 2007

Definition
Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [2390].

Explanation
A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions

1. Leave blank if not applicable.

2. Record the last name followed by a blank space and then the first name.

3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.

4. No other special characters are allowed.

Examples:

a. Ralph Williams uses the name Bud Williams. Record William Bud in the **NAME-ALIAS** field.

b. Janice Smith uses the name Janice Brown. Record Brown Janice in the **NAME-ALIAS** field.

c. Samuel Clemens uses the name Mark Twain. Record Twain Mark in the **NAME-ALIAS** field.

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STREET ADDRESS (NAACCR ITEM #2330) (FORDS pg. 42)

Description
Identifies the patient's address (number and street) at the time of diagnosis.

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.
Note: *ACoS facilities* ***are*** *required to provide information for this field regardless of class of case.*

Coding Instructions

1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in **25 characters or less.**

2. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.

3. Punctuation marks are limited to periods, slashes, hyphens and pound signs in this field.

4. If the address contains more than 25 characters, omit the least important elements, such as the apartment or space number.

5. **Do not** omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type.

6. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

ABBREV.	DEFINITION	ABBREV.	DEFINITION	ABBREV.	DEFINITION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

Example:

Patient's street address is 1232 Southwest Independence Apartment 400.
Record: 1232 SW Independence Apt 400

Patients with an Unknown Address:

7. If the patient's address is not available in the medical record, record **NO ADDRESS** or **UNKNOWN. Do not** leave blank. These cases should be rare and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ,** the zip code should be **99999** and the FIPS as **999. Do not record the reporting facility's city, state, zip and FIPS.**

8. Be aware that an excessive amount of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

   Note: *Document in* ***TEXT REMARKS - OTHER PERTINENT INFORMATION:*** *Patient address is unknown.*

9. **Do not** update this data item for the first primary if the patient's address changes with subsequent admissions or subsequent primaries.

10. For helpful complete address information log onto www.zip4.usps.com/zip4/welcome.jsp.

Persons with More than One Residence:

These include snowbirds that live in the south for the winter months, sunbirds that live in the north during the summer months, people with vacation residences that they occupy for a portion of the year.

11. Code the residence where the patient spends the majority of time (usual residence).

12. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence:

Homeless people and transients are examples of persons with no usual residence.

13. Code the patient's residence at the time of diagnosis such as the shelter or the hospital where diagnosis was confirmed.

Note: *Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.*

Temporary Residents:

14. Code the place of usual residence rather than the temporary address for:

    Migrant workers
    Persons **temporarily residing** with family during cancer treatment
    Military personnel on **temporary** duty assignment
    Boarding school students below the college level (code the parent's residence)

15. Code the residence where the student is living while attending **college.**

16. Code the address of the institution for **Persons in Institutions**.

    Persons who are incarcerated
    Persons who are physically handicapped, mentally retarded, or mentally ill who are residents of homes, schools, hospitals, or wards.
    Residents of nursing and rest homes
    Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (Merchant Marine):

17. **Armed Forces**—For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

18. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships**—The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules at www.census.gov.

ADDRESS AT DX—SUPPLEMENTAL (NAACCR ITEM #2335) (FORDS pg. 43)

Description
Provides the ability to store additional address information such as the name of a place or facility (a nursing home or name of an apartment complex).

Explanation
A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, or other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions

1. Do not use this data item to record the number and street address of the patient.

2. Do not update this data item if the patient's address changes.

3. If this address space is not needed, leave blank.

CITY (NAACCR ITEM #70) (FORDS pg. 44)

Description
Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions

1. Enter the city of residence at the time the cancer is diagnosed.

2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting.

3. If the patient has multiple primaries, the address may be different for subsequent primaries.

Note:** Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

STATE (NAACCR ITEM #80) (FORDS pgs. 45–46)

Description
Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Explanation
It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions

1. Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.

2. If the patient is a resident of Mexico or Canada, record the appropriate **two-letter abbreviation** for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See next page for a list of Canadian Provinces/Territories.

3. If the patient is a foreign resident, other than Mexico or Canada, record either **XX** or **YY** depending on the circumstance. Refer to the table below for specific instructions.

4. If the patient has multiple primaries, the state of residence may be different for subsequent cases.

Note: *Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available* ***do not*** *leave blank. The address data fields for these cases should be recorded as* ***Unknown*** *in the street address,* ***Unknown*** *in the city,* ***ZZ*** *in the state,* ***99999*** *in the zip code and* ***999*** *in the FIPS data field.* ***Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.***

CODE	DEFINITION
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
MX	Resident of Mexico.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Mexico and Canada, and the country is **known.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Mexico and Canada, and the country is **unknown.**
ZZ	Residence unknown.

Examples:

a. A patient's country of residence is documented as France; record XX in the state field.

b. Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field.

c. The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided; record US in the state field.

d. If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field.

Canadian Provinces/Territories:

Province/Territory	Abbreviation	Province/Territory	Abbreviation
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS		

State and Territory Abbreviations:

(Refer to the ZIP Code directory for further listings).

STATE		STATE		STATE	
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

OTHER U.S. TERRITORIES	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

ZIP CODE (NAACCR ITEM #100) (FORDS pg. 47)

Description
Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Explanation
It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions

1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, **no dash** should be placed between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available.

2. If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS Web site, www.usps.gov. This website is useful in obtaining missing address information in order to record a complete address.

3. If the patient is a resident of a foreign country at the time of diagnosis, record **88888** for the zip code.

Note:** Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.

CODE	DEFINITION
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the *National Zip Code Directory* of the USPS Web site at www.zip4.usps.com/zip4/welcome.jsp.
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

Examples:

a. A patient's country of residence is documented as France; record 88888 in the zip code field.

b. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.

c. A patient's address is not documented in the medical record and remains unknown after researching all your facilities' resources; record 99999 in the zip code field.

FIPS COUNTY CODE AT DIAGNOSIS (NAACCR ITEM #90) (FORDS pg. 48)

Description
Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Explanation
This data item may be used for epidemiological purposes (e.g., to measure the cancer burden in a particular geographical area).

Coding Instructions

1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available at: www.epa.gov/enviro/html/codes/state.html.

2. Refer to *Appendix C* for the list of Texas FIPS county codes.

3. If the patient has multiple tumors, the FIPS county codes may be different for each tumor.

4. Enter the three-digit code 998 if the patient lives out of state, but the address is unknown.

5. For facilities using SCL, the FIPS code will automatically display when the city and zip is entered.

6. Do not update this data item if the patient's county of residence changes after diagnosis.

7. ACoS facilities following the FORDS' guideline to code the country of residence in this data field for non-U.S. residents, **MX, CD** and **XX** will be accepted by the TCR Edits.

Note: *Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available* ***do not*** *leave blank. The address data*

fields for these cases should be recorded as Unknown in the street address, ***Unknown*** *in the city,* ***ZZ*** *in the state,* ***99999*** *in the zip code and* ***999*** *in the FIPS data field.* ***Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.***

CODE	DESCRIPTION	DEFINITION
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

SOCIAL SECURITY NUMBER (NAACCR ITEM #2320) (FORDS pg. 37)

Description
Identifies the patient by social security number.

Explanation
This item is used by the TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions

1. Every effort should be made to obtain the social security number.
2. Enter the patient's nine-digit social security number in this field.
3. If the social security number is unavailable or unknown, enter all 9's in this field.
4. A patient's Medicare number may not be identical to the person's social security number.
5. Do not put dashes or slashes in this field.

Note: *Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits.* ***Take caution to enter the patient's social security number and not the spouse's or guardian's number.***

The following are not allowed:

- First 3 digits= 000 or 666
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit= 8 or 9 (except for 9999999999)

Example:

A wife may be registered under her husband's Medicare account number, e.g., 584-24-4457**B** or 584-24-4457**D**. In this case, record all 9's.

CODE	DEFINITION
123456789	Record the patient's social security number (SSN) without dashes.
999999999	Use when the patient does not have a social security number, or the information is not available. Do not code with 000000000 or 888888888 if social security number is unknown.

DATE OF BIRTH (NAACCR ITEM #240) (FORDS pg. 57; SEER pgs. 42-43)

Description
Identifies the patient's month, day, century and year of birth. Patients with multiple tumors must have the same date of birth on all records.

Explanation
This item is used by the TCR to match records, and to calculate age at diagnosis.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed.

2. The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.

3. Unknown birth date 99999999 will no longer be accepted by the TCR edits.

4. If month and/or day of birth are not known, code 9's; the year **must** be entered in full (99991960).

CODE	DEFINITION
MMDDCCYY	The date of birth is the month, day, and year the patient was born. The first two 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.

Examples:

a. The patient's date of birth is June 30, 1899, record 06301899.

b. The patient is admitted on June 15, 2006 and states he is 60 years old. The medical record does not have a date of birth. Subtract 60 from 2006 to calculate the year of birth as 1946 and record 99991946 as the date of birth.

c. The medical record contains only the year of birth–1927; record 99991927 as the date of birth. The TCR Edits will no longer accept unknown for the year of birth. Every effort must be made to obtain this information. This information is critical for analysis.

PLACE OF BIRTH (NAACCR ITEM #250) (FORDS pg. 56; SEER pg. 41)

Description
Identifies the patient's place of birth. A patient with multiple tumors should have the same place of birth coded for all tumors.

Explanation
Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and epidemiological analyses.

Coding Instructions

1. Use the most specific code.

2. Record the patient's place of birth (if available) using the *SEER Geo-codes* in *Appendix G.* If the place of birth is unknown, code to 999.

   Note: *At the time SEER assigned Geo-codes in the 1970's, the United States owned or controlled islands in the Pacific. Many of these islands are now independent and controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.*

RACE 1 (NAACCR ITEM #160) (FORDS pg. 59; SEER pgs. 45–50)

Description
Identifies the primary race of the person.

Explanation
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions

Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000.

1. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2001.

2. The race field is used in conjunction with *Spanish/Hispanic Origin.* Both items must be coded. All tumors for the same patient should have the same race code.

3. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.

4. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07 Hawaiian and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.

5. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."

6. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in race 1 and 88 in race 2–race 5.

7. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.

8. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

9. In using the patient name to determine race:

    a. Do not code race from name alone, especially for females with no maiden name given.

    b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

10. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.

11. If only one race is reported for a person, race 2–race 5 must be coded to 88.

12. If race 1 is coded to 99 unknown, race 2–race 5 must also be coded 99 unknown.

13. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.

14. Document the specified race code in the ***TEXT REMARKS - OTHER PERTINENT INFORMATION*** field. A more specific race that is not included in the list of race code such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

CODE	RACE	CODE	RACE
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
09	Asian Indian, Pakistani, Sri Lankan	31	Fiji Islander
10	Vietnamese	32	New Guinean
11	Laotian	96	Other Asian, including Asian NOS, and Oriental NOS
12	Hmong	97	Pacific Islander, NOS
13	Kampuchean (Cambodian)	98	Other
14	Thai	99	Unknown

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians.

- The **Black** category includes the designation African-American.

Examples:

RACE CODE	EXPLANATION
01	A patient was born in Mexico of Mexican parentage. A patient stated to be German-Irish.
02	A black female patient. A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code the person's primary race as Chinese and code the other race in race 2 as appropriate. In this case, Korean to race 2.
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in the race 1 field and 01 Caucasian in the race 2 field.
05	The race is recorded as Oriental or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation. Code the race based on birthplace information as this is more specific.

RACE CODE	EXPLANATION
07	A patient's race is a combination of Hawaiian and any other race(s), code race 1 to 07 Hawaiian, and race 2–race 5 as appropriate.
11	A patient is stated to be Asian-American born in Laos. Code race 1 as 11 Laotian because it is more specific than 96 Asian, NOS.
99	A patient's race is unknown. Race 1 code 99 and race 2–race 5 must also be 99. A patient has a Spanish last name stated to be a native of Indiana would be coded to 99 unknown because nothing is known about her race.

RACE 2, RACE 3, RACE 4, RACE 5 (NAACCR ITEMS #161, 162, 163, 164) (FORDS pgs. 61-64; SEER pgs. 51-56)

Description
Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Explanation
Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons.

Coding Instructions

1. Record the two-digit code to identify a multi-racial patient.

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All tumors for the same patient should have the same race code.

3. All resources in the facility must be used to determine the race of the patient.

4. If more than the *race 1* code is entered, and if any race is **99**, then all race codes (*race 1,2,3,4* and *5*) must be **99**. If more than the *race 1* code is entered, and if any race codes (for *race 2,3,4* and *5*) are **88** (no further race documented), then all **subsequent** race codes must also be **88**.

5. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07 Hawaiian and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.

6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."

7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in race 1 and 88 in race 2–race 5.

8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.

9. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

10. In using the patient name to determine race:

    a. Do not code race from name alone, especially for females with no maiden name given.

    b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.

12. If only one race is reported for a person, race 2–race 5 must be coded to 88.

13. If race 1 is coded to unknown 99, race 2–race 5 must also be coded unknown 99.

14. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.

15. Document the specified race code in the ***TEXT REMARKS - OTHER PERTINENT INFORMATION*** text field. A more specific race that is not included in the list of race code such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

CODE	RACE	CODE	RACE
01	White	20	Micronesian, NOS
02	Black	21	Chamorran
03	American Indian, Aleutian, Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
09	Asian Indian, Pakistani, Sri Lankan	31	Fiji Islander
10	Vietnamese	32	New Guinean
11	Laotian	88	No further race documented

CODE	RACE	CODE	RACE
12	Hmong	96	Other Asian, including Asian NOS, and Oriental NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
		99	Unknown

SPANISH/HISPANIC ORIGIN (NAACCR ITEM #190) (FORDS pg. 65; SEER pg. 57)

Description
Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

Explanation
This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *race.*

Coding Instructions

1. The information is coded from the medical record or is based on Spanish/Hispanic names.
2. Review all sources available to determine the correct code, including stated ethnicity as Hispanic.
3. Origin on the death certificate, birthplace and information about life history and language spoken should be considered.
4. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.
5. Refer to the list of Spanish/Hispanic surnames on the TCR website at: www.dshs.state.tx.us/tcr.

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (includes European)
6	Spanish, NOS, Hispanic, NOS; Latino, NOS. There is evidence, other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5.

CODE	DESCRIPTION
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

*Note: Use **code 0** if patient has a Spanish/Hispanic name and there is reason to believe he/she is **not** Hispanic e.g., patient is Filipino, patient is a woman known to be non-Hispanic who has a Hispanic married name.*

6. Use codes 1–5 if specific ethnicity is known.

7. Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.

8. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name. Ordinarily used at the central registry level.

9. Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Examples:

a. Patient's last name is Gonzales and the medical record states the patient was born in Mexico, code to 1.

b. Patient's medical record states race as Hispanic, without mention of whether his/her origin was Mexico, Puerto Rico, Cuba, etc., code to 6.

c. Patient's medical record states patient is White/Caucasian and the last name is Gonzales; code to 7.

Note: Persons of Spanish/Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.

SEX (NAACCR ITEM #220) (FORDS pg. 66; SEER pg. 61)

Description
Identifies the gender of the patient at the time of diagnosis. Patients with multiple tumors must have the same sex coded on all records.

Explanation
The code must be gender-specific to the primary site, e.g., prostate carcinoma— male; ovarian carcinoma—female for the purposes of calculating sex-specific rates.

Coding Instructions

1. Record the patient's gender as indicated in the medical record.

CODE	DEFINITION
1	Male
2	Female
3	Other (Hermaphrodite)
4	Trans-sexual
9	Not Stated/Unknown

Note: *Trans-sexual is defined as surgically altered gender.*

TEXT REMARKS - OTHER PERTINENT INFORMATION (NAACCR ITEM #2680)

Description
Includes text area for information that is coded on the patient's disease and adequate or appropriate space is not provided for supporting text. Overflow or problematic coding issues can be documented in this text field.

Explanation
Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation may include additional staging information, additional treatment documentation, documentation of race and sex, history of the disease, comments regarding lack of information in the medical record and cause of death. The name of the facility that referred the patient to your facility or the name of the facility the patient was referred to for further care may be documented in this data field.

PHYSICIAN MANAGING (NAACCR ITEM #2460) (FORDS pg. 76)

Description
Records the identification number of the physician responsible for the overall management of the patient's care during diagnoses and/or treatment for this cancer. The TCR requires the physician's state license number.

Explanation
The managing physician is the first contact for obtaining information on the care of this cancer. This information may be used for outcome studies.

Coding Instructions

1. Record the state license number of the physician responsible for the overall management of the

patient's care during diagnosis and/or treatment for this cancer. Physician license numbers for Texas can be found at the following web site: www.docboard.org/tx/df/txsearch.htm.

2. Cancer reporter's using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.

PHYSICIAN FOLLOW UP (NAACCR ITEM #2470)

Description
Identifies the physician currently responsible for the patient's medical care. The TCR requires the physician's state license number.

Explanation
The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following web site: www.docboard.org/tx/df/txsearch.htm

2. Cancer reporter's using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.

FACILITY REFERRED FROM (NAACCR ITEM #2410) (FORDS pg. 85)

Description
Identifies the facility that referred the patient to the reporting facility.

Explanation
Each facility's ID number is unique. The number assigned will be the TCR facility number. The information is used to document and monitor referral patterns.

Coding Instructions

1. Document the name of the facility that referred the patient to **your** facility under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**

2. If the facility is unknown or the patient was not referred, also document this under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**

Note: *For Class of Case 0 and 1 cases, the appropriate documentation is "patient not referred."*

CODE	DEFINITION
5102999999	Patient referred from Anywhere Facility
0000000000	Patient was not referred to the reporting facility from another facility.
0099999999	Patient was referred, but the referring facility's ID number is unknown.

Example:

Patient referred from Daytown Hospital (this facility is not one of the choices from the selection pop-up box), code 0099999999 and document under **TEXT REMARKS - OTHER PERTINENT INFORMATION** - Patient referred from Daytown Hospital, Daytown, Texas.

Notes:

a. *Referral and transfer are not the same. A patient may request a transfer to another facility; for example, a facility closer to home. This would not be considered a referral.*

b. *For SCL, if the facility that referred the patient is not one of the choices listed in the selection pop-up box; document the name of the facility that referred the patient under* ***TEXT REMARKS - OTHER PERTINENT INFORMATION.***

FACILITY REFERRED TO (NAACCR ITEM #2420) (FORDS pg. 86)

Description
Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Explanation
Each facility's ID number is unique. The number assigned will be the TCR facility number. The information is used to document and monitor referral patterns.

Coding Instructions

1. Document the name of the facility that the patient was referred to for further care after discharge from your facility under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**

2. If the facility is unknown or the patient was not referred, also document this under **TEXT REMARKS - OTHER PERTINENT INFORMATION.**

Note: *For Class of Case 3 and autopsy-only cases, the appropriate documentation is "patient not referred."*

CODE	DEFINITION
5220999999	Patient referred to Anywhere Facility.
0000000000	Patient was not referred to another facility.
0099999999	Patient was referred, but the facility's ID number is unknown.

Note: *For SCL users, if the facility where the patient was referred to is not listed in the selection pop-up box; document the name of the facility where the patient was referred to under* ***TEXT REMARKS - OTHER PERTINENT INFORMATION.***

Example:

Patient was referred to Daytown Hospital (this facility is not one of the choices from the selection pop-up box), code 0099999999 and document under **TEXT REMARKS - OTHER PERTINENT INFORMATION** - Patient referred to Daytown Hospital, Daytown, Texas.

SEQUENCE NUMBER (NAACCR ITEM #560) (FORDS pgs. 34–35)

Description

Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, a registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facilities' reference date.

Explanation

This data item is used to distinguish among cases having the same registry numbers, to select patients with only one primary tumor for certain follow-up studies and to analyze factors involved in the development of multiple tumors.

Coding Instructions

1. Codes 00–35 and 99 indicate reportable cases of malignant or in situ behavior.

2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.

3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility in 2004 should be sequenced according to this guideline.

   Note: *CDC and NAACCR edits require benign CNS tumors diagnosed in 2004 to start with sequence number 60.*

5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).

6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.

MALIGNANT NEOPLASMS		
ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE UNKNOWN
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	
NON-MALIGNANT NEOPLASMS		
ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE UNKNOWN
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

7. The **Sequence Number** refers to the number of malignant or non-malignant primaries **in the patient's lifetime.**

   Note: *Squamous and/or basal cell carcinoma of the skin (except genital sites)* ***is no longer*** *considered when assigning the appropriate sequence number.*

Examples:

a. A person is diagnosed with one primary. *Code the sequence number to 00.*

b. A person was diagnosed in 2001 with lung cancer. A colon cancer is diagnosed in 2006. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.

c. A person was diagnosed with breast cancer in April 2006 and metastasis to the lungs in June 2006. Since the lung is a metastatic site and not a second primary, it would not be abstracted. *Code the sequence number of the breast cancer to 00.*

d. A person was diagnosed with signet ring cell carcinoma of the bladder in 2004. In 2006, this person developed a benign meningioma in the temporal area of the brain. *Code the bladder to a sequence number of 00, and code the brain to a sequence number of 60.*

e. A person was diagnosed with carcinoma of the stomach in 2003, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2005, and non-Hodgkin's lymphoma in 2006. *Code the sequence number of the stomach to 01.* The sequence number of the left forearm would not be sequenced, abstracted or reported. *Code the sequence number of the lymphoma to 02.*

f. A person was diagnosed with a benign meningioma in June 2005 and comes to your facility for a MRI in 2006. *Code the sequence number to 60 for the benign meningioma.*

OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, DATE) NAACCR ITEM #2220)

Description
State-specific data field to capture information on other reportable tumors.

Explanation
Records tumor specific information on other reportable tumors in the patient's lifetime.

Coding Instructions

Record the site, morphology, and date of other primaries. **Do not** include metastatic lesions or the primary currently being reported in this field. **Do not** leave this area blank due to lack of specific information. Record the information you have available.

Examples:

a. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2006 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and record duct cell carcinoma, left breast, 2005 in this area.

b. The patient has a history of prostate cancer, no date is given and no specific morphology is given. Patient is admitted in 2006 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

PRIMARY PAYER AT DIAGNOSIS (NAACCR Item #630) (FORDS pgs. 67-68)

Note: Primary Payer at Diagnosis** will be collected for patients diagnosed **on or after January 1, 2007

Definition
Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Explanation
This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions

1. Record the type of insurance reported on the patient's admission page.

2. Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2007.

3. If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

4. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

CODE	DEFINITION
01	Not insured
02	Not insured, self pay
10	Insurance, NOS
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid-Administered through a Managed Care plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare-Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Services
99	Insurance status unknown

Examples:

a. An indigent patient is admitted with no insurance coverage. Code the **PRIMARY PAYER AT DIAGNOSIS** as 01.

b. A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the **PRIMARY PAYER AT DIAGNOSIS** as 20.

c. A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO. Code the **PRIMARY PAYER AT DIAGNOSIS** as 62.

d. Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the **PRIMARY PAYER AT DIAGNOSIS** as 99 because we do not have this information from the facility where originally diagnosed.

CANCER INFORMATION

DATE OF INITIAL DIAGNOSIS (NAACCR Item #390) (FORDS pgs. 89–90; SEER pgs. 65–68)

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, for epidemiology purposes, and for outcomes analysis.

Coding Instructions

1. 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.

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

3. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was created.

4. Refer to the *List of Ambiguous Terms* on page 27 to aid in determining reportability for cases diagnosed prior to 2007. For cases diagnosed on or after 1/1/2007, refer to the list of ambiguous terms in Appendix O.

5. If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, record the date of diagnosis as the earlier date. If later documentation shows the diagnosis was an earlier date, record the earlier date. Check with the TCR regional office for the appropriate procedure if this case has already been submitted to the TCR.

6. For autopsy-only and death-certificate only cases the date of initial diagnosis will be the date of death.

7. Positive tumor markers alone are not diagnostic of cancer. Use the date of clinical, positive histologic or positive cytologic confirmation as the date of diagnosis. Positive tumor markers alone are never used for case ascertainment.

8. Suspicious cytology alone is not diagnostic of cancer. Use the date of clinical, positive histologic or positive cytologic confirmation as the date of diagnosis. Suspicious cytology alone is never

used for case ascertainment.

9. If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, code the date of diagnosis as the earlier date.

10. If the initial pathology slides are reviewed and the reviewing pathologist documents cancer, code the diagnosis date as the date the original slides were made.

Examples:

a. The patient has an excision of a benign fibrous histiocytoma in January 2005. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The pathologist reviews the original slides and documents that the previous tumor (benign fibrous histiocytoma) was malignant. Code the diagnosis date as January 2005.

   Do not back date if there is no review of previous slides with a revised physician statement of diagnosis of cancer or reportable tumor.

b. The patient had a total hysterectomy and bilateral salpingo oophorectomy (BSO) in June 2005 with pathology diagnosis of papillary cystadenoma of the ovaries. In December 2005 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2005 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of initial diagnosis is December 2005.

In the absence of an exact date of initial diagnosis, record 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, for example, 99992005. Document in the final diagnosis field "Date of DX Unknown" along with the primary site, histology and behavior information.

> ***Note:*** *Every resource available at the reporting facility must be reviewed in order to determine the date of diagnosis.*

For vague dates, estimate the date of diagnosis for month and year. An approximate date is preferable to an unknown date of diagnosis. Refer to the table and examples on the next page.

Code the month and year of admission when there is no basis for estimation.

Example:

Patient admitted to your facility on April 26, 2006. Date of diagnosis is unknown. Code the date of diagnosis as 04992006 and document in the final diagnosis field "Date of DX Unknown."

Note: *Estimating both the month and year: Use whatever information is available to best estimate the month and year of diagnosis.*

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.
Early in Year	Use January (01) for the month
Middle of Year	Use July (07) for the month
Late in Year	Use December (12) 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 first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown.
A Couple of Years	Code to two years earlier
A Few Years	Code to three years earlier

Examples:

a. A patient was admitted to your facility on January 15, 2006. The History and Physical states the patient has prostate carcinoma diagnosed approximately two months ago. Record the date of diagnosis as 11992005.

b. A patient was admitted to your facility on September 10, 2005. The History and Physical states the patient has bone and brain metastasis from malignant melanoma diagnosed in the fall, four years ago. Record the date of diagnosis as 10992001.

c. On March 12, 2006, 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, 2006, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 03122006.

Note: *Remember to check with the TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to the TCR.* ***Do NOT resubmit the abstract****. These cases will result in duplicate records and require manual resolution.*

MORPHOLOGY AND BEHAVIOR (NAACCR Item #522, #523) (FORDS pgs. 93–94; SEER pgs. 83–90) (ICD-O-3)

Description
Identifies the microscopic structure of cells and the behavior of the tumor being reported. For all cases diagnosed prior to January 01, 2001, the International Classification of Diseases for Oncology, 2nd Edition (IDC-0-2) **must** be used.

Explanation
The histological (morphology) type helps to determine staging and treatment options. It also assists in determining the disease course and prognosis, and in identifying multiple primaries. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

Coding Instructions

Morphology:

Record the morphology code using the Alphabetic Index (ICD-O-3 pages 105–218) and the Numerical Index (ICD-O-3 pgs. 69–104). It is important to review both parts of the ICD-O-3 to **ensure accurate coding.**

Follow the coding rules outlined on pages 20–40 of *ICD-O-3*.

The term [obs] in *ICD-O-3* indicates a diagnosis for which a better diagnostic term(s) is available but which may still be used to code the cancer in certain circumstances. Obsolete terms are retained in *ICD-O-3* for historical reference.

Adequate text documentation must be provided to support coding. Auto coding 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 final pathologic diagnosis should be reviewed for specific information relating to the cell type of the tumor.

The words **cancer (8000)** and **carcinoma, NOS (8010)** are **not** interchangeable. Record the appropriate histology code from the physician documentation.

Carcinoma, NOS (8010) and **adenocarcinoma** (8140) are interchangeable (see cross-references in the *alphabetic index of ICD-O-3*).

Histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to *"Determining Multiple Primaries"* in *Appendix D and E* of this manual to determine the number of primaries. Use all of the information for a single primary to code the histology.

Code the **final** pathologic diagnosis. Use the histology stated in the **final diagnosis** from the pathology report. Use the pathology report from the procedure that resected the majority of the primary tumor.

> ***EXCEPTION:*** *If a more specific histologic type is definitively described in the microscopic portion of the pathology report or the comment, code the more specific diagnosis.*

> ***EXCEPTION:*** *If the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.*

If there is no tumor specimen, code the morphology described by the medical practitioner.

Examples:

a. The patient has a CT scan of the brain with a final diagnosis of glioblastoma multiforme (9440). The patient refuses all further workup or treatment. Code the histology to glioblastoma multiforme (9440).

b. If the physician says that the patient has carcinoma, code carcinoma, NOS (8010).

Lymphomas may be classified by the **WHO** Classification, **REAL** system, **Rappaport classification**, **Working Formulation**, or other lymphoma classification. The WHO Classification is the current preferred terminology. See page 13 in the *ICD-O-3* for a discussion of hematologic malignancies.

Definitions:

Synonyms and Equivalent Terms: Mixed and combined, can usually be used interchangeable in histologic descriptions. Either term indicates the presence of different cell types in a single tumor.

Complex (mixed or combined) histology: When the pathologist uses **multiple histologic terms** to describe a tumor. The histologic terms are frequently connected by the word "and" (e.g., ductal and lobular carcinoma).

Same histology: when the first three digits of the ICD-O-3 histology code are identical.

Different histology: when the first three digits of the ICD-O-3 histology code are different.

Different subtypes: The NOS morphology codes can have various subtypes; for example, scirrhous adenocarcinoma (8143), adenocarcinoma, intestinal type (8144), and linitis plastica (8141) are subtypes of Adenocarcinoma, NOS (8140). When a subtype is reported, code the subtype.

Behavior Codes:

0 Benign (Reportable for intracranial and CNS sites only)
1 Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2 Carcinoma in situ; intraepithelial; noninfiltrating; noninvasive
3 Malignant, primary and/or metastatic site (invasive)

Note: Cases reported to the TCR cannot have a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology.

Example:

A patient is diagnosed with metastatic brain tumors and a fine needle aspiration biopsy shows that the tumor is metastatic small cell carcinoma (8041/6). The pathology report indicates that the tumor originated in the lung. Code the primary site as lung and the morphology as small cell carcinoma (8041/3)

Behavior Coding Instructions

1. Behavior codes benign /0 and borderline /1 are reportable for intracranial and CNS sites only. These tumors have always been reportable to the TCR.

2. Clinical evidence alone cannot identify the behavior as in situ; the code must be based on pathologic examination and documentation.

3. Code the behavior as malignant /3 if any portion of the primary tumor is invasive no matter how limited; such as microinvasion.

Example:
Pathology from mastectomy specimen: Large mass composed of intraductal carcinoma with a single focus of invasion. Code the behavior as malignant (8500/3).

4. Code the behavior as in situ /2 if the pathology report describes the histology as in situ/2 and the ICD-O-3 histology is listed only with a malignant /3 behavior code.

5. Code the behavior as malignant /3 if the pathology report describes the histology as malignant /3 and the ICD-O-3 histology codes is listed only with an in situ /2 behavior.

6. Certain histologies will never have in situ behaviors (8000–8005, 8020, 8021, 8331, 8332, 8800–9055, 9062, 9082, 9083, 9110–9493, 9501–9989).

7. If more than one behavior is reported, select the morphology code with the higher behavior code (the invasive tumor). Refer to the following table.

BEHAVIOR CODE	FIFTH DIGIT TERM	EXAMPLE
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C440–C449)
		Clark's Level I for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50_)
2	Terms synonymous with in situ	Confined to epithelium
		AIN III (C211)
		Behavior code /2
		Hutchinson's melanotic freckle, NOS (C44_)
		Intracystic, non-infiltrating
		Intraductal
		Intraepidermal, NOS
		Intraepithelial
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44_)
		Lobular, noninfiltrating(C50_)
		Noninfiltrating
		Noninvasive
		No stromal invasion/involvement
		Papillary, non-infiltrating or intraductal
		Precancerous melanosis (C44_) Preinvasive
		Queyrat's erythroplasia (C60)
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamia propria)
		VAIN III (C529)
		VIN III (C51_)
3	Invasive	Invasive or microinvasive

Histology Coding Rules for a Single Tumor:

- The rules are in hierarchical order. Rule 1 has the highest priority.
- Use the rules in priority order.
- Use the first rule that applies to the case. (Do not apply any additional rules).

Rule 1: Code the histology if only one type is mentioned in the pathology report.

Rule 2: Code the **invasive histology** when both invasive and in situ tumor are present.

Examples:

a. Pathology report reads infiltrating ductal carcinoma and cribriform ductal carcinoma in situ. *Code the invasive histology (8500/3).*

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

b. The pathology report states squamous cell carcinoma in situ (8070/2) and papillary squamous cell carcinoma (8052/3). Code as papillary squamous cell carcinoma (8052/3).

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

Rule 3: Use a **mixed** or **combination** histology code if one exists.

Examples of mixed codes: (This is not a complete list, these are examples only).

8490 Mixed tumor, NOS
9085 Mixed germ cell tumor
8855 Mixed liposarcoma
8990 Mixed mesenchymal sarcoma
8951 Mixed mesodermal tumor
8950 Mixed Mullerian tumor
9362 Mixed pineal tumor
8940 Mixed salivary gland tumor, NOS
9081 Teratocarcinoma, mixed embryonal carcinoma and teratoma
8255 Renal cell carcinoma, mixed clear cell and chromophobe types
8523 Infiltrating duct carcinoma mixed with other types of carcinoma
8524 Infiltrating lobular carcinoma mixed with other types of carcinoma
8560 Adenosquamous carcinoma
8045 Combined small cell carcinoma, combined small cell-large cell

Rule 4: Code the **more specific term** when one of the terms is 'NOS' and the other is a more specific description of the same histology.

Examples:

a. Pathology report reads poorly differentiated carcinoma, probably squamous in origin. Code the histology as squamous cell carcinoma rather than the non-specific term "carcinoma."

b. The pathology report from a nephrectomy reads renal cell carcinoma (8312) (renal cell identifies the affected organ system rather than the histologic cell type) in one portion of the report and clear cell carcinoma (8310) (a histologic cell type of kidney cancer) in another section of the report. Code clear cell carcinoma (8310); renal cell carcinoma (8312) refers to the renal system rather than the cell type, so renal cell is the less specific code.

Rule 5: Code the **majority** of tumor.

a. Based on the pathology report description of the tumor.

b. Based on the use of majority terms. See definition for majority terms below:

Majority of Tumor:

TERMS THAT MEAN THE MAJORITY OF TUMOR	TERMS THAT DO NOT MEAN THE MAJORITY OF TUMOR
Predominantly	With foci of
With features of	Focus of/focal
Major	Areas of
Type	Elements of
With .... Differentiation	Component
Pattern (only if written in College of American Pathologists [CAP] Protocol)	
Architecture (only if written in College of American Pathologists [CAP] Protocol)	

Note: *Examples of CAP protocols for specific primary sites may be found on the web site: www.cap.org/apps/docs/cancer_protocols/protocols_intro.html.*

Examples:

a. Duct carcinoma, **desmoplastic** type, code to 8514/3.

b. Duct carcinoma, predominantly **medullary,** code to 8510/3.

c. Duct carcinoma with features of **comedocarcinoma**, code to 8501/3.

Rule 6: 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. This is the rule with the lowest priority and should be used infrequently.

Examples:

a. Mixed transitional cell carcinoma and squamous cell carcinoma, code to 8120/3.

b. Poorly differentiated carcinoma with squamous and neuroendocrine differentiation, code to 8246/3.

c. Carcinoma was trabecular and acinar pattern, code to 8550/3.

d. The pathology report states transitional cell epidermoid carcinoma. Transitional cell carcinoma, NOS is coded to 8120/3 and epidermoid carcinoma, NOS is coded to 8070/3. Code the numerically higher code, 8120/3.

Histology Coding Rules for MULTIPLE Tumors in the Same Organ With Different Behaviors Reported as a Single Primary

Rule 1: Code the histology of the invasive tumor when one lesion is in situ /2 and the other is invasive /3.

Example:

At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Code histology and behavior as invasive ductal carcinoma (8500/3).

Histology Coding Rules for MULTIPLE Tumors in Same Organ Reported as a Single Primary

Rule 1: Code the histology when multiple tumors have the same histology.

Rule 2: Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/_) in the same segment of the colon or rectum.

Rule 3: Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and a carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.

Rule 4: Use a **combination** code for the following:

Bladder: Papillary and urothelial (transitional cell) carcinoma (8130)

Breast: Paget disease and duct carcinoma (8541)
Breast: Duct carcinoma and lobular carcinoma (8522)
Thyroid: Follicular and papillary carcinoma (8340)

Rule 5: Code the more specific term when one of the terms is 'NOS' and the other is a more specific description of the same histology.

Rule 6: Code all other multiple tumors with different histologies as different primaries.

*Note: See Appendix D (prior to 2007) and **Appendix O** (on or after 1/1/2007) for specific instructions and examples for determining single versus multiple primaries for solid tumors.*

How to Determine Same versus Different Histologies for Benign and Borderline Primary Intracranial and CNS Tumors (C700–C729, C751–C753) Based on Histologic Groupings

When there are **multiple tumors**, use the following table to determine if the tumors are the same or different histologies.

Histologic Groupings to Determine Same Histology for Non-Malignant Brain Tumors:

Choroid Plexus neoplasms	9390/0, 9390/1
Ependyomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Note: Refer to Appendix D, page 13–16 for specific instructions and examples for determining single versus multiple primaries for non-malignant CNS tumors and refer to Appendix E for determining multiple primaries for hematopoietic and lymphatic primaries.

Note: The new 2007 multiple primary and histology rules (Appendix O) do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors.

PRIMARY SITE (NAACCR Item #400) (FORDS pg. 91; SEER pgs. 73–77)

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.

Site-Specific Topography Terms:

(See the *Coding Guidelines for Topography and Morphology* in the introduction of the *ICD-O-3* for additional details). Primary site codes may be found in the *ICD-O-3 Topography, Numerical List Section* (*ICD-O-3*, page 43) and in the *Alphabetic Index* (*ICD-O-3*, page 105).

Refer to *"Determining Multiple Primaries"* in the *Multiple Primaries Section* (*Appendix D* and *Appendix E*) to determine the number of primaries. Use all of the information for a single primary to code the site.

Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation. In general, when a primary site is preceded by *carcinoma of...*, or *malignancy of...*, code to that primary site.

Coding Instructions

The *ICD-O-3* has topography codes listed in two sections; the first is a numeric listing by code number, the second is an alphabetic listing by anatomic site. The topography code consists of an initial character (the letter 'C') followed by two numeric digits, a decimal point, and one additional numeric digit. The decimal point is not entered as part of the code.

Example:

The pathology report says the primary site is the cardia of the stomach. The code (C160) is found in the *Alphabetic Index* under either "stomach" or "cardia." Enter the code as (C160); do not record the decimal point.

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 (C504).*

1. Code the site in which the primary tumor originated, even if it extends into an adjacent "subsite."

Examples:

a. Final diagnosis is adenocarcinoma of the upper lobe of the right lung. *Code the topography to lung, upper lobe (C341).*

b. Pathology report shows adenocarcinoma arising in an ectopic patch of endometriosis on the sigmoid colon. *Code primary site to sigmoid colon (C187) where the cancer originated.*

c. Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. *Code primary site to branchial cleft (C104).*

d. The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non-cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. *Code the primary site to peritoneum, NOS (C482).* (The chart may or may not state that the patient has extra-ovarian or primary peritoneal carcinoma).

e. The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. *Code primary site to upper inner quadrant of breast (C502).*

2. Use the *SEER Site Grouping Table* in the Rules for *Determining Multiple Primaries Section (Appendix D)* to code the primary site specified in the table in those rare cases when:

   a. A single tumor overlaps adjacent sites in the same group.

   b. Multiple tumors reported as a single primary involve adjacent sites in the same group.

Example:

The patient has a 5 cm tumor overlapping the base of tongue and anterior 2/3 of tongue. Use the *SEER Site Grouping Table* to determine the correct code for the primary site, Tongue, NOS (C029).

3. Code the last digit of the primary site code to 8 when a **single tumor overlaps** an adjacent **subsite**(s) of an organ and the point of origin cannot be determined.

Example:

The patient has a 5 cm tumor that involves the dorsal surface and anterior 2/3 of tongue.
Code the primary site to overlapping lesion of tongue (C028).

4. Code the last digit of the primary site code to 9 for single primaries, when **multiple tumors arise in different subsites** of the same anatomic site, unless the subsite is defined in one of the site groups listed in the *SEER Site Grouping Table*. For cases **diagnosed prior to 2007**, refer to the table in the section *Multiple Primaries (Appendix D)* to determine the primary site code for specified groups.

Examples:
a. During a TURB, the physician describes multiple papillary tumors in the bladder neck

(C675) and the lateral wall of the bladder (C672). *Code the primary site as bladder, NOS (C679).*

b. Patient has an infiltrating duct tumor in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. *Code the primary site as breast, NOS (C509).*

5. Some histology/behavior terms in *ICD-O-3* have **a related site code** in parenthesis; e.g., hepatoma (C220).

Note: *Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a primary site is specified in the medical record.*

Example:

The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in *ICD-O-3* is infiltrating duct carcinoma 8500/3 (C50). Code the primary site to head of pancreas, NOT to breast as suggested by the *ICD-O-3*.

***Note*:** *Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.*

Examples:

a. The biopsy is positive for hepatoma, but there is no information available about the primary site. *Code the primary site to liver (C220) as suggested by ICD-O-3.*

b. The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The *ICD-O-3* shows duct carcinoma (8500) with a suggested site of breast (C50_). *Code the primary site as breast, NOS (C509).*

6. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

Common Metastatic Sites:

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

Bone
CNS Sites (brain, spinal cord, meninges)
Liver
Lymph Nodes (excluding lymphoma)
Pericardium (excluding mesothelioma)

Pleura (excluding mesothelioma)
Peritoneum
Retroperitoneum

When the medical record does **not** contain **enough information** to assign a primary site:

a. Consult a physician advisor to assign the site code.

b. Use the NOS category for the organ system or the Ill Defined Sites (C760–C768) if the physician advisor cannot identify a primary site.

c. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site category.

d. Refer to pages 81–84 for primary sites with very specific guidelines.

Guidelines for the four character site codes:

According to *ICD-O-3*, each of the following four-character site codes is a separate primary:

colon (C180–C189)
rectum, anus, and anal canal (C199, C209, C210–C218)
bone (C400–C419)
connective tissue (C490–C499)
peripheral nerves (C470–C479)
melanoma of the skin (C440–449)

Example:

Separate tumors in the cecum (C180) and ascending colon (C182) would be considered two separate primaries unless one is stated to be metastatic from the other.

Note: *All other four-character site codes are sub-sites of a major site and are not separate primaries.*

Example:

Upper-inner quadrant of the breast (C502) is a sub-site of the breast (C50_).

Leukemia Coding Instructions:

1. Code leukemia primaries to bone marrow (C421); blood cells originate in the bone marrow.

2. Malignant histiocytosis is coded to bone marrow (C421).

Lymphoma Coding Instructions:

Refer to *Determining Multiple Primaries for Lymphatic and Hematopoietic Diseases (Appendix E)* for further instructions.

Definitions:

Nodal lymphoma: A lymphoma originating in lymph nodes.

Extranodal lymphoma: Lymphoma originating in tissue or organ other than lymph nodes. Lymphatic system organs may be extranodal, for example, spleen is a lymphatic system organ and is also extranodal.

Extralymphatic: Originating in tissue or an organ that is not a part of the lymphatic system, for example, lymphoma of the stomach or colon. The terms extranodal and extralymphatic may be used interchangeably when coding primary site.

Lymphatic system: An umbrella term that includes all lymphoid tissues: lymph nodes, spleen, thymus, tonsils, Waldeyer's ring, and Peyer's patches of the small intestine.

1. When a single lymph node chain is involved, code that chain as the primary site.

2. When multiple lymph node chains are involved at the time of diagnosis, do not simply code the lymph node chain that was biopsied.

    a. If it is possible to determine where the disease originated, code the primary site to that lymph node chain.

    b. If multiple lymph node chains are involved and all involved chains are located in the same ICD-O-3 primary site code, code the primary site to lymph nodes of the specified nodal region (C77_).

    c. If multiple lymph node chains are involved and the involved chains are in different lymph node regions, code C778 (lymph nodes of multiple regions).

3. When the lymphoma is **extranodal** and is:

    a. Confined to the organ of origin, code the organ of origin.

Example:

Pathology from a stomach resection shows lymphoma. No other pathologic or clinical disease is identified. *Code the primary site as stomach, NOS (C16.9), use the surgery codes for stomach (C16.9) and use the Lymphoma CS schema.*

b. Present in an **extranodal organ/site and** in that organ/site's **regional lymph nodes** code the extranodal organ/site as the primary site.

Lymphomas that are primary in an extranodal organ/site may metastasize to that organ/site's regional lymph nodes. In rare cases a lymphoma may spread from the lymph node to an extranodal site or extralymphatic organ by direct extension.

Example:
Lymphoma is present in the lung and hilar lymph nodes. *Code the primary site to lung (C34.9), use the surgery codes for lung (C34.9) and use the Lymphoma CS schema.*

c. Present in **extranodal organ(s)/site and non-regional lymph nodes**, consult the physician to determine the primary site. If a site cannot be determined, code primary site to lymph node, NOS (C779). This situation will be very rare.

Note: 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 and use the surgery codes for that site.*** *The code for the primary site, in some cases, may not be the biopsy site.* ***Always use the Lymphoma CS schema even if the lymphoma did not originate in the lymph nodes.*** *If a specific lymph node is the primary site, code accordingly.*

4. If the primary site is unknown or not given:

a. Code retroperitoneal lymph nodes if described as retroperitoneal mass
b. Code inguinal lymph nodes if described as inguinal mass
c. If the primary site is unknown code lymph nodes, NOS (C779)

EXCEPTION: *Code unknown primary site (C809) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma. This situation will be very rare.*

Esophagus Coding Instructions:

There are two systems that divide the esophagus into sub-sites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the sub-sites as the cervical esophagus, the thoracic esophagus and the abdominal esophagus. The sub-sites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the *SEER Self Instructional Manual for Tumor Registrars, Book 4* for illustrated descriptions of each system.

Kaposi Sarcoma Coding Instructions:

Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site.

AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of **mucosal surfaces, visceral surfaces of organs, and skin**. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code Kaposi Sarcoma to the **site in which it arises**.
2. If the Kaposi Sarcoma is present in the **skin and another site** simultaneously, code to the specified skin site, (C44_).
3. If the **primary site is unknown** or cannot be determined, code **skin, NOS (C449).**

Sarcoma Coding Instructions:

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is C499 rather than C809. Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example:
The pathology identifies a leiomyosarcoma of the uterus. Code the site to uterus, NOS (C559).

Additional Guidelines for Coding Primary Site:

A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C501), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.

Melanoma, NOS is coded to skin, NOS (449).

Mycosis Fungoides is coded to skin (C44_) unless a specific site is stated to be the primary.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

GRADE OF TUMOR (NAACCR Item #440) (FORDS pg. 96–97; SEER pgs. 91–97)

Definition
Describes how much or how little the tumor cells resemble normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade IV) is the least like normal tissue. This data item is useful for determining prognosis.

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

1. Code grade/differentiation according to the rules in the *ICD-O-3*, (pages 30–31, 67).

2. For sites other than breast, prostate and kidney (see below), code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; 3) nuclear grade.

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, dedifferentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
4	Grade IV	Undifferentiated; anaplastic, 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 sometimes essential parts of morphologic terms for neoplasms in ICD-O-3 (as well as the phenotype [t-cell and b-cell for lymphomas and leukemias). These terms must be reported with the appropriate grade code.*

Examples:

8020/34 Carcinoma, undifferentiated
8021/34 Carcinoma, anaplastic
8331/31 Follicular adenocarcinoma, well differentiated
8332/31 Follicular carcinoma, well differentiated
8332/32 Follicular adenocarcinoma, moderately differentiated
8332/32 Follicular carcinoma, moderately differentiated
8585/31 Thymic carcinoma, well differentiated
8631/33 Sertoli-Leydig cell tumor, poorly differentiated
8634/33 Sertoli-Leydig cell tumor with heterologous elements, poorly differentiated
8805/34 Sarcoma, undifferentiated
8851/31 Liposarcoma, NOS, well differentiated
9062/34 Seminoma, anaplastic
9082/34 Malignant teratoma, undifferentiated
9082/34 Malignant teratoma, anaplastic

9083/32	Malignant teratoma, intermediate type
9187/31	Intraosseous osteosarcoma, well differentiated
9362/32	Pineal parenchymal tumor, intermediate differentiation
9382/34	Oligoastrocytoma, anaplastic
9390/34	Choroid plexus papilloma, anaplastic (synonym of malignant)
9392/34	Ependymoma, anaplastic
9401/34	Astrocytoma, anaplastic
9451/34	Oligodendroglioma, anaplastic
9505/34	Ganglioglioma, anaplastic
9511/31	Retinoblastoma, differentiated type
9512/34	Retinoblastoma, undifferentiated
9530/34	Meningioma, anaplastic
9591/33	Diffuse lymphocytic lymphoma, poorly differentiated (obs)
9591/34	Non-Burkitt lymphoma, anaplastic (***note:*** *phenotype (B-cell) takes precedence over differentiation)*
9591/36	Malignant B-cell lymphoma
9670/36	Malignant lymphoma, small B lymphocytic
9670/31	Diffuse lymphocytic lymphoma, well differentiated
9679/36	Mediastinal large B-cell lymphoma
9680/36	Large B-cell lymphoma, anaplastic (***note:*** *phenotype (B-cell) takes precedence over differentiation)*
9687/34	Burkitt type lymphoma, undifferentiated (obs)
9689/36	Splenic marginal zone B-cell lymphoma
9680/36	Large B-cell lymphoma
9699/36	Marginal zone B-cell lymphoma, NOS
9702/35	Mature T-cell lymphomas, NOS
9714/37	Large cell lymphoma, T cell and null cell type, anaplastic (***note:*** *a combination of phenotypes is coded to higher codes and takes precedence over differentiation)*
9823/36	Chronic lymphocytic leukemia, B-cell type
9827/35	Adult T-cell leukemia/lymphoma
9714/37	Large cell lymphoma, T cell and null cell type
9836/36	Precursor B-cell lymphoblastic leukemia

Coding Instructions

1. The site-specific schemas in *Appendix A* provide specific coding guidelines for grade for the breast, prostate, kidney, bladder, lymphoma, leukemia, brain, and sarcoma as a reminder when coding those specific primaries.

2. Code the grade from the final diagnosis in the pathology report. If there is more than one path report and the grades in the final diagnoses differ, code the highest grade for the primary site from any pathology report.

Note*: 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.*

3. If grade is not stated in the final pathology diagnosis, use the information in the microscopic section, addendum, or comment to code grade.

4. If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.

Example:

Pathology report reads: Grade II adenocarcinoma with a focus of undifferentiated adenocarcinoma. Code the tumor grade as grade 4.

5. Code the grade from the **primary tumor** only, **never from a metastatic site or a recurrence.**

6. Code the grade for all **unknown primaries** to 9 (unknown grade) unless grade is explicit by histology, for example, anaplastic carcinoma (grade = 4).

7. Code the grade of the invasive component when the tumor has **both in situ** and **invasive** portions. If the **invasive** component **grade** is **unknown**, code the grade as 9 (unknown).

8. Code the information from the **consult** if the specimen is sent to a specialty pathology department for a consult.

9. If there are **multiple pathology consults**, ask the pathologist or physician advisor to determine which information should be used.

10. Do **not code** the grade assigned to **dysplasia**; for example high grade dysplasia (adenocarcinoma in situ) would be coded to 9 (unknown grade).

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

Coding Grade for Cases without Pathology or Cytology Confirmation:

Code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report). Use the MRI or PET grade only when there is no tissue diagnosis.

In situ Tumors:

In situ tumors are not usually graded. Code the grade if it is specified for an in situ lesion unless there is an invasive component. Do not code the in situ grade if the tumor has both in situ and invasive components.

Terminology Conversion Table:

DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Differentiated, NOS	I	1
Well differentiated	I	1
Fairly well differentiated	II	2
Intermediate differentiation	II	2
Low grade	I–II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Moderately well differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I–II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II–III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
Dedifferentiated	III	3
High grade	III–IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

Two-Grade System:

Some cancers are graded using a two-grade system, for example, colon cancer. If the grade is listed as 1/2 or as low grade, assign code 2. If the grade is listed as 2/2 or as high grade, assign code 4.

Two-Grade Conversion Table:

DIFFERENTIATION/ DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Low grade	1/2, I/II	2
High grade	2/2, II/II	4

Three-Grade System:

There are several sites for which a three-grade system is used, such as peritoneum, endometrium, fallopian tube, prostate, bladder and soft tissue sarcoma. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into 3 rather than 4 categories (see *Three-Grade Conversion Table* below). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes:

Three-Grade Conversion Table:

DIFFERENTIATION / DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Low grade	1/3, I/III	2
Intermediate grade	2/3, II/III	3
High grade	3/3, III/III	4

Do not the Three-Grade Conversion Table for breast primaries.

Breast Coding Instructions:

Code grade in the following priority order:

1. Bloom-Richardson scores 3–9 converted to grade (see following table)
2. Bloom Richardson grade (low, intermediate, high)
3. Nuclear grade only
4. Terminology: Differentiation (well differentiated, moderately differentiated, etc)
5. Histologic grade: Grade 1/I/i, grade 2/II/ii, grade 3/III/iii, grade 4/IV/iv

Breast Grading Conversion Table:

BR SCORES	BR GRADE	NUCLEAR GRADE	TERMINOLOGY	HISTOLOGIC GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
3, 4, 5	Low	1/3	Well differentiated	I/III; 1/3	1
6, 7	Intermediate	2/3	Moderately differentiated	II/III; 2/3	2
8, 9	High	2/2; 3/3	Poorly differentiated	III/III; 3/3	3

Bloom-Richardson (BR):

1. **BR** may **also** be **called**: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade.
2. BR may be expressed in **scores** (range 3–9).
3. The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells).
4. Use the Breast Grading Conversion Table to convert the score, grade or term into the ICD-O-3 morphology 6th Digit code.
5. BR may be expressed as a **grade** (low, intermediate, high).
6. BR grade is derived from the BR score. Note that the conversion of low, intermediate, and high for breast is different from the conversion used for all other tumors.

Kidney Coding Instructions:

Code grade in the following priority order:

1. Fuhrman grade
2. Nuclear grade
3. Terminology (well diff, mod diff)
4. Histologic grade (grade 1, grade 2)

These prioritization rules do not apply to Wilms tumor (8960). Use the general rules for coding grade for Wilms tumor.

Prostate Coding Instructions:

Code grade in the following priority order:

1. Gleason grade (Use the table to convert Gleason grade information into the appropriate code)
2. Terminology: Differentiation (well differentiated, moderately differentiated, etc.)
3. Histologic grade: Grade 1/I/i, grade 2/II/ii, grade 3/III/iii, grade 4/IV/iv
4. Nuclear grade only

Gleason Pattern

Prostate cancers are commonly graded using the Gleason score or pattern. Gleason grading is based on five well-defined histologic patterns. The pathologist will evaluate the tissue to determine the primary (majority) and secondary (background) patterns for the tumor. The pattern is written with the majority pattern appearing first and the secondary pattern as the last number.

Example:

A Gleason pattern of 2 + 4 means that the primary pattern is 2 and the secondary pattern is 4.

Gleason Score

The patterns are added together to create a score.

Notes:

a. *If the pattern is 2 + 4, the pattern score is 6 (the sum of 2 and 4).*

b. *If the pathology report contains only **one number**, and that number is **less than or equal to 5,** it is a pattern.*

c. *If the pathology report contains only **one number**, and that number is **greater than 5**, it is a score.*

d. *If the pathology report specifies a specific **number out of a total of 10**, the first number given is the score.*

Examples:

a. The pathology report says "Gleason's 3/10." The Gleason score would be 3.

*Note: If there are **two numbers other than 10**, assume they refer to two patterns. The first number is the primary pattern and the second is the secondary pattern.*

b. The pathology report says "Gleason's 3 + 5." The Gleason's score is 8, the sum of 3 and 5.

Use the table below to convert Gleason's pattern or score into the ICD-O-3 morphology 6th digit codes:

Gleason Conversion Table:

GLEASON SCORE	GLEASON PATTERN	HISTOLOGIC GRADE	TERMINOLOGY	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
2, 3, 4	1, 2	I	Well differentiated	1
5, 6	3	II	Moderately differentiated	2
7, 8, 9, 10	4, 5	III	Poorly differentiated	3

***Note:** Gleason score 7 was previously coded to moderately differentiated (2). Effective with cases diagnosed 1/1/2003, Gleason's score 7 is coded to poorly differentiated (3).*

Astrocytoma Coding Instructions:

Grade astrocytomas according to ICD-O-3 rules.

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

1. Do not use the **WHO grade** to code this field.

2. Do not automatically code **glioblastoma multiforme** as grade IV. If no grade is given, code unknown, 9.

3. If **no grade** is given, code unknown, 9.

Lymphoma and Leukemia Coding Instructions:

1. Do not use the terms "high grade," "low grade," and "intermediate grade" to code differentiation. These terms refer to Working Formulation categories, not grade.

2. The designation of T-cell, B-cell, null cell, or NK cell phenotype has **precedence** over any statement of differentiation.

   a. Code ANY statement of **T-cell, B-cell, null cell,** or **NK cell.**

   b. Use any source in the patient record to code information on cell type whether or not marker studies are documented. Do not code the phenotype from the ICD-O-3 numeric list headings.

Lymphoma and Leukemia Grade:

T-CELL (CODE 5)	B-CELL (CODE 6)	NULL-CELL (CODE 7)	NATURAL KILLER CELL (CODE 8)	UNKNOWN CELL TYPE (CODE 9)
Cortical T	B-cell phenotype	Null-Cell	N/K cell	Combined B and T cell
Mature T	B-precursor	Non-T-non-B	NK/T cell	
Pre-T	Pre-B	Common cell		
Pro-T	Pre-pre-B			
T-cell phenotype	Pro-B			
T-precursor				

Example:

The history portion of the medical record documents that the patient has a T-cell lymphoma. There are no marker studies on the chart. *Code the grade as T-cell.*

Sarcoma Coding Instructions:

If sarcomas are graded low, intermediate or high grade by the pathologist use the three-grade system table.

LATERALITY (NAACCR Item #410) (FORDS pg. 92; SEER pgs. 78–80)

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

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

Coding Instructions

1. Starting with cases diagnosed January 1, 2004 laterality is coded for specified invasive, benign, and borderline primary intracranial and CNS tumors. See *Paired Organ Sites Table* beginning on page 94.

2. Non-paired sites are coded to 0.

3. Unknown (C809) and Ill-defined (C760–C768) sites are coded to 0.

4. Assign code 9 when there is a midline tumor or when the disease originated in a paired site, but the laterality is unknown.

Examples:

a. Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer. Assign code 9.

b. Patient has an excision of a melanoma located just above the umbilicus. Assign code 9 for a midline tumor.

5. **Do not** code metastatic sites as bilateral involvement.

Example:

Patient is diagnosed with adenocarcinoma of the left lung and the physician states patient has metastasis to the right lung. Assign laterality code 2, left origin of primary.

6. For primaries of in situ behavior, if laterality 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.

7. Assign code 3 if laterality is unknown but the tumor is confined to a single side of a paired organ.

Example:

Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code

laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

***NOTE:** Code laterality to 9 if stage is no longer localized.*

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

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.

- Code laterality using codes 1–4 or 9 for all of the sites listed in the following table:

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690
Connective, subcutaneous and other soft tissues of lower limb & hip	C492
Connective, subcutaneous and other soft tissue of upper limb & shoulder	C491
Cranial nerve, NOS	C725
Epididymis	C630
Fallopian tube	C570

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Frontal lobe	C711
Frontal sinus	C312
Kidney, NOS	C649
Long bones of upper limb, scapula and associated joints	C400
Long bones of lower limb and associated joints	C402
Lung	C341–C349
Main bronchus [excluding carina]	C340
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [midline code 9]	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of trunk [midline code 9]	C445
Spermatic cord	C631

PAIRED ORGAN SITES - ALPHABETICAL ORDER	
PRIMARY SITE	**ICD-O-3 CODES**
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091
Ureter	C669

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3	**PRIMARY SITE**
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity [excluding nasal cartilage and nasal septum code 0]
C301	Middle ear [tympanic cavity]
C310	Maxillary sinus [antrum]
C312	Frontal sinus
C340	Main bronchus [excluding carina]
C341–C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib and clavicle [excluding sternum code 0]
C414	Pelvic bones [excluding sacrum, coccyx, and symphysis pubis code 0]
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face [midline code 9]
C445	Skin of trunk [midline code 9]

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3	**PRIMARY SITE**
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500–C509	Breast
C569	Ovary
C570	Fallopian tube
C620–C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690–C699	Eye and adnexa
C700	Cerebral meninges , NOS
C710	Cerebrum [effective with cases diagnosed 01/01/2004]
C711	Frontal lobe [effective with cases diagnosed 01/01/2004]
C712	Temporal lobe [effective with cases diagnosed 01/01/2004]
C713	Parietal lobe [effective with cases diagnosed 01/01/2004]
C714	Occipital lobe [effective with cases diagnosed 01/01/2004]
C722	Olfactory nerve [effective with cases diagnosed 01/01/2004]
C723	Optic nerve [effective with cases diagnosed 01/01/2004]
C724	Acoustic nerve [effective with cases diagnosed 01/01/2004]
C725	Cranial nerve, NOS [effective with cases diagnosed 01/01/2004]
C740–C749	Adrenal gland [cortex, medulla]
C754	Carotid body

Notes:

a. *A laterality code of 1–4 or 9* ***must*** *be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.*

b. *All primary brain and CNS tumors diagnosed prior to 2004 are coded laterality 0, not a paired site.*

c. *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:

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:

Patient admitted for surgical resection of tumor in right colon. Code to 0, 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 ITEMS #2580, 2590)

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

Documenting Instructions

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

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

Examples:

a. **Morphology:** Moderately well differentiated mucin-producing adenocarcinoma
Primary Site: Colon, ascending

b. **Morphology:** Grade 3, infiltrating ductal and lobular carcinoma
Primary Site: Right breast, upper outer quadrant

c. **Morphology:** Anaplastic astrocytoma
Primary Site: Brain, temporal-parietal lobe

d. **Morphology:** Intermediate grade large cell carcinoma
Primary Site: Left lung lower lobe

DIAGNOSTIC CONFIRMATION (NAACCR ITEM #490) (FORDS pg. 99; SEER pgs. 81–82)

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. It is the best method of confirmation at any time during the entire course of the disease. This field is used to calculate the percentage of microscopically confirmed cancers.

Coding Instructions

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.

2. Change to a lower code, if ANY TIME during the course of disease the patient has a diagnostic confirmation that has a higher priority.

3. If diagnosed elsewhere, copies of the previous pathology or radiology reports included in the medical record may be used to code this field.

4. 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. If diagnosed prior to admission to the reporting facility, review the history section of the record to identify information regarding previous diagnostic tests and treatments.

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

6. Assign **code 1** when the microscopic diagnosis is based on:

   a. Tissue specimens from biopsy, frozen section, surgery, autopsy or D&C

   b. Bone marrow specimens (aspiration and biopsy)

   c. For all hematopoietic disease (leukemia, multiple myeloma, etc.) positive findings including peripheral blood smears, CBCs and WBCs.

7. Assign **code 2** when the microscopic diagnosis is based on:

   a. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid,

peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears.

b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid

8. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

9. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies, which are clinically diagnostic for that specific cancer.

Examples:

a. The presence of alpha-fetoprotein for liver cancer.

b. An abnormal electrophoretic spike for multiple myeloma or Waldenstrom macroglobulinemia.

c. If the workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA, code the diagnostic confirmation to 5.

10. Assign **code 6** when the diagnosis is based only on:

    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.

    b. Gross autopsy findings (no tissue or cytologic confirmation).

11. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes. The diagnostic confirmation is coded 8 when the only confirmation of disease is a physician's clinical diagnosis.

12. Assign **code 9** when it is unknown if the diagnosis was confirmed microscopically. Death certificate only cases will be assigned **code 9**.

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.***

Examples:

a. 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.

b. 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.

c. 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.

d. 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.

e. Fine needle aspiration (FNA) is positive for malignant cells. 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. Code the diagnostic confirmation field to 1 (positive histology) for all hematopoietic diseases diagnosed by either peripheral blood or bone marrow biopsy.*

CODE	DESCRIPTION	DEFINITION
	MICROSCOPICALLY CONFIRMED	
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.

NOT MICROSCOPICALLY CONFIRMED		
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*. For cases diagnosed on or after 1/1/2007, refer to Appendix O.
CONFIRMATION UNKNOWN		
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.

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

Notes:

a. This data field is coded only for cases diagnosed prior to 2004.

b. Code tumor size using CS tumor size (NAACCR Item #2800) for cases diagnosed on or after January 1, 2004. For specific CS tumor size coding instructions, refer to *Appendix A*.

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

Explanation
Tumor size aids in determining prognosis and making 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 lower priority.

1. 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:

3.2 **cm** tumor is recorded as 032 mm.

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

Example:

A 0.5 **mm** tumor is recorded as 001.

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

Examples:

a. A 4.8 **mm** tumor is recorded as 005.

b. A 4.2 **mm** tumor is recorded as 004.

4. 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:

a. The colonoscopy 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 carcinoma. Record the tumor size as 035.

b. 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.

5. 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:

a. The pathology report states an excisional biopsy was performed that contained a 2 cm in situ tumor with clear margins. Record the tumor size as 020.

b. 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.

6. Code tumor size to 000 if no mass or tumor is found.

Example:

A tumor of a stated primary is not found, but the tumor has metastasized, **code to 000**.

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

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

a. Esophagus (C150–C155, C158, C159): Entire circumference

b. Stomach (C160–C166, C168, C169): Diffuse, widespread, ¾ or more, linitis plastica

c. Colorectal (C180–C209 with M-8220/8221 and /2 or /3): Familial/multiple polyposis

d. Lung and main stem bronchus (C340–C343, C348, C349): Diffuse, entire lobe or lung

e. Breast (C500–C506, C508, C509): Inflammatory carcinoma, diffuse, widespread, ¾ or more of breast

Code to 999 for the following scenarios:

a. If only one size is given for a tumor with mixed *in situ* **and** invasive components.

b. If the size of the tumor is unknown or 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 (C420, C421, C423, C424 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 (C760–C768, C809)

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

Do not add 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. If patient received neoadjuvant radiation therapy or systemic therapy (chemotherapy, hormone therapy, or immunotherapy), code the tumor size prior to the start of any treatment.

Guidelines for Coding Site-Specific Tumor Sizes:

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.

Tumor Size:

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		VEGETABLE	
Bantam	040	Doughnut	090	Bean	010
Goose	070	Lentil	009	Bean, lima	020
Hen	030	Millet	009	Pea	009
Pigeon	030			Pea, split	009
Robin	020				

FRUIT		NUTS		MISCELLANEOUS ITEMS	
Apple	070	Almond	030	Ball, golf	040
Apricot	040	Chestnut	040	Ball, ping-pong	030
Cherry	020	Chestnut, horse	040	Ball, tennis	060
Date	040	Hazel	020	Baseball	070
Fig (dried)	040	Hickory	030	Fist	090
Grape	020	Peanut	010	Marble	010
Grapefruit	100	Pecan	030	Match head	009
Kumquat	050	Walnut	030	Microscope focus	001
Lemon	080	**MONEY**		Pencil eraser	009
Olive	020	Dime	010		
Orange	090	Dollar, half	030		
Peach	060	Dollar, silver	040		
Pear	090	Nickel	020		
Plum	030	Quarter	020		
Tangerine	060	Penny	010		

REGIONAL LYMPH NODES POSITIVE (NAACCR ITEM #820) (FORDS pg. 103; SEER pg. 146, CS MANUAL pg. I-45)

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.
Note: *This field has been moved to CS in Appendix A for consistency with national standards that became effective in 2004.*

Coding Instructions

1. 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. Involved distant lymph nodes should be coded in *CS Mets at DX (NAACCR Item #2850).*

2. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

3. This field is to be recorded regardless of whether the patient received preoperative treatment.

4. This field is based on pathologic information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed but no lymph nodes were found, code as 98.

5. 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).

6. Code as 95 when the lymph nodes are not removed, but cytology or histology from a regional lymph node aspiration is positive for malignant cells.

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

   a. Placenta (C589)

   b. Brain and cerebral meninges (C700, C710–C719

   c. Other parts of Central Nervous System (C701, C709, C720–C725, C728–C729)

   d. Hodgkin and non-Hodgkin lymphoma (M-959–972) **EXCEPT** 9700/3 and 9701/3

   e. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)

   f. Unknown and ill-defined primary sites (C809,C420–C424, C760–C765, C767–C768, C770–C775, C778–C779; Note: For C42_ and C77_ other than hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin lymphomas as listed above, and Kaposi sarcoma 9140/3

EXCEPTION: *The field Lymph Nodes Positive is always coded 99 for* ***both*** *nodal and extranodal lymphomas.*

NOTE: *Table may also be found in the Standard Table Quick Reference.*

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 or core biopsy of lymph node(s) was performed.
97	Positive regional nodes are documented, but the number is unspecified.

CODE	DESCRIPTION
98	No regional nodes were examined
99	Unknown whether regional lymph nodes are positive; not applicable; not stated in patient record

REGIONAL LYMPH NODES EXAMINED (NAACCR Item #830) (FORDS pg. 102; SEER pgs. 148–149, CS MANUAL pg. I-46)

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.

Note: *In SCL, this field has been moved to CS in Appendix A for consistency with national standards that became effective in 2004.*

Coding Instructions

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

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

3. This field is to be recorded regardless of whether the patient had preoperative treatment.

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

4. 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).

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

a. Placenta (589)

b. Brain and cerebral meninges (C70.0, C71.0–C71.9)

c. Other parts of central nervous system (C701, C709, C720–C725, C728–C729)

d. Hodgkin and non-Hodgkin lymphoma (M-959–972) EXCEPT 9700/3 and 9701/3

e. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823,

9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)

f. Unknown and ill-defined primary sites (C809,C420–C424, C760–C765, C767–C768, C770–C775, C778–C779; ***Note:*** *For C42_ and C77_ other than hematopoietic, reticuloendothelial, Immunoproliferative, or myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin lymphomas as listed above, and Kaposi sarcoma 9140/3.*

EXCEPTION*: The field Lymph Nodes Positive is always coded 99 for* ***both*** *nodal and extranodal lymphomas.*

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

Note*: Table may also be found on Standard Table Quick Reference.*

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 or core biopsy 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 or negative; not stated in patient record.

Examples:

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

Code:
Regional nodes positive: 09
Regional nodes examined: 22

Document in text:
9/22 hilar nodes

b. 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.

Code:
Regional nodes positive: 98
Regional nodes examined: 00

Document in text:
No nodes removed or examined

c. Pathology report states: Moderately differentiated mucinous adenocarcinoma of the cecum. Two of 10 right colic lymph nodes are positive for metastasis.

Code:
Regional nodes positive: 02
Regional nodes examined: 10

Document in text:
2/10 right colic nodes

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

Code:
Regional nodes positive: 00
Regional nodes examined: 98.

Document in text:
Regional nodes neg., # examined unknown

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

Code:
Regional nodes positive: 98
Regional nodes examined: 00

Document in text:
Per CT probable metastatic iliac nodes

f. Patient was diagnosed with multiple myeloma.

Code:
Regional nodes positive: 99
Regional nodes examined: 99

TREATMENT INFORMATION

FIRST COURSE OF TREATMENT

Cancer-directed therapy or definitive treatment is limited to procedures that normally affect, control, change, remove, or destroy cancer tissue of the primary or metastatic site, and administered to the patient before disease progression or recurrence. The **first course** of treatment can be defined as cancer-directed treatment that begins **within four months** of initial diagnosis. This could be over a year for some cancer sites (see examples below). Any and all types of first course treatment administered at the reporting facility or elsewhere must be coded in the appropriate treatment field and documented in the *Treatment Documentation* field. First course ends when the treatment plan is completed, or there is disease progression, recurrence or treatment failure.

Examples:

a. The planned first course treatment for a breast primary could include surgery, chemotherapy, radiation and hormone therapy.

b. First course for childhood leukemia typically spans two years from induction, and consolidation, to maintenance.

c. In the **absence of documentation of** a treatment plan, disease progression or recurrence, or treatment failure in the medical record, first course ends one year after the date of diagnosis. Any treatment given after one year is second course of therapy in the absence of a documented treatment plan.

d. "Watchful waiting" is considered first course treatment and the appropriate treatment data fields should be coded to 00, not done. Document "Watchful waiting."

e. When the patient refuses treatment the appropriate treatment fields should be coded to patient refused. If the patient changes his/her mind and decides to have the prescribed treatment:

   i. Code and document the treatment as first course of therapy if it has been less than one year since the cancer was diagnosed and there has been no documented disease progression.

   ii. If time lapsed has been more than a year or there is documented disease progression, all therapy thereafter should be considered second course of therapy.

f. Code and document all treatment that was started.

   Example:

   The patient completed only the first dose of a planned 30 day chemotherapy regimen.

Code chemotherapy as administered.

g. If a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary, code the treatment for both primaries.

Example:

The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional nodes for the bladder. Code and document the radiation as treatment for both the bladder and the prostate cases.

h. If a patient has multiple primaries and the treatment given affects only one of the primaries, code the treatment(s) only on the site that is affected.

Example:

The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and the regional nodes. Do not code the radiation to the tonsil and regional nodes for the colon primary. Do not code the hemicolectomy for the tonsil.

i. If a patient is diagnosed with an unknown primary, code and document the treatment given as first course even if the correct primary is identified later.

Example:

A patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code and document the chemotherapy as first course treatment. The hormone therapy is considered second course and not coded.

ALL MALIGNANCIES EXCEPT LEUKEMIA

The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.

***Note**: Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.*

***EXCEPTION:** The first course of treatment for leukemia includes all therapies planned and delivered by the physician(s) during the first diagnosis of leukemia. Record all treatment that*

is remission-inducing or remission-maintaining. Treatment can include multiple methods and may last a year or more. Treatment administered after relapse of the first remission is not considered first course.

Leukemia:

Leukemia is grouped or typed by how quickly the disease develops and gets worse. Chronic leukemia gets worse slowly. Acute leukemia gets worse quickly. Leukemias are also grouped by the type of white blood cells affected. There are lymphoid and myeloid leukemias.

Treatment for leukemias is divided into three phases:

a. Remission induction (chemotherapy and/or biological response modifiers)

b. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)

c. Remission continuation or maintenance (chemotherapy or bone marrow transplants)

Definitions:

Induction: Initial intensive course of chemotherapy.

Consolidation: Repetitive cycles of chemotherapy given immediately after remission.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

Remission: the bone marrow is normocellular with less than 5% blasts, there are no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values are within normal limits: white blood count and differential, hematocrit/hemoglobin level, and platelet count.

Coding Guidelines for First Course Therapy for Leukemia and Hematopoietic Diseases:

1. If a patient has a partial or complete remission during the first course therapy:

    a. Code and document all therapy that is "remission-inducing" as first course.

    b. Code and document all therapy that is "consolidation" as first course.

    c. Code and document all therapy that is "remission-maintaining" as first course.

***Note:** Do not code the treatment given after the patient relapses (is no longer in remission).*

2. Some patients do not have a remission. A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

a. Code and document the treatment given in an attempt to induce a remission.

b. Do not record treatment administered after the change in treatment plan.

Other Reportable Hematopoietic Diseases:

1. Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue" for newly reportable hematopoietic diseases only. Follow the guidelines in the *Abstracting and Coding Guide for the Hematopoietic Disease, NIH, NCI, SEER Program* to identify treatments.

   a. Phlebotomy also may be referred to as blood removal, blood letting or venisection.

   b. Transfusions may include whole blood, RBC's, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.

   c. Aspirin (also known as ASA, acetylsalicylic acid, or by brand name) is used as a treatment for essential thrombocythemia. Aspirin should only be coded if given to thin the blood for symptomatic control of thrombocythemia. Below are guidelines to help make that determination:

      i. Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.

      ii. The dosage for pain control is approximately 325–1000 mg every 3–4 hours.

      iii. Cardiovascular protection starts at about 160 mg/day.

***Note:** These are not considered treatment for hematopoietic diseases which have always been reportable.*

DATE OF INITIAL TREATMENT (NAACCR ITEM #1260) (FORDS pg. 129; SEER pg. 174)

Definition
The date the first course of treatment (surgery, radiation, systemic or other) started at any facility. **Reporting facilities will no longer be responsible for coding this data field.** This data field will be populated by the TCR from the dates coded in the data fields listed in coding instruction 1 (Page 115).

Explanation
This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date can not be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Coding Instructions:

1. Record the earliest of the following dates:
   a. RX DATE-SURGERY NAACCR Data Item #1200
   b. RX DATE-RADIATION NAACCR Data Item #1210
   c. RX DATE-SYSTEMIC NAACCR Data Item # 3230
   d. RX DATE-OTHER NAACCR Data Item #1250

2. Record 00000000 in cases in which treatment was not administered to the patient.

*Note: ACoS facilities using third-party software may be required to enter the date the decision was made not to administer treatment as the **DATE OF INITIAL TREATMENT**.*

3. The date of first course of treatment is the month, day, and year MMDDYYYY of the beginning of treatment (surgery, radiation, systemic, or other treatment) at any facility.

4. Record 00000000 for diagnosed at autopsy.

5. Record 99999999 when it is unknown whether any treatment was administered to the patient, the date is unknown, or the case was diagnosed by death certificate only.

RX. SUMMARY - SCOPE OF REG LN SURGERY (NAACCR ITEM #1292) (FORDS pg. 138; SEER pg. 179)

Definition
Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure.

Explanation
This information is used to compare and evaluate the extent of surgical treatment.

Coding Instructions

1. The scope of regional lymph node surgery is collected for surgical procedure(s) of lymph nodes even if surgery of the primary site is not performed. Codes 0–7 are hierarchical. Code the procedure that is numerically higher.

2. Information to be coded for this data field is **cumulative**. It is appropriate to add the number of all the lymph nodes removed during each surgical procedure performed as part of the first course treatment.

3. Document and code the **SCOPE OF REG LN SURGERY** using the chart on the following page.

4. If the operative report lists a lymph node dissection but no nodes were found by the pathologist, code the **SCOPE OF REG LN SURGERY** to 0 (No lymph nodes removed).

5. If the patient has two primaries with common regional lymph nodes, code and document the removal of regional nodes for both primaries.

6. Code to 9 for:
   a. Primaries of the meninges, brain, spinal cord, cranial nerves, and other central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9).

   b. Lymphomas (M-9590–9596, 9650–9719, 9727–9729) with a lymph node primary site (C77.0–C77.9).

   c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease
      i. Primary sites: C42.0, C42.1, C42.3, or C42.4 (all histologies)
      ii. Histologies: 9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989 (all sites)
      iii. Unknown or ill defined sites (C80.9,C76.0–C76.8) (all histologies)

7. Do not code **distant** lymph nodes removed during surgery to the primary site in this field. Record distant lymph node removal in Surgical Procedure Other Site.

8. Refer to the *Collaborative Staging System Manual* or *Appendix A* of the *2006 CRH* for site-specific identification of regional lymph nodes to assist you in coding this field.

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODE	DESCRIPTION	DEFINITION
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.

5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5. Or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Examples:

a. Patient has a radical neck dissection and the number of lymph nodes removed is not stated. The appropriate code would be 3.

b. The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.

c. Transverse colon: Grade IV adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. The appropriate code would be 5, 4 or more regional lymph nodes removed.

RX DATE– SURGERY (NAACCR ITEM #1200) (FORDS pg. 131)

Description

The earliest date of the first cancer-directed surgical procedure performed at any facility.

Explanation

Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

Coding Instructions

1. Record the month, day, century and year (MMDDCCYY) of the first cancer-directed surgery.
2. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

3. If the exact date of cancer-directed surgery is not available, record an approximate date.

4. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

Examples:

a. A patient was found to have a large polyp during a colonoscopy on September 8, 2005. A polypectomy confirmed adenocarcinoma of the descending colon. On September 23, 2005 the patient underwent a left hemicolectomy. The date of surgery would be recorded as 09082005.

b. An incisional biopsy is performed on March 3, 2005 followed by a resection on March 17, 2005. Record the date of the resection (03172005) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed treatment procedure.

c. February 1, 2005 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2005, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 02152005.

SURGICAL PROCEDURE OF PRIMARY SITE (NAACCR ITEM #1290) (FORDS pg. 135; SEER pgs.177–178)

Description
Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment.

Note: *This field is for surgery of primary site only.*

Explanation
Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions

1. Code the type of surgery the patient received as part of the **first course of treatment** at any facility.

2. Site-specific surgery codes are in *Appendix A*. Refer to the site-specific schema of the primary site for a complete listing of surgery codes.

CODE	TYPE	DEFINITION
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix A* for correct site-specific procedure code.
20–80*	Site-specific codes; resection	Refer to *Appendix A* for correct site-specific procedure code.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific surgery codes; special	Special codes. Refer to *Appendix A* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

3. Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. Codes 00–80 are listed in **hierarchical** but **not necessarily numerical order**. When more than one surgical procedure is performed, code the procedure listed furthest down the list within the codes 10–80.

   Example:

   Patient has excisional breast biopsy that is positive for carcinoma. The patient chooses to have a modified radical mastectomy. The pathologic examination of the mastectomy specimen shows no residual tumor. Code the modified radical mastectomy.

4. Code 98 takes precedence over code 00.

5. Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field.

   Note: *Code an* ***excisional biopsy****, even when documented as* ***incisional,*** *when:*

   a. All disease is removed (margins free) OR

   b. All gross disease is removed and there is only ***microscopic residual at the margin.***

   Note: *Do not code an excisional biopsy when there is macroscopic residual disease.*

6. Surgery to remove regional or distant tissue or organs is coded in this field only if the tissue or organs are removed in continuity with the primary site (en bloc), except where noted in *Appendix*

7. *A.* Specimens from an en bloc resection may be submitted to pathology separately.

   SEER Note: *In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.*

   Example:

   Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

8. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is **not** considered cancer-directed surgery. Brushings, washings, and aspiration of cells are not surgical procedures.

9. If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results.

   Example:

   Patient has a partial mastectomy with positive margins. Two weeks later the patient has a modified radical mastectomy. Code the modified radical mastectomy.

10. For bladder, when only random biopsy procedures are performed code surgery of primary site field to 00. [None; no surgery of primary site.]

11. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

12. Code 98 for the following sites unless the case is death certificate only:

    a. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease
       i. Primary sites: C42.0, C42.1, C42.3, or C42.4 (all histologies)
       ii. Histologies: 9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989 (all sites)
       iii. Unknown or ill defined sites (C80.9,C76.0–C76.8) (all histologies)

Reason for No Surgery of Primary Site (NAACCR ITEM #1340) (FORDS pg. 147)

Note: Reason for no surgery of primary site *field is collected for cases diagnosed* ***January 1, 2006 or later.***

Description
Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site.

Explanation
This data item provides information related to quality of care.

Coding Instructions

1. If *surgical procedure of primary site* (NAACCR Item #1290) is coded, then record the reason based on documentation in the patient record.

2. Code 1 if the treatment plan offered multiple options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.

3. Code 1 if *surgical procedure of primary site* (NAACCR Item #1290) is coded 98.

4. Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

5. Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Note: *This table is also available in the Quick Reference, Standard Table Section.*

CODE	DEFINITION
0	Surgery of the primary site was performed
1	Surgery of the primary site was not performed because it was not part of the planned first course.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.
7	Surgery of the primary site was not performed: it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's record
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

Examples:

a. A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. The reason for no primary site surgery is 2, not recommended due to comorbid conditions.

b. A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. The reason for no surgery of primary site is 8, recommended but unknown if performed.

RX SUMM– SURG OTH REG/DIST RX CODE (NAACCR ITEM #1294) (FORDS pg. 142; SEER pg. 181)

Description
Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Explanation
Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

The codes are **hierarchical**. Record the **highest numbered code** that describes the surgical resection of *distant lymph nodes or regional/distant tissues or organs* the patient received as part of the **first course of treatment** at any facility.

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site that is not included in combination surgery codes of the primary site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).

CODE	DESCRIPTION	DEFINITION
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

Examples:

a. The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.

b. Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.

c. Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2.

d. Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.

e. Removal of a solitary brain metastasis with a lung primary is coded to 4.

f. Excision of a solitary liver metastasis and hilar lymph node with a recto-sigmoid primary is coded to 5.

g. For unknown primaries treated with a lymph node dissection, code Surgical Procedure of Other Site to 1 [Non-primary surgical procedure to other site(s) or node(s), NOS; unknown if regional or distant].

DATE RADIATION STARTED (NAACCR ITEM #1210) (FORDS pg. 148)

Description
The date the radiation therapy began at any facility as part of the first course of treatment.

Explanation
Identifies the date radiation therapy was initially started.

Coding Instructions

1. Record the month, day, century, and year MMDDCCYY of the first cancer-directed radiation therapy.

2. If the exact date of cancer-directed radiation therapy is not available, record an approximate date.

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If two or more types of radiation therapy are delivered i.e., beam and isotopes; beam and implants, enter the date for the **first** type of radiation therapy.

5. Record all zeros 00000000 when no radiation therapy is delivered or the cancer was diagnosed at autopsy.

6. Record all nines 99999999 when it is unknown whether any radiation therapy was delivered or the case was identified by death certificate only.

7. Record the year if month and day are not known 99992006.

RADIATION– REGIONAL TREATMENT MODALITY (NAACCR ITEM #1570) (FORDS pgs. 155–157)

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during first course of treatment.

Explanation
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Coding Instructions

1. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost, and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

2. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality (the greatest dose of radiation). It may be necessary to consult with the radiation oncologist to determine the dominant modality.

3. Note that in some circumstances the boost treatment may precede the regional treatment of the patient. Record only the dominant modality.

4. For purposes of this data item, photons and x-rays are equivalent.

Note: This Table is also available in the Quick Reference, Standard Tables Section.

CODE	TYPE	DEFINITION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with a beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.

CODE	TYPE	DEFINITION
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above.
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes.
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80.
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

*For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation therapy administered to the patient as part or all the first course of treatment. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS* rules and **should not** be used to record regional radiation therapy for cases diagnosed on or later than January 1, 2003.

RX Summary-Surgery/Radiation Sequence (NAACCR ITEM #1380) (FORDS pgs. 164–165; SEER pg.188)

Note: RX Summary-Surgery/Radiation Sequence** will be collected with cases **diagnosed on or after January 1, 2006.

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Explanation

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. For the purpose of coding radiation sequence with surgery, "Surgery" is defined as a surgical procedure to the primary site (codes 10–90) or scope of regional lymph node surgery (codes 1–7) or surgical procedure of other site (codes 1–5). If all of these procedures are coded 0, then this item should be coded 0.

2. If a patient received both radiation therapy and any one or a combination of the following surgical procedures: Surgical procedure of primary site, regional lymph node surgery, or surgical procedure/other site, then code this item 2–9 as appropriate.

3. Assign code 0 when
   a. The patient did not have either surgery or radiation
   b. The patient had surgery but not radiation
   c. The patient had radiation but not surgery

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODE	LABEL	DEFINITION
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery. Diagnosed at autopsy.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

CODE	LABEL	DEFINITION
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph nodes(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site: scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) were performed. Death certificate only.

Examples:

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Use code 0.

b. Patient received radiation therapy prior to resection of a lung lesion. Use code 2.

c. A patient received excisional biopsy of a right breast mass followed by radiation therapy to breast. Use code 3.

d. Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. Use code 4.

e. A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. Use code 5.

f. Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy. Use code 6.

g. A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. Use code 9.

h. Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. Use code 3.

DATE SYSTEMIC THERAPY STARTED (NAACCR ITEM #3230) (FORDS pg. 169; SEER pg. 174, *Date Therapy Initiated)*

Definition
Identifies the date systemic therapy began at any facility. Systemic therapy includes the following treatment modalities:

a. Chemotherapy agents
b. Hormonal agents
c. Immunotherapy
d. Bone marrow transplants
e. Stem cell harvests
f. Surgical and/or radiation endocrine therapy

Explanation
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment to recurrence.

Coding Instructions

1. Record the month, day, century, and year (MMDDCCYY) the **first** systemic therapy was delivered.

2. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

3. If the exact date of the first systemic therapy is not available, record an approximate date.

4. Record all zeros (00000000) when no systemic therapy was delivered or the cancer was diagnosed at autopsy.

Example:

The patient had biopsy ONLY, bypass or "watchful waiting."

5. Record all nines (99999999) when it is unknown if any systemic therapy was delivered or the case was identified by death certificate only.

6. Record all eights (88888888) if systemic therapy was planned, but not started or unknown if administered.

7. Record the year if month and day are unknown (99992006).

CHEMOTHERAPY (NAACCR ITEM #1390) (FORDS pg. 171; SEER pg. 189)

Definition
Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Explanation
This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions
1. Refer to SEER *RX Version 1.1.1, Drug Database located at: www.seer.cancer.gov/tools/seerrx/ for direction on coding systemic therapy appropriately. This website has replaced *Self Instructional Manual for Tumor Registrars (SEER) Book 8 - Antineoplastic Drugs, Third Edition.*

2. Code the type of chemotherapy the patient received as part of the **first course of treatment** at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents.

***Note:** This table is also available in the Quick Reference, Standard Tables Section.*

CODE	DEFINITION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.

86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

3. Code 00 if the chemotherapy was not delivered and it is known that it is not usually delivered for this type and stage of cancer, or if the physician discussed multiple options including chemotherapy and the patient selected treatment that did not include chemotherapy.

4. Code to 82, 85, 86, or 87 if it is known that chemotherapy is usually administered for this type and stage of cancer, but it was not delivered.

5. Code to 87 if the patient refused the recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

6. If the physician changes one of the agents in a combination regimen and the replacement agent is in a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen is the beginning of subsequent treatment and is **not** recorded as first course treatment.

Examples:

a. A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agents delivered is not documented in the medical record. Record **code 01** and document the information in the treatment documentation data field.

b. A patient with Stage III colon cancer is treated with a combination of fluorouraciland levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. Record **code 02** and document the information in the treatment documentation data field.

c. A patient with early stage breast cancer receives chemotherapy. The medical record indicated a **combination regimen** containing doxorubicin is to be administered. Record **code 03** and document the information in the treatment documentation data field.

d. Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered and the reason is not documented. Record **code 86** and document that the medical record states chemo

not delivered but no reason given.

e. A patient with kidney cancer receives Interleukin. Record **code 02** and document the information in the treatment documentation data field.

HORMONE THERAPY (HORMONE/STEROID THERAPY) (NAACCR ITEM #1400) (FORDS pg. 175–176; SEER pg. 192–193)

Description
Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: *Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.*

Explanation
This data item allows for the analysis of hormone treatment as part of the first course of therapy.

Coding Instructions

1. Code the type of hormone therapy the patient received as part of the **first course of treatment** at any facility. Hormone therapy may involve the delivery of one or a combination of agents.

2. Refer to *SEER *RX Version 1.1.1, Drug Database* located at: www.seer.cancer.gov/tools/seerrx/ for direction on coding systemic therapy appropriately. This website has replaced *Self Instructional Manual for Tumor Registrars (SEER) Book 8 - Antineoplastic Drugs, Third Edition.*

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODE	DEFINITION
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.

CODE	DEFINITION
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

3. Code prednisone as hormone therapy when it is administered in a combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

4. Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

Example:

Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.

5. Code to 00 if hormone therapy was not delivered to the patient and it is known that it is not usually administered for this type and stage of cancer, or if the physician discussed multiple options and the patient selected treatment that did not include hormone therapy.

6. Code to 01 for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.

7. Code to 82, 85, 86, or 87 if it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not delivered.

8. Code to 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

Examples:

a. A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-estrogen agent) as part of the first course of therapy. Code to 01 and document the information in the Treatment Documentation data field.

b. A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. Code to 87 and document the information in the Treatment Documentation data field.

c. Patient with endometrial cancer is treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. Code to 01 and document the information in the Treatment Documentation data field.

d. A patient with follicular or papillary cancers of the thyroid is treated with thyroid hormone to suppress serum thyroid stimulating hormone (TSH). **Code to 01** and document the information in the Treatment Documentation data field.

9. Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.

10. If prednisone or other hormone is delivered for other reasons, **do not** code as hormone therapy.

Examples:

a. A patient is given Prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

b. A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. Code to 00.

EXCEPTION: Decadron is coded as hormonal treatment **only for leukemias, lymphomas, and multiple myelomas.** It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

Note: *Surgical removal of organs for hormone manipulation (such as Orchiectomy for prostate cancer) is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.*

IMMUNOTHERAPY (NAACCR ITEM #1410) (FORDS pg. 179; SEER pg. 194–196)

Description
Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Explanation
This data item allows for the analysis of the administration of Immunotherapy agents as part of the first course of therapy.

Immunotherapy is designed to:

1. Make **cancer cells** more **recognizable** and therefore more **susceptible** to destruction by the immune system.

2. **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.

3. **Alter growth patterns** of cancer cells to promote behavior like that of healthy cells.

4. **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.

5. **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.

6. **Prevent** cancer cells from **spreading** to other parts of the body.

Types of Immunotherapy:

Cancer vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field Other Therapy. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma, ovary, and cervix.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2): are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies are produced in a laboratory, and are used in a variety of ways in systemic therapy. Some artificial antibodies are injected into the patient to seek out and disrupt cancer cell activities and to enhance the immune response against cancer. For example, trastuzumab (Herceptin) may be used for certain breast cancers. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy.

Coding Instructions

1. Refer to *SEER *RX Version 1.1.1, Drug Database* located at: www.seer.cancer.gov/tools/seerrx/ for direction on coding systemic therapy appropriately. This website has replaced *Self Instructional Manual for Tumor Registrars (SEER) Book 8 - Antineoplastic Drugs, Third Edition.*

2. Code the type of Immunotherapy the patient received as part of the **first course of treatment** at any facility.

Note: This table is also available in the Quick Reference, Standard Tables Section.

CODE	DESCRIPTION
00	None, Immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether Immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

3. Code to 00 if Immunotherapy was not delivered to the patient and it is known that it is not usually delivered for this type and stage of cancer, or if the treatment plan offered multiple options and the patient selected treatment that did not include immunotherapy.

4. Code to 82, 85, 86, or 87 if it is known that immunotherapy is usually delivered for this type and stage of cancer, but it was not.

5. Code to 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

RX SUMM– TRANSPLANT/ENDOCRINE (NAACCR ITEM #3250) (FORDS pgs. 182–183; SEER pgs 197–199)

Description
Systemic therapeutic procedures that include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy received at any facility as first course of treatment.

Explanation
This treatment involves the alteration of the immune system or change the patient's response to tumor cells, but does not involve the delivery of antineoplastic agents.

Coding Instructions

1. Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the **first course of treatment** at any facility.

Definitions:

Bone marrow transplant (BMT): Procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cell allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow or stem cells from a donor.

BMT Autologous: Uses the patient's own bone marrow and/or stem cells. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

Note: *Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.*

Conditioning: High dose of chemotherapy with or without radiation administered prior to transplants such as BMT and stem cell to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplant (PBSCT): Rescue that replaces stem cells after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODE	DEFINITION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy.

CODE	DEFINITION
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest and infusion.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age.
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

2. Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (bone marrow donated from an identical twin), the item is coded as allogeneic.

3. Stem cell harvests involve the collection of immature blood cells from the patient and the re-introduction of a transfusion of the harvested cells following chemotherapy or radiation therapy.

4. Endocrine irradiation and/or endocrine surgery are procedures that suppress the naturally occurring hormonal activity of the patient and therefore alter or affect the long-term control of the cancer's growth. These procedures must be **bilateral** to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland

qualify as endocrine surgery or endocrine radiation.

Examples:

a. Bilateral orchiectomy for prostate cancer.

b. Bilateral oophorectomy for breast cancer.

c. Bilateral adrenalectomy for microadenoma.

d. Bilateral hypophysectomy for pituitary cancer.

e. Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer.

5. Code to 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.

6. Code 86 if the treatment plan offered multiple options which included a transplant, and the patient selected treatment that did include a transplant procedure.

7. Code to 82, 85, 86, or 87 if it is known that a transplant or endocrine procedure is usually delivered for this type and stage of cancer, but it was not.

8. Code to 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

SYSTEMIC /SURGERY SEQUENCE (NAACCR ITEM #1639) (FORDS pg. 183A)

Note: Systemic/Surgery Sequence** will be collected for patients diagnosed **on or after January 1, 2006

Definition
Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Explanation
The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. Code the administration of systemic therapy in sequence with the first surgery performed,

described in the item *date of first surgical procedure* (NAACCR Item #1200).

2. If none of the following surgical procedures were performed: *Surgical procedure of primary site* (NAACCR Item #1290), *scope of regional lymph node surgery* (NAACCR Item #1292), *surgical procedure/other site* (NAACCR Item #1294), then this item should be coded 0.

3. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical procedure of primary site* (NAACCR Item #1290), *scope of regional lymph node surgery* (NAACCR Item #1292), *surgical procedure/other site* (NAACCR Item #1294), then code this item 2–9, as appropriate.

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODES	LABEL	DEFINITION
0	No systemic therapy and/or surgical procedures	No systemic therapy was given: and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.

CODES	LABEL	DEFINITION
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed. Death certificate only.

Examples:

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Record **code 0** and document the information in the treatment documentation data field.

b. Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. Record **code 2** and document the information in the treatment documentation data field.

c. Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. Record **code 3** and document the information in the treatment documentation data field.

d. Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. Record **code 4** and document the information in the treatment documentation data field.

e. Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. Record **code 5** and document the information in the treatment documentation data field.

f. Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5FU. Record **code 6** and document the information in the treatment documentation data field.

g. An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy. Record **code 9** and document the information in the treatment documentation data field.

DATE OTHER TREATMENT STARTED (NAACCR ITEM #1250) (FORDS pg. 184)

Definition
The date other treatment began as first course of therapy.

Explanation
Records the date **other** treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment.

Coding Instructions

1. Record the month, day, century and year MMDDCCYY the other treatment was delivered.
2. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
3. Record all zeros 00000000 when no other treatment was delivered or the cancer was diagnosed at autopsy.
4. Record all nines 99999999 when it is unknown if other treatment was delivered or it is a death certificate only case.
5. If month and day are unknown record the year 99992006.

OTHER TREATMENT (NAACCR ITEM #1420) (FORDS pg. 186; SEER pg. 200–201)

Definition
"Other treatment" is designed to modify or control the cancer cells, but is not defined as surgery, radiation, or systemic therapy fields.

Explanation
Used to evaluate treatment practices and for special studies.

Coding Instructions

1. Code the type of "other treatment" the patient received as part of the **first course of treatment** at any facility.
2. This data field is used to record other treatment (transfusions, phlebotomy, and supportive care) for **Hematopoietic diseases that became reportable in 2001.** For additional direction on other treatment for these diseases refer to *Clarifications for Abstracting and Coding Hematopoietic Diseases* (May 22, 2001), available from www.seer.cancer.gov./
3. **Do not** code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Note: *"Other treatment" for Newly Reportable Hematopoietic Diseases (NRHD) can be supportive care, observation, or any treatment that does* ***not*** *meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Such*

treatments should be coded to 1 (see examples below). This information is ***not*** *considered cancer directed therapy for diseases which have always been reportable (such as leukemias and lymphomas) and should not be coded.*

Note: *This table is also available in the Quick Reference, Standard Tables Section.*

CODES	TYPE	DEFINITION
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *see **Examples**
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

Examples:

a. A patient with polycythemia vera is treated with phlebotomies. Use code 1. Phlebotomy may be called blood removal, blood letting, or venisection.

b. A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.

Note: *Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.*

Note: *Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record aspirin therapy ONLY to thin the blood for*

symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protections, or thinning of platelets in the blood, use the following general guideline:

a. *Pain control is approximately 325–1000 mg every 3–4 hours.*

b. *Cardiovascular protection starts at about 160 mg/day.*

c. *Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.*

TREATMENT DOCUMENTATION (NAACCR ITEMS #2610, #2620, #2630, #2640, #2650, #2660, #2670)

Description
Text field used for documenting tumor-specific treatment information.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document any and all types of **first course** definitive treatment administered, regardless of where the treatment was received, in date order in this data field.

2. Document if the medical record indicates no treatment was given (0's entered for Type of Treatment) or if there is no information in the medical record that definitive treatment was given (9's entered for Type of Treatment).

3. If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, "radiation, recommended; unknown if given," (99 entered for Type of Treatment).

4. See more specific examples of required supporting documentation on page 156.

DATE OF LAST CONTACT OR DEATH (NAACCR ITEM #1750) (FORDS pg. 199; SEER pg. 204)

Definition

The date of last contact with the patient or the date the patient expired.

Explanation

This information is used for follow-up and patient outcome studies.

Coding Instructions

1. Record the month, day, century and year (MMDDCCYY) the patient was last seen at your facility, date of last contact, or date of death.

2. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

3. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the **TEXT REMARKS-OTHER PERTINENT INFORMATION** text area, document that the patient is deceased and the date of death is not available.

VITAL STATUS (NAACCR ITEM #1760) (FORDS pg. 200; SEER pg. 206)

Definition

Records the vital status of the patient as of the *date of last contact or death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Explanation

This information is used for outcome studies.

Coding Instructions

1. Code the patient's vital status as of the date recorded in the *date of last contact or death* field. Use the most current and accurate information available.

2. If a patient has multiple primaries **simultaneously**, all records should have the same vital status.

CODE	LABEL
0	Dead
1	Alive

DATE ABSTRACTED (NAACCR ITEM #2090)

Definition:
Record the date the registrar determined the tumor report was complete (all first course therapy administered or treatment plan coded and documented) and the case has passed edits.

Explanation
This field is used for TCR data quality and timeliness evaluation.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

2. Record the day, month, century and year (MMDDCCYY) the form was completed.

ABSTRACTOR INITIALS (NAACCR ITEM #570) (FORDS pg. 207)

Description
Records the initials or assigned code of the individual abstracting the case.

Explanation
This data item is used for providing feedback for quality control.

Coding Instruction

1. Record the initials of the person abstracting the case.

NAACCR RECORD VERSION (NAACCR ITEM #50)

Description
Records the NAACCR record version used to create the case. This data field is normally populated by the software being used to report cancer cases from your facility (SCL, cancer registry software).

Explanation
Used to indicate record version and record layout/format.

- 2004-2006 cases in NAACCR version 11.0
- 2007 and forward cases in NAACCR version 11.1 required

DOCUMENTATION OF CANCER DIAGNOSIS EXTENT OF DISEASE AND TREATMENT

(NAACCR Item #'s 2600, 2610, 2620, 2630, 2640, 2650, 2660, 2670)

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in date order.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies. Text is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources. The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

Always use text to document certain basic information:

1. The date of the examination or procedure (06152006); **keep dates in chronological order.**
2. The name of the examination or procedure (excisional biopsy).
3. The results of the examination or procedure—any pertinent **positive or negative** information (negative margins, chest X-ray negative, liver biopsy positive for metastasis.
4. The diagnostic impression, final diagnosis, or final conclusion if one is given (Ductal carcinoma of left breast).
5. The planned treatment, whether or not it is known if treatment was given (chemotherapy planned after left modified mastectomy).
6. The date and type of treatment given, even if it was done at another institution (06152006 5FU administered at ABC hospital).
7. Specific subsite of primary site (upper outer left breast).
8. Specific number, chain of lymph nodes examined and results (0/15 left axillary lymph nodes).
9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (metastasis to 15 supraclavicular lymph nodes, brain metastasis).

Documentation is used to verify all coded fields regarding the patient, disease, extent of disease and spread of disease. Text should be documented in the appropriate text fields (staging text should be in staging text field).

Extent of Disease:

In situ means "in place." It describes a neoplasm that is non-invasive and confined to a small, circumscribed area within the tissue of origin. There is no penetration of the basement membrane of the tissue and no stromal invasion. Clinical evidence alone cannot identify the behavior as in situ. In situ behavior must be based on pathological examination and documentation. (Figure 1)

Note: *Organs and tissues that have no epithelial layer cannot be staged as in situ, since they do not have a basement membrane. There cannot be a diagnosis of "sarcoma in situ." The following histologies are not accepted with in situ behavior:*

8000–8005
8020, 8021
8331, 8332
8800–9055
9062
9082, 9083

9110–9493
9501–9989

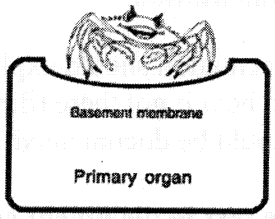


Figure 1

In situ and/or carcinoma In situ Synonymous with In situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
	AIN III (C211)
	Bowen Disease
	Clark's Level I for melanoma (limited to epithelium)
	Comedocarcinoma, noninfiltrating (C50._)
	Confined to epithelium
	Hutchinson's melanotic freckle, NOS (C44._)
	Intracystic, non-infiltrating
	Intraductal
	Intraepidermal, NOS
	Intraepithelial, NOS
	Intrasquamous
	Involvement up to, but not including, the basement membrane
	Lentigo maligna (C44._)
	Lobular neoplasia (C50._)
	Lobular, noninfiltrating (C50._)
	Noninfiltrating
	Noninvasive

	No stromal invasion
	Papillary, noninfiltrating or intraductal
	Precancerous melanosis (C44._)
	Preinvasive
	Queyrat erythroplasia (C60_)
	Stage 0 (except Paget's disease (8540/3) of breast and colon and rectal tumors confined to the lamina propria)
	VAIN III (C529)
	VIN III (C51_)

Localized: describes a neoplasm that has not spread beyond the organ of origin or basement membrane. There must be no extension beyond the boundary of the organ and no evidence of metastasis elsewhere in the body. The tumor may be widely invasive, or even show metastasis within the organ of origin and still be considered localized. (Figure 2)

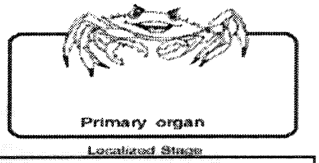
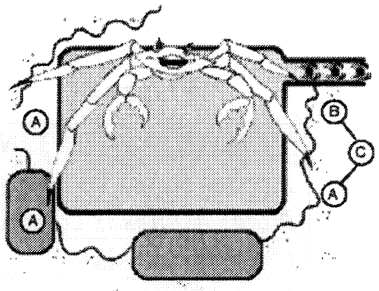


Figure 2

Regional: describes a neoplasm that has spread to adjacent organs or tissues or to lymph nodes surrounding the primary organ. Two factors are important in assigning cases to this stage: first, it must be established that the cancer is more than localized; and second, remote or distant spread must be reasonably ruled out on the basis of all evidence available in the medical record. (Figure 3)



Regional Stages
A. Direct extension
B. To regional lymph nodes
C. Combination of A and B

Figure 3

Distant: describes tumor cells that have broken away from the primary tumor to remote areas of the body and have started growing at the new area. Distant stage is also called remote, diffuse, disseminated, metastatic or secondary disease. For more details, refer to page 8 of the *SSM2K Manual*. (Figure 4, through the blood system; Figure 5, distant lymph nodes; Figure 6, implantation metastases).

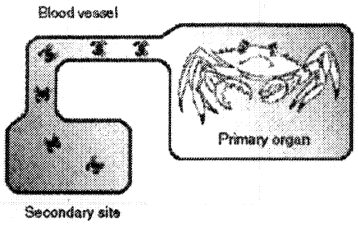
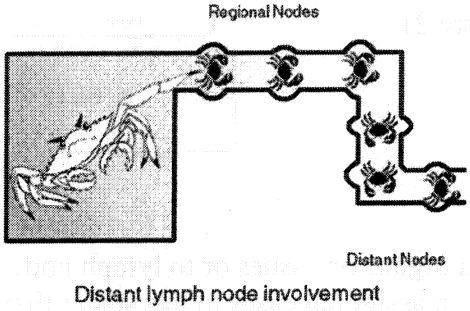
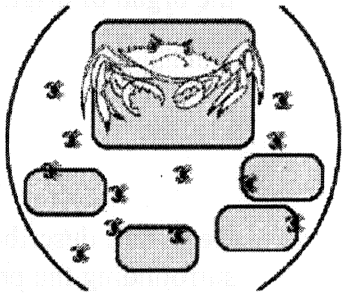


Figure 4



Distant lymph node involvement

Figure 5



Implantation metastases

Figure 6

TERMS INDICATING DISTANT OR DISCONTINUOUS METASTASIS
Ascites (must be documented as malignant) ***Note:*** *Ascites is considered local for fallopian tubes, C57.0 (pg C521 SEER 2004).*
Carcinomatosis
Implantation
Implants ***Note:*** *Implants is considered regional for ovary, C56.9 (pg C514, SEER 2004).*
Pleural effusion (must be documented as malignant)
Seeding
Studding

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C80.9) or a benign CNS tumor, then the Summary Stage must be unknown.

Call your Health Service Region for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Documentation is necessary to verify all coded fields regarding types and timing of treatment. Be sure to document in the Treatment Documentation field if the medical record indicates no treatment was planned or given, or if there is no information in the medical record that definitive treatment was given. If it cannot be determined whether therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, "radiation recommended, unknown if given."

Types of reports to review:

Medical imaging can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.

Physical exam or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Collaborative Staging and must be noted in the Summary Stage Documentation field to support coding.

Pathology reports provide key information including **cell type, grade, size** and **location** of tumor, **number of lesions or foci, depth of invasion, spread of tumor to other organs**, and **lymph node involvement**. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.

Operative reports will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. Record these findings in the Summary Stage Documentation.

Discharge summaries, clinical notes, or progress reports are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.

Specific Instruction on Involvement

Lymph Node Involvement: For solid tumors, the terms "fixed" or "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes. Any other terms, such as "palpable," "enlarged," "visibly

swelling," "shotty," or "lymphadenopathy" should be ignored; look for a statement of involvement, either clinical or pathological. A metastatic nodule in connective tissue of a lymph drainage area is considered to be evidence of lymph node metastasis.

Note: *Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, and ovary. The best description concerning regional lymph node involvement will be the surgeon's evaluation at the time of exploratory surgery or definitive surgery.*

Venous Invasion: An assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: A microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report. ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed. ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Lymphomas: *Any* mention of lymph nodes is indicative of involvement. In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral inguinal nodes, bilateral iliac nodes, etc., would be considered 2 chains.

Note: *When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.*

Consider the following terms as involvement:

Adherent
Apparent(ly)
Appears to
Comparable with
Compatible with
Consistent with
Contiguous/continuous with
Encroaching upon
Extension to, into, onto, out onto
Features of
Fixation to another structure
Induration
Infringe/infringing
Into
Intrude
Invasion to, into, onto, out onto
Matted (for lymph nodes only)
Most likely
Onto
Overstep
Presumed
Probable

Fixed
Impending perforation of
Impinging upon
Impose/imposing on
Incipient invasion
Protruding into (unless encapsulated)
Suspected
Suspicious
To, Up to

Do not consider the following terms as involvement:

Abuts
Approaching
Approximates
Attached
Entrapped
Equivocal
Extension to without invasion/involvement of
Kiss/Kissing
Matted (except for lymph nodes)
Possible
Cannot be excluded/ruled out
Efface/effacing/effacement
Encased/encasing
Encompass(ed)
Questionable
Reaching
Rule out
Suggests
Very close to
Worrisome

The pertinent information in the following examples has been documented in **bold lettering** for easier identification of required text.

DOCUMENTATION EXAMPLES

Case #1 Lung

Imaging Reports

2/18/05 VA Clinic: **CT Chest**: Findings: **Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy**.There is a **2.8 x 2.4 x 4.8cm mass in the right lower lobe.** The margins are well defined with minimal peripheral ground-glass opacity, **probably some degree of obstructive pneumonitis**. The **remainder of the lungs is clear.**

IMPRESSION
1. Lobulated soft tissue **mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.**

2/28/05 CT Brain Your Hospital: Impression: **No evident disease process.**

Pathology Reports

2/28/05 Your Hospital: Final Diagnosis: **Fine Needle Aspirate, right lower lobe lung: positive for malignant cells**

3/1/05 Your Hospital: Final Diagnosis: Superior segment **right lower lobe, resection: moderately differentiated squamous cell carcinoma**, maximum tumor diameter **5.0cm**, resection **margin free** of tumor, **peribronchial lymph node negative** for tumor, right lower **paratracheal lymph node negative for tumor**, right **pretracheal lymph node negative** for tumor.

Clinic Reports

3/15/05 SWRCC: **Oncologist recommended 4 cycles of adjuvant taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.**

Summary Stage Documentation (2600)

2/18/05 CT Chest: 4.8cm mass in RLL c/w neoplasm, supraclavicular, axillary, and mediastinal structures unremarkable, no mediastinal or hilar lymphadenopathy, probably some obstructive pneumonitis, remainder of lungs clear
2/28/05 Fine Needle Aspirate RLL lung: positive for malignant cells
2/28/05 Ct Brain: No evident dz process
3/1/05 RLL Resection: MD Squamous cell car, 5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

3/1/05 RLL lobectomy with mediastinal ln dissection
3/15/05 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

Case #2 Lung

Imaging Reports

6/25/05 River Ranch Radiology **CT Chest**: I see **no pneumothorax or pleural effusion**. There is an **11.7 x 8.5cm soft tissue mass in the right apex.** There is associated **marked mediastinal lymphadenopathy** with enlarged **nodes in** the **anterior mediastinum, enlarged nodes lying lateral to** the **main pulmonary artery,** and **enlarged nodes in** the **pretracheal and precarinal region.** There are **enlarged nodes around the right hilum.** The **left lung appears normal.**

Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are **highly suspicious for a primary carcinoma of the lung.**

7/1/05 Oncology Associates **Bone scan**: Non-specific increased uptake at L3 and L5, **no obvious metastasis.**

7/1/05 Oncology Associates **MRI brain: Diffuse cerebral atrophy**

Bronchoscopy Report

6/26/05 Bronchoscopy: The **vocal cords** were visualized and **appeared to move normally.** The bronchoscope was passed to the trachea, which was widely patent. **No endobronchial lesions were noted.** There was a small amount of bleeding from the right upper orifice. **No lesions were noted at the right lower lobe or right middle lobe**. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.

Pathology Report

6/26/05 Right upper lobe mass biopsy Final Diagnosis: **non-small cell carcinoma**

Clinical Reports

7/5/05 Oncology Clinic Consultation: This patient has at least Stage 3b disease. This **condition can best be treated with a combination of chemotherapy and radiation therapy concurrently**. We want to start treatment as soon as possible

7/15/05 Discharge Summary: The **patient has been treated with VP-16 times three days along with daily radiation therapy** for a diagnosis of non-small cell carcinoma. He was hospitalized because of shortness of breath and iron deficiency anemia. At this time his condition has stabilized.

Summary Stage Documentation (2600)
6/25/05 CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum,

enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal
6/26/05 Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions
6/26/05 RUL mass bx: Non-small cell carcinoma
7/1/05 Bone Scan: no mets
7/1/05 MRI brain: diffuse cerebral atrophy

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/05 concurrent chemo/radiation therapy recommended
7/15/05 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

Imaging Reports

1/2/05 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. **In the right breast** there is a **3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.**

Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.

1/12/05 CT Chest: COPD with mild parynchymal scarring. No evidence of cardiomegaly. There is **bone destruction of posterior ribs/spine. CT Abdomen and Pelvis no abnormal findings. Impression: Bone destruction of posterior ribs/spine, probably mets from known breast cancer.**

Pathology Reports

1/10/05 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated

Clinical Reports

1/15/05 Surgery consult: Patient noted a mass in the lower-outer quadrant of her **right breast**. There is **marked lymphadenopathy in the right axilla**. The **left breast is with-in normal limits**.
HEENT: Clear conjunctivae, pupils equal, round and reactive to light. Nasal passages clear without drainage.
Neck: Supple, full range of motion. No thyromegaly, trachea is midline.
Lungs: No wheezing or crackles. There are no bronchial breath sounds or pleural rub.
Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds.

Patient will be referred to Radiation Oncology for consideration of radiation therapy to known bony mets.

2/1/05 Oncology Note: Patient has decided to try alternative therapy and has declined radiation therapy and chemotherapy.

Summary Stage Documentation (2600)

1/2/05 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.
1/10/05 Bx rt breast LOQ Infil ductal car, PD
1/12/05 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings
1/15/05 Surg consult: marked lymphadenopathy in rt axilla

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/05 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.
2/1/05 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

Imaging Reports

6/1/05 Mammogram: In the **right breast** there is a **1.2 x 1.5cm mass in the upper-outer quadrant.** There is **no evidence of axillary lymphadenopathy**. The **left breast appears normal.**

6/14/05 Chest Xray: With-in normal limits

6/14/05 Bone Scan: Impression: **No evidence of skeletal disease. Thoracic and lumbar spine negative for metastatses.**

Pathology Reports

6/8/05 Right breast fine needle aspiration cytology: Adencarcinoma

6/15/05 Right breast modified radical mastectomy: Final Diagnosis: **Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes.**

Clinical Reports

6/1/05 History and Physical: Family physician noted **2cm mass in right breast on physical exam.** No pain or tenderness; **no nipple discharge; no skin changes**. Slight nipple retraction. Freely movable mass. **Left breast: no masses palpated. No enlarged lymph nodes.**

10/12/05 Oncology Clinic Follow-up Note: Patient started **3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/05**, recently completed and now **has begun Tamoxifen.**

Summary Stage Documentation (2600)

6/1/05 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lft breast appears normal
6/1/05 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes
6/14/05 CXR: WNL; Bone Scan: no evident mets
6/8/05 Rt Breast fine needle aspiration = adenoca
6/15/05 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/05 Rt breast modified radical mastectomy
10/12/05 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/05, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

IMAGING REPORTS:

4/20/2005 CT ABDOMEN AND PELVIS

CONCLUSION:

1. **Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded** at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted **although there are shotty lymph nodes present, there is no definite lymphadenopathy** demonstrated.

2. History of uterine cancer with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.

3. **Otherwise, unremarkable CT scan of the abdomen and pelvis** with other incidental findings as noted above.

4/25/05 WHOLE BODY PET SCAN

CONCLUSION:

1. Radionuclide uptake in the left abdomen, representing a nonspecific finding.
   No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

PATHOLOGY REPORTS:

4/15/2005 Final Diagnosis: **Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade**

5/1/2005 Final Diagnosis **right hemicolectomy**

A. **High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue**, (PT3)
B. **No evidence of lymph node metastasis among seven lymph nodes**. (PNO)
C. Distant metastasis cannot be assessed. (PMX)
D. Excision margin is negative.

OPERATIVE REPORT:

Date of Procedure: 5/1/05

PREOPERATIVE DIAGNOSIS: Right colon cancer.

POSTOPERATIVE DIAGNOSIS: Right colon cancer, with adhesive bowel disease.

PROCEDURES PERFORMED: Exploratory laparotomy, lysis of adhesions, **right hemicolectomy, Findings: On exploration of the abdomen, the liver was palpated found to be unremarkable. There were no lesions in the colon other than in the right colon.** In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum

Oncology Consult 5/15/05

HISTORY OF PRESENT ILLNESS: Patient is a 56-year old female who had a diagnosis of endometrial cancer, status post surgery followed by radiation therapy fifteen years ago. A few weeks ago the patient had a routine colonoscopic examination and the patient was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2005.

ASSESSMENT: The patient has a new diagnosis of **high-grade mucin producing signet ring cell adenocarcinoma of colon.** This is about **4 cm in size** with **pericolonic tissue invasion**. Based on these reports and findings, **the patient may benefit from adjuvant chemotherapy**.

Summary Stage Documentation (2600)

4/15/05 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.
4/20/05 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; shotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis
4/25/05 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets
5/1/05 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon
5/1/05 Right hemi-colectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/05 Right Hemi-colectomy
5/15/05 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Case #6 Melanoma

IMAGING REPORTS

5/10/05 CT Chest : Impression: **Probably malignant involvement of left axillary lymph nodes.** Several lymph nodes seen in supraclavicular region too small to characterize. **The remainder of the exam is normal.**

PATHOLOGY REPORTS

5/3/05 Final Diagnosis: **Shave biopsy skin of left forearm, Malignant melanoma**

5/11/05 Final Diagnosis: **Wide excision of skin of left forearm, Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded. Margins of resection free, but within less than 2mm.**

ONCOLOGY REPORT

6/15/05 The patient was **started on an interferon regimen today**.

Summary Stage Documentation (2600)

5/3/05 Shave bx skin of lt forearm: Malignant melanoma
5/10/05 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal
5/11/05 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, margin free but within less than 2mm

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/05 Wide excision of skin of lt forearm
6/15/05 started interferon regimen

Case #7 Melanoma

IMAGING REPORTS

11/18/05 Chest Xray: With-in normal limits

11/24/05 CT Chest, Abdomen and Pelvis: Impression: Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but would be consistent with benign parenchymal scar or granuloma. The remainder of the lungs is clear.
There is no evidence of metastatic disease in the chest, abdomen or pelvis.

PATHOLOGY REPORTS

Outside Facility:
11/12/05 Final Diagnosis: **Excision of lesion** on **right side of neck**, 1.5 x .0.8 x 0.5 cm specimens contains a pigmented, **0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.**

Your Facility:
11/25/05 Final Diagnosis: **Wide re-excision skin of right neck**, Inflammation and organizing granulation tissue, **negative for any residual melanoma, margins of resection negative.**

Summary Stage Documentation (2600)
11/18/05 CXR: Within normal limits 11/24/05 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)
11/12/05 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin 11/25/05 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

Imaging Reports

2/2/05 CT Chest Impression: Extensive **right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.**

2/2/05 CT Abdomen Impression: **Splenomegaly, otherwise with-in normal limits.**

2/4/05 PET scan: Intense **focus of tracer uptake seen in peri-portal region consistent with lymphoma.**

Pathology Reports

2/3/05 Biopsy of **left axillary lymph nodes, Follicular Lymphoma, Gr 1**

H&P

2/2/05 Patient presents with **bilateral cervical and axillary lymphadenopathy**, night sweats, and subjective fevers.

Oncology Consult

2/12/05 The patient was started on **combination chemotherapy including Rituxan on February 5** and has done well with the exception of nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation (2600)
2/2/05 H&P Pt has bilateral cervical and axillary lymphadenopathy 2/2/05 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum 2/2/05 CT Abdomen: Splenomegaly, otherwise with-in normal limits 2/3/05 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1 2/4/05 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)
2/5/05 Combination chemotherapy including Rituxan, other types of chemo not mentioned

Case #9 Prostate

Imaging Reports

4/14/05 CT Abdomen/Pelvis Impression: 1. Tiny cyst in the liver.
2. **No lymphadenopathy in abdomen or pelvis.**

4/14/05 Bone scan Impression: Evidence of previous fracture in right 12th rib, otherwise **negative bone scan.**

Pathology Reports

4/1/05 Final Diagnosis: Prostate **core needle biopsy, adenocarcinoma present in 8 of 12 cores, Gleason Score 3+3=6**

Clinical Reports

3/27/05 Surgical consult: Patient is seen in consultation because of elevated PSA. **DRE shows slightly enlarged prostate with no nodularity or enduration**. The **abdomen and pelvis** are examined and **show no palpable abnormalities.**

7/1/05 Patient was counseled regarding various treatment options including radiation therapy, surgery and hormonal treatment. He decided to proceed with **external beam radiation therapy** and this was **completed on 6/15/05.**

Summary Stage Documentation (2600)

3/27/05 PE: DRE shows slightly enlarged prostate with no nodularity or enduration, abdomen and pelvis with no palpable abnormalities
4/1/05 Prostate core needle biopsy: adenocarcinoma in 8/12 cores, Gleason Score 3+3=6
4/14/05 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis
4/14/05 Bone scan: negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/05, start date not given; estimate start date 5/2005

Explanation of Changes to Appendix A

Previously Appendix A of the Texas Cancer Registry Reporting Handbook contained only site-specific surgery codes. In an effort to stream-line the abstracting process, Collaborative Staging Coding Guidelines and Instructions from Part I and Part II of the Collaborative Staging Manual, Version 01.03.00 (September 2006) as well as the site specific surgery codes are included. Additional coding guidelines and helpful information from the SEER Program Coding and Staging Manual 2004 Revision 1 have been included for some sites. A Standard table has been developed in an attempt to facilitate coding for CS Tumor Size and CS Mets at DX where instructed; Regional LN Positive and Examined; and standard treatment tables. (*)

The surgery codes are from The American College of Surgeons Commission on Cancer's *Facility Oncology Registry Data System,* American College of Surgeons, Chicago, IL, (Revised 2007) (FORDS), Appendix B: Site-specific Surgery Codes (Revised 2004). The codes are identical to the FORDS manual, however, formatting and annotations may vary. Further explanations for some surgery codes come from the SEER Program Coding and Staging Manual 2004 Revision 1.

*The TCR only collects Site-Specific Factor 1 for pleura primaries and Site-Specific Factor 3 for prostate primaries. All other Site-Specific Factors have been excluded from Appendix C.

Table of Contents

INTRODUCTION TO COLLABORATIVE STAGING SYSTEM

The majority of instructions 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. The TCR collects the CS data items required to derive the SEER Summary Stage (SSS).

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:
A patient has been treated surgically and is asymptomatic. During the follow-up exam after 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 information specific to that cancer site/histology is extracted from the medical record and coded in the CS System fields using the appropriate schema. 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; however, the TCR requires only the CS data fields needed to derive the SSS. The 2006 TCR CRH provides codes and instructions for the correct coding of these data items in Appendix A. To derive the desired SSS, the computer algorithms must be used.

From time to time, it is necessary to revise CS coding tables by reassigning concepts from one code to another to maintain the underlying structure and rules for code assignment. Codes affected by these changes will be marked as OBSOLETE. **OBSOLETE** codes may **NOT** be used. *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.

Examples:

a. Patient admitted March 17, 2006 for surgery for recurrent colon cancer. Chart states original colon cancer was diagnosed on September 7, 2003. Document date of diagnosis is 09/07/2003. This case would be staged according to 2003 guidelines (SSSM2K).

b. Patient admitted April 4, 2006 and diagnosed with ductal carcinoma of the right breast. This case would be staged according to 2006 guidelines (CS).

c. Cases with date of diagnosis is not available, should be staged according to the guideline in place for the Date of First Contact. All facility resources must be reviewed in order to obtain the data of diagnosis.

NOTE: *TCR will collect 8 of the 15 fields collected for the collaborative staging system in order to derive the SSS.*

CS DATA FIELDS COLLECTED BY THE TCR

1. CS TUMOR SIZE (#2800)
2. CS EXTENSION (#2810)
3. CS LYMPH NODES (#2830)
4. REGIONAL LYMPH NODES POSITIVE (#820)
5. REGIONAL LYPH NODES EXAMINED (#830)
6. CS METS AT DX (#2850)
7. CS SITE-SPECIFIC FACTOR 1, FOR PLEURA PRIMARIES ONLY (#2880)
8. CS SITE SPECIFIC FACTOR 3, FOR PROSTATE PRIMARIES ONLY (#2900)

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

All staging information available in the medical record should be documented. Include dates in chronological order. 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 all-inclusive.

Pathology Report: Details on morphology, topography, tumor size, and stage of disease.

Operative 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 TCR does not collect all the data items necessary to derive the TNM stage.

2. ***Timing of Data Collection:*** The data collected in the CS System are limited to:
   a. Information gathered through completion of surgery(ies) in first course of treatment, OR
   b. 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); whichever 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 sets. 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. These two data fields are part of the CS System and have been incorporated into this section and added to the standard table of the 2006 TCR CRH.*

9. **The TCR will only collect the SSF's for sites required to derive the SS.** SSF 1 will be collected only for pleura primaries and SSF 3 for prostate primaries. Information on pleural effusions collected in SSF1 in the pleura schema and pathological information from prostatectomy and other surgical procedures is collected in SSF 3 in the prostate schema.

10. 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.

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

12. The TNM characteristics do not always translate one to one for SS and does not meet the documentation requirement. TNM values should not be documented as staging information. The TCR **does not** accept TNM staging to code or evaluate the accuracy of CS coding. The only exception to this will be when the T, N, or M values are under the description column in the schema such as code 18 under the CS Lymph Nodes on page A-95.

USE OF AUTOPSY INFORMATION IN COLLABORATIVE STAGING

Information obtained from autopsy may be used in the CS System. 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*	** Interpreted as involvement of other organ(s) or tissue(s)
overstep	
presumed	
probable	
protruding into unless encapsulated)	
suspected	
suspicious	
to*	
up to	

CODING "NONE" VS. "UNKNOWN" IN THE COLLABORATIVE STAGING SYSTEM

As noted in the introduction, cancers of certain primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods. These "inaccessible" primary sites include but are not limited to, bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary.

A coding rule in the Collaborative Staging System applies to these inaccessible sites, primarily for localized or early (localized) stage cancers. The Collaborative Staging System allows data collectors to record 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 usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician).

This new coding guideline also permits data collectors to record distant metastasis clinically as none rather than unknown (again, based on clinical evaluation) when the clinician proceeds with usual treatment of the primary site, since this action presumes that there are no distant metastasis that would otherwise change the treatment approach.

The code(s) for unknown information can and should be used in situations where there is reasonable doubt that the tumor is no longer localized. For example, when there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (regional direct extension) and regional lymph node involvement is not mentioned, it would be correct to code lymph node involvement and metastases at diagnosis as unknown in the absence of specific information regarding nodes or distant metastases.

For accessible primary sites that can be observed, palpated or examined without instruments, such as breast, oral cavity, skin, salivary gland, thyroid, and other organs, there should be some description of the regional lymph node status. A statement such as "remainder of examination negative" is sufficient to code regional lymph nodes as clinically negative.

CHOOSING THE CORRECT CODING SCHEMA FOR A CASE

Most of the Collaborative Staging System schemas apply to cases defined by their primary site codes in ICD-O-3. A few of the schemas apply to cases defined by their histologic type codes in ICD-O-3, and these schemas take precedence over the schema for the site.

Histology specific coding schemas:

Melanoma (ICD-O-3 morphology codes 8720-8790)
Kaposi sarcoma (9140)
Retinoblastoma (9510-9514)
Lymphoma (9590-9699 and 9702-9729)
Mycosis Fungoides (9700-9701)
Hematopoietic and reticuloendothelial system (9731-9989)

A case with one of these ICD-O-3 histologic types must be coded using the schema for the histologic type group.

Melanomas are further broken down by primary site code as follows:

Malignant melanoma of the skin, vulva, penis and scrotum (C440-C449, C510-C512, C518-C519, C600-C601, C608-C609, C632)
Malignant melanoma of conjunctiva (C690)
Malignant melanoma of iris and ciliary body (C694)
Malignant melanoma of choroid (C693)
Malignant melanoma of other eye (C691, C692, C695, C698-C699)

For cases with other histologic types, the correct schema to use is determined by the primary site code. Each schema clearly states the applicable primary site codes and histologic type codes at the beginning of the schema.

Note: *The appropriate site or histology schema to use for coding surgical treatment(s) may be different from the site or histology schema used for coding the Collaborative Staging data set.* ***For example, an extralymphatic lymphoma of the stomach treated surgically would use the lymphoma schema in this manual to code Collaborative Staging, but surgery would be coded using the stomach codes for surgery of primary site. Refer to pages 118-120 for further instructions. Lymphomas are coded to the site and staged to the disease.***

CS TUMOR SIZE (NAACCR Item # 2800) (CS MANUAL pg. I-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, record size as 001 if largest dimension or diameter of tumor is between 0.1 and 0.9 mm.*

Tumor Size General Guidelines

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

1. Code and 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 immunotherapy) or radiation therapy, document the largest size of tumor prior to treatment unless post-operative disease is more extensive.

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. Tumor size should be documented and coded as the pre-treatment size shown on CT, 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.

Example:
Patient has a 3.5 cm mass per CT in the left upper lobe. Squamous cell carcinoma is identified by fine needle aspiration. Patient receives XRT to shrink the tumor prior to surgery. Pathological size of tumor after total resection is 4 cm. The tumor size should be documented as 4 cm and coded as 040.

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 or clinical examination.

Example:
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.

   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 which the TCR does **not** currently collect.

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:

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

2. 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. For the following diagnoses and/or primary sites, 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.

CS Tumor Size

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," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm", or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
	SITE-SPECIFIC SCHEMA CODES WHERE NEEDED
999	Unknown; size not stated; not stated in patient record.

For schemas that do not use tumor size:

Code	Description
888	Not applicable

Note: *For cases diagnosed prior to 01/01/2004, use the tumor size chart on page 105.*

Examples:
a. Tumor of stated primary not found: ***Code as 000***

b. Mammogram shows 2.5 cm breast malignancy: ***Code as 025*** *(2.5 cm = 25 mm)*

c. CT of chest shows 4 cm mass in RUL: ***Code as 040*** *(4 cm = 40 mm)*

d. Thyroidectomy specimen yields 8 mm carcinoma: ***Code as 008***

e. Prostate needle biopsy shows 0.6 mm carcinoma: ***Code as 001*** *(round up sixth-tenths of mm)*

f. Tumor stated to be "less than 3 cm" with no other information available on a more specific tumor size: ***Code as 993***

DETERMINING DESCRIPTIVE TUMOR SIZE (NAACCR Item #780) (CS MANUAL pg. I-66)

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
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				

Size conversions for 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. Document the exact tumor size from the pathology report, imaging or physical exam. Specify if the patient had preoperative chemotherapy or radiation. Treatment includes surgery, chemotherapy, or radiation.*

CS EXTENSION (NAACCR Item # 2810) (CS MANUAL pg. I-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 and corpus uteri, 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. Code and document the farthest extension of the primary tumor. Do not code discontinuous metastases to the distant sites in this data field.

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. Clinically to the farthest extension identified prior to treatment if the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, and immunotherapy) or radiation therapy.

Example:
Patient has rectal mass firmly attached to pelvic wall (CS Ext code 60). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (CS ext code 40). Code CS Ext to 60, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.

   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.

Example:
Patient found to have an obstructing central lung tumor very close to the main stem bronchus (CS Ext code 20). Patient undergoes six weeks of intensive chemotherapy. At thoracotomy, tumor was observed directly extending into trachea (CS Ext code 70). The tumor was noted to be more extensive after preoperative treatment and should be coded to 70.

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 and code accordingly.

f. With the exception of corpus uteri, ovary, and prostate, extension codes represent direct extension from the site of origin to the organ/structure/tissue.

Example:
Infiltrating ductal carcinoma of the right breast with extension to the chest wall would be coded in the CS Extension 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 no 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.

CS Extension

Code	Description	TNM	SS 77	SS 2000
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. Document extent of tumor involvement or extent of disease from pathology, surgery, or imaging reports and code the appropriate CS data fields. Be sure to state if information is pre or post treatment.*

Examples:

a. Lung: Tumor in left lower lobe invades chest wall.
Document: LLL invasion into chest wall, no tumor size given.

b. 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, 1.5 cm mass.

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

Description

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

CS Lymph Nodes General Guidelines

1. Code and 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. Regional nodes are listed in each site/histology schema. Nodes farther away from the primary or in farther lymph node chain have higher codes with the exceptions of codes for Regional Nodes, NOS; Lymph Nodes, NOS Stated as N1, no other information; and so forth. Record the highest applicable code.

Example:
Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. Code the contralateral mediastinal lymph node involvement as it is higher than the code for Peribronchial lymph nodes.

   b. Pathologic information takes precedence over clinical when there is a discrepancy on the same lymph node chain(s) if preoperative therapy was not 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 did not affect the lymph nodes.

e. Lymph nodes should be considered as not involved for primaries with in situ extension and coded as 00 (None). In situ by definition means noninvasive.

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 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 and should be coded to 00.

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. Coding of NOS categories such as "lymph nodes, NOS"; "Stated as N_"; and "regional lymph node(s), NOS" should be used only after an exhaustive search for more specific information.

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:
   1. Consider regional node involvement if the nodule has a smooth contour
   2. 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.

CS Lymph Nodes

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			
99	Unknown; regional lymph nodes cannot be assessed; not stated in medical record.	NX	U	U

For schemas that do not use CS Lymph Nodes field:

Code	Description
88	Not applicable

Note: *Documentation is* ***required*** *to support coding.*

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

CS METS AT DX (NAACCR Item #2850) (CS MANUAL pg. I-47)

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

CS Mets at DX General Guidelines

1. Code and 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 or coded.

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.

CS Mets at DX

Code	Description	TNM Mapping	SS 77 Mapping	SS 2000 Mapping
00	No; None	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 patient record.	MX	U	U

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

Code	Description
88	Not applicable

***Note:** Documentation **is required** to support coding.*

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

CS SITE-SPECIFIC FACTOR 1 (NAACCR Item #2880) (CS MANUAL pg. I-51)

***Note: TCR collects this data field for pleura primaries only**. Facilities that collect this information for other sites refer to CS Manual pg. I-51.*

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

Example:
Patient is diagnosed with mesothelioma of the pleura. CT of chest shows pleural effusion. Cytologic exam of pleural fluid is positive for malignant cells. Code CS Site Specific Factor to 020, Pleural effusion, malignant.

***Note:** Documentation is required to support coding. Collection of this data field is required in order to derive SSS.*

CS SITE-SPECIFIC FACTOR 3 (NAACCR Item #2900) (CS MANUAL pg. I-55)

Note: TCR collects this field for prostate primaries only. *Facilities that collect this information for other sites should refer to CS Manual pg. I-55.*

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

Example:
Patient is diagnosed with adenocarcinoma of the prostate and decides to have a radical prostatectomy. The pathology report states tumor extends to seminal vesicles. Code CS Site Specific Factor 3 to 045, Extension to seminal vesicle(s).

Example:
Patient with adenocarcinoma of the prostate is treated with hormone therapy only. Code CS Site Specific Factor 3 to 097, No prostatectomy done within first course of treatment.

Note: Documentation is required to support coding. Collection of this data field is required in order to derive SSS.

Collaborative Staging Codes
Lip, Upper
Lip (Vermilion or Labial Mucosa)
C00.0, C00.3
C00.0 External upper lip
C00.3 Mucosa of upper lip
Note: AJCC includes labial mucosa (C00.3) with buccal mucosa (C06.0)

Lip, Upper
CS Tumor Size
SEE STANDARD TABLE

Lip, Upper
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Labial mucosa (inner lip) Lamina propria Multiple foci Submucosa (superficial invasion) Vermilion surface Superficial extension to: Skin of lip Subcutaneous soft tissue of lip	*	L	L
20	Musculature	*	L	L
30	Localized, NOS	*	L	L
50	Buccal mucosa (inner cheek) Commissure Opposite (both) lip(s)	*	RE	RE
51	Gingiva	*	RE	RE
70	Maxilla	T4	RE	RE
74	Upper lip/commissure: Nose	T4	RE	D
75	Tongue	T4	D	D
76	Skin of face/neck	T4	D	D
77	Cortical bone (other than code 70) Floor of mouth	T4	D	D

77 cont'd	Inferior alveolar nerve			
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 50 and 51 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Lip, Upper

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Other groups Facial Buccinator (buccal) Nasolabial Parotid Infra-auricular Intraparotid Periparotid Preauricular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric)	*	D	RN

11 cont'd	Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Parapharyngeal Retropharyngeal Sub-occipital ** Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D

29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
** Updated July 1, 2005

Lip, Upper
CS Reg Nodes Eval
SEE STANDARD TABLE

Lip, Upper
Reg LN Pos
SEE STANDARD TABLE

Lip, Upper
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Lip, Lower
Lip (Vermilion or Labial Mucosa)
C00.1, C00.4, C00.6
C00.1 External lower lip
C00.4 Mucosa of lower lip
C00.6 Commissure of lip
Note: AJCC includes labial mucosa (C00.4) with buccal mucosa (C06.0)

Lip, Lower
CS Tumor Size
SEE STANDARD TABLE

Lip, Lower
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Labial mucosa (inner lip) Lamina propria Multiple foci Submucosa (superficial invasion) Vermilion surface Superficial extension to: Skin of lip Subcutaneous soft tissue of lip	*	L	L
20	Musculature	*	L	L
30	Localized, NOS	*	L	L
50	Buccal mucosa (inner cheek) Commissure Opposite (both) lip(s)	*	RE	RE
51	Gingiva	*	RE	RE
70	Mandible	T4	RE	RE
74	Nose	T4	RE	D
75	Tongue	T4	D	D
76	Skin of face/neck	T4	D	D
77	Cortical bone (other than code 70)	T4	D	D

77 cont'd	Floor of mouth Inferior alveolar nerve			
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 50 and 51 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Lip, Lower

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Other groups Facial: Mandibular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level II node Upper deep cervical Upper jugular Level III node Middle deep cervical Mid-jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical	*	D	RN

11 cont'd	Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital ** Supraclavicular, NOS (See note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10:	*	RN	RN

30 cont'd	Positive ipsilateral node(s), not stated if single or multiple			
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Lip, Lower
Reg LN Pos
SEE STANDARD TABLE

Lip, Lower
Reg LN Exam
SEE STANDARD TABLE

Lip, Lower
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Other Lip
Lip (Vermilion or Labial Mucosa)
C00.2, C00.5, C00.8-C00.9
C00.2 External lip, NOS
C00.5 Mucosa of lip, NOS
C00.8 Overlapping lesion of lip
C00.9 Lip, NOS (excludes skin of lip C44.0)
Note: AJCC includes labial mucosa (C00.5) with buccal mucosa (C06.0)

CS Tumor Size
SEE STANDARD TABLE

Other Lip
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Labial mucosa (inner lip) Lamina propria Multiple foci Submucosa (superficial invasion) Vermilion surface Superficial extension to: Skin of lip Subcutaneous soft tissue of lip	*	L	L
20	Musculature	*	L	L
30	Localized, NOS	*	L	L
50	Buccal mucosa (inner cheek) Commissure Opposite (both) lip(s)	*	RE	RE
51	Gingiva	*	RE	RE
75	Tongue	T4	D	D
76	Skin of face/neck	T4	D	D
77	Cortical bone Floor of mouth Inferior alveolar nerve	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 50 and 51 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Other Lip

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node: Submandibular (Submaxillary) Submental Other groups: Facial: Buccinator (buccal) Mandibular Nasolabial Parotid: Infra-auricular Intraparotid Periparotid Preauricular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS	*	D	RN

12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Parapharyngeal Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN

41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Other Lip
Reg LN Pos
SEE STANDARD TABLE

Other Lip
Reg LN Exam
SEE STANDARD TABLE

Other Lip
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes

Oral Cavity

Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029, Gum C030–C039, Floor of Mouth C040–C049, Palate C050–C059, Other Parts of Mouth C060–C069
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[**SEER Note:** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[**SEER Note:** Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS
41 Radical excision of tumor ONLY

42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[**SEER Note**: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Base of Tongue, Lingual Tonsil
C01.9, C02.4
C01.9 Base of tongue, NOS
C02.4 Lingual tonsil
Note: AJCC includes base of tongue (C01.9) with oropharynx (C10._).

Base of Tongue, Lingual Tonsil
CS Tumor Size
SEE STANDARD TABLE

Base of Tongue, Lingual Tonsil
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor on one side confined to posterior 1/3 of tongue: Lamina propria Submucosa	*	L	L
20	Musculature, intrinsic or NOS	*	L	L
30	Localized, NOS Midline tumor	*	L	L
40	Tumor crosses midline	*	L	L
50	Anterior 2/3 of tongue for base of tongue Base of tongue for lingual tonsil Floor of mouth Lower gingiva	*	RE	RE
53	Sublingual gland	*	RE	RE
60	Epiglottis, lingual (pharyngeal) surface Glossoepiglottic fold Glossopharyngeal fold Lateral pharyngeal wall Pharyngoepiglottic fold Tonsillar pillars and fossa Tonsils Vallecula	*	RE	RE
62	Soft palate, inferior surface or NOS	*	D	RE
71	Mandible for lingual tonsil	T4a	RE	D

72	Mandible for base of tongue	T4a	D	D
74	Medial pterygoid Hard palate	T4a	D	D
75	Musculature, extrinsic: Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Styloglossus	T4a	D	D
77	Larynx	T4a	D	D
78	Skin	T4b	D	D
80	Contiguous extension to: Base of skull Carotid artery Hypopharynx Lateral nasopharynx Lateral pterygoid muscle Pterygoid plates Uvula	T4b	D	D
82	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 40, 53, 60 and 62 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Base of Tongue, Lingual Tonsil
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Sublingual Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node	*	D	D

12 cont'd	Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN

99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Base of Tongue, Lingual Tonsil
Reg LN Pos
SEE STANDARD TABLE

Base of Tongue, Lingual Tonsil
CS Reg Nodes Exam
SEE STANDARD TABLE

Base of Tongue, Lingual Tonsil
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
C02.0-C02.3, C02.8-C02.9
C02.0 Dorsal surface of tongue, NOS
C02.1 Border of tongue
C02.2 Ventral surface of tongue, NOS
C02.3 Anterior 2/3 of tongue, NOS
C02.8 Overlapping lesion of tongue
C02.9 Tongue, NOS

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
CS TUMOR SIZE
SEE STANDARD TABLE

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor on one side confined to: Lamina propria Submucosa	*	L	L
20	Musculature, intrinsic or NOS	*	L	L
30	Localized, NOS Midline tumor	*	L	L
40	Tumor crosses midline	*	L	L
50	Base of tongue Floor of mouth Gingiva, lower Retromolar trigone	*	RE	RE
53	Sublingual gland	*	RE	RE
60	Lateral pharyngeal wall Soft palate, inferior surface Tonsillar pillars and fossae Tonsils	*	D	RE
70	Mandible	T4a	RE	D
72	(60) + (70)	T4a	D	D
74	Maxilla Maxillary sinus	T4a	D	D

75	Musculature, extrinsic: Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Styloglossus	T4a	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For codes 10, 20, 30, 40, 50, 53, and 60 ONLY, the T category is assigned based on the value of CS Tumor size, as shown in the Extension size Table for this site.

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Sublingual Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular	*	RN	RN

10 cont'd	Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10:	*	RN	RN

30 cont'd	Positive ipsilateral nodes(s), not stated if single or multiple			
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
Reg LN Pos
SEE STANDARD TABLE

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
Reg LN Exam
SEE STANDARD TABLE

Anterior 2/3 of Tongue, Tip, Border, and Tongue, NOS
CS Mets at Dx

****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40)	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes

Oral Cavity
Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029,
Gum C030–C039, Floor of Mouth C040–C049, Palate C050–C059,
Other Parts of Mouth C060–C069
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 **Radical excision** of tumor, NOS
41 Radical excision of tumor ONLY

42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Gum, Upper
C03.0
C03.0 Upper gum

Gum, Upper
CS Tumor Size
SEE STANDARD TABLE

Gum, Upper
CS Extension
Note: Superficial erosion alone of bone/tooth socket by gingival primary is not sufficient to code as bone involvement. (Code 70)

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to lamina propria (mucoperiosteum) (stroma)	*	L	L
30	Localized, NOS	*	L	L
50	Buccal mucosa (inner cheek) Floor of mouth Labial mucosa (inner lip), lip Tongue	*	RE	RE
55	Facial muscle, NOS Subcutaneous soft tissue of face	*	RE	RE
60	Lateral pharyngeal wall (tonsillar pillars and fossae, tonsils)	*	RE	RE
70	Maxilla	T4a	RE	RE
72	Deep muscle of tongue: Genioglossus Hyoglossus Palatoglossus Styloglossus	T4a	RE	RE
74	Maxillary antrum (sinus) Nasal cavity	T4a	D	D
76	Skin	T4a	D	D
79	Skull	T4b	D	D

80	Further contiguous extension, including: Masticator space Pterygoid plates Skull base Encases internal carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For codes 10, 30, 50, 55, 60, and 65 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Gum, Upper

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Retropharyngeal, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal	*	D	D

12 cont'd	Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN

70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Gum, Upper
Reg LN Pos
SEE STANDARD TABLE

Gum, Upper
Reg LN Exam
SEE STANDARD TABLE

Gum, Upper
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Gum, Lower and Retromolar Area
Retromolar gingiva (trigone)
C03.1, C06.2
C03.1 Lower gum
C06.2 Retromolar area

Gum, Lower and Retromolar Area
CS Tumor Size
SEE STANDARD TABLE

Gum, Lower and Retromolar Area
CS Extension
Note: Superficial erosion alone of bone/tooth socket by gingival primary is not sufficient to code as bone involvement (code 70).

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to lamina propria (mucoperiosteum)(stroma)	*	L	L
30	Localized, NOS	*	L	L
50	Buccal mucosa (inner cheek) Floor of mouth Labial mucosa (inner lip), lip Tongue	*	RE	RE
55	Facial muscle, NOS Subcutaneous soft tissue of face	*	RE	RE
60	Lateral pharyngeal wall (tonsillar pillars and fossae, tonsils)	*	RE	RE
65	Soft palate including uvula	*	RE	RE
70	Mandible	T4a	RE	RE
72	Deep muscle of tongue: Genioglossus Hyoglossus Palatoglossus Styloglossus	T4a	RE	RE
76	Skin	T4a	D	D
79	Skull	T4b	D	D

80	Further contiguous extension, including: Masticator space Pterygoid plates Skull base Encases internal carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For codes 10, 30, 50, 55, 60, and 65 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Gum, Lower and Retromolar Area
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular	*	RN	RN

10 cont'd	Other groups Facial: Buccinator (buccal) Nasolabial Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital ** Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D

29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, LymphNodes Size Table for this site.
**Updated July 1, 2005

Gum, Lower and Retromolar Area
Reg LN Pos
SEE STANDARD TABLE

Gum, Lower and Retromolar Area
Reg LN Exam
SEE STANDARD TABLE

Gum, Lower and Retromolar Area
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Gum, NOS
C03.9
C03.9 Gum, NOS

Gum, NOS
CS Tumor Size
SEE STANDARD TABLE

Gum, NOS
CS Extension
Note: Superficial erosion alone of bone/tooth socket by gingival primary is not sufficient to code as bone involvement. (Code 70)

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to lamina propria mucoperiosteum) (stroma)	*	L	L
30	Localized, NOS	*	L	L

50	Buccal mucosa (inner cheek) Labial mucosa (inner lip), lip	*	RE	RE
55	Facial muscle, NOS Subcutaneous soft tissue of face	*	RE	RE
60	Lateral pharyngeal wall (tonsillar pillars and fossae, tonsils)	*	RE	RE
72	Deep muscle of tongue: Genioglossus Hyoglossus Palatoglossus Styloglossus	T4a	RE	RE
76	Skin	T4a	D	D
79	Skull	T4b	D	D
80	Further contiguous extension, including: Masticator space Pterygoid plates Skull base Encases internal carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For codes 10, 30, 50, 55, 60 and 65 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Gum, NOS

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE

10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Other groups Facial: Buccinator (buccal) Nasolabial Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups	*	D	D

12 cont'd	Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital ** Supraclavicular (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated	NX	U	U

99 cont'd	Regional lymph node(s) cannot be assessed Not documented in patient record			

For codes 10, 20, 30, 40, 49, 50, and 80 only, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site. **Updated July 1, 2005

Gum, NOS
Reg LN Pos
SEE STANDARD TABLE

Gum, NOS
Reg LN Exam
SEE STANDARD TABLE

Gum, NOS
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Floor of Mouth
C04.0-C04.1, C04.8-C04.9
C04.0 Anterior floor of mouth
C04.1 Lateral floor of mouth
C04.8 Overlapping lesion of floor of mouth
C04.9 Floor of mouth, NOS

Floor of Mouth
CS Tumor Size
SEE STANDARD TABLE

Floor of Mouth
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor on one side confined to: Lamina propria Submucosa	*	L	L
30	Localized, NOS	*	L	L
40	Tumor crosses midline	*	L	L
50	Anterior 2/3 of tongue Base of tongue Gingiva (alveolar ridge), lower	*	RE	RE
53	Sublingual gland, including ducts Submandibular (submaxillary) glands, including ducts	*	RE	RE
60	Epiglottis Glossoepiglottic fold Glossopharyngeal sulcus Lateral pharyngeal wall Pharyngeal (lingual) surface Pharyngoepiglottic fold Tonsillar pillars and fossae Tonsils Vallecula	*	RE	RE
62	Extension to deep extrinsic muscle of tongue: Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Styloglossus	T4a	L	L
63	(62) + any of [(50) or (53) or (60)]	T4a	RE	RE
64	Subcutaneous soft tissue of chin/neck	T4a	RE	RE
70	Mandible	T4a	RE	RE

76	Skin of undersurface of chin/neck	T4a	RE	RE
77	Further contiguous extension: Maxillary sinus	T4a	D	D
80	Further contiguous extension: Base of skull Masticator space Pterygoid plates	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

***Note:** For Extension codes 10, 20, 30, 40, 50, 53, and 60 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Floor of Mouth

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemes, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid)	*	RN	RN

10 cont'd	Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Sublingual Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN

30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 20, 30, 40, 49, 50 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Floor of Mouth
Reg LN Pos
SEE STANDARD TABLE

Floor of Mouth
Reg LN Exam
SEE STANDARD TABLE

Floor of Mouth
CS Mets at Dx

****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2006

Site-Specific Surgery Codes
Oral Cavity
Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029,
Gum C030–C039, Floor of Mouth C040–C049, Palate C050–C059,
Other Parts of Mouth C060–C069
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 **Radical excision** of tumor, NOS

41 Radical excision of tumor ONLY
42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Hard Palate
C05.0
C05.0 Hard palate

Hard Palate
CS Tumor Size
SEE STANDARD TABLE

Hard Palate
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor on one side confined to mucoperiosteum (stroma)	*	L	L
30	Localized, NOS	*	L	L
40	Tumor crosses midline	*	L	L
50	Buccal mucosa (inner cheek) Gingiva, upper Glossopalatine arch Pharyngopalatine arch Soft palate Uvula	*	RE	RE
70	Maxillary bone Palatine bone	T4a	RE	RE
74	Deep muscle of tongue Floor of nose Maxillary antrum (sinus) Nasal cavity Nasopharynx Skin of face Sphenoid bone	T4a	D	D
76	Pterygoid plate	T4b	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension	TX	U	U

99 cont'd	Primary tumor cannot be assessed Not documented in patient record			

*For Extension codes 10, 30, 40, and 50 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Hard Palate

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Retropharyngeal Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I node	*	D	RN

11 cont'd	Submental			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Parapharyngeal Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)		D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN

32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Hard Palate
Reg LN Pos
SEE STANDARD TABLE

Hard Palate
Reg LN Exam
SEE STANDARD TABLE

Hard Palate
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Soft Palate, Uvula
C05.1-C05.2
C05.1 Soft Palate, NOS
C05.2 Uvula
Note 1: AJCC includes inferior surface of the soft palate (C05.1) and uvula (C05.2) with oropharynx (C09._, C10._).
Note 2: Soft palate excludes nasopharyngeal (superior) surface of soft palate (C11.3).

Soft Palate, Uvula
CS Tumor Size
SEE STANDARD TABLE

Soft Palate, Uvula
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor on one side confined to: Lamina propria Submucosa	*	L	L
20	Musculature invaded	*	L	L
30	Localized, NOS	*	L	L
40	Tumor crosses midline	*	L	L
50	Buccal mucosa (inner cheek) Gum (gingiva), upper	*	RE	RE
60	Lateral pharyngeal wall Tonsillar pillars and fossae Tonsils	*	RE	RE
65	Hard palate	T4a	RE	RE
70	Mandible Maxilla Palatine bone (bone of hard palate)	T4a	D	D
71	Pterygoid muscle, medial or NOS	T4a	D	D
72	Tongue Deep extrinsic muscle of tongue	T4a	D	D
73	Larynx	T4a	D	D

74	Maxillary antrum (sinus) Nasopharynx, lateral or NOS	T4b	D	D
77	Nasal cavity	T4a	RE	D
78	Pterygoid muscle, lateral Pterygoid plates **Note:** For medial pterygoid muscle or pterygoid muscle, NOS, see code 71	T4b	RE	D
79	[(77) or (78)] with any of [(70) to (76)]	T4b	D	D
80	Further contiguous extension Carotid artery Skull base	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 40, 50, and 60 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Soft Palate, Uvula
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical	*	RN	RN

10 cont'd	Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS			
11	Single positive ipsilateral regional node: Other groups Retropharyngeal	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Parapharyngeal Retropharyngeal	*	D	D

12 cont'd	Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D

60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Siæ Table for this site.
**Updated July 1, 2005

Soft Palate, Uvula
Reg LN Pos
SEE STANDARD TABLE

Soft Palate, Uvula
Reg LN Exam
SEE STANDARD TABLE

Soft Palate, Uvula
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes

Oral Cavity

Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029,
Gum C030–C039, Floor of Mouth C040–C049, **Palate C050–C059**,
Other Parts of Mouth C060–C069
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 **Radical excision** of tumor, NOS
41 Radical excision of tumor ONLY
42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Other Mouth
C05.8-C05.9, C06.8-C06.9
C05.8 Overlapping lesion of palate
C05.9 Palate, NOS
C06.8 Overlapping lesion of other and unspecified parts of mouth
C06.9 Mouth, NOS

Other Mouth
CS Tumor Size
SEE STANDARD TABLE

Other Mouth
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Lamina propria Submucosa	*	L	L
20	Musculature invaded	*	L	L
30	Localized, NOS	*	L	L
50	Adjacent oral cavity	*	RE	RE
60	Extension to oropharynx: Inferior surface of soft palate Lateral pharyngeal wall Lingual surface of epiglottis Vallecula	*	RE	RE
70	Extension to adjacent structures: Mandible Maxilla Maxillary antrum (sinus) Nasal cavity Skin of face/neck Tongue	T4a	D	D
71	Deep extrinsic muscle of tongue	T4a	D	D
72	Skull	T4b	D	D
75	Base of skull	T4b	D	D

75 cont'd	Encases internal carotid artery Masticator space Pterygoid plates			
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 50, and 60 ONLY, the T category is assigned based on the value of Tumor Size, as shown in the Extension Size Table for this site.

Other Mouth

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS	*	RN	RN

10 cont'd	Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital ** Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN

32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site
** Updated July 1, 2005

Other Mouth
Reg LN Pos
SEE STANDARD TABLE

Other Mouth
Reg LN Exam
SEE STANDARD TABLE

Other Mouth
CS Mets at Dx
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Cheek (Buccal) Mucosa, Vestibule
C06.0-C06.1
C06.0 Cheek mucosa
C06.1 Vestibule of mouth

Cheek (Buccal) Mucosa, Vestibule
CS Tumor Size
SEE STANDARD TABLE

Cheek (Buccal) Mucosa, Vestibule
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Lamina propria Submucosa	*	L	L
20	Musculature (buccinator)	*	RE	L
30	Localized, NOS	*	L	L

50	Lip(s) including commissure	*	RE	RE
51	Gingiva	*	RE	RE
60	Lateral pharyngeal wall Tonsillar pillars and fossae Tonsils	*	RE	RE
65	Subcutaneous soft tissue of cheek	T4a	RE	RE
66	Skin of cheek (WITH or WITHOUT ulceration)	T4a	RE	D
67	Maxillary sinus	T4a	D	D
70	Bone (cortical): Mandible Maxilla	T4a	D	D
73	Skull	T4b	D	D
75	Tongue Deep extrinsic muscle of tongue	T4a	D	D
79	Other contiguous extension: Base of skull Encases internal carotid artery Masticator space Pterygoid plates	T4b	D	D
80	Further contiguous extension: Hard palate Soft palate	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 50, 51, and 60 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Cheek (Buccal) Mucosa, Vestibule

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

**Note 4: For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Other groups Facial: Buccinator (buccal) Nasolabial Parotid, NOS Infra-auricular Preauricular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node	*	D	D

12 cont'd	Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at Dx) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple or regional	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or	*	D	D

52 cont'd	contralateral AND not stated if single or multiple			
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
** Updated July 1, 2005

Cheek (Buccal) Mucosa, Vestibule
Reg LN Pos
SEE STANDARD TABLE

Cheek (Buccal) Mucosa, Vestibule
Reg LN Exam
SEE STANDARD TABLE

Cheek (Buccal) Mucosa, Vestibule
CS Mets at DX
Note:**Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D

99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes

Oral Cavity
Lip C000–C009, Base of Tongue C019, Other Parts of Tongue C020–C029,
Gum C030–C039, Floor of Mouth C040–C049, **Palate C050–C059,**
Other Parts of Mouth C060–C069
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Codes 20-27 include shave and wedge resection]

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 **Radical excision** of tumor, NOS
41 Radical excision of tumor ONLY
42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Codes 40–43 include:
Total glossectomy
Radical glossectomy

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Parotid Gland
C07.9
C07.9 Parotid gland
Note: Laterality must be coded for C07.9.

Parotid Gland
CS Tumor Size
SEE STANDARD TABLE

Parotid Gland
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to gland/duct of origin Multiple foci confined to substance of parotid gland	*	L	L
30	Localized, NOS	*	L	L
35	Microscopic extraparenchymal extension ONLY	*	RE	RE
**40	Another major salivary gland (submaxillary, sublingual) Periglandular soft/connective tissue including macroscopic extraparenchymal extension Pharyngeal mucosa Skeletal muscle: Digastric Masseter Pterygoid Sternocleidomastoid Stylohyoid	T3	RE	RE
42	External auditory meatus Skin overlying gland	T4a	RE	RE
45	Periosteum of mandible	T4a	RE	RE
50	Auricular nerve Mandible Mastoid	T4a	RE	RE
70	Facial (7th) nerve	T4a	RE	D
72	Spinal accessory nerve	T4a	RE	D

75	Major blood vessel(s): Carotid artery Facial artery or vein Jugular vein Maxillary artery	T4b	RE	RE
76	Base of skull Skull, NOS	T4b	RE	D
77	Pterygoid plates	T4b	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 30, and 35 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Extension by Size Table for this site.
**Updated August 14, 2006

Parotid Gland

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Parotid nodes Infra-auricular Intraparotid Periparotid Preauricular Cervical, NOS	*	RN	RN

10 cont'd	Deep cervical, NOS Facial Internal jugular Mandibular, NOS Regional lymph node, NOS			
11	Single positive ipsilateral regional node: Level II node Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical Lower jugular	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Parapharyngeal Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN

20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed	NX	U	U

99 cont'd	Not documented in patient record			

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes,using the extra table, Lymph Nodes Size table, for this site
**Updated July 1, 2005

Parotid Gland
Reg LN Pos
SEE STANDARD TABLE

Parotid Gland
Reg LN Exam
SEE STANDARD TABLE

Parotid Gland
CS Mets at DX
****Note**: Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Submandibular Gland
C08.0
C08.0 Submandibular Gland
Note: Laterality must be coded for C08.0

Submandibular Gland
CS Tumor Size
SEE STANDARD TABLE

Submandibular Gland
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to gland/duct of origin	*	L	L
30	Localized, NOS	*	L	L
35	Microscopic extraparenchymal extension ONLY	*	RE	RE
**40	Another major salivary gland (parotid, sublingual) Periglandular soft/connective tissue including macroscopic extraparenchymal extension Skeletal muscle: Digastric Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Pterygoid Styloglossus Stylohyoid	*	RE	RE
45	Periosteum of mandible	T4a	RE	RE
50	Mandible Nerves: Facial (7th) Lingual	T4a	RE	RE
51	External auditory meatus	T4a	D	D

52	Major blood vessels: Carotid artery Facial artery or vein Maxillary artery	T4b	RE	RE
71	Base of skull Skull, NOS	T4b	RE	D
72	Spinal accessory nerve	T4a	RE	D
77	Pterygoid plates	T4b	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 30, and 35 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site.
**Updated August 14, 2006

Submandibular Gland
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node	*	RN	RN

10 cont'd	Middle deep cervical Mid jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level IV node Lower deep cervical Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN

30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Submandibular Gland
Reg LN Pos
SEE STANDARD TABLE

Submandibular Gland
Reg LN Exam
SEE STANDARD TABLE

Submandibular Gland
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Other and Unspecified Major Salivary Glands
C08.1, C08.8-C08.9
C08.1 Sublingual gland
C08.8 Overlapping lesion of major salivary glands
C08.9 Major salivary gland, NOS
Note: Laterality must be coded for C08.1.

Other and Unspecified Major Salivary Glands
CS Tumor Size
SEE STANDARD TABLE

Other and Unspecified Major Salivary Glands
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to gland/duct of origin	*	L	L
30	Localized, NOS	*	L	L
35	Microscopic extraparenchymal extension ONLY	*	RE	RE
40	Extension to: Another major salivary gland (parotid, submandibular) Periglandular soft/connective tissue including extraparenchymal extension Skeletal muscle: Digastric Pterygoid Stylohyoid	T3	RE	RE
45	Periosteum of mandible	T4a	RE	RE
51	Mandible Nerves: Facial (7th) Lingual	T4a	RE	RE
60	Skin	T4a	D	D
62	External auditory meatus	T4a	D	D
65	Blood vessel(s): Carotid artery	T4b	RE	RE

65 cont'd	Facial artery or vein Maxillary artery			
71	Base of skull Skull, NOS	T4b	RE	D
72	Spinal accessory nerve	T4a	RE	D
79	Pterygoid plates	T4b	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 30, and 35 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site

Other and Unspecified Major Salivary Glands

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to sternocleidmastoid muscle, in the lower jugular chain) or level V (in the posterior triangle, inferior to the transverse cervical artery) and cod appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Cervical, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN

12	Single positive ipsilateral regional node: Level II node Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D

29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 49, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size T
**Updated July 1, 2005

Other and Unspecified Major Salivary Glands
Reg LN Pos
SEE STANDARD TABLE

Other and Unspecified Major Salivary Glands
Reg LN Exam
SEE STANDARD TABLE

Other and Unspecified Major Salivary Glands
CS Mets at DX

****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes
Parotid and Other Unspecified Glands
Parotid Gland C079, Major Salivary Glands C080–C089
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Codes 30-80 include major salivary gland, NOS]

30 **Less** than **total parotidectomy**, NOS; **less** than total removal of major salivary gland, NOS

[SEER Notes: Includes less than total removal of other major salivary gland. When the operative report specifies nerve monitoring, it means that a nerve sparing surgery is being done]

31 Facial nerve spared

32 Facial nerve sacrificed
33 Superficial lobe ONLY
34 Facial nerve spared
35 Facial nerve sacrificed
36 Deep lobe (Total)

[***SEER Note:*** With or without superficial lobe]

37 Facial nerve spared
38 Facial nerve sacrificed

[***SEER Note:*** Codes 40-80 include submandibulectomy; submaxillectomy]

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
41 Facial nerve spared
42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
51 WITHOUT removal of temporal bone
52 WITH removal of temporal bone
53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Tonsil, Oropharynx
C09.0-C09.1, C09.8-C09.9, C10.0, C10.2-C10.4, C10.8-C10.9
C09.0 Tonsillar fossa
C09.1 Tonsillar pillar
C09.8 Overlapping lesion of tonsil
C09.9 Tonsil, NOS (excludes lingual tonsil C02.4)
C10.0 Vallecula
C10.2 Lateral wall of oropharynx
C10.3 Posterior wall of oropharynx
C10.4 Branchial cleft (site of neoplasm)
C10.8 Overlapping lesion of oropharynx
C10.9 Oropharynx, NOS
Note 1: Laterality must be coded for C09.0, C09.1, C09.8, and C09.9.
Note 2: AJCC includes base of tongue (C01.9) with oropharynx (C09._, C10._).

Tonsil, Oropharynx
CS Tumor Size
SEE STANDARD TABLE

Tonsil, Oropharynx
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to one of the following subsites: Anterior wall (including vallecula and lingual (anterior) surface of epiglottis) One lateral wall Posterior wall	*	L	L
20	Involvement of two or more subsites: Posterior, anterior or lateral wall(s)	*	L	L
30	Localized, NOS	*	L	L
40	Soft palate, inferior surface including uvula, or soft palate, NOS	*	RE	RE
41	Hypopharynx NOS Pyriform sinus	*	RE	RE
42	Soft palate, superior (nasopharyngeal) surface	*	RE	RE

50	Base of tongue Buccal mucosa (inner cheek) Floor of mouth Gum (gingiva)	*	RE	RE
55	Any extension coded in 10-50 WITH fixation	*	RE	RE
60	Prevertebral fascia or muscle Soft tissue of neck	*	RE	RE
62	Nasopharynx, lateral, or NOS	T4b	RE	RE
65	Larynx, NOS Medial pterygoid muscle, or pterygoid muscle, NOS Posterior surface of epiglottis	T4a	RE	RE
70	Deep extrinsic muscles of tongue: Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Styloglossus Hard palate Mandible	T4a	D	D
72	Lateral pterygoid muscle Pterygoid plates	T4b	D	D
75	Bone of skull	T4b	D	D
76	Bone	T4b	D	D
77	Carotid artery	T4b	D	D
80	Further contiguous extension: Anterior 2/3 of tongue Parotid gland	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For codes 10, 20, 40, 41, 42, 50, 55, and 60 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Extension Size Table for this site.

Tonsil, Oropharynx
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that	*	D	D

12 cont'd	define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN

42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site

**Updated July 1, 2005

Tonsil, Oropharynx
Reg LN Pos
SEE STANDARD TABLE

Tonsil, Oropharynx
Reg LN Exam
SEE STANDARD TABLE
Tonsil, Oropharynx
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE

10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Anterior Surface of Epiglottis
C10.1
C10.1 Anterior surface of epiglottis
Note: AJCC includes lingual (anterior) surface of epiglottis (C10.1) with larynx. SEER Extent of Disease included it with oropharynx.

Anterior Surface of Epiglottis
CS Tumor Size
SEE STANDARD TABLE

Anterior Surface of Epiglottis
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to anterior surface of epiglottis with normal vocal cord mobility	T1	L	L
20	Mucosa of adjacent subsite(s) of oropharynx	T2	L	L
30	Localized, NOS	T1	L	L
31	Vallecula without fixation of larynx	T2	L	L
32	Mucosa of adjacent subsite(s) of supraglottis (including posterior surface of epiglottis) without fixation of larynx	T2	RE	RE
33	Larynx, glottic or NOS, without fixation of larynx	T2	RE	RE
34	Pyriform sinus, medial wall or NOS, without fixation of larynx	T2	RE	RE
35	Mucosa of base of tongue without fixation of larynx	T2	RE	RE
36	Any of (10) to (35) with vocal cord fixation	T3	RE	RE
37	Paraglottic space Pre-epiglottic tissues	T3	RE	RE
38	Minor thyroid cartilage erosion (inner cortex) (see also code 67)	T3	D	D
39	Hypopharynx, NOS Postcricoid area Pyriform sinus except medial wall (see code 34)	T3	RE	RE

43	(38) + (39)	T3	D	D
45	Soft palate, inferior surface including uvula, or soft palate, NOS	T4a	RE	RE
47	Nasopharynx, NOS Soft palate, superior (nasopharyngeal) surface	T4a	RE	RE
50	Base of tongue, except mucosa (see code 35) Buccal mucosa (inner cheek) Floor of mouth Gum (gingiva)	T4a	RE	RE
62	Soft tissues of neck	T4a	RE	RE
65	Pterygoid muscle	T4a	RE	RE
66	[(38) or (43)] + any of [(45) to (65)]	T4a	D	D
67	Invasion through thyroid cartilage (see also code 38) Thyroid cartilage, NOS	T4a	D	D
68	Trachea	T4a	D	D
69	Esophagus Strap muscles Thyroid	T4a	D	D
70	Extrinsic muscles of tongue: Genioglossus Geniohyoid Hyoglossus Mylohyoid Palatoglossus Styloglossus	T4a	D	D
75	Prevertebral fascia or muscle Prevertebral space	T4b	RE	RE
77	(75) + any of [(66) to (70)]	T4b	D	D
80	Further contiguous extension, including: Anterior 2/3 of tongue Bone Encases carotid artery Hard palate Mandible Mediastinal structures Parotid gland	T4b	D	D

95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Anterior Surface of Epiglottis
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical Lower jugular Retropharyngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental	*	D	RN
12	Single positive ipsilateral regional node:	*	D	D

12 cont'd	Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D

40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph nodes, using the extra table, Lymph Nodes Size Table for this site
**Updated July 1, 2005

Anterior Surface of Epiglottis
Reg LN Pos
SEE STANDARD TABLE

Anterior Surface of Epiglottis
Reg LN Exam
SEE STANDARD TABLE

Anterior Surface of Epiglottis
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), including mediastinal	M1	D	D
40	Distant metastases except distant lymph node(s) (codes 08 - 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Nasopharynx
C11.0-C11.3, C11.8-C11.9
C11.0 Superior wall of nasopharynx
C11.1 Posterior wall of nasopharynx
C11.2 Lateral wall of nasopharynx
C11.3 Anterior wall of nasopharynx
C11.8 Overlapping lesion of nasopharynx
C11.9 Nasopharynx, NOS

Nasopharynx
CS Tumor Size
SEE STANDARD TABLE

Nasopharynx
CS Extension
Note: Parapharyngeal involvement denotes postero-lateral infiltration of tumor beyond the pharyngobasilar fascia. Involvement of the masticator space denotes extension of tumor beyond the anterior surface of the lateral pterygoid muscle, or lateral extension beyond the postero-lateral wall of the maxillary antrum, pterygo-maxillary fissure.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to one of the following subsites: Inferior wall (superior surface of soft palate) One lateral wall Posterior superior wall (vault)	T1	L	L
20	Involvement of two or more subsites: Lateral wall extending into eustachian tube/middle ear Posterior, inferior, or lateral wall(s)	T1	L	L
30	Confined to nasopharynx Localized, NOS	T1	L	L
40	Oropharynx Soft palate, inferior surface	T2a	RE	RE
50	Nasal cavity	T2a	RE	RE
55	Any extension coded in 10-50 WITH fixation or tumor Described only as FIXED	T4	RE	RE
56	Any extension coded in 10-50 WITH parapharyngeal extension	T2b	RE	RE

57	Hard palate	T4	D	RE
58	Pterygopalatine fossa	T4	RE	RE
60	Bone, including skull	T3	RE	RE
62	Paranasal sinus	T3	D	RE
65	Orbit	T4	RE	D
70	Brain Cranial nerves Hypopharynx Infratemporal fossa Orbit Intracranial extension, NOS	T4	D	D
75	Masticator space	T4	D	D
80	Further contiguous extension Soft tissues of the neck	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Nasopharynx
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE

10	Single positive ipsilateral regional node: Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical Lower jugular Retropharyngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular Regional lymph node, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups	*	D	D

12 cont'd	Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital Supraclavicular fossa			
18	Stated as N1, no other information	N1	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D

60	Stated as N2, no other information	N2	RN	RN
70	Stated as N3, NOS	N3NOS	RN	RN
75	Regional lymph nodes in the supraclavicular fossa: Inferior deep cervical (scalene) Spinal accessory (posterior cervical)* **Supraclavicular (transverse cervical) (See note 4)	N3b	D	D
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table, for this site.
**Updated July 1, 2005

Nasopharynx
Reg LN Pos
SEE STANDARD TABLE

Nasopharynx
Reg LN Exam
SEE STANDARD TABLE

Nasopharynx
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Pyriform Sinus, Hypopharynx, Laryngopharynx
C12.9, C13.0-C13.2, C13.8-C13.9
C12.9 Pyriform sinus
C13.0 Postcricoid region
C13.1 Hypopharyngeal aspect of aryepiglottic fold
C13.2 Posterior wall of hypopharynx
C13.8 Overlapping lesion of hypopharynx
C13.9 Hypopharynx, NOS

Pyriform Sinus, Hypopharynx, Laryngopharynx
CS Tumor Size
SEE STANDARD TABLE

Pyriform Sinus, Hypopharynx, Laryngopharynx
CS Extension
Note: If fixation of hemilarynx or larynx code to 55 not 51.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to one of the following subsites: Laryngopharynx Postcricoid area Posterior pharyngeal wall Pyriform sinus	*	L	L
20	Tumor involves adjacent subsite(s) (listed in code 10) WITHOUT fixation	*	L	L
30	Localized, NOS	*	L	L
40	Oropharynx	*	RE	RE
50	Larynx	*	RE	RE
51	Any of codes 10-40 WITH fixation of tumor or fixation, NOS	*	RE	RE
55	Fixation of hemilarynx or larynx	T3	RE	RE
60	Soft tissues of neck including Prelaryngeal strap muscles and subcutaneous fat	T4a	RE	RE
61	Esophagus	T4a	RE	RE
62	Thyroid gland	T4a	D	RE

63	Cricoid cartilage Thyroid cartilage	T4a	D	RE
64	Prevertebral fascia/muscle(s)	T4b	RE	RE
65	Carotid artery	T4b	D	RE
66	Hyoid bone	T4a	D	D
70	Mediastinal structures	T4b	D	D
80	Further contiguous extension	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 20, 30, 40, 50, and 51 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site.

Pyriform Sinus, Hypopharynx, Laryngopharynx
CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Lower deep cervical	*	RN	RN

10 cont'd	Lower jugular Retropharyngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular Regional lymph node, NOS			
11	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) **Supraclavicular, NOS, (See Note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN

21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN

99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Pyriform Sinus, Hypopharynx, Laryngopharynx
Reg LN Pos
SEE STANDARD TABLE

Pyriform Sinus, Hypopharynx, Laryngopharynx
Reg LN Exam
SEE STANDARD TABLE

Pyriform Sinus, Hypopharynx, Laryngopharynx
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recodes. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
C14.0, C14.2, C14.8
C14.0 Pharynx, NOS
C14.2 Waldeyer ring
C14.8 Overlapping lesion of lip, oral cavity
Note: AJCC does not define TNM staging for this site.

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
CS Tumor Size
SEE STANDARD TABLE

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
CS Extension
Note: Definition of Adjacent Structures: Connective tissues large enough to be given a specific name would be considered adjacent structures. For example, the brachial artery has a name, as does the broad ligament. Continuous tumor growth from one organ into an adjacent named structure would be coded to less than 60 in the schemes for ill-defined or non-specific sites.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	NA	IS	IS
10	Invasive tumor confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	More than one region of pharynx involved (oropharynx, nasopharynx, hypopharynx)	NA	RE	RE
50	Pharynx and oral cavity involved	NA	RE	RE
55	Any of codes 10-50 WITH fixation	NA	RE	RE
60	Extension to adjacent structures (See note)	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if they are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as Level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s) bilateral and/or contralateral: Cervical, NOS Internal jugular, NOS Deep cervical, NOS: Lower, NOS Jugulo-omohyoid (supraomohyoid) Middle Upper, NOS: Jugulodigastric (subdigastric) Mandibular, NOS Submandibular (submaxillary) Submental Paratracheal Recurrent laryngeal nerve chain Prelaryngeal Delphian node Retropharyngeal Regional lymph node(s), NOS	NA	RN	RN
**12	Regional lymph node(s) bilateral and/or contralateral: Supraclavicular, NOS (See Note 4)	NA	D	D
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

**Updated July 1, 2005

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
Reg LN Pos
SEE STANDARD TABLE

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
Reg LN Exam
SEE STANDARD TABLE

Pharynx, NOS, and Other Ill-Defined Oral Cavity Sites
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), including: Mediastinal	NA	D	D
40	Distant metastasis, NOS Distant metastases except distant lymph node(s) (code 10) Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	NA	U	U

****Updated July 1, 2005**

Site-Specific Surgery Codes
Pharynx
Tonsil C090–C099, Oropharynx C100–C109, Nasopharynx C110–C119
Pyriform Sinus C129, Hypopharynx C130–C139, Pharynx C140
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Stripping

No specimen sent to **pathology** from surgical events 10–15

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision
28 Stripping

[***SEER Note:*** Codes 21 to 25 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, 25 Laser excision, or 28 Stripping]

Specimen sent to **pathology** from surgical events 20–28

30 Pharyngectomy, NOS
31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)

[***SEER Notes:*** Code 40 includes mandibulectomy (marginal, segmental, hemi-, and/or laryngectomy) NOS; Contiguous bone tissue refers to the mandible]

41 WITH laryngectomy (laryngopharyngectomy)
42 WITH bone [mandibulectomy]
43 WITH both 41 and 42

[***SEER Notes:***
Use code 40 when the patient had a pharyngectomy and maybe some sort of mandibulectomy and/or maybe a laryngectomy, but the exact procedures are not clear
Use code 41 when the patient had pharyngectomy and laryngectomy but no mandibulectomy
Use code 42 when the patient had pharyngectomy and mandibulectomy but no laryngectomy
Use code 43 when it is certain that the patient had both a mandibulectomy and laryngectomy in addition to the pharyngectomy]

50 **Radical pharyngectomy** (includes total mandibular resection), NOS
51 WITHOUT laryngectomy
52 WITH laryngectomy

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
ESOPHAGUS
C150-C155, C158-C159

Primary Site

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, the thoracic esophagus and the abdominal esophagus. The subsites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the SEER *Self Instructional Manual for Tumor Registrars, Book 4* for illustrated descriptions of each system

Collaborative Staging Codes
Esophagus
C15.0-C15.5, C15.8-C15.9
C15.0 Cervical esophagus
C15.1 Thoracic esophagus
C15.2 Abdominal esophagus
C15.3 Upper third of esophagus
C15.4 Middle third of esophagus
C15.5 Lower third of esophagus
C15.8 Overlapping lesion of esophagus
C15.9 Esophagus, NOS
Anatomic Limits of Esophagus:
Cervical Esophagus (C15.0): From the lower border of the cricoid cartilage to the thoracic inlet (suprasternal notch), about 18 cm from the incisors.
Intrathoracic (including abdominal esophagus) (C15.1 - C15.5): Upper thoracic portion (C15.3): From the thoracic inlet to the level of the tracheal bifurcation (18-24 cm). Mid-thoracic portion (C15.4): From the tracheal bifurcation midway to the gastroesophageal (GE) junction (24-32 cm).
Lower thoracic portion (C15.5: From midway between the tracheal bifurcation and the gastroesophageal junction to the GE junction, including the abdominal esophagus (C15.2) between 32-40 cm.

Esophagus
CS Tumor Size
Note: For esophagus, this field is used for size of tumor/length of involved esophagus.

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

Esophagus
CS Extension
Note: Ignore intraluminal extension to adjacent segment(s) of esophagus or to cardia of stomach and code depth of invasion or extra-esophageal spread as indicated.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS (including intramucosal, NOS)	T1	L	L
11	Invades lamina propria	T1	L	L
12	Invades muscularis mucosae	T1	L	L
16	Invades submucosa	T1	L	L
20	Muscularis propria invaded	T2	L	L
30	Localized, NOS	T1	L	L
40	Adventitia and/or soft tissue invaded Esophagus is described as "FIXED"	T3	RE	RE
60	Tumor invades adjacent structures Cervical esophagus: Blood vessel(s): Carotid artery Jugular vein Subclavian artery Thyroid gland Intrathoracic, upper or mid-portion, esophagus: Blood vessel(s), major: Aorta Azygos vein Pulmonary artery/vein Vena cava Carina Diaphragm Main stem bronchus Trachea Intrathoracic, lower portion (abdominal), esophagus: Blood vessel(s): Aorta Gastric artery/vein Vena cava Diaphragm, not fixed, or NOS	T4	RE	RE

60 cont'd	Stomach, cardia (via serosa)			
65	Cervical esophagus: Carina Cervical vertebra(e) Hypopharynx Larynx Trachea Intrathoracic esophagus: Lung via bronchus Mediastinal structure(s), NOS Pleura Rib(s) Thoracic vertebra(e)	T4	RE	RE
78	Thoracic/middle esophagus: Pericardium	T4	RE	D
80	Further contiguous extension: Cervical/upper esophagus: Lung Main stem bronchus Pleura Abdominal/lower esophagus: Diaphragm fixed	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Esophagus
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) (including contralateral or bilateral) For all subsites: Peri-/paraesophageal Cervical esophagus only: Cervical, NOS Anterior deep cervical (laterolateral) (recurrent laryngeal) Internal jugular, NOS: Deep cervical, NOS: Upper, NOS: Jugulodigastric (subdigastric) Intrathoracic esophagus, upper or middle, only: Internal jugular, NOS: Deep cervical, NOS: Lower, NOS: Jugulo-omohyoid (supraomohyoid) Middle Upper cervical, NOS: Jugulodigastric (subdigastric) Intrabronchial: Carinal (tracheobronchial) (tracheal bifurcation) Hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Peritracheal Left gastric (superior gastric): Cardiac (cardial) Lesser curvature Perigastric, NOS Posterior mediastinal (tracheoesophageal) Intrathoracic esophagus, lower (abdominal) only: Left gastric (superior gastric): Cardiac (cardial) Lesser curvature Perigastric, NOS Posterior mediastinal (tracheoesophageal)	N1	RN	RN

20	Cervical Esophagus only: Scalene (inferior deep cervical) Supraclavicular (transverse cervical)	N1	D	RN
22	Intrathoracic, upper thoracic or middle, only: Superior mediastinal	N1	D	RN
30	All esophagus subsites: Anterior mediastinal Mediastinal, NOS Cervical esophagus only: Aortopulmonary Paratracheal Posterior mediastinal Superior mediastinal Intrathoracic esophagus,upper or middle, only: Aortopulmonary Pulmonary ligament Intrathoracic esophagus, lower (abdominal) only: Common hepatic Diaphragmatic Paratracheal Splenic Superior mediastinal	N1	RN	RN
50	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Esophagus
Reg LN Pos
SEE STANDARD TABLE

Esophagus
Reg LN Exam
SEE STANDARD TABLE

Esophagus
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1NOS	D	D
11	Upper thoracic esophagus only: Cervical lymph node(s) Lower thoracic (abdominal) esophagus only: Celiac lymph node(s)	M1a	D	D
12	Specified distant lymph node(s), other than code 11, including: Cervical esophagus only: Common hepatic Diaphragmatic Pulmonary ligament Splenic Intrathoracic esophagus, upper or middle, only: Common hepatic Diaphragmatic Splenic Lower thoracic (abdominal) esophagus only: Aortopulmonary Pulmonary ligament	M1NOS	D	D
40	Distant metastases except distant lymph node(s) (codes 10 - 12) Distant metastasis, NOS Carcinomatosis	M1b	D	D
50	(40) + any of [(10) to (12)] Distant lymph node(s) plus other distant metastases	M1b	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Esophagus
C150–C159
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS

[***SEER Note:*** Esophagectomy WITH other procedures may be partial, total, or NOS]

51 WITH laryngectomy
52 WITH gastrectomy, NOS
53 Partial gastrectomy

54 Total gastrectomy
55 Combination of 51 WITH any of 52–54

80 Esophagectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Stomach
C16.0-C16.6, C16.8-C16.9
C16.0 Cardia, NOS
C16.1 Fundus of stomach
C16.2 Body of stomach
C16.3 Gastric antrum
C16.4 Pylorus
C16.5 Lesser curvature of stomach, NOS
C16.6 Greater curvature of stomach, NOS
C16.8 Overlapping lesion of stomach
C16.9 Stomach, NOS

Stomach
CS Tumor Size

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as 'less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as 'less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as 'less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
998	Diffuse; widespread; 3/4's or more: linitis plastica
999	Unknown; size not stated Not documented in patient record

Stomach
CS Extension
Note 1: INTRALUMINAL or INTRAMURAL extension to esophagus and duodenum is classified by the depth of greatest invasion in any of these sites, including stomach. (For extension to esophagus or duodenum via serosa, see code 60.)
Note 2: If the diagnosis states "linitis plastica" and no other information regarding extension is available, use code 35.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
05	(Adeno)carcinoma in a polyp, noninvasive	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS (including intramucosal,NOS	T1	L	L
11	Invades lamina propria	T1	L	L
12	Invades muscularis mucosae	T1	L	L
13	Confined to head of polyp Extension to stalk	T1	L	L
14	Confined to stalk of polyp	T1	L	L
15	Tumor in polyp, NOS	T1	L	L
16	Invades submucosa (superficial invasion)	T1	L	L
20	Invades into but not through muscularis propria	T2a	L	L
30	Localized, NOS Implants inside stomach	T1	L	L
35	Linitis plastica (see Note 2) and no other information regarding extension is available.	T2a	RE	L
40	Invasion through muscularis propria or muscularis, NOS Extension through wall, NOS Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded	T2b	L	L
45	Extension to adjacent (connective) tissue WITHOUT perforation of visceral peritoneum: Gastric artery Ligaments: Gastrocolic Gastrohepatic	T2b	RE	RE

45 cont'd	Gastrosplenic Omentum, NOS Greater Lesser Perigastric fat			
50	Invasion of/through serosa (mesothelium) (tunica serosa) (visceral peritoneum), including perforation of visceral peritoneum covering the gastric ligaments or the omentum WITHOUT invasion of adjacent structures	T3	RE	RE
55	(45) + (50)	T3	RE	RE
60	Diaphragm Duodenum via serosa or NOS Esophagus via serosa Ileum Jejunum Liver Pancreas Small intestine, NOS Spleen Transverse colon (including flexures)	T4	RE	RE
70	Abdominal wall Adrenal gland Kidney Retroperitoneum	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Stomach
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Left gastric (superior gastric), NOS: Cardial Cardioesophageal Gastric, left Gastropancreatic, left Lesser curvature Lesser omental Paracardial Pancreaticosplenic (pancreaticolienal) Pancreatoduodenal Perigastric, NOS Peripancreatic Right gastric (inferior gastric), NOS: Gastrocolic Gastroduodenal Gastroepiploic (gastro-omental), right or Gastrohepatic Greater curvature Greater omental Pyloric, NOS Infrapyloric (subpyloric) Suprapyloric Splenic (lienal), NOS: Gastroepiploic (gastro-omental), left Splenic hilar Nodule(s) in perigastric fat	*	RN	RN
40	Celiac Hepatic (excluding gastrohepatic, [see code 10] and hepatoduodenal [see code 42])	*	D	RN
42	For lesser curvature only: Hepatoduodenal	*	D	D
50	Regional lymph node(s), NOS	*	RN	RN
80	Lymph node(s), NOS	*	RN	RN

99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-80 ONLY, the N category is assigned based on the value of the Reg LN Pos using the Lymph Nodes Number Positive table for this site.

Stomach
Reg LN Pos
SEE STANDARD TABLE

Stomach
Reg LN Exam
SEE STANDARD TABLE

Stomach
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s): For all subsites: Inferior mesenteric Para-aortic Porta hepatis (portal) (hilar) (in hilus of liver) Retropancreatic Retroperitoneal Superior mesenteric or mesenteric, NOS For all subsites EXCEPT lesser curvature Hepatoduodenal	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Stomach
C160–C169
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY
10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any combination of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 **Gastrectomy**, NOS (**partial**, subtotal, hemi-)
31 Antrectomy, lower (distal-less than 40% of stomach)***
32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS

41 Near-total gastrectomy
42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach

50 **Gastrectomy**, NOS WITH removal of a portion of **esophagus**

51 Partial or subtotal gastrectomy
52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure

60 **Gastrectomy** with a resection in continuity with the resection of **other organs**, NOS***

61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
62 Near total or total gastrectomy, in continuity with the resection of other organs***
63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resection with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

> [***SEER Notes:*** A portion of the duodenum may be removed during this procedure; assign codes 60-63 unless the entire duodenum was removed and a gastrojejunostomy was performed. Codes 60-63 may include omentectomy among the organs/tissues removed. In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Gastrectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

*** Incidental splenectomy NOT included

Collaborative Staging Codes
Small Intestine
C17.0-C17.3, C17.8-C17.9
C17.0 Duodenum
C17.1 Jejunum
C17.2 Ileum (excludes ileocecal valve C18.0)
C17.3 Meckel diverticulum (site of neoplasm)
C17.8 Overlapping lesion of small intestine
C17.9 Small intestine, NOS

Small Intestine
CS Tumor Size
SEE STANDARD TABLE

Small Intestine
CS Extension
Note 1: Ignore intraluminal or lateral extension to adjacent segment(s) of small intestine and code depth of invasion or spread outside the small intestine as indicated.
Note 2: The nonperitonealized perimuscular tissue is, for jejunum and ileum, part of the mesentery and, for duodenum in areas where serosa is lacking, part of the retroperitoneum.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
05	(Adeno)carcinoma in a polyp, noninvasive	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS, including intramucosal, NOS	T1	L	L
11	Invasion of lamina propria	T1	L	L
12	Invasion of muscularis mucosae	T1	L	L
13	Confined to head of polyp	T1	L	L
14	Confined to stalk of polyp	T1	L	L
15	Invasion of polyp, NOS	T1	L	L
16	Invasion of submucosa (superficial invasion)	T1	L	L
20	Muscularis propria invaded	T2	L	L

30	Localized, NOS Intraluminal spread to other segments of small intestine or cecum	T1	L	L
40	Invasion through muscularis propria or muscularis, NOS Extension through wall, NOS Subserosal tissue/(sub) serosal fat invaded Transmural, NOS	T3	L	L
42	Fat, NOS	T3	RE	RE
45	Adjacent connective tissue Mesentery, including mesenteric fat, invaded less than or equal to 2 cm in depth or NOS Nonperitonealized perimuscular tissue invaded less than or equal to 2 cm in depth or NOS Retroperitoneum invaded less than or equal to 2 cm in depth or NOS	T3	RE	RE
50	Invasion of/through serosa(mesothelium)(tunica serosa) (visceral peritoneum)	T4	L	RE
55	(50) + [(42) or (45)]	T4	RE	RE
60	For duodenum primary only: Ampulla of Vater Diaphragm Extrahepatic bile ducts Gallbladder Pancreas Pancreatic duct	T4	RE	RE
65	For duodenum primary only: Blood vessel(s), major: Aorta Gastroduodenal artery Portal vein Renal vein Superior mesenteric artery or vein Vena cava Greater omentum Hepatic flexure Kidney, NOS Kidney, right Liver, NOS	T4	RE	RE

65 cont'd	Liver, quadrate lobe Liver, right lobe Omentum, NOS Transverse colon Ureter, right For jejunum or ileum primary only: Colon, including appendix			
66	For duodenum primary only: Stomach	T4	RE	RE
67	For all small intestine sites: Abdominal wall Mesentery invaded greater than 2 cm in depth Non-peritonealized perimuscular tissue invaded greater than 2 cm in depth Retroperitoneum invaded greater than 2 cm in depth	T4	RE	RE
68	For all small intestine sites: Other segments of the small intestine via serosa	T4	RE	RE
70	For jejunum or ileum primary only: Bladder Fallopian tube Ovary Uterus	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Small Intestine
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): For duodenum primaries only: Duodenal	N1	RN	RN

10 cont'd	Gastroduodenal Hepatic Infrapyloric (subpyloric) Pancreaticoduodenal Pyloric For jejunum or ileum primaries only: Ileocolic for terminal ileum primary Mesenteric, NOS Posterior cecal (retrocecal) for terminal ileum primary Superior mesenteric			
20	Regional lymph node(s) for duodenum primaries only: Pericholodochal (common bile duct) Superior mesenteric (See code 11 in CS Mets at DX for other lymph nodes of of small intestine)	N1	D	RN
30	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Small Intestine
Reg LN Pos
SEE STANDARD TABLE

Small Intestine
Reg LN Exam
SEE STANDARD TABLE

Small Intestine
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), other than those listed in code 11 including celiac lymph node(s) Distant lymph node(s), NOS	M1	D	D
11	For jejunum and ileum primaries only: Pericholodochal	M1	D	RN

11 cont'd	(For duodenal primary, see Lymph Nodes field)			
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) or (11)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, **C170–C179**, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
COLON
C180–C189
Grade
Colon cancer is often graded using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as low grade, convert to a grade 2. If the grade is listed as 2/2 or as high grade, convert to a code 4.

Code the highest grade given.

Term	Grade	SEER Code
Well differentiated	I	1
Fairly well differentiated	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Partially well differentiated	II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Pleomorphic	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4

Familial Polyposis

Familial polyposis is an inherited, benign disease. The patients have hundreds of adenomatous polyps throughout their large intestines, and at times, throughout the digestive system. These polyps, if left untreated, invariably develop cancer.

Patients develop polyps as early as ten years of age, but more commonly at puberty. Approximately half of all patients with familial polyposis develop polyps by age 14 and 90% have detectable polyps by age 25.

These patients are usually treated with a colectomy. The pathology report will frequently identify carcinoma in situ in many of the polyps and may also identify invasive carcinomas. Prepare one abstract and code the primary site to colon, NOS (C189). Code the stage of disease using the most invasive of the cancers.

Synonyms for familial polyposis:
Adenomatosis of the colon and rectum (ACR)
Familial adenomatous colon polyposis
Familial adenomatous polyposis (FAP)
Familial colonic polyposis
Multiple familial polyposis
Polyposis coli

Collaborative Staging Codes
Colon
C18.0-C18.9
C18.0 Cecum
C18.1 Appendix
C18.2 Ascending colon
C18.3 Hepatic flexure of colon
C18.4 Transverse colon
C18.5 Splenic flexure of colon
C18.6 Descending colon
C18.7 Sigmoid colon
C18.8 Overlapping lesion of colon
C18.9 Colon, NOS

Colon
CS Tumor Size

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
998	Familial/multiple polyposis (M-8220/8221)
999	Unknown; size not stated Not documented in patient record

Colon

CS Extension

Note 1: Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extracolonic spread as indicated.

Note 2: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Note 3: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
05	(Adeno)carcinoma in a polyp or adenoma, noninvasive	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS (including intramucosal, NOS)	Tis	L	L
**11	Lamina propria, including lamina propria in the stalk of a polyp	Tis	L	L
12	Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp	Tis	L	L
13	Confined to head of polyp, NOS	T1	L	L
14	Confined to stalk of polyp, NOS	T1	L	L
15	Invasive tumor in polyp, NOS	T1	L	L
16	Invades submucosa (superficial invasion), including submucosa in the stalk of a polyp	T1	L	L
20	Muscularis propria invaded	T2	L	L
30	Localized, NOS Confined to colon, NOS	T1	L	L
40	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Non-peritonealized pericolic tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS	T3	L	L
42	Fat, NOS	T3	RE	RE

45	Extension to: All colon sites: Adjacent tissue(s), NOS Connective tissue Mesenteric fat Mesentery Mesocolon Pericolic fat Ascending and descending colon Retroperitoneal fat Transverse colon/flexures Gastrocolic ligament Greater omentum	T3	RE	RE
46	Adherent to other organs or structures, but no microscopic tumor found in adhesion(s)	T3	RE	RE
50	Invasion of/through serosa (mesothelium) (visceral peritoneum)	T4	RE	RE
55	Any of [(42) to (45)] + (50)	T4	RE	RE
57	Adherent to other organs or structures, NOS	T4	RE	RE
60	All colon sites: Small intestine Cecum and appendix: Greater omentum Ascending colon: Greater omentum Liver, right lobe Tranverse colon and flexures: Gallbladder/bile ducts Kidney Liver Pancreas Spleen Stomach Descending colon: Greater omentum Pelvic wall Spleen Sigmoid colon: Greater omentum Pelvic wall	T4	RE	RE

65	All colon sites: Abdominal wall Retroperitoneum (excluding fat)	T4	RE	RE
66	Ascending colon: Right kidney Right ureter Descending colon: Left kidney Left ureter	T4	RE	RE
70	Cecum, appendix, ascending, descending and sigmoid colon: Fallopian tube Ovary Uterus	T4	D	D
75	All colon sites unless otherwise stated above: Adrenal (suprarenal) gland Bladder Diaphragm Fistula to skin Gallbladder Other segment(s) of colon via serosa	T4	D	D
80	Further contiguous extension: Cecum and appendix: Kidney Liver Ureter Transverse colon and flexures: Ureter Sigmoid colon: Cul de sac (rectouterine pouch) Ureter Other contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Revised July 1, 2005

Colon

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Note 3: Inferior mesenteric nodes are coded in CS Mets at DX for cecum, appendix, ascending colon, transverse colon, and hepatic flexure. Superior mesenteric nodes are coded in CS Mets at DX for all colon sites.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) for all colon sites: Colic (NOS) Epicolic (adjacent to bowel wall) Mesocolic (NOS) Paracolic/pericolic Nodule(s) or foci in pericolic fat/adjacent mesentery/ mesocolic fat	*	RN	RN
20	Regional lymph node(s), for specific subsites: Cecum and appendix: Cecal: anterior (prececal), posterior (retrocecal); NOS Ileocolic Right colic Ascending colon: Ileocolic Middle colic Right colic Transverse colon and flexures: Inferior mesenteric for splenic flexure only Left colic for splenic flexure only Middle colic Right colic for hepatic flexure only Descending colon: Inferior mesenteric Left colic Sigmoid Sigmoid colon: Inferior mesenteric Sigmoidal (sigmoid mesenteric) Superior hemorrhoidal	*	RN	RN

20 cont'd	Superior rectal			
30	Regional lymph node(s) for all colon sites: Mesenteric, NOS Regional lymph node(s), NOS	*	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-80 ONLY, the N category is assigned based on the value of Reg LN Pos, using the Lymph Nodes Number Positive Table for this site.

Colon
Reg LN Pos
SEE STANDARD TABLE

Colon
Reg LN Exam
SEE STANDARD TABLE

Colon
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
08	Cecum, appendix, ascending, hepatic flexure and transverse colon: Superior mesenteric lymph node(s)	M1	RN	D
10	Distant lymph node(s) other than code 08 For all colon sites: Common iliac Distant lymph node(s), NOS External iliac Para-aortic Retroperitoneal For cecum, appendix, ascending colon, transverse colon, and hepatic flexure:	M1	D	D

10 cont'd	Inferior mesenteric For splenic flexure, descending colon, and sigmoid colon: Superior mesenteric			
40	Distant metastases except distant lymph node(s) (codes 08-10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + [(08) or (10)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Colon
C180–C189
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
27 Excisional biopsy
26 Polypectomy, NOS
28 Polypectomy-endoscopic
29 Polypectomy-surgical excision

Any **combination** of **20** or **26–29** WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic or 29 Polypectomy-surgical excision WITH 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–29

30 **Partial colectomy**, [but less than hemicolectomy] **segmental** resection
32 Plus resection of contiguous organ; example: small bowel, bladder

Codes 30 and 32 include but are not limited to: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection, such as cecectomy or sigmoidectomy. Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ.

40 **Subtotal colectomy/hemicolectomy** (total right or left colon and a portion of transverse colon)
41 Plus resection of contiguous organ; example: small bowel, bladder

[***SEER Notes:*** Code 40 includes extended (but less than total) right or left colectomy Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]

50 **Total colectomy** (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
51 Plus resection of contiguous organ; example: small bowel, bladder

[***SEER Note:*** Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)

[***SEER Note:*** Commonly used for familial polyposis or polyposis coli]

61 Plus resection of contiguous organ; example: small bowel, bladder

[***SEER Note:*** Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

[***SEER Note:*** **Code 70 includes**: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Rectosigmoid, Rectum
C19.9, C20.9
C19.9 Rectosigmoid junction
C20.9 Rectum, NOS

Rectosigmoid, Rectum
CS Tumor Size

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only; no size 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
998	Familial/multiple polyposis (M-8220/8221)
999	Unknown; size not stated Not documented in patient record

Rectosigmoid, Rectum
CS Extension
Note 1: Ignore intraluminal extension to adjacent segment(s) of colon/rectum and code depth of invasion or extracolonic spread as indicated.
Note 2: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.
Note 3: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS

05	(Adeno)carcinoma in a polyp or adenoma, noninvasive	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS, including intramucosal, NOS	Tis	L	L
11	Lamina propria, including lamina propria in the stalk of a polyp	Tis	L	L
12	Muscularis mucosae, including muscularis mucosae in the stalk of a polyp	T1	L	L
13	Confined to head of polyp, NOS	T1	L	L
14	Confined to stalk of polyp, NOS	T1	L	L
15	Invasive tumor in polyp, NOS	T1	L	L
16	Submucosa (superficial invasion), including submucosa in the stalk of a polyp	T1	L	L
20	Muscularis propria invaded	T2	L	L
30	Localized, NOS Confined to rectum, NOS	TX	L	L
40	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Non-peritonealized pericolic tissues invaded Transmural, NOS	T3	L	L
42	Fat, NOS	T3	RE	RE
45	Adjacent (connective) tissue: For all sites: Perirectal fat For rectosigmoid: Mesentery (including mesenteric fat, mesocolon) Pericolic fat For rectum: Extension to anus Rectovaginal septum	T3	RE	RE
46	Adherent to other organs or structures but no tumor found in adhesion(s)	T3	RE	RE
50	Invasion of/through serosa (mesothelium) (visceral peritoneum)	T4	RE	RE

55	(50) with [(42) or (45)]	T4	RE	RE
57	Adherent to other organs or structures, NOS	T4	RE	RE
60	Rectosigmoid: Cul de sac (rectouterine pouch) Pelvic wall Small intestine Rectum: Bladder for males only Cul de sac (rectouterine pouch) Ductus deferens Pelvic wall Prostate Rectovesical fascia for male only Seminal vesicle(s) Skeletal muscle of pelvic floor Vagina	T4	RE	RE
70	Rectosigmoid: Bladder Colon via serosa Fallopian tube(s) Ovary(ies) Prostate Ureter(s) Uterus Rectum: Bladder for female only Bone(s) of pelvis Urethra Uterus	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Rectosigmoid, Rectum
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: A tumor nodule in the perirectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Rectosigmoid: Paracolic/pericolic Perirectal Rectal Nodule(s) or foci in pericolic fat/adjacent mesentery/mesocolic fat Rectum: Perirectal Rectal, NOS Nodule(s) or foci in perirectal fat	*	RN	RN
20	Regional lymph node(s): Rectosigmoid: Colic, NOS Left colic Hemorrhoidal, superior or middle Inferior mesenteric Middle rectal Sigmoidal (sigmoid mesenteric) Superior rectal Rectum: Hemorrhoidal, superior, middle or inferior Inferior mesenteric Internal iliac (hypogastric) Obturator Rectal, superior, middle, or inferior Sacral, NOS Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Sacral promotory Sigmoidal (sigmoid mesenteric)	*	RN	RN

30	Mesenteric, NOS Regional lymph node(s), NOS	*	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For Lymph Nodes codes 10-80 ONLY, the N category is assigned based on the value of Reg LN Pos, using the Lymph Nodes Number Positive Table for this site:

Rectosigmoid, Rectum
Reg LN Pos
SEE STANDARD TABLE

Rectosigmoid, Rectum
Reg LN Exam
SEE STANDARD TABLE

Rectosigmoid, Rectum
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Rectosigmoid: Internal iliac (hypogastric) Obturator	M1	RN	D
12	Other distant lymph node(s), including external iliac or common iliac	M1	D	D
40	Distant metastases except distant lymph node(s) codes 10-12 Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) to (12)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Anus
Anal Canal; Anus, NOS; Other Parts of Rectum
C21.0-C21.2, C21.8
C21.0 Anus, NOS (excludes skin of anus and perianal skin C44.5)
C21.1 Anal canal
C21.2 Cloacogenic zone
C21.8 Overlapping lesion of rectum, anus and anal canal
Note: Skin of anus is coded separately (C44.5).

Anus
CS Tumor Size
SEE STANDARD TABLE

Anus
CS Extension
Note: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to mucosa, NOS (including intramucosal, NOS)	*	L	L
11	Invades lamina propria	*	L	L
12	Invades muscularis mucosae	*	L	L
16	Invades submucosa (superficial invasion)	*	L	L
20	Invades muscularis propria (internal sphincter)	*	L	L
30	Localized, NOS	*	L	L
40	Ischiorectal fat/tissue Perianal skin Perirectal skin Rectal mucosa or submucosa Rectal wall Skeletal muscles: Anal sphincter (external) Levator ani Subcutaneous perianal tissue	*	RE	RE
60	Perineum Vulva	T4	RE	RE

70	Bladder Pelvic peritoneum Urethra Vagina	T4	D	D
75	Broad ligament(s) Cervix uteri Corpus uteri Prostate	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For codes 10-40 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Anus

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Unilateral and bilateral: For all subsites: Anorectal Inferior hemorrhoidal Lateral sacral (laterosacral) Perirectal	N1	RN	RN
20	Unilateral: For anal canal: Internal iliac (hypogastric) Obturator	N2	RN	RN
21	Unilateral: For anus: Internal iliac (hypogastric) Obturator	N2	D	RN
30	Unilateral: For anal canal:	N2	RN	RN

30 cont'd	Superficial inguinal (femoral)			
31	Unilateral: For anus: Superficial inguinal (femoral)	N2	D	RN
40	(20) + (30)	N2	RN	RN
41	(10) + (30)	N3	RN	RN
42	(10) + (31)	N3	D	RN
50	Bilateral: For anal canal: Internal iliac (hypogastric) Obturator Superficial inguinal (femoral)	N3	RN	RN
51	Bilateral: For anus: Internal iliac (hypogastric) Obturator Superficial inguinal (femoral)	N3	D	RN
60	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Anus
Reg LN Pos
SEE STANDARD TABLE

Anus
Reg LN Exam
SEE STANDARD TABLE

Anus
CS Mets at DX
SEE STANDARD TABLE

Site-Specific Surgery Codes
Rectosigmoid
C199
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:
- Anterior resection
- Hartmann operation
- Low anterior resection (LAR)

Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

[***SEER Note:*** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's o peration]

50 Total proctectomy

[***SEER Note:*** Procedures coded 50 include but are not limited to: Abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]

51 Total colectomy

[***SEER Note:*** Removal of the colon from cecum to rectosigmoid or portion of rectum]

55 Total colectomy WITH ileostomy, NOS
56 Ileorectal reconstruction
57 Total colectomy WITH other pouch; example: Koch pouch

60 **Total proctocolectomy**, NOS [combination of 50 and 51]
65 Total proctocolectomy WITH ileostomy, NOS
66 Total proctocolectomy WITH ileostomy and pouch

[***SEER Note:*** Removal of the colon from cecum to the rectosigmoid junction including the entire rectum.]

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

[***SEER Notes:*** Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary. In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
Rectum
C209
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 **Local** tumor **destruction**, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10-14

20 **Local** tumor **excision**, NOS
27 Excisional biopsy
26 Polypectomy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision
28 Curette and fulguration

[***SEER Note:*** Codes 21 to 25 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, 25 Laser excision, or 28 Curette and fulguration]

Specimen sent to **pathology** from surgical events 20–28

30 **Wedge or segmental resection**; partial proctectomy, NOS
Procedures coded 30 include, but are not limited to:
Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

[***SEER Note:*** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50 Total proctectomy
Procedure coded 50 includes, but is not limited to: Abdominoperineal resection (Miles Procedure)

[***SEER Note:*** Also called A & P resection, anterior/posterior (A/P) resection/Miles' operation, Rankin's operation]

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Proctectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
Anus
C210–C218
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Thermal ablation

No specimen sent to **pathology** from surgical events 10–15

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Note:*** Margins of resection may have microscopic involvement]

60 **Abdominal perineal resection**, NOS (APR; Miles procedure)
61 APR and sentinel node excision
62 APR and unilateral inguinal lymph node dissection
63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Liver and Intrahepatic Bile Ducts
C22.0-C22.1
C22.0 Liver
C22.1 Intrahepatic bile duct

Liver and Intrahepatic Bile Ducts
CS Tumor Size
SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts
CS Extension
Note 1: In codes 30, 40, and 65, "multiple (satellite) nodules/tumors" includes satellitosis, multifocal tumors, and intrahepatic metastases.
Note 2: Major vascular invasion (code 63) is defined as invasion of the branches of the main portal vein (right or left portal vein, not including sectoral or segmental branches) or as invasion of one or more of the three hepatic veins (right, middle, or left). Invasion of hepatic artery or vena cava is coded to 66.

Code	Description	TNM	SS77	SS2000
10	Single lesion (one lobe) WITHOUT intrahepatic vascular invasion, including vascular invasion not stated	T1	L	L
20	Single lesion (one lobe) WITH intrahepatic vascular invasion	T2	L	L
30	Multiple (satellite) nodules/tumors (one lobe) WITHOUT intrahepatic vascular invasion, including vascular invasion not stated	*	L	L
40	Multiple (satellite) nodules/tumors (one lobe) WITH intrahepatic vascular invasion	*	L	L
50	Confined to liver, NOS Localized, NOS	T1	L	L
51	More than one lobe involved by contiguous growth (single lesion) WITHOUT vascular invasion, including vascular invasion not stated	T1	RE	RE
52	More than one lobe involved by contiguous growth (single lesion) WITH vascular invasion	T2	RE	RE

53	Extension to gallbladder, extent within liver not stated	T1	RE	RE
54	Single lesion with extension to gallbladder + [(10) or (51)]	T1	RE	RE
55	Single lesion with extension to gallbladder + [(20) or (52)]	T2	RE	RE
56	Extension to gallbladder + [(30) or (40)]	*	RE	RE
58	Extrahepatic bile ducts	T2	RE	RE
63	Major vascular invasion: major branch(es) of portal or hepatic vein(s) (see Note 2)	T3	RE	RE
64	Direct extension/perforation of visceral peritoneum	T4	RE	RE
65	Multiple (satellite) nodules/tumors in more than one lobe of liver or on surface of parenchyma Satellite nodules, NOS	*	D	RE
66	Extension to hepatic artery or vena cava	T4	RE	RE
67	(63) + (65)	T3	D	RE
70	Diaphragm	T4	RE	RE
75	Lesser omentum Ligament(s): Coronary Falciform Round [of liver] Hepatoduodenal Hepatogastric Triangular Parietal peritoneum	T4	RE	RE
76	[(65) or (67)] + any of [(64) or (66) or (70) or (75)]	T4	D	RE
80	Further contiguous extension: Pancreas Pleura Stomach Other contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 30, 40, 56, and 65 ONLY, the T category is assigned based on the value of CS Tumor Size, as

shown in the Extension Size Table for this site.

Liver and Intrahepatic Bile Ducts
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Hepatic NOS: Hepatic artery Hepatic pedicle Inferior vena cava Porta hepatis (hilar) [in hilus of liver] Hepatoduodenal ligament Periportal Portal vein Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Liver and Intrahepatic Bile Ducts
Reg LN Pos
SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts
Reg LN Exam
SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph node(s): Cardiac Lateral (aortic) (lumbar)	M1	RN	D

11 cont'd	Pericardial (pericardiac) Posterior mediastinal (tracheoesophageal) including juxtaphrenic nodes Retroperitoneal, NOS			
12	Distant lymph node(s): Coronary artery Renal artery	M1	RN	D
13	Distant lymph node(s): Aortic (para-, peri-) Diaphragmatic, NOS Peripancreatic (near head of pancreas only)	M1	D	D
15	Distant lymph node(s) other than codes 10-13, including inferior phrenic nodes	M1	D	D
40	Distant metastasis except distant lymph node(s) (codes 10-15) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) or (11) or (15)] Distant lymph node(s) plus other distant metastases	M1	D	D
52	(40) + [(12) or (13)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Primary tumor cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Liver and Intrahepatic Bile Ducts
C220–C221
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)
Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Alcohol (Percutaneous Ethanol Injection-PEI)
16 Heat-Radio-frequency ablation (RFA)
17 Other (ultrasound, acetic acid)

No specimen sent to **pathology** from surgical events 10–17

[***SEER Note:*** Code 15 Alcohol (Percutaneous Ethanol Injection-PEI) can also be described as an "intratumoral injection of alcohol" or "alcohol ablation"]

20 Wedge or segmental resection, NOS
21 Wedge resection
22 Segmental resection, NOS
23 One
24 Two
25 Three
26 Segmental resection AND local tumor destruction

Specimen sent to **pathology** from surgical events 20–26

30 Lobectomy, NOS
36 Right lobectomy
37 Left lobectomy
38 Lobectomy AND local tumor destruction

[***SEER Note:*** Code 30 also referred to as simple lobectomy]

50 **Extended lobectomy**, NOS (extended: resection of a single lobe plus a segment of another lobe)
51 Right lobectomy
52 Left lobectomy
59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
61 Total hepatectomy and **transplant**

65 **Excision** of a **bile duct** (for an intrahepatic bile duct primary only)
66 Excision of a bile duct PLUS partial hepatectomy

75 Bile duct and hepatectomy WITH transplant

90 Surgery, NOS
99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Gallbladder
C23.9
C23.9 Gallbladder

Gallbladder
CS Tumor Size
SEE STANDARD TABLE

Gallbladder
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion)	T1a	L	L
20	Muscularis propria	T1b	L	L
30	Localized, NOS	T1NOS	L	L
40	Perimuscular connective tissue	T2	RE	RE
50	Invasion of/through serosa (visceral peritoneum)	T3	L	RE
55	(40) + (50)	T3	RE	RE
60	Extension into liver, NOS	T3	RE	RE
61	Extension into liver less than or equal to 2 cm	T3	RE	RE
62	Extension to ONE of the following: Ampulla of Vater Duodenum Extrahepatic bile duct(s) Omentum, NOS Greater Lesser Pancreas Small intestine, NOS	T3	RE	RE

65	Extension to ONE of the following WITHOUT extension to any structure in (62): Colon Stomach	T3	RE	RE
66	Extension to cystic artery/vein WITHOUT extension to any structure in [(62) to (65)]	T3	RE	D
67	[(60) or (61)] PLUS extension to ONE structure in codes [(62) to (65)]	T3	RE	RE
68	(66) + [(60) or (61)]	T3	RE	D
71	Extension into liver greater than 2 cm WITHOUT extension to any structure in codes [(62) to (66)]	T3	D	D
72	Extension into liver greater than 2 cm PLUS extension to ONE structure in codes [(62) to (66)]	T3	D	D
73	Extension to two or more structures in codes [(62) to (66)], WITH or WITHOUT extension into liver of any depth	T4	D	D
75	Extension to: Hepatic artery Portal vein	T4	RE	D
78	(75) + any of [(60) to (73)]	T4	D	D
80	Further contiguous extension, including: Abdominal wall Diaphragm	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Gallbladder

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX. Also note that celiac and superior mesenteric nodes are listed in this field rather than Mets at DX, because AJCC classifies them as N1 and not M1.

Code	Description	TNM	SS77	SS2000

00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Cystic duct (Calot's node) Node of foramen of Winslow (omental) (epiploic) Pericholedochal (common bile duct)	N1	RN	RN
11	Regional lymph node(s): Porta hepatis (portal) (periportal) (hilar) (in hilus of liver)	N1	D	RN
20	Regional lymph node(s): Pancreaticoduodenal	N1	RN	RN
21	Regional lymph node(s): Periduodenal Peripancreatic (near head of pancreas only)	N1	D	RN
25	(11) + (20)	N1	D	RN
30	Regional lymph node(s), NOS	N1	RN	RN
**50	Celiac lymph node(s)	N1	D	D
**60	Superior mesenteric lymph node(s)	N1	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

**Updated July 1, 2005

Gallbladder
Reg LN Pos
SEE STANDARD TABLE

Gallbladder
Reg LN Exam
SEE STANDARD TABLE

Gallbladder
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), including:	M1	D	D

10 cont'd	Para-aortic Peripancreatic (along body and tail of pancreas only) Distant lymph node(s), NOS			
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Extrahepatic Bile Duct(s)
C24.0
C24.0 Extrahepatic bile duct

Extrahepatic Bile Duct(s)
CS Tumor Size
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor of extrahepatic bile duct(s) (choledochal, common, cystic, and hepatic) confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion)	T1	L	L
20	Muscularis propria	T1	L	L
30	Localized, NOS	T1	L	L
40	Beyond wall of bile duct Periductal/fibromuscular connective tissue	T2	RE	RE
60	Gallbladder Liver, porta hepatis Pancreas	T3	RE	RE
61	Unilateral branches of hepatic artery (right or left) Unilateral branches of portal vein (right or left)	T3	RE	RE
65	Colon, NOS Transverse including flexure Duodenum, NOS Omentum, NOS Lesser Stomach, distal	T4	RE	RE
66	Common hepatic artery Hepatic artery, NOS Main main portal vein or its branches bilaterally Portal vein, NOS	T4	RE	RE
70	Other parts of colon	T4	D	RE

70 cont'd	Greater omentum Stomach, proximal			
75	Abdominal wall	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Extrahepatic Bile Duct(s)
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
15	Regional lymph node(s): Cystic duct (node of the neck of the gallbladder) (Calot's node) Hepatic Hilar (in the hepatoduodenal ligament) Node of the foramen of Winslow (omental) (epiploic) Pancreaticoduodenal Pericholedochal (node around common bile duct) Periduodenal Peripancreatic (near head of pancreas only) Periportal Porta hepatis (portal) (hilar) (in hilus of liver) Regional lymph node(s), NOS	N1	RN	RN
35	Regional lymph node(s): Celiac Superior mesenteric	N1	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Extrahepatic Bile Duct(s)
Reg LN Pos
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
Reg LN Exam
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) including: Para-aortic Peripancreatic (along body and tail of pancreas only) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastases, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Ampulla of Vater
C24.1
C24.1 Ampulla of Vater

Ampulla of Vater
CS Tumor Size
SEE STANDARD TABLE

Ampulla of Vater
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined/limited to ampulla of Vater or extending to sphincter of Oddi	T1	L	L
30	Localized, NOS	T1	L	L
42	Duodenal wall	T2	RE	RE
52	Pancreas	T3	RE	RE
62	Common bile duct	T4	RE	RE
65	Extrahepatic bile ducts other than common bile duct or sphincter of Oddi	T4	RE	RE
70	Extension to other adjacent organs or tissues: Blood vessels(major): Hepatic artery Portal vein Gallbladder Hepatic flexure Lesser omentum Liver including porta hepatis Peripancreatic soft tissues Stomach, NOS: Distal Transverse colon	T4	RE	RE
75	Stomach, proximal	T4	RE	D
80	Further contiguous extension Other adjacent organs	T4	D	D
95	No evidence of primary tumor	T0	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Ampulla of Vater
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: Splenic lymph nodes and those located at the tail of the pancreas are not considered regional and should be coded under Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Hepatic Hepatic artery Node of the foramen of Winslow (epiploic) (omental) Pancreaticoduodenal Peripancreatic (except at tail of pancreas, see CS Mets at DX) Periportal Lymph node(s): Anterior to the ampulla of Vater Inferior to the ampulla of Vater Posterior to the ampulla of Vater Superior to the ampulla of Vater Regional lymph node(s), NOS	N1	RN	RN
11	Regional lymph node(s): Celiac Infrapyloric (subpyloric) Lateral aortic (lumbar) Proximal mesenteric Retroperitoneal Superior mesenteric	N1	D	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Ampulla of Vater
Reg LN Pos
SEE STANDARD TABLE

Ampulla of Vater
Reg LN Exam
SEE STANDARD TABLE

Ampulla of Vater
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Node(s) at the tail of the pancreas Para-aortic Splenic lymph node(s) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Carcinomatosis Distant metastasis, NOS (Includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology)	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patientrecord	MX	U	U

Collaborative Staging Codes
Other Biliary and Biliary, NOS
C24.8-C24.9
C24.8 Overlapping lesion of biliary tract (neoplasms involving both intrahepatic and extrahepatic bile ducts)
C24.9 Biliary tract, NOS

Other Biliary and Biliary, NOS
CS Tumor Size
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion)	T1	L	L
20	Muscularis propria	T1	L	L
30	Localized, NOS Tumor confined to bile duct	T1	L	L
40	Perimuscular connective tissue Tumor invades beyond the wall of the bile duct	T2	RE	RE
50	Invasion of/through serosa	T2	L	RE
55	(40) + (50)	T2	RE	RE
60	Extension into liver, NOS	T3	RE	RE
61	Extension into liver less than or equal to 2 cm	T3	RE	RE
62	Extension to ONE of the following: Ampulla of Vater Omentum, NOS Greater Lesser Pancreas Small intestine, NOS	T3	RE	RE
63	Gallbladder	T3	RE	RE

63 cont'd	Unilateral branches of the right or left portal vein Unilateral branches of the right or left hepatic artery			
65	Extension to ONE of the following: Colon Stomach	T4	D	D
66	Abdominal wall Duodenum	T4	RE	RE
70	Extension into liver greater than 2 cm Extension to two or more adjacent organs listed in codes [(60) to (63)]	T3	D	D
71	Extension to two or more adjacent organs any of which are in codes [(65) to (66)]	T4	D	D
75	Common hepatic artery Cystic artery/vein Hepatic artery, NOS Portal vein or its branches bilaterally Portal vein, NOS	T4	RE	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Other Biliary and Biliary, NOS
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Cystic duct (Calot's node) Node of foramen of Winslow (epiploic) (omental) Pericholedochal (common bile duct)	N1	RN	RN
11	Regional lymph node(s):	N1	D	RN

11 cont'd	Porta hepatis (portal) (hilar) [in hilus of liver]			
20	Regional lymph node(s): Pancreaticoduodenal Periportal	N1	RN	RN
21	Regional lymph node(s): Periduodenal Peripancreatic (near head of pancreas only)	N1	D	RN
30	Regional lymph node(s), NOS	N1	RN	RN
**50	Celiac	N1	D	D
**60	Superior mesenteric	N1	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

**Updated July 1, 2005

Other Biliary and Biliary, NOS
Reg LN Pos
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
Reg LN Exam
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) including: Para-aortic	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastases, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, **C239**, **C240–C249**, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Pancreas: Head
C25.0
C25.0 Head of pancreas
Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and the corresponding Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified.

Pancreas: Head
CS Tumor Size
SEE STANDARD TABLE

Pancreas: Head
CS Extension
Note 1: Islets of Langerhans are distributed throughout the pancreas, and therefore any extension code can be used.
Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive PanIn III Pancreatic Intraepithelial Neoplasia III	Tis	IS	IS
10	Confined to pancreas	*	L	L
30	Localized, NOS	*	L	L
40	Extension to peripancreatic tissue, NOS Fixation to adjacent structures, NOS	T3	RE	RE
44	Ampulla of Vater Duodenum Extrahepatic bile duct(s)	T3	RE	RE
50	Adjacent stomach Stomach, NOS	T3	RE	RE
54	Blood vessel(s) (major): Gastroduodenal artery Hepatic artery Pancreaticoduodenal artery Portal vein ** Superior mesenteric artery Transverse colon, including hepatic flexure	T3	RE	RE

55	Mesenteric fat Mesentery Mesocolon Peritoneum	T3	RE	D
57	Gallbladder	T3	RE	D
58	Body of stomach	T3	D	RE
59	(58) + [(55) or (57)]	T3	D	D
60	Tumor is inseparable from the superior mesenteric artery Superior mesenteric artery	T4	RE	RE
61	Omentum	T4	RE	D
63	Liver (including porta hepatis)	T4	RE	D
65	(60) + [(55) or (57)]	T4	RE	D
66	(60) + (58)	T4	D	RE
67	(60 + 59) OR any of [(61 to 65)] + [(58) or (59)] OR (66) + any of [(55) or (57) or (59) or (61) or (63) or (65)]	T4	D	D
68	Tumor is inseparable from the celiac axis Aorta Celiac artery	T4	D	D
69	Colon (other than transverse colon including hepatic flexure) Spleen	T4	D	D
78	Adrenal (suprarenal) gland Ileum Jejunum Kidney Retroperitoneum Ureter	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension 10 and 30, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table. ** Updated July 1, 2005

Pancreas: Head
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Celiac Gastroepiploic (gastro-omental), left Hepatic Infrapyloric (subpyloric) Lateral aortic (lumbar) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Superior mesenteric Regional lymph node(s), NOS	N1	RN	RN
20	Pancreaticosplenic (pancreaticolienal) Splenic (lienal), NOS Superior hilum Suprapancreatic	N1	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Pancreas: Head
Reg LN Pos
SEE STANDARD TABLE

Pancreas: Head
Reg LN Exam
SEE STANDARD TABLE

Pancreas: Head
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Pancreas: Body and Tail
C25.1-C25.2
C25.1 Body of pancreas
C25.2 Tail of pancreas
Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and corresponding the Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified

Pancreas: Body and Tail
CS Tumor Size
SEE STANDARD TABLE

Pancreas: Body and Tail
CS Extension
Note 1: Islets of Langerhans are distributed throughout the pancreas, and therefore any extension code can be used.
Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive PanIn III Pancreatic Intraepithelial Neoplasia III	Tis	IS	IS
10	Confined to pancreas	*	L	L
30	Localized, NOS	*	L	L
40	Extension to peripancreatic tissue, NOS Fixation to adjacent structures, NOS	T3	RE	RE
44	Duodenum	T3	RE	RE
48	Ampulla of Vater Extrahepatic bile duct(s)	T3	RE	RE
50	Spleen	T3	RE	RE
56	Blood vessel(s): Hepatic artery Portal vein Splenic artery/vein Superior mesenteric vein Splenic flexure of colon	T3	RE	RE

57	Kidney, NOS Left adrenal (suprarenal) gland Left kidney Left ureter	T3	RE	D
58	Mesenteric fat Mesentery Mesocolon Peritoneum	T3	RE	D
59	Retroperitoneal soft tissue (retroperitoneal space)	T3	D	D
60	Tumor is inseparable from the celiac axis or superior mesenteric artery Aorta Celiac artery Superior mesenteric artery	T4	RE	RE
62	Stomach	T4	RE	RE
70	[(60) or (62)] + [(57) or (58)]	T4	RE	D
71	Ileum Jejunum	T4	RE	D
73	Gallbladder Liver (including porta hepatis)	T4	RE	D
75	(59) + any of [(60) or (62) or (71) or (73)]	T4	D	D
77	Colon (other than splenic flexure)	T4	D	D
78	Diaphragm Right adrenal (suprarenal) gland Right kidney Right ureter	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Pancreas: Body and Tail
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Hepatic Lateral aortic (lumbar) Pancreaticosplenic (pancreaticolienal) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Splenic (lienal) Gastroepiploic Splenic hilum Suprapancreatic Superior mesenteric Regional lymph node(s), NOS	N1	RN	RN
20	Regional lymph node(s): Celiac Infrapyloric (subpyloric)	N1	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Pancreas: Body and Tail
Reg LN Pos
SEE STANDARD TABLE

Pancreas: Body and Tail
Reg LN Exam
SEE STANDARD TABLE

Pancreas: Body and Tail
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Pancreas: Other and Unspecified
C25.3-C25.4, C25.7-C25.9
C25.3 Pancreatic duct
C25.4 Islets of Langerhans
C25.7 Other specified parts of pancreas
C25.8 Overlapping lesion of pancreas
C25.9 Pancreas, NOS
Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and the corresponding Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified.

Pancreas: Other and Unspecified
CS Tumor Size
SEE STANDARD TABLE

Pancreas: Other and Unspecified
CS Extension
Note 1: Islets of Langerhans are distributed throughout the pancreas, and, therefore, any extension code can be used.
Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive PanIn III Pancreatic intraepithelial neoplasia III	Tis	IS	IS
10	Confined to pancreas	*	L	L
30	Localized, NOS	*	L	L
40	Peripancreatic tissue	T3	RE	RE
45	Ampulla of Vater Duodenum Extra hepatic bile duct(s)	T3	RE	RE
50	Adjacent large vessel(s) (except as listed in code 60) Colon Spleen Stomach	T3	RE	RE
60	Tumor is inseparable from the celiac axis or superior mesenteric artery	T4	RE	RE

60 cont'd	Aorta Celiac artery Superior mesenteric artery			
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Pancreas: Other and Unspecified

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Celiac Hepatic Infrapyloric (subpyloric) Lateral aortic (lumbar) Pancreaticosplenic (pancreaticolienal) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Splenic (lienal), NOS Gastroepiploic (gastro-omental), left Splenic hilum Suprapancreatic Superior mesenteric Regional lymph node(s), NOS	N1	RN	RN

80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Pancreas: Other and Unspecified
Reg LN Pos
SEE STANDARD TABLE

Pancreas: Other and Unspecified
Reg LN Exam
SEE STANDARD TABLE

Pancreas: Other and Unspecified
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Other and Ill-Defined Digestive Organs
C26.0, C26.8-C26.9
C26.0 Intestinal tract, NOS
C26.8 Overlapping lesion of digestive system
C26.9 Gastrointestinal tract, NOS
Note: AJCC does not define TNM staging for this site.

Other and Ill-Defined Digestive Organs
CS Tumor Size
SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs
CS Extension
Note 1: Definition of Adjacent Connective Tissue: Some of the schemes for ill-defined or non-specific sites in this manual contain a code 40, adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs.
Note 2: Definition of Adjacent Structures: Connective tissues large enough to be given a specific name would be considered adjacent structures. For example, the brachial artery has a name, as does the broad ligament. Continuous tumor growth from one organ into an adjacent named structure would be coded to 60 in the schemes for ill-defined or non-specific sites.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Invasion of submucosa	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (see Note 1)	NA	RE	RE
60	Adjacent organs/structures (see Note 2)	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Ill-Defined Digestive Organs
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s) Intra-abdominal Paracaval Pelvic Subdiaphragmatic Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Other and Ill-Defined Digestive Organs
Reg LN Pos
SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs
Reg LN Exam
SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
Pancreas
C250–C259
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

25 **Local excision** of tumor, NOS

30 **Partial pancreatectomy**, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
36 WITHOUT distal/partial gastrectomy
37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, **C260–C269**, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Nasal Cavity
C30.0
C30.0 Nasal cavity (excludes nose, NOS C76.0)
Note: Laterality must be coded for this site, except subsites Nasal cartilage and Nasal septum, for which laterality is coded 0

Nasal Cavity
CS Tumor Size
SEE STANDARD TABLE

Nasal Cavity
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive	Tis	IS	IS
10	Invasive tumor confined to site of origin Meatus (superior, middle, inferior) Nasal chonchae (superior, middle, inferior) Septum Tympanic membrane	T1	L	L
30	Localized, NOS	T1	L	L
40	Extending to adjacent connective tissue within the nasoethomoidal complex Nasolacrimal duct	T2	RE	RE
60	Adjacent organs/structures including: Bone of skull Choana Frontal sinus Hard palate Nasopharynx	T3	RE	RE
65	Cribriform plate	T3	RE	RE
66	Maxillary sinus	T3	RE	RE
67	Medial wall or floor of the orbit	T3	RE	RE

70	Tumor invades: Anterior orbital contents Skin of cheek Skin of nose Minimal extension to: Anterior cranial fossa Pterygoid plates Sphenoid or frontal sinuses	T4a	D	D
71	Tumor invades: Orbital apex Dura Brain Middle cranial fossa Cranial nerves other than (V2), nasopharynx, or clivus	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Nasal Cavity
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of nvolved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Sublingual Submandibular (submaxillary) Submental Level II node	*	RN	RN

10 cont'd	Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Retropharyngeal Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotrachea Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D

18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple or regional	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Nasal Cavity
Reg LN Pos
SEE STANDARD TABLE

Nasal Cavity
Reg LN Exam
SEE STANDARD TABLE

Nasal Cavity
CS Mets at Diagnosis
SEE STANDARD TABLE

Collaborative Staging Codes
Middle Ear
C30.1
C30.1 Middle ear
Note 1: Laterality must be coded for this site.
Note 2: AJCC does not define TNM staging for this site

Middle Ear
CS Tumor Size
SEE STANDARD TABLE

Middle Ear
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive	NA	IS	IS
10	Invasive tumor confined to: Cochlea Incus Malleus Semicircular ducts, NOS: Ampullae Saccule Utricle Septum Stapes Tympanic membrane	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue: Auditory tube Nerve(s) Pharyngotympanic tube	NA	RE	RE
60	Adjacent organs/structures: External auditory meatus Internal carotid artery Mastoid antrum Nasopharynx Temporal bone	NA	RE	RE
80	Further contiguous extension Meninges	NA	D	D

95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Middle Ear

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Sublingual Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Retropharyngeal Regional lymph node, NOS	NA	RN	RN
12	Single positive ipsilateral regional node: Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical	NA	D	D

12 cont'd	Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotrachea Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

**Updated July 1, 2005

Middle Ear
Reg LN Pos
SEE STANDARD TABLE

Middle Ear
Reg LN Exam
SEE STANDARD TABLE

Middle Ear
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes

All Other Sites

C142–C148, C170–C179, C239, C240–C249, C260–C269, **C300–C301,** C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Maxillary Sinus
C31.0
C31.0 Maxillary sinus
Note: Laterality must be coded for this site.

Maxillary Sinus
CS Tumor Size
SEE STANDARD TABLE

Maxillary Sinus
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Invasive tumor confined to mucosa of maxillary antrum (sinus) without erosion or destruction of bone	T1	L	L
30	Localized, NOS	T1	L	L
40	Invasion of infrastructure: Hard palate except extension to posterior wall of sinus pterygoid plates (code 68) Middle nasal meatus, except extension to posterior wall of sinus and pterygoid plates (code 68) Nasal cavity (floor, lateral wall, septum, turbinates) Palatine bone Tumor causing bone erosion or destruction, except for the posterior antral wall	T2	RE	RE
60	Invasion of suprastructure: Ethmoid sinus, anterior Floor or medial wall of orbit Floor or posterior wall of maxillary sinus Subcutaneous tissues	T3	RE	RE
65	Bone of the posterior wall of maxillary sinus Invasion of maxilla, NOS	T3	RE	RE
66	Ethmoid sinus Posterior ethmoid, NOS Pterygoid sinus	T3	RE	RE
68	Anterior orbital contents Cribriform plate	T4a	RE	RE

68 cont'd	Frontal sinus Infratemporal fossa Pterygoid plates Skin of cheek Sphenoid sinus			
70	Base of skull Orbital contents, including eye Pterygomaxillary or temporal fossa Soft palate	T4b	RE	RE
75	Brain Clivus Cranial nerves other than (V2) Dura Middle cranial fossa Nasopharynx Orbital apex	T4b	RE	RE
80	Further contiguous extension	T4NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Maxillary Sinus

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary)	*	RN	RN

10 cont'd	Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohoyoid (supramohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	D

18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple or regional	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Tablefor this site.
**Updated July 1, 2005

Maxillary Sinus
Reg LN Pos
SEE STANDARD TABLE

Maxillary Sinus
Reg LN Exam
SEE STANDARD TABLE

Maxillary Sinus
CS Mets at DX
SEE STANDARD TABLE

Collaborative Staging Codes
Ethmoid Sinus
C31.1
C31.1 Ethmoid sinus

Ethmoid Sinus
CS Tumor Size
SEE STANDARD TABLE

Ethmoid Sinus
CS Extension
Note 1: Involvement of or extension to bone includes any type of tumor extension to the bone, such as erosion, invasion, extension, penetration, or destruction.
Note 2: Extension to structures in codes 40 and higher may be from one or both ethmoid sinuses.
Note 3: In code 70, "minimal extension to anterior cranial fossa" implies tumor pushing through cribriform plate, but without invasion of the dura or brain.
Note 4: For involvement of base of skull, NOS, try to determine if the involvement is anterior skull base (cribriform plate, code 63, or roof of orbit, code 76) or central (clivus, code 76). If more specific information is not available, use code 62.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
12	Invasive tumor confined to left or right ethmoid sinus without bone involvement	T1	L	L
14	Confined to both ethmoid sinuses without bone involvement	T2	RE	RE
16	Confined to ethmoid, NOS without bone involvement	T1	L	L
22	Invasive tumor confined to either left or right ethmoid WITH bony invasion (involvement of perpendicular plate of ethmoid bone or ethmoid air cells)	T1	L	L
24	Confined to both ethmoid sinuses WITH bony invasion (involvement of perpendicular plate of ethmoid bone or ethmoid air cells)	T2	RE	RE
26	Confined to ethmoid, NOS with bone invasion (involvement of perpendicular plate of ethmoid bone or ethmoid air cells)	T1	L	L
30	Localized, NOS	T1	L	L
40	Extension to nasal cavity with or without bony invasion (involvement of perpendicular plate of ethmoid bone or ethmoid air cells)	T2	RE	RE

	Floor Lateral wall Nasal vestibule Nasal cavity, NOS Septum Turbinates			
62	Base of skull, NOS	T3	RE	RE
63	Cribriform plate	T3	RE	RE
64	Medial wall or floor of orbit; orbital plate	T3	RE	RE
65	Maxillary sinus	T3	RE	RE
66	Palate	T3	D	D
70	Anterior orbital contents Frontal sinus Maillary nerve (the second division of the 5th cranial nerve) Minimum extension to anterior cranial fossa (**see note 3) Pterygoid plate Skin of external nose or cheek Sphenoid sinus	T4a	RE	RE
72	(66) + (70)	T4a	D	D
76	Brain Clivus Cranial nerves other than the maxillary nerve (the second division of the 5th cranial nerve) Dura Middle cranial fossa Nasopharynx Orbital apex or roof	T4b	RE	RE
78	(66) + (76)	T4b	D	D
80	Further contiguous extension	T4NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Ethmoid Sinus

CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and

Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Regional lymph node, NOS	*	RN	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotracheal Paralaryngeal	*	D	D

12 cont'd	Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral nodes(s), not stated if single or multiple or regional	*	RN	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN

52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, 20, 22, 30, 32, 40, 42, 50, 52 and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
Updated July 1, 2005

Ethmoid Sinus
Reg LN Pos
SEE STANDARD TABLE

Ethmoid Sinus
Reg LN Exam
SEE STANDARD TABLE

Ethmoid Sinus
CS Mets at DX
SEE STANDARD TABLE

Collaborative Staging Codes
Accessory (Paranasal) Sinuses
C31.2-C31.3, C31.8-C31.9
C31.2 Frontal sinus
C31.3 Sphenoid sinus
C31.8 Overlapping lesion of accessory sinuses
C31.9 Accessory sinus, NOS
Note 1: Laterality must be coded for Frontal sinus, C31.2
Note 2: AJCC does not define TNM staging for this site.

Accessory (Paranasal) Sinuses
CS Tumor Size
SEE STANDARD TABLE

Accessory (Paranasal) Sinuses
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Invasive tumor confined to mucosa of one of the following: Frontal sinus Sphenoid sinus	NA	L	L
30	Localized, NOS	NA	L	L
40	More than one accessory sinus invaded Destruction of bony wall of sinus	NA	RE	RE
50	Palate Nasal cavity, NOS: Floor Lateral wall Septum Turbinates	NA	RE	RE
60	Bone: Facial bones Maxilla Orbital structures Pterygoid fossa Zygoma	NA	RE	RE
70	Brain Cranial nerves Muscles:	NA	RE	RE

70 cont'd	Masseter Pterygoid Nasopharynx Orbital contents, including eye Soft tissue Skin			
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Accessory (Paranasal) Sinuses

CS Lymph Nodes

Note 1: For head and neck schemes, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemes, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Single positive ipsilateral regional node: Level I node Sublingual Submandibular (submaxillary) Submental Level II node Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Retropharyngeal Regional lymph node, NOS	NA	RN	RN

12	Single positive ipsilateral regional node: Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohoyoid (supramohyoid) Lower deep cervical Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VI node Anterior deep cervical Laterotrachea Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Retropharyngeal Sub-occipital **Supraclavicular, NOS (See Note 4)	NA	D	D
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

**Updated July 1, 2005

Accessory (Paranasal) Sinuses
Reg LN Pos
SEE STANDARD TABLE

Accessory (Paranasal) Sinuses
Reg LN Exam
SEE STANDARD TABLE

Accessory (Paranasal) Sinuses
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, **C310–C319**, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Glottic Larynx
C32.0
C32.0 Glottis

Glottic Larynx
CS Tumor Size
SEE STANDARD TABLE

Glottic Larynx
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor with normal vocal cord mobility Confined to glottis, NOS; intrinsic larynx; laryngeal commisure(s) anterior, posterior; vocal cord(s), NOS, true vocal cord(s), true cord(s)	T1NOS	L	L
11	One vocal cord	T1a	L	L
12	Both vocal cords	T1b	L	L
30	Tumor involves adjacent regions(s) of larynx Subglottis Supraglottis False vocal cord (s)	T2	L	L
35	Impaired vocal cord mobility	T2	L	L
40	Tumor limited to larynx WITH vocal cord fixation Involvement of intrinsic muscle(s): Aryepiglottic Corniculate tubercle Cuneiform tubercle Arytenoid Cricoarytenoid Cricothyroid Thyroarytenoid Thyroepiglottic Vocalis	T3	L	L
45	Localized, NOS	T1NOS	L	L
51	Paraglottic space	T3	RE	RE

52	Minor thyroid cartilage erosion (e.g., inner cortex)	T3	RE	D
60	Base of tongue Hypopharynx, NOS Pre-epiglottic tissues Postcricoid area Pyriform sinus Vallecula	T4a	RE	RE
68	Extension to/through Cricoid cartilage Thyroid cartilage except minor erosion, see code 52	T4a	RE	D
70	Extension to/through tissues beyond larynx: Extrinsic (strap) muscles Omohyoid Sternohyoid Sternothyroid Thryohyoid Oropharynx Skin Soft tissue of neck Thyroid gland Trachea	T4a	D	D
71	Cervical esophagus	T4a	D	D
73	Deep extrinsic muscle(s) of tongue	T4a	D	D
80	Further contiguous extension, including: Mediastinal structures Prevertebral space Tumor encases carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Glottic Larynx
CS Lymph Nodes
****Note 1:** For head and neck schemas, this field includes all lymph nodes devined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
****Note 2:** For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension and levels involved) is coded in Site-Specific Factors 1-6.
****Note 3:** If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

**Note 4: For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III Middle deep cervical Mid-jugular Level IV Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Level VI Anterior deep cervical Delphian node Laterotracheal Paralaryngeal Paratracheal Prelaryngeal (Delphian) Pretracheal Recurrent laryngeal Cervical, NOS Deep cervical, NOS Internal jugular NOS: Regional lymph node, NOS Stated as N1, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I Submandibular (submaxillary) Submental Other groups Retropharyngeal Mandibular, NOS	*	D	RN
12	Single positive ipsilateral regional node: Level V node	*	D	RN

12 cont'd	Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Sub-occipital **Supraclavicular, NOS (See Note 4)			
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN

50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Glottic Larynx
Reg LN Pos
SEE STANDARD TABLE

Glottic Larynx
Reg LN Exam
SEE STANDARD TABLE

Glottic Larynx
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal	M1	D	D

10 cont'd	Supraclavicular (transverse cervical) Distant lymph node(s), NOS			
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Supraglottic Larynx
C32.1
C32.1 Supraglottis
Note: Excludes Anterior Surface of Epiglottis - see separate schema (C10.1).

Supraglottic Larynx
CS Tumor Size
SEE STANDARD TABLE

Supraglottic Larynx
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor with normal vocal cord mobility confined to: Supraglottis (one subsite): Aryepiglottic fold Arytenoid cartilage Corniculate cartilage Cuneiform cartilage Epilarynx, NOS False cords Ventricular bands Ventricular cavity Ventricular fold Infrahyoid epiglottis Laryngeal cartilage, NOS Laryngeal (posterior) surface of epiglottis Suprahyoid epiglottis (including tip, lingual {anterior} and laryngeal surfaces)	T1	L	L
20	Tumor involves more than one subsite of supraglottis WITHOUT fixation or NOS	T2	L	L
30	Tumor involves adjacent regions(s) of larynx	T2	L	L
35	Impaired vocal cord mobility	T2	L	L
40	Tumor limited to larynx WITH vocal cord fixation	T3	L	L
45	Localized, NOS	T1	L	L
52	Paraglottic space	T3	RE	RE

60	Tumor involves region outside the supraglottis WITHOUT fixation, including: Medial wall of pyriform sinus Mucosa of base of tongue Vallecula	T2	RE	RE
62	Code 60 WITH fixation	T3	RE	RE
65	Hypopharynx, NOS Postcricoid area Pre-epiglottic tissues	T3	RE	RE
66	Deep base of tongue	T3	RE	RE
67	Cricoid cartilage	T3	RE	RE
68	Minor thyroid cartilage erosion (e.g., inner cortex)	T3	RE	D
70	Extension to/through: Esophagus Oropharynx Soft tissues of neck Thyroid cartilage (except minor erosion, see code 68) Thyroid gland	T4a	D	D
72	Extension to/through: Extrinsic (strap) muscle(s) Omohyoid Sternohyoid Sternothyroid Thyrohyoid Skin	T4a	D	D
73	Extension to/through: Deep extrinsic muscle of tongue Trachea	T4a	D	D
80	Further contiguous extension, including: Mediastinal structures Prevertebral space Tumor encases carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Supraglottic Larynx
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III Middle deep cervical Mid-jugular Level VI Anterior deep cervical Delphian node Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS: Regional lymph node, NOS Stated as N1, NOS	*	RN	RN
11	Single positive ipsilateral regional node: Level I Submandibular (submaxillary) Submental Other groups Retropharyngeal	*	D	RN

11 cont'd	Mandibular, NOS			
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Sub-occipital **Supraclavicular, NOS (See note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN

42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

**Updated July 1, 2005

Supraglottic Larynx
Reg LN Pos
SEE STANDARD TABLE

Supraglottic Larynx
Reg LN Exam
SEE STANDARD TABLE

Supraglottic Larynx
CS Mets at DX

****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Supraclavicular (transverse cervical) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Subglottic Larynx
C32.2
C32.2 Subglottis

Subglottic Larynx
CS Tumor Size
SEE STANDARD TABLE
Subglottic Larynx
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Invasive tumor with normal vocal cord mobility confined to subglottis	T1	L	L
30	Tumor involves adjacent regions(s) of larynx Vocal cords with normal or impaired mobility	T2	L	L
40	Tumor limited to larynx WITH vocal cord fixation	T3	L	L
45	Localized, NOS	T1	L	L
60	Base of tongue Hypopharynx, NOS Postcricoid area Pre-epiglottic tissues Pyriform sinus (pyriform fossa) Vallecula	T4a	RE	RE
68	Extension to/through cricoid cartilage or thyroid cartilage	T4a	RE	D
70	Extension to/through: Cervical esophagus Deep extrinsic muscles of tongue Extrinsic (strap) muscles Omohyoid Sternohyoid Sternothyroid Thyrohyoid Oropharynx Skin Soft tissues of neck Thyroid gland Trachea	T4a	D	D

73	Contiguous extension to other tissues beyond larynx not specified in codes 70 or 80	T4a	D	D
80	Further contiguous extension: Mediastinal structures Prevertebral space Tumor encases carotid artery	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Subglottic Larynx
CS Lymph Nodes
Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.
Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.
Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.
****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III Middle deep cervical Mid-jugular Level VI Anterior deep cervical Delphian node Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal	*	RN	RN

10 cont'd	Recurrent laryngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS: Regional lymph node, NOS Stated as N1, NOS			
11	Single positive ipsilateral regional node: Level I Submandibular (submaxillary) Submental Other groups Retropharyngeal Mandibular, NOS	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Sub-occipital **Supraclavicular, NOS (See note 4)	*	D	D
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN
21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN

31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Subglottic Larynx
Reg LN Pos
SEE STANDARD TABLE

Subglottic Larynx
Reg LN Exam
SEE STANDARD TABLE

Subglottic Larynx
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Larynx, Overlapping Lesion or Not Otherwise Specified
C32.3, C32.8-C32.9
C32.3 Laryngeal cartilage
C32.8 Overlapping lesion of larynx
C32.9 Larynx, NOS

Larynx, Overlapping Lesion or Not Otherwise Specified
CS Tumor Size
SEE STANDARD TABLE

Larynx, Overlapping Lesion or Not Otherwise Specified
CS Extension

Code	Description	TNM	SS77	**SS2000**
00	In situ; noninvasive	Tis	IS	**IS**
10	Invasive tumor confined to site of origin	T1	L	**L**
20	Tumor involves more than one subsite, WITHOUT fixation or NOS	T2	L	**L**
30	Tumor involves adjacent regions(s) of larynx	T2	L	**L**
35	Impaired vocal cord mobility	T2	L	**L**
40	Tumor limited to larynx WITH vocal cord fixation	T3	L	**L**
45	Localized, NOS	T1	L	**L**
60	Hypopharynx, NOS Postcricoid area Pre-epiglottic tissues Pyriform sinus (pyriform fossa) Vallecula	T3	RE	**RE**
68	Extension to/through cricoid cartilage and thyroid cartilage	T4a	RE	**D**
70	Extension to/through: Cervical esophagus Deep muscle of tongue Extrinsic (strap) muscles Omohyoid Sternohyoid Sternothyroid Thyrohyoid Oropharynx	T4a	D	**D**

70 cont'd	Skin Soft tissues of neck Thyroid gland Trachea			
80	Further contiguous extension, including: Mediastinal structures Prevertebral space Tumor encases carotid artery	T4b	D	**D**
95	No evidence of primary tumor	T0	U	**U**
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	**U**

Larynx, Overlapping Lesion or Not Otherwise Specified
CS Lymph Nodes

Note 1: For head and neck schemas, this field includes all lymph nodes defined as Levels I-VII and Other by AJCC. The complete definitions are provided in the General Instructions.

Note 2: For head and neck schemas, additional information about lymph nodes (size of involved nodes, extracapsular extension, and levels involved) is coded in Site-Specific Factors 1-6.

Note 3: If laterality of lymph nodes is not specified, assume nodes are ipsilateral. Midline nodes are considered ipsilateral.

****Note 4:** For Head and neck cancers, if lymph nodes are described only as "supraclavicular", try to determine if the are in Level IV (deep to the sternocleidomastoid muscle, in the lower jugular chain) or Level V (in the posterior triangle, inferior to the transverse cervical artery) and code appropriately. If the specific level cannot be determined, consider them as level V nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Single positive ipsilateral regional node: Level II Jugulodigastric (subdigastric) Upper deep cervical Upper jugular Level III Middle deep cervical Mid-jugular Level IV Jugulo-omohyoid (supraomohyoid) Lower deep cervical Lower jugular Level VI Anterior deep cervical	*	RN	RN

10 cont'd	Delphian node Laterotracheal Paralaryngeal Paratracheal Prelaryngeal Pretracheal Recurrent laryngeal Cervical, NOS Deep cervical, NOS Internal jugular, NOS Regional lymph node, NOS Stated as N1, NOS			
11	Single positive ipsilateral regional node: Level I Submandibular (submaxillary) Submental Other groups Retropharyngeal Mandibular, NOS	*	D	RN
12	Single positive ipsilateral regional node: Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) (upper, middle, and lower corresponding to the levels that define upper, middle, and lower jugular nodes) Level VII node Upper mediastinum (for other mediastinal nodes see CS Mets at DX) Other groups Intraparotid Parapharyngeal Periparotid Sub-occipital **Supraclavicular, NOS (See Note 4)	*	D	RN
18	Stated as N1, no other information	N1	RN	RN
19	Stated as N2a, no other information	N2a	RN	RN
20	Multiple positive ipsilateral nodes listed in code 10	*	RN	RN

21	Multiple positive ipsilateral nodes listed in code 11	*	D	RN
22	Multiple positive ipsilateral nodes listed in code 12	*	D	D
29	Stated as N2b, no other information	N2b	RN	RN
30	Regional lymph nodes as listed in code 10: Positive ipsilateral node(s), not stated if single or multiple	*	RN	RN
31	Regional lymph nodes as listed in code 11: Positive ipsilateral node(s), not stated if single or multiple	*	D	RN
32	Regional lymph nodes as listed in code 12: Positive ipsilateral node(s), not stated if single or multiple	*	D	D
40	Regional lymph nodes as listed in code 10: Positive bilateral or contralateral nodes	*	RN	RN
41	Regional lymph nodes as listed in code 11: Positive bilateral or contralateral nodes	*	D	RN
42	Regional lymph nodes as listed in code 12: Positive bilateral or contralateral nodes	*	D	D
49	Stated as N2c, no other information	N2c	RN	RN
50	Regional lymph nodes as listed in code 10: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	RN	RN
51	Regional lymph nodes as listed in code 11: Positive node(s) not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	RN
52	Regional lymph nodes as listed in code 12: Positive node(s), not stated if ipsilateral, or bilateral, or contralateral AND not stated if single or multiple	*	D	D
60	Stated as N2, NOS	N2NOS	RN	RN
70	Stated as N3, no other information	N3	RN	RN
80	Lymph nodes, NOS, no other information	*	RN	RN

99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10-12, 20-22, 30-32, 40-42, 50-52, and 80 ONLY, the N category is assigned based on the value of Site-Specific Factor 1, Size of Lymph Nodes, using the extra table, Lymph Nodes Size Table for this site.
**Updated July 1, 2005

Larynx, Overlapping Lesion or Not Otherwise Specified
Reg LN Pos
SEE STANDARD TABLE

Larynx, Overlapping Lesion or Not Otherwise Specified
Reg LN Exam
SEE STANDARD TABLE

Larynx, Overlapping Lesion or Not Otherwise Specified
CS Mets at DX
****Note:** Supraclavicular and transverse cervical lymph nodes are now coded in CS Lymph Nodes because they are categorized as N rather than M in AJCC TNM. Any cases coded to 10 or 50 can be reviewed and recoded. The volume of cases affected should be small.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Mediastinal Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes
Larynx
C320–C329
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Stripping

No specimen sent to **pathology** from surgical events 10–15

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision
28 Stripping

[***SEER Note:*** Codes 21 to 25 and 28 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, 25 Laser excision, or 28 Stripping]

Specimen sent to **pathology** from surgical events 20–28

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
31 Vertical laryngectomy
32 Anterior commissure laryngectomy
33 Supraglottic laryngectomy

[***SEER Note:*** Vertical laryngectomy: Removal of involved true vocal cord, ipsilateral false vocal cord, intervening ventricle, ipsilateral thyroid and may include removal of the arytenoids.
Supraglottic laryngectomy: Conservative surgery intended to preserve the laryngeal function. Standard procedure involves removal of epiglottis, false vocal cords, aryepiglottic folds, arytenoid cartilages, ventricle, upper one third of thyroid cartilage, thyroid membrane. The true vocal cords and arytenoids remain in place to allow vocalization and deglutition.]

40 Total or radical laryngectomy, NOS
41 Total laryngectomy ONLY
42 Radical laryngectomy ONLY

[***SEER Note:*** Radical laryngectomy: Includes removal of adjacent sites. Do not code the removal of adjacent sites in Surgical Procedure of Other Site.]

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

90 Surgery, NOS

99 Unknown **if surgery performed;** death certificate **ONLY**

Collaborative Staging Codes
Trachea
C33.9
C33.9 Trachea
Note: AJCC does not define TNM staging for this site.

Trachea
CS Tumor Size
SEE STANDARD TABLE

Trachea
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	NA	IS	IS
10	Invasive tumor confined to trachea	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue Arch of aorta Azygos vein, right Brachiocephalic vein Carotid sheath Common carotid artery(ies) Jugular arch Phrenic nerves Pretracheal fascia Recurrent laryngeal nerve Subclavian artery(ies) Vagus nerve	NA	RE	RE
60	Adjacent organs/structures Cricoid cartilage Esophagus Pleura Right and left main bronchi Sternum Thymus Thyroid gland Vertebral column	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Trachea
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s): Mediastinal, NOS: Posterior (tracheoesophageal) Paratracheal Pretracheal Tracheal, NOS Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Trachea
Reg LN Pos
SEE STANDARD TABLE

Trachea
Reg LN Exam
SEE STANDARD TABLE

Trachea
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D

50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, **C339**, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 **Local** tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
LUNG
C340–C349

Primary Site

C340 **Main bronchus**
Carina
Hilum

C341 **Upper lobe**, lung
Lingula
Apex

C342 **Middle lobe**, lung (right lung only)

C343 **Lower lobe**
Lung base

C348 **Overlapping** lesion of lung

C349 **Lung, NOS**
Bronchus, NOS

Laterality
Laterality **must** be **coded** for all subsites except carina.

Tumor Size
Priorities for coding size
1. **Pathology** report
2. **Operative** report
3. **Endoscopic** examination, where applicable
4. **Imaging** reports

Imaging reports do not have a priority. Code the largest size of tumor recorded on any of the imaging reports.

General Instructions for Coding Tumor Size

DO **NOT** CODE size of **hilar mass** unless primary is stated to be in the hilum.

Collaborative Staging Codes
Lung
C34.0-C34.3, C34.8-C34.9
C34.0 Main bronchus
C34.1 Upper lobe, lung
C34.2 Middle lobe, lung
C34.3 Lower lobe, lung
C34.8 Overlapping lesion of lung
C34.9 Lung, NOS
Note: Laterality must be coded for this site (except carina).

Lung
CS Tumor Size
Note: Do not code size of hilar mass unless primary is stated to be in the hilum.

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus given
991	Described as less than 1 cm
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
996	Malignant cells present in bronchopulmonary secretions, but no tumor seen radiographically or during bronchoscopy; "occult" carcinoma
997	Diffuse (entire lobe)
998	Diffuse (entire lung or NOS)
999	Unknown; size not stated Not documented in patient record

Lung
CS Extension
Note 1: Direct extension to or other involvement of structures considered M1 in AJCC staging is coded in the data item CS Mets at DX. This includes: sternum; skeletal muscle; skin of chest;

contralateral lung or mainstem bronchus; separate tumor nodule(s) in different lobe, same lung, or in contralateral lung.

Note 2: Distance from Carina. Assume tumor is greater than or equal to 2 cm from carina if lobectomy, segmental resection, or wedge resection is done.

Note 3: Opposite Lung. If no mention is made of the opposite lung on a chest x-ray, assume it is not involved.

Note 4: Bronchopneumonia. "Bronchopneumonia" is not the same thing as "obstructive pneumonitis" and should not be coded as such.

Note 5: Pulmonary Artery/Vein. An involved pulmonary artery/vein in the mediastinum is coded to 70 (involvement of major blood vessel). However, if the involvement of the artery/vein appears to be only within lung tissue and not in the mediastinum, it would not be coded to 70.

Note 6: Pleural Effusion.

A. Note from SEER manual: Ignore pleural effusion that is negative for tumor. Assume that a pleural effusion is negative if a resection is done.

B. Note from AJCC manual: Most pleural effusions associated with lung cancers are due to tumor. However, there are a few patients in whom multiple cytopathologic examinations of pleural fluid are negative for tumor. In these cases, fluid is non-bloody and is not an exudate. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the patient should be staged T1, T2, or T3.

Note 7: Vocal cord paralysis (resulting from involvement of recurrent branch of the vagus nerve), superior vena cava obstruction, or compression of the trachea or the esophagus may be related to direct extension of the primary tumor or to lymph node involvement. The treatment options and prognosis associated with these manifestations of disease extent fall within the T4-Stage IIIB category; therefore, generally use code 70 for these manifestations. HOWEVER, if the primary tumor is peripheral and clearly unrelated to vocal cord paralysis, vena cava obstruction, or compression of the trachea or the esophagus, code these manifestations as mediastinal lymph node involvement (code 20) in CS Lymph Nodes unless there is a statement of involvement by direct extension from the primary tumor.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Tumor confined to one lung, WITHOUT extension or conditions described in codes 20-80 (excluding primary in main stem bronchus) (EXCLUDES superficial tumor as described in code 11)	*	L	L
11	Superficial tumor of any size with invasive component limited to bronchial wall, with or without proximal extension to the main stem bronchus	T1	L	L

20	Extension from other parts of lung to main stem bronchus, NOS (EXCLUDES superficial tumor as described in code 11) Tumor involving main stem bronchus greater than or equal to 2.0 cm from carina (primary in lung or main stem bronchus)	T2	L	L
21	Tumor involving main stem bronchus, NOS (distance from carina not stated and no surgery as described in Note 2)	T2	L	L
23	Tumor confined to hilus	*	L	L
25	Tumor confined to the carina	*	L	L
**30	Localized, NOS	*	L	L
40	Atelectasis/obstructive pneumonitis that extends to the hilar region but does not involve the entire lung (or atelectasis/obstructive pneumonitis, NOS) WITHOUT pleural effusion	T2	RE	RE
45	Extension to: Pleura, visceral or NOS (WITHOUT pleural effusion) Pulmonary ligament (WITHOUT pleural effusion)	T2	RE	RE
50	Tumor of/involving main stem bronchus less than 2.0 cm from carina	T3	L	RE
52	(40) + (50)	T3	RE	RE
53	(45) + (50)	T3	RE	RE
55	Atelectasis/obstructive pneumonitis involving entire lung	T3	RE	RE
56	Parietal pericardium or pericardium, NOS	T3	RE	RE
59	Invasion of phrenic nerve	T3	RE	RE
60	Direct extension to: Brachial plexus, inferior branches or NOS, from superior sulcus Chest (thoracic) wall Diaphragm Pancoast tumor (superior sulcus syndrome), NOS Parietal pleura **Note**: For separate lesion in chest wall or diaphragm, see CS Mets at DX.	T3	D	RE

61	Superior sulcus tumor WITH encasement of subclavian vessels OR WITH unequivocal involvement of superior branches of brachial plexus (C8 or above)	T4	D	RE
65	Multiple masses/separate tumor nodule(s) in the SAME lobe "Satellite nodules" in SAME lobe	T4	L	RE
70	Blood vessel(s), major (EXCEPT aorta and inferior vena cava, see codes 74 and 77) Azygos vein Pulmonary artery or vein Superior vena cava (SVC syndrome) Carina from lung/mainstem bronchus Compression of esophagus or trachea not specified as direct extension Esophagus Mediastinum, extrapulmonary or NOS Nerve(s): Cervical sympathetic (Horner's syndrome) Recurrent laryngeal (vocal cord paralysis) Vagus Trachea	T4	RE	RE
71	Heart Visceral pericardium	T4	D	D
72	Malignant pleural effusion Pleural effusion, NOS	T4	D	D
73	Adjacent rib	T3	D	D
74	Aorta	T4	D	RE
75	Vertebra(s) Neural foramina	T4	D	D
76	Pleural tumor foci separate from direct pleural invasion	T4	D	D
77	Inferior vena cava	T4	D	D
**78	(73) plus any of (61-72) or (74-77)	T4	D	D
79	Pericardial effusion, NOS; malignant pericardial effusion	T4	D	D
80	Further contiguous extension (except to structures specified	T4	D	D

	in CS Mets at DX)			
95	No evidence of primary tumor	T0	U	U
98	Tumor proven by presence of malignant cells in sputum or bronchial washings but not visualized by imaging or bronchoscopy; "occult" carcinoma	TX	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10, 23, 25 and 30 ONLY, the T category is assigned based on the value of tumor size, as shown in the Extension Size table for this site.

**** Version 01.02.00 Revision effective for cases diagnosed on or after January 1, 2005**

Lung

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

**Note 2: If at mediastinoscopy/x-ray, the description is "mass", "adenopathy", or "enlargement" of any of the lymph nodes named as regional in codes 10 and 20, assume that at least regional lymph nodes are involved.

Note 3: The words "no evidence of spread" or "remaining examination negative" are sufficient information to consider regional lymph nodes negative in the absence of any statement about nodes.

Note 4: Vocal cord paralysis (resulting from involvement of recurrent branch of the vagus nerve), superior vena cava obstruction, or compression of the trachea or the esophagus may be related to direct extension of the primary tumor or to lymph node involvement. The treatment options and prognosis associated with these manifestations of disease extent fall within the T4-Stage IIIB category; therefore, generally use CS Extension code 70 for these manifestations and not CS lymph nodes. HOWEVER, if the primary tumor is peripheral and clearly unrelated to vocal cord paralysis, vena cava obstruction, or compression of the trachea or the esophagus, code these manifestations as mediastinal lymph node involvement (code 20) in CS Lymph Nodes unless there is a statement of involvement by direct extension from the primary tumor.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s), ipsilateral: Bronchial Hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Intrapulmonary nodes, including involvement by direct extension: Interlobar Lobar	N1	RN	RN

10 cont'd	Segmental Subsegmental Peri/parabronchial			
20	Regional lymph node(s), ipsilateral: Aortic [above diaphragm], NOS: Peri/para-aortic, NOS: Ascending aorta (phrenic) Subaortic (aortico-pulmonary window) Carinal (tracheobronchial) (tracheal bifurcation) Mediastinal, NOS: Anterior Posterior (tracheoesophageal) Pericardial Peri/paraesophageal Peri/paratracheal, NOS: Azygos (lower peritracheal) Pre- and retrotracheal, NOS: Precarinal Pulmonary ligament Subcarinal	N2	RN	RN
50	Regional lymph node(s), NOS	N1	RN	RN
60	Contralateral/bilateral hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Contralateral/bilateral mediastinal Scalene (inferior deep cervical), ipsilateral or contralateral Supraclavicular (transverse cervical), ipsilateral or contralateral	N3	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

**Updated July 1, 2005

Lung
Reg LN Pos
SEE STANDARD TABLE

Lung
Reg LN Exam
SEE STANDARD TABLE

Lung
CS Mets at Diagnosis

Code	Description	TNM	SS77	SS2000
00	No; none	*	NONE	NONE
10	Distant lymph node(s), including cervical nodes	M1	D	D
35	Separate tumor nodule(s) in different lobe, same lung	M1	L	D
37	Extension to: Sternum Skeletal muscle Skin of chest	M1	D	D
39	Extension to: Contralateral lung Contralateral main stem bronchus Separate tumor nodule(s) in contralateral lung	M1	D	D
40	Abdominal organs Distant metastases except distant lymph node(s) (code 10) except those specified in codes 35 to 39, including separate lesion in chest wall or diaphragm Distant metastasis, NOS Carcinomatosis	M1	D	D
50	Distant metastases + Distant node(s) (10) + any of [(35) to (40)]	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	**	U	U

*For CS Mets at DX code 00 only, the M category is assigned based on the value of CS Tumor Size, using the Mets Size Table for Mets at DX code 00 for this site.

**For CS Mets at DX code 99 only, the M category is assigned on the value of CS Tumor Size, using the Mets Size Table for Mets at DX code 99 for this site.

Site-Specific Surgery Codes
Lung
C340–C349
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 **Local** tumor **destruction** or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded 19 (Used principally for cases diagnosed prior to January 1, 2003)

15 Local tumor destruction, NOS
12 Laser ablation or cryosurgery
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to **pathology** from surgical events 12-13 and 15

20 Excision or resection of less than one lobe, NOS
23 Excision, NOS
24 Laser excision
25 Bronchial sleeve resection ONLY
21 Wedge resection
22 Segmental resection, including lingulectomy

Specimen sent to **pathology** from surgical events 20–25

30 **Resection** of [at least one] **lobe** or **bilobectomy**, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm

55 Pneumonectomy, NOS

[***SEER Note:*** Code 55 includes complete pneumonectomy, Sleeve pneumonectomy, Standard pneumonectomy, Total pneumonectomy, Resection of whole lung]

56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

65 Extended pneumonectomy

66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

[***SEER Note:*** An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes]

80 Resection of lung, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Heart, Mediastinum
C38.0-C38.3, C38.8
C38.0 Heart
C38.1 Anterior mediastinum
C38.2 Posterior mediastinum
C38.3 Mediastinum, NOS
C38.8 Overlapping lesion of heart, mediastinum and pleura

Heart, Mediastinum
CS Tumor Size
SEE STANDARD TABLE

Heart, Mediastinum
CS Extension
Note: Sarcomas of the heart and mediastinum are classified as deep tumors. A deep tumor is located either exclusively beneath the superficial fascia, superficial to the fascia with invasion of or through the fascia, or both superficial yet beneath the fascia.

Code	Description	TNM	SS77	SS2000
10	Invasive tumor confined to site of origin	*	L	L
30	Localized, NOS	*	L	L
40	Adjacent connective tissue: Heart: Visceral pericardium (epicardium) (See note in General Instructions on adjacent connective tissue)	*	RE	RE
60	Adjacent organs/structures: Heart: Ascending aorta Parietal pericardium Vena cava Mediastinum: Descending aorta Esophagus Large (named) artery(ies) Large (named) vein(s) Pericardium, NOS Parietal Visceral (epicardium) Phrenic nerve(s)	*	RE	RE

60 cont'd	Pleura, NOS Parietal pleura Visceral pleura of lung Sternum Sympathetic nerve trunk(s) Thoracic duct Thymus Trachea, parietal pleura Vertebra(e)			
80	Further contiguous extension	*	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10-80 ONLY, the T category is assigned based on value of CS Tumor Size from the Extension Size Table for this site.

Heart, Mediastinum

CS Lymph Nodes

Note 1: Regional lymph nodes are defined as those in the vicinity of the primary tumor.

Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative (code 00). Use code 99 (Unknown) only when there is no available information on the extent of the patient's disease, for example, when a lab-only case is abstracted from a biopsy report and no clinical history is available.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Aortic (above diaphragm), NOS: Peri/para-aortic, NOS Ascending aorta (phrenic) Subaortic (aortico-pulmonary window) Carinal (tracheobronchial) (tracheal bifurcation) Mediastinal, NOS: Anterior Posterior (tracheoesophageal) Pericardial Peri/paraesophageal Peri/paratracheal, NOS: Azygos (lower peritracheal) Pre- and retrotracheal, NOS:	N1	RN	RN

10 cont'd	Precarinal Pulmonary ligament Subcarinal Regional lymph node(s), NOS			
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown (see Note 2)	NX	U	U

Heart, Mediastinum
Reg LN POS
SEE STANDARD TABLE

Heart, Mediastinum
Reg LN Exam
SEE STANDARD TABLE

Heart, Mediastinum
CS Mets at DX
SEE STANDARD TABLE

Collaborative Staging Codes
Pleura
C38.4
C38.4 Pleura, NOS

Pleura
CS Tumor Size
SEE STANDARD TABLE

Pleura
CS Extension
Note: Pleural effusion does not affect the coding of the CS Extension field, but is coded as Site-Specific Factor 1.

Code	Description	TNM	SS77	SS2000
10	Invasive tumor (mesothelioma) confined to pleura, NOS	T1NOS	*	*
12	Ipsilateral parietal pleura, including mediastinal or diaphragmatic pleura, WITHOUT involvement of visceral pleura	T1a	*	*
14	Ipsilateral parietal pleura, including mediastinal or diaphragmatic pleura, WITH focal involvement of visceral pleura	T1b	*	*
16	Ipsilateral parietal pleura, including mediastinal or diaphragmatic pleura, involvement of visceral pleura not stated	T1NOS	*	*
20	Ipsilateral pleura WITH nodule(s) beneath visceral pleural surface Ipsilateral pleural surface with confluent visceral pleural tumor (including fissure)	T2	*	*
30	Localized, NOS	T1NOS	*	*
42	Diaphragm (diaphragmatic muscle)	T2	*	*
50	Mesothelioma nodule(s) which have broken through the visceral pleural surface to the lung surface Lung parenchyma, or lung involvement, NOS	T2	*	*
52	Adjacent connective tissue: Endothoracic fascia Pericardium, non-transmural or NOS	T3	*	*

61	Chest wall, solitary focus of tumor ONLY Mediastinal tissues, mediastinal fat	T3	*	*
63	Diffuse or multifocal invasion of soft tissues of chest wall Heart muscle, myocardium Mediastinal organs Rib	T4	*	*
65	Extension to internal surface of pericardium	T4	*	*
69	Pericardial effusion with positive cytology	T4	*	*
78	Contralateral pleura (For contralateral lung, see CS Mets at DX)	T4	*	*
80	Further contiguous extension: Brachial plexus Cervical tissues Intra-abdominal organs Peritoneum Spine	T4	*	*
95	No evidence of primary tumor	T0	*	*
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	*	*

The mapping to Summary Stage 1977 and Summary Stage 2000 depends on the valueof Site-Specific Factor 1, Pleural Effusion. See the extra table, Extension Pleural Effusion Table, for details

Pleura

CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s), ipsilateral, intrapulmonary: Hilar: Bronchopulmonary Proximal lobar Pulmonary root Intrapulmonary: Interlobar Lobar Segmental Subsegmental Peri/parabronchial	N1	RN	RN

20	Regional lymph node(s), ipsilateral, mediastinal: Aortic [above diaphragm], NOS: Aorto-pulmonary window Ascending aorta Peri/para-aortic Phrenic Subaortic Carinal: Tracheobronchial Tracheal bifurcation Internal mammary (parasternal) Mediastinal, NOS: Anterior Posterior (tracheoesophageal) Pericardial Peri/paraesophageal [below carina] Peri/paratracheal, NOS: Lower peritracheal (azygos) Upper paratracheal Pretracheal and retrotracheal, NOS: Precarinal Prevascular Pulmonary ligament Subcardial Subcarinal	N2	RN	RN
50	Regional lymph node(s), NOS	N1	RN	RN
70	Contralateral or bilateral nodes specified in codes 10 or 20 Ipsilateral, contralateral or bilateral nodes: Scalene (inferior deep cervical) Supraclavicular (transverse cervical)	N3	D	D
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Pleura
Reg LN Pos
SEE STANDARD TABLE

Pleura
Reg LN Exam
SEE STANDARD TABLE

Pleura
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), including cervical nodes	M1	D	D
35	Direct extension to contralateral lung	M1	D	D
40	Distant metastases, except code [(10) or (35)] Distant metastasis, NOS (includes discontinuous involvement of contralateral pleura/chest wall) Carcinomatosis	M1	D	D
50	Distant metastases + Distant node(s)	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Pleura
CS Site-Specific Factor 1 Pleural Effusion

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

Collaborative Staging Codes
Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
C39.0, C39.8-C39.9
C39.0 Upper respiratory tract, NOS
C39.8 Overlapping lesion of respiratory system and intrathoracic organs
C39.9 Ill-defined sites within respiratory system
Note: AJCC does not define TNM staging for this site.

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
CS Tumor Size
SEE STANDARD TABLE

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	NA	IS	IS
10	Invasive tumor confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue	NA	RE	RE
60	Adjacent organs/structures Descending aorta Esophagus Large (named) artery(ies) Large (named) vein(s) Pericardium, NOS Parietal Visceral (epicardium) Phrenic nerve(s) Pleura, NOS Parietal Visceral Sternum Sympathetic nerve trunk(s) Thoracic duct Thymus Trachea Vertebra(e) Visceral pleura of lung	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph nodes: Aortic [above diaphragm], NOS: Peri/para-aortic, NOS: Ascending aorta (phrenic) Subaortic (aortico-pulmonary window) Carinal (tracheobronchial) (tracheal bifurcation) Hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Intrapulmonary, NOS: Interlobar Lobar Segmental Subsegmental Mediastinal, NOS: Anterior Posterior (tracheoesophageal) Peri/parabronchial Pericardial Peri/paraesophageal Peri/paratracheal, NOS: Azygos (lower peritracheal) Pre- and retrotracheal, NOS: Precarinal Pulmonary ligament Subcarinal Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
Reg LN Pos
SEE STANDARD TABLE

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
Reg LN Exam
SEE STANDARD TABLE

Other and Ill-Defined Respiratory Sites and Intrathoracic Organs
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, **C380–C388, C390–C399**, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
BONES, JOINTS, AND ARTICULAR CARTILAGE C400–C419
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C470–C479
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C490–C499
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Laterality

Laterality is required for sites C40.0-C40.3, C41.3-C41.4, C47.1-C47.2, and C49.1-C49.2.

Three Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table below). The expected outcome is more favorable for lower grades. Soft tissue sarcomas are evaluated using a three-grade system.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to ICD-0-3 Morphology 6th Digit Code:

Term	Grade	ICD-0-3 Morphology 6th Digit Code
1/3, 1/2	Low grade	2
2/3	Intermediate grade	3
3/3, 2/2	High grade	4

Sarcoma

Sarcomas are graded low, intermediate or high grade by the pathologist. Use the following table to convert these terms to a histologic grade.

Term	Grade	ICD-0-3 Morphology 6th Digit Code
Well differentiated	I	1
Fairly well differentiated	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Partially well differentiated	II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3

Term	Grade	ICD-0-3 Morphology 6th Digit Code
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Pleomorphic	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4

Collaborative Staging Codes
Bone
C40.0-C40.3, C40.8-C40.9, C41.0-C41.4, C41.8-C41.9
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
C40.8 Overlapping lesion of bones, joints and articular cartilage of limbs
C40.9 Bone of limb, NOS
C41.0 Bones of skull and face and associated joints (excludes mandible C41.1)
C41.1 Mandible
C41.2 Vertebral column (excludes sacrum and coccyx C41.4)
C41.3 Rib, sternum, clavicle and associated joints
C41.4 Pelvic bones, sacrum, coccyx and associated joints
C41.8 Overlapping lesion of bones, joints and articular cartilage
C41.9 Bone, NOS
Note: Laterality must be coded for C40.0-C40.3, and C41.3-C41.4. For sternum, sacrum, coccyx, and symphysis pubis, laterality is coded 0.

Bone
CS Tumor Size
SEE STANDARD TABLE

Bone
CS Extension
Note: The cortex of a bone is the dense outer shell that provides strength to the bone; the spongy center of a bone is the cancellous portion. The periosteum of the bone is the fibrous membrane covering of a bone that contains the blood vessels and nerves; the periosteum is similar to the capsule on a visceral organ.

Code	Description	TNM	SS77	SS2000
10	Invasive tumor confined to cortex of bone	*	L	L
20	Extension beyond cortex to periosteum (no break in periosteum)	*	L	L
30	Localized, NOS	*	L	L
40	Extension beyond periosteum to surrounding tissues, including adjacent skeletal muscle(s)	*	RE	RE
60	Adjacent bone/cartilage	*	RE	RE
70	Skin	*	D	D
80	Further contiguous extension	*	D	D

82	Skip metastases or discontinuous tumors in the same bone	T3	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

For codes 10, 20, 30, 40, 60, 70, and 80 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Bone
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: Regional lymph nodes are defined as those in the vicinity of the primary tumor.
Note 3: Regional lymph node involvement is rare. If there is no mention of lymph node involvement clinically, assume that lymph nodes are negative.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Bone
Reg LN Pos
SEE STANDARD TABLE

Bone
Reg LN Exam
SEE STANDARD TABLE

Bone
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	M1b	D	D
30	Distant metastasis to lung only	M1a	D	D

40	Distant metastases except distant lymph node(s) or lung Distant metastasis, NOS Carcinomatosis	M1b	D	D
50	(10) + (30) + 40) Distant lymph node(s) plus other distant metastases	M1b	D	D
55	Stated as M1, NOS	M1NOS	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Bones, Joints, And Articular Cartilage **C400–C419**
Peripheral Nerves And Autonomic Nervous System C470–C479
Connective, Subcutaneous, And Other Soft Tissues C490–C499
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded 19
(Principally for cases diagnosed prior to January 1, 2003)

15 Local tumor destruction

No specimen sent to **pathology** from surgical event 15

25 Local excision

26 Partial resection

Specimen sent to **pathology** from surgical events 25–26

30 **Radical excision** or **resection** of lesion WITH limb salvage

40 Amputation of limb
41 Partial amputation of limb
42 Total amputation of limb

50 Major amputation, NOS
51 Forequarter, including scapula
52 Hindquarter, including ilium/hip bone
53 Hemipelvectomy, NOS
54 Internal hemipelvectomy

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
C44.0, C44.2-C44.9
C44.0 Skin of lip, NOS
C44.2 External ear
C44.3 Skin of ear and unspecified parts of face
C44.4 Skin of scalp and neck
C44.5 Skin of trunk
C44.6 Skin of upper limb and shoulder
C44.7 Skin of lower limb and hip
C44.8 Overlapping lesion of skin
C44.9 Skin, NOS
Note: Laterality must be coded for C44.2-C44.3 and C44.5-C44.7. For codes C44.3 and C44.5, if the tumor is midline (e.g., chin), code as 9, midline, in the laterality field.

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Tumor Size
SEE STANDARD TABLE

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Extension
Note 1: In the case of multiple simultaneous tumors, code the tumor with greatest extension.
Note 2: Skin ulceration does not alter the Collaborative Stage classification.
Note 3: Skin of genital sites is not included in this schema. These sites are skin of vulva (C51.0-C51.2, C51.8-C51.9), skin of penis (C60.0-C60.1, C60.8, C60.9) and skin of scrotum (C63.2).

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepidermal; Bowen disease	Tis	IS	IS
10	Lesion(s) confined to dermis	*	L	L
40	Localized, NOS	*	L	L
50	Subcutaneous tissue (through entire dermis)	*	L	L
70	Underlying cartilage, bone, skeletal muscle	T4	D	RE
80	Further contiguous extension	T4	D	D

95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) by primary site (includes bilateral or contralateral nodes for head, neck, and trunk) HEAD AND NECK: All subsites: Cervical Lip: Mandibular, NOS: Submandibular (submaxillary) External ear/auditory canal: Mastoid (post-/retro-auricular) (occipital) Preauricular Face, Other (cheek, chin, forehead, jaw, nose and temple): Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Scalp: Mastoid (post-/retro-auricular) (occipital) Parotid, NOS: Infra-auricular Preauricular	N1	RN	RN

10 cont'd	Spinal accessory (posterior cervical) Neck: Axillary Mandibular, NOS Mastoid (post-/retro-auricular) (occipital) Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Supraclavicular (transverse cervical) UPPER TRUNK: Axillary Cervical Internal mammary (parasternal) Supraclavicular (transverse cervical) LOWER TRUNK: Femoral (superficial inguinal) ARM/SHOULDER: Axillary Epitrochlear for hand/forearm Spinal accessory for shoulder LEG/HIP: Femoral (superficial inguinal) Popliteal for heel and calf ALL SITES: Regional lymph node(s), NOS			
20	HEAD AND NECK: Lip: Facial, NOS : Buccinator (buccal) Submental Parotid, NOS: Infra-auricular Preauricular Face, Other (cheek, chin, forehead, jaw, nose, and temple):	N1	D	RN

20 cont'd	Submental Neck: Submental			
30	(10) + (20)	N1	D	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
Reg LN Pos
SEE STANDARD TABLE

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
Reg LN Exam
SEE STANDARD TABLE

Skin [excl. Skin of Eyelid] [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Mets at DX
SEE STANDARD TABLE

Collaborative Staging Codes
Skin of Eyelid
C44.1
C44.1 Eyelid
Note: Laterality must be coded for this site.

Skin of Eyelid
CS Tumor Size
SEE STANDARD TABLE

Skin of Eyelid
CS Extension
Note 1: In the case of multiple simultaneous tumors, code the tumor with greatest extension.
Note 2: Skin ulceration does not alter the Collaborative Stage classification.
Note 3: Presence of tumor at eyelid margin takes priority over depth of invasion in dermis/tarsal plate; i.e., code 25 takes priority over codes 10-20.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial Bowen disease; intraepidermal	Tis	IS	IS
10	Lesion(s) confined to dermis Minimal infiltration of dermis (not invading tarsal plate)	T1	L	L
20	Infiltrates deeply into dermis (invading tarsal plate)	T2	L	L
25	Tumor at eyelid margin	*	L	L
30	Involves full eyelid thickness	T3	L	L
40	Localized, NOS	T1	L	L
50	Subcutaneous tissue (through entire dermis)	T3	L	L
60	Adjacent structures, including Bulbar conjunctiva Globe Perineural space Sclera Soft tissues of orbit	T4	D	RE
70	Bone/periosteum of orbit	T4	D	RE

70 cont'd	Skeletal muscle Underlying cartilage			
72	Nasal cavity Paranasal sinuses	T4	D	D
74	Central nervous system	T4	D	D
75	Metastatic skin lesion(s)	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension code 25 ONLY, the T category is assigned based on value of CS Tumor Size as shown in Extension Size Table. Tumors 5mm or less are T1, tumors 6-10mm are T2, and tumors more than 10mm are T3.

Skin of Eyelid

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) Cervical, NOS Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Submental Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN

99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Skin of Eyelid
Reg LN Pos
SEE STANDARD TABLE

Skin of Eyelid
Reg LN Exam
SEE STANDARD TABLE

Skin of Eyelid
CS Mets at Dx
SEE STANDARD TABLE

Site-Specific Surgery Codes
Skin
C440–C449
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Notes:*** Code UVB phototherapy for mycosis fungoides primaries under Surgery of Primary Site for skin. Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen.Codes 20-27 include shave and wedge resection]

30 **Biopsy** of primary tumor **followed by** a **gross excision** of the lesion (does not have to be done nder the same anesthesia)
31 Shave biopsy followed by a gross excision of the lesion
32 Punch biopsy followed by a gross excision of the lesion
33 Incisional biopsy followed by a gross excision of the lesion

34 Mohs surgery, NOS
35 Mohs with 1-cm margin or less
36 Mohs with more than 1-cm margin

[***SEER Notes:*** Codes 30 to 33 include less than a wide excision, less than 1 cm margin or margins are unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30. Code 45 represents a wide excision in which it is known that the margins of excision are greater than 1 cm.]

45 **Wide excision** or **reexcision** of lesion or **minor** (local) **amputation** with margins more than 1cm, NOS; margins must be microscopically negative.

46 WITH margins more than 1 cm and less than or equal to 2 cm
47 WITH margins greater than 2 cm
If the excixion does not have microscopically negative margins greater than 1cm use appropriate code 20-36.

60 Major amputation

90 Surgery, NOS

99 **Unknown if surgery performed** ; death certificate only cases

Collaborative Staging Codes
Malignant Melanoma of Skin, Vulva, Penis, Scrotum
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
(M-8720-8790)
C44.0 Skin of lip, NOS
C44.1 Eyelid
C44.2 External ear
C44.3 Skin of ear and unspecified parts of face
C44.4 Skin of scalp and neck
C44.5 Skin of trunk
C44.6 Skin of upper limb and shoulder
C44.7 Skin of lower limb and hip
C44.8 Overlapping lesion of skin
C44.9 Skin, NOS
C51.0 Labium majus
C51.1 Labium minus
C51.2 Clitoris
C51.8 Overlapping lesion of vulva
C51.9 Vulva, NOS
C60.0 Prepuce
C60.1 Glans penis
C60.2 Body of penis
C60.8 Overlapping lesion of penis
C60.9 Penis
C63.2 Scrotum, NOS
Note 1: Laterality must be coded for C44.1-C44.3, and C44.5-C44.7. For codes C44.3 and C44.5, if the tumor is midline (e.g., chin), code as 9, midline, in the laterality field.
Note 2: For melanoma of sites other than those above, use the site-specific schema for the appropriate site.
Note 3: The level of invasion, as defined by Dr. Wallace Clark, is used when defining subcategories of T1 melanomas, but not for thicker melanoma (i.e, T2, T3 or T4).

Malignant Melanoma of Skin, Vulva, Penis, Scrotum
CS Tumor Size
Note: Record the size of the tumor in the CS Tumor Size table below, **not depth or thickness.** Depth or thickness is recorded in Site-Specific Factor 1 in the Measured Thickness (Depth), Breslow's Measurement table.

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

Malignant Melanoma of Skin, Vulva, Penis, Scrotum

CS Extension

Note 1: If there is a discrepancy between the Clark level and the pathologic description of extent, use the higher (more extensive) code.

Note 2: Satellite or in-transit metastases are coded under CS Lymph Nodes.

Note 3: Ulceration of melanoma is coded in Site-Specific Factor 2.

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepidermal Clark's level I Basement membrane of the epidermis is intact	Tis	IS	IS
10	Papillary dermis invaded Clark's level II	*	L	L
20	Papillary-reticular dermal interface invaded Clark's level III	*	L	L
30	Reticular dermis invaded Clark's level IV	*	L	L

40	Skin/dermis, NOS Localized, NOS	*	L	L
50	Subcutaneous tissue invaded (through entire dermis) Clark's level V	*	L	RE
80	Further contiguous extension: Underlying cartilage, bone, skeletal muscle	*	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed (e.g., shave biopsy or regressed melanoma) Not documented in patient record	*	U	U

* For Extension codes 10 - 80, and 99 ONLY, the T category is assigned based on values the of CS Site-Specific Factor 1, Measured Thickness and CS Site-Specific Factor 2, Ulceration, as shown in Extra Table 1, Thickness and Ulceration and Extra Table 2, Extension and Ulceration.

Malignant Melanoma of Skin, Vulva, Penis, Scrotum

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: Satellite or in-transit metastases are coded under CS Lymph Nodes.

****Note 3:** Use codes 10-12 if there is regional node involvement without satellite nodule(s) or in-transit metastases. Use codes 12-15 if there are satellite nodule(s) or in-transit metastases but there is either no regional lymph node involvement, or involvement of regional lymph nodes is not stated. Use codes 20-22 if both satellite nodule(s)/in-transit metastases and regional lymph node(s) are present.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
**10	Regional lymph node(s) by primary site: (includes bilateral or contralateral nodes for head, neck, and trunk) HEAD AND NECK SITES: All subsites: Cervical, NOS Lip: Mandibular, NOS: Submandibular(submaxillary) Eyelid/canthus:	*	RN	RN

**10 cont'd	Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular External ear/auditory canal: Mastoid (post-/retro-auricular) (occipital) Preauricular Face, Other (cheek, chin forehead, jaw, nose and temple): Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Scalp: Mastoid (post-/retro-auricular) (occipital) Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Neck: Axillary Mandibular, NOS Mastoid (post-/retro-auricular) Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Supraclavicular (transverse cervical) UPPER TRUNK: Axillary Cervical Internal mammary			

**10 cont'd	Supraclavicular Lower Trunk: Superficial inguinal (femoral) ARM/SHOULDER: Axillary Epitrochlear for hand/forearm Spinal accessory (posterior cervical) for shoulder LEG/HIP: Popliteal for heel and calf Superficial inguinal (femoral) VULVA/PENIS/SCROTUM: Deep inguinal: Rosenmuller or Cloquet node Superficial inguinal (femoral) ALL SITES: Regional lymph node(s), NOS			
**12	Regional lymph node(s) by primary site: HEAD AND NECK SITES: Lip: Facial, NOS Buccinator (buccal) Nasolabial Mandibular, NOS Submental Parotid, NOS Infra-auricular Preauricular Eyelid/canthus: Facial, NOS: Mandibular, NOS Submental Face, Other (cheek, chin, forehead, jaw, nose, and temple) Mandibular, NOS Submental Neck: Mandibular, NOS Submental	*	D	RN
**13	Satellite nodule(s) or in-transit metastases, NOS (distance	N2c	RE	RE

**13 cont'd	from primary tumor not stated) WITHOUT regional lymph node involvement or regional nodes not stated.			
**14	Satellite nodule(s) or in-transit metastases less than or equal to 2cm from primary tumor WITHOUT regional lymph node involvement or involvement of regional nodes not stated	N2c	RE	RE
**15	Satellite nodule(s) or in-transit metastastases greater than 2cm from primary tumor WITHOUT regional lymph node involvement or involvement of regional nodes not stated.	N2c	RE	RN
**17	Matted lymph nodes in code 10	N3	RN	RN
**18	Matted lymph nodes in code 12	N3	D	RE + RN
**20	Satellite nodule(s) or in-transit metastases WITH regional lymph nodes listed in code 10	N3	RE + RN	RE + RN
**22	Satellite nodule(s) or in-transit metastases WITH regional lymph nodes listed in code 12.	N3	D	RE + RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

*For codes 10, 12, and 80 ONLY, the N category depends on the values in Reg LN Pos and SSF 3, as shown in the CS Nodes Pos and Clinical Status table.

** Version 1.02 revision effective for cases diagnosed on or after January 1, 2005

Malignant Melanoma of Skin, Vulva, Penis, Scrotum

Reg LN Pos

Note 1: Record this field even if there has been preoperative treatment.

Note 2: Although satellite nodules and in-transit metastasis are coded under CS Lymph Nodes, DO NOT count as Reg LN Pos in this field.

Code	Description
00	All nodes examined negative.
01-89	01 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Reg LN Exam

Malignant Melanoma of Skin, Vulva, Penis, Scrotum

Note: Although satellite nodules and in-transit metastasis are coded under CS Lymph Nodes, DO NOT count as Reg LN Exam in this field

Code	Description
00	No nodes examined
01-89	01 - 89 nodes examined (code exact number of regional lymph nodes examined)
90	90 or more nodes examined
95	No regional nodes removed, but aspiration or core biopsy of regional nodes performed
96	Regional lymph node removal documented as sampling and number of nodes unknown/not stated
97	Regional lymph node removal documented as dissection and number of nodes unknown/not stated
98	Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection; nodes examined, but number unknown

99	Unknown if nodes were examined; not applicable or negative Not documented in patient record

Malignant Melanoma of Skin, Vulva, Penis, Scrotum
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
05	Underlying cartilage, bone, skeletal muscle	*	D	D
10	Distant lymph node(s)	*	D	D
40	Distant metastasis, NOS	*	D	D
42	Metastases to skin or subcutaneous tissue beyond regional lymph nodes	*	D	D
43	Lung	*	D	D
44	All other visceral sites Carcinomatosis Other distant sites	M1c	D	D
52	(10) + (42)	*	D	D
53	(10) + (43)	*	D	D
54	(10) + (44)	M1c	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

*For codes 05, 10, 40, 42, 43, 52 and 53 ONLY, the M category is assigned based on the status of serum LDH as coded in Site-Specific Factor 4 LDH table and shown in the Special Mets at DX and LDH table.

Site-Specific Surgery Codes
Skin
C440–C449
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 5 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Notes:*** Code UVB phototherapy for mycosis fungoides primaries under Surgery of Primary Site for skin. Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen.
Codes 20-27 include shave and wedge resection]

30 **Biopsy** of primary tumor **followed by** a **gross excision** of the lesion (does not have to be done under the same anesthesia)
31 Shave biopsy followed by a gross excision of the lesion
32 Punch biopsy followed by a gross excision of the lesion
33 Incisional biopsy followed by a gross excision of the lesion

34 Mohs surgery, NOS
35 Mohs with 1-cm margin or less
36 Mohs with more than 1-cm margin

[***SEER Notes:*** Codes 30 to 33 include less than a wide excision, less than 1 cm margin or margins are unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30. Code 45 represents a wide excision in which it is known that the margins of excision are greater than 1 cm.]

45 **Wide excision** or **reexcision** of lesion or **minor** (local) **amputation** with margins more than 1 cm, NOS. Margins MUST be microscopically negative.

46 WITH margins more than 1 cm and less than or equal to 2 cm
47 WITH margins greater than 2 cm
If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, **C510–C519**, C529, C570–C579, C589, **C600–C609**, **C630–C639**, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
(M-9700-9701)
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
C44.0 Skin of lip, NOS
C44.1 Eyelid
C44.2 External ear
C44.3 Skin of ear and unspecified parts of face
C44.4 Skin of scalp and neck
C44.5 Skin of trunk
C44.6 Skin of upper limb and shoulder
C44.7 Skin of lower limb and hip
C44.8 Overlapping lesion of skin
C44.9 Skin, NOS
C51.0 Labium majus
C51.1 Labium minus
C51.2 Clitoris
C51.8 Overlapping lesion of vulva
C51.9 Vulva, NOS
C60.0 Prepuce
C60.1 Glans penis
C60.2 Body of penis
C60.8 Overlapping lesion of penis
C60.9 Penis
C63.2 Scrotum, NOS
Note 1: Laterality must be coded for C44.1-C44.3 and C44.5-C44.7. For codes C44.3 and C44.5, if the tumor is midline (e.g., chin), code as 9 (midline) in the laterality field.
Note 2: Source: Developed by the Mycosis Fungoides Cooperative Group (MFCG)

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
CS Tumor Size
SEE STANDARD TABLE
Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
CS Extension
Note 1: In approximating body surface, the palmar surface of the hand, including digits, is about 1%.
Note 2: Use code 25 when skin involvement is present but only a general location/site is mentioned (i.e., face, legs, torso, arms). Use code 30 when there is skin involvement but there is no mention of location/site.

Code	Description	TNM	SS77	SS2000

10	Plaques, papules, or erythematous patches ("plaque stage"): Less than 10% of skin surface, no tumors Limited plaques/patches MFCG Stage I	T1	L	L
20	Plaques, papules, or erythematous patches ("plaque stage"): Greater than or equal to 10% of skin surface, no tumors Generalized plaques/patches MFCG Stage II	T2	L	L
25	Plaques, papules, or erythematous patches ("plaque stage"): % or body surface not stated, no tumors	T2	L	L
30	Skin involvement, NOS: Extent not stated, no tumors Localized, NOS	T1	L	L
50	One or more tumors (tumor stage) Cutaneous tumors	T3	RE	RE
70	Generalized erythroderma (greater than 50% of body involved with diffuse redness) Sezary syndrome/Sezary disease MFGC Stage III	T4	RE	RE
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
CS Lymph Nodes
Note: For this site, code ALL lymph node (regional and distant) involvement in this field.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Clinically enlarged palpable lymph node(s) (adenopathy), and either pathologically negative nodes or no pathological statement	N1	RN	RN
20	No clinically enlarged palpable lymph node(s) (adenopathy); pathologically positive lymph node(s)	N2	RN	RN
30	Both clinically enlarged palpable lymph node(s) (adenopathy) and pathologically positive lymph node(s)	N3	RN	RN

80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
Reg LN Pos
SEE STANDARD TABLE

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
Reg LN Exam
SEE STANDARD TABLE

Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
CS Mets at DX
Note: For this site, code ALL lymph node (regional and distant) involvement in the CS Lymph Nodes field.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
40	Visceral (non-cutaneous, extra nodal) involvement: MFCG Stage IV Carcinomatosis Distant metastasis, NOS	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
SkinC440–C449
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Notes:*** Code UVB phototherapy for mycosis fungoides primaries under Surgery of Primary Site for skin. Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen.
Codes 20-27 include shave and wedge resection]

30 **Biopsy** of primary tumor **followed by** a **gross excision** of the lesion (does not have to be done under the same anesthesia)
31 Shave biopsy followed by a gross excision of the lesion
32 Punch biopsy followed by a gross excision of the lesion
33 Incisional biopsy followed by a gross excision of the lesion
34 Mohs surgery, NOS
35 Mohs with 1-cm margin or less
36 Mohs with more than 1-cm margin

[***SEER Notes:*** Codes 30 to 33 include less than a wide excision, less than 1 cm margin or margins are unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30. Code 45 represents a wide excision in which it is known that the margins of excision are greater than 1 cm.]

45 **Wide excision** or **reexcision** of lesion or **minor** (local) **amputation** with margins more than 1 cm, NOS. Margins MUST be microscopically negative.

46 WITH margins more than 1 cm and less than or equal to 2 cm
47 WITH margins greater than 2 cm
If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, **C510–C519**, C529, C570–C579, C589, **C600–C609**, **C630–C639**, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
BONES, JOINTS, AND ARTICULAR CARTILAGE C400–C419
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C470–C479
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C490–C499
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Three Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table below). The expected outcome is more favorable for lower grades. Soft tissue sarcomas are evaluated using a three-grade system.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to ICD-0-3 Morphology 6th Digit Code:

Term	Grade	ICD-0-3 Morphology 6th Digit Code
1/3, 1/2	Low grade	2
2/3	Intermediate grade	3
3/3, 2/2	High grade	4

Sarcoma

Sarcomas are graded low, intermediate or high grade by the pathologist. Use the following table to convert these terms to a histologic grade.

Term	Grade	ICD-0-3 Morphology 6th Digit Code
Well differentiated	I	1
Fairly well differentiated	II	2
Low grade	I-II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I-II	2
Partially well differentiated	II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II-III	3

Term	Grade	ICD-0-3 Morphology 6th Digit Code
Moderately poorly differentiated	III	3
Moderately undifferentiated	III	3
Pleomorphic	III	3
Poorly differentiated	III	3
Relatively poorly differentiated	III	3
Relatively undifferentiated	III	3
Slightly differentiated	III	3
High grade	III-IV	4
Undifferentiated, anaplastic, not differentiated	IV	4

Collaborative Staging Codes
Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
C47.0-C47.6, C47.8-C47.9, C49.0-C49.6, C49.8-C49.9
C47.0 Peripheral nerves and autonomic nervous system of head, face and neck
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
C47.3 Peripheral nerves and autonomic nervous system of thorax
C47.4 Peripheral nerves and autonomic nervous system of abdomen
C47.5 Peripheral nerves and autonomic nervous system of pelvis
C47.6 Peripheral nerves and autonomic nervous system of trunk, NOS
C47.8 Overlapping lesion of peripheral nerves and autonomic nervous system
C47.9 Autonomic nervous system, NOS
C49.0 Connective, subcutaneous and other soft tissues of head, face, and neck
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
C49.3 Connective, subcutaneous and other soft tissues of thorax
C49.4 Connective, subcutaneous and other soft tissues of abdomen
C49.5 Connective, subcutaneous and other soft tissues of pelvis
C49.6 Connective, subcutaneous and other soft tissues of trunk
C49.8 Overlapping lesion of connective, subcutaneous and other soft tissues
C49.9 Connective, subcutaneous and other soft tissues, NOS
Note 1: Laterality must be coded for C47.1-C47.2 and C49.1-C49.2.
Note 2: Soft tissue sarcomas of the heart and mediastinum (C38.0-C38.3 and C38.9) use the Heart, Mediastinum schema.

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
CS Tumor Size
SEE STANDARD TABLE

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
CS Extension
Note 1: Connective tissue includes adipose tissue; aponeuroses; arteries; blood vessels; bursa; connective tissue, NOS; fascia; fatty tissue; fibrous tissue; ligaments; lymphatic channels (not nodes); muscle; skeletal muscle; subcutaneous tissue; synovia; tendons; tendon sheaths; veins; and vessels, NOS. Peripheral nerves and autonomic nervous system includes: ganglia, nerve, parasympathetic nervous system, peripheral nerves, spinal nerves, sympathetic nervous system.
Note 2: If a vessel has a name, for example, brachial artery or recurrent laryngeal nerve, consider it a structure (code 60).
Note 3: For tumors of the extremities and trunk ONLY, superficial lesions are defined as those not involving the superficial muscular fascia. Deep lesions are those that involve or are beneath the superficial fascia.
Note 4: According to AJCC, "All intraperitoneal visceral lesions, retroperitoneal lesions, and

intrathoracic lesions, and the majority of head and neck tumors are considered deep." For coding extension of soft tissue tumors in these sites (C47.0, C47.3-5, C49.0, C49.3-5), use only codes 12, 32, 42, 62, 80, 95, or 99.

Note 5: Definition of Adjacent Connective Tissue: Some of the schemes for ill-defined or non-specific sites in this manual contain a code 40, adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs. In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients. Blood, cartilage and bone are sometimes considered connective tissues, but in this manual they are listed separately.

Code	Description	TNM	SS77	SS2000
10	Invasive tumor confined to site/tissue of origin, NOS	***	L	L
11	Superficial invasive tumor confined to site/tissue of origin (lesion does not involve superficial fascia)	*	L	L
12	Deep tumor confined to site/tissue of origin	**	L	L
30	Localized, NOS	***	L	L
31	Superficial: localized tumor, NOS	*	L	L
32	Deep: localized tumor, NOS	**	L	L
40	Adjacent connective tissue (see Note 5)	***	RE	RE
41	Superficial tumor involving adjacent connective tissue	*	RE	RE
42	Deep tumor involving adjacent connective tissue	**	RE	RE
60	Adjacent organs/structures including bone/cartilage (including major vessel invasion) (see Note 5)	***	RE	RE
61	Superficial tumor involving adjacent organs/structures including bone/cartilage (including major vessel invasion) (see Note 5)	*	RE	RE
62	Deep tumor involving adjacent organs/structures including bone/cartilage (including major vessel invasion) (see Note 5)	**	RE	RE
80	Further contiguous extension	**	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension	TX	U	U

99 cont'd	Primary tumor cannot be assessed Not documented in patient record			

* For Extension codes 11, 31, 41, and 61 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 1 for this site.
** For Extension codes 12, 32, 42, 62 and 80 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 2 for this site.
*** For Extension codes 10, 30, 40, and 60 ONLY, the T category is assigned based on the value ofCS Tumor Size as shown in the Special Extension Size Table 3 for this site.

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues

CS Lymph Nodes

Note 1: Regional lymph nodes are defined as those in the vicinity of the primary tumor.
Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative (code 00). Use code 99 (Unknown) only when there is no available information on the extent of the patient's disease, for example, when a lab-only case is abstracted from a biopsy report and no clinical history is available.
Note 3: For head, neck and trunk primaries ONLY, regional lymph nodes include bilateral or contralateral nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) by primary site (bilateral or contralateral for head, neck, trunk) All Head and Neck Subsites: All subsites: Cervical, NOS Lip: Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Submental Parotid, NOS: Infra-auricular Preauricular Eyelid/canthus: Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Submental Parotid, NOS: Infra-auricular	N1	RN	RN

10 cont'd	External ear and auditory canal: Mastoid (posterior, retro-auricular) (occipital) Preauricular Face, Other (cheek, chin, forehead, jaw, nose and temple): Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Submental Parotid, NOS: Infra-auricular Preauricular Scalp: Mastoid (posterior, retro-auricular) (occipital) Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Neck: Axillary Mastoid (posterior, retro-auricular) (occipital) Mandibular, NOS: Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Supraclavicular (transverse cervical) Arm/shoulder: Axillary Spinal accessory for shoulder Epitrochlear for hand/forearm Leg/hip: Femoral (superficial inguinal) Popliteal for heel and calf Thorax: Hilar (bronchopulmonary) (proximal lobar) (pulmonary root) Mediastinal Abdomen: Celiac Iliac Para-aortic Pelvis:			

10 cont'd	Deep inguinal, NOS: Rosenmuller or Cloquet node Superficial inguinal (femoral) Upper trunk: Axillary Cervical Internal mammary Supraclavicular (transverse cervical) Lower trunk: Superficial inguinal (femoral) All sites: Regional lymph node(s), NOS			
12	Submental nodes for neck primary only (bilateral or contralateral)	N1	D	RN
15	Neck primary only: (10) + (12)	N1	D	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown (see Note 2)	NX	U	U

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
Reg LN Pos
SEE STANDARD TABLE

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
Reg LN Exam
SEE STANDARD TABLE

Peripheral Nerves and Autonomic Nervous System; Connective, Subcutaneous, and Other Soft Tissues
CS Mets at DX
SEE STANDARD TABLE

Collaborative Staging Codes
Retroperitoneum and Peritoneum
C48.0-C48.2, C48.8
C48.0 Retroperitoneum
C48.1 Specified parts of peritoneum (including omentum and mesentery)
C48.2 Peritoneum, NOS
C48.8 Overlapping lesion of retroperitoneum and peritoneum
Note: AJCC includes these sites with soft tissue sarcomas (C47.0-C48.9)

Retroperitoneum and Peritoneum
CS Tumor Size
SEE STANDARD TABLE

Retroperitoneum and Peritoneum
CS Extension
Note: For AJCC TNM staging, all retroperitoneal lesions are considered deep lesions.

Code	Description	TNM	SS77	SS2000
10	Tumor confined to site of origin	*	L	L
30	Localized, NOS	*	L	L
40	Adjacent connective tissue see; definition of adjacent connective tissue in General Instructions.	*	RE	RE
60	Adjacent organs/structures including bone/cartilage Retroperitoneum: Adrenal(s) (suprarenal gland(s)) Aorta Ascending colon Descending colon Kidney(s) Pancreas Vena cava Vertebra Peritoneum: Colon (except ascending and descending colon) Esophagus Gallbladder Liver Small intestine Spleen Stomach	*	RE	RE

80	Further contiguous extension, including: For retroperitoneum: extension to colon other than ascending or descending For peritoneum: extension to ascending or descending colon	*	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For codes 10-80 ONLY, the T category is assigned based on value of CS Tumor Size, as shown in the Extension Size Table for this site.

Retroperitoneum and Peritoneum
Cs Lymph Nodes

Note 1: Regional lymph nodes are defined as those in the vicinity of the primary tumor.

Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative (code 00). Use code 99 (Unknown) only when there is no available information on the extent of the patient's disease, for example, when a lab-only case is abstracted from a biopsy report and no clinical history is available.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Intra-abdominal Paracaval Pelvic Subdiaphragmatic Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown (see Note 2)	NX	U	U

Retroperitoneum and Peritoneum
Reg LN Pos
SEE STANDARD TABLE

Retroperitoneum and Peritoneum
Reg LN Exam
SEE STANDARD TABLE

Retroperitoneum and Peritoneum
CS Mets at Diagnosis
SEE STANDARD TABLE

Site-Specific Surgery Codes
BONES, JOINTS, AND ARTICULAR CARTILAGE C400–C419
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C470–C479
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES C490–C499
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded 19
(Principally for cases diagnosed prior to January 1, 2003)

15 Local tumor destruction

No specimen sent to **pathology** from surgical event 15

25 Local excision

26 Partial resection

Specimen sent to **pathology** from surgical events 25–26

30 **Radical excision** or **resection** of lesion WITH limb salvage

40 Amputation of limb
41 Partial amputation of limb
42 Total amputation of limb

50 Major amputation, NOS
51 Forequarter, including scapula
52 Hindquarter, including ilium/hip bone
53 Hemipelvectomy, NOS
54 Internal hemipelvectomy

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, **C480–C488,** C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
BREAST
C500–C509

Primary Site

C500 **Nipple** (areolar)
Paget disease without underlying tumor

C501 **Central** portion of **breast** (**subareolar**) area extending 1 cm around areolar complex
Retroareolar
Infraareolar
Next to areola, NOS
Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
Paget disease with underlying tumor

C502 **Upper inner quadrant** (UIQ) of breast
Superior medial
Upper medial
Superior inner

C503 **Lower inner quadrant** (LIQ) of breast
Inferior medial
Lower medial
Inferior inner

C504 **Upper outer quadrant** (UOQ) of breast
Superior lateral
Superior outer
Upper lateral

C505 **Lower outer quadrant** (LOQ) of breast
Inferior lateral
Inferior outer
Lower lateral

C506 **Axillary tail** of breast
Tail of breast, NOS
Tail of Spence

C508 **Overlapping** lesion of breast
Inferior breast, NOS
Inner breast, NOS
Lateral breast, NOS
Lower breast, NOS
Midline breast NOS

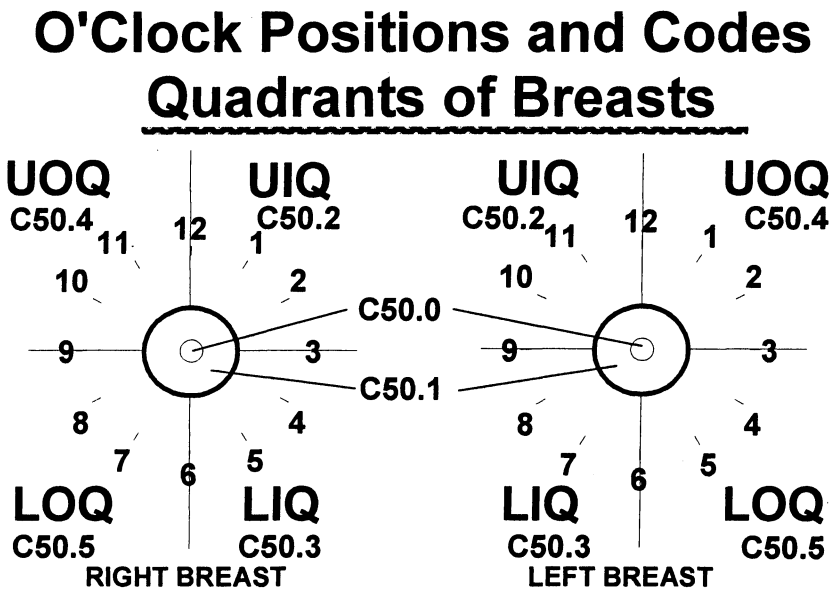
Outer breast NOS
Superior breast, NOS

Upper breast, NOS
3:00, 6:00, 9:00, 12:00 o'clock

C509 Breast, NOS
Entire breast
Multiple tumors in different subsites within breast
Inflammatory without palpable mass
¾ or more of breast involved with tumor
Diffuse (tumor size 998)

Additional Subsite Descriptors

The position of the tumor in the breast may be described as the positions on a clock



Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

1 Pathology report
2 Operative report
3 Physical examination
4 Mammogram, ultrasound

If the pathology proves **invasive** tumor in **one subsite** and **in situ tumor** in all **other** involved subsites, code to the subsite involved with invasive tumor

When to Use Subsites 8 and 9

A. Code the primary site to C50**8** when there is a **single tumor** that **overlaps** two or more subsites, and the **subsite** in which the tumor **originated cannot be determined.**
B. Code the primary site to C50**8** when there is a **single tumor** located at the **12, 3, 6, or 9 o'clock** position on the breast
C. Code the primary site to C50**9** when there are **multiple tumors** (two or more) in **at least two quadrants** of the breast

Laterality

Laterality **must** be **coded** for all subsites.

Single Tumor with Complex Histology

Note: For cases diagnosed on or after 1/1/2007, refer to Appendix O.

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

Example 1: Code duct carcinoma and lobular carcinoma in situ to the combination code 8522/3

Example 2: Code LCIS and DCIS to the combination code 8522/2.

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

Example 1: Code ductal carcinoma with extensive cribriforming DCIS to the invasive ductal carcinoma (8500/3).

Example 2: Code mucinous carcinoma in a background of ductal carcinoma in situ to invasive mucinous carcinoma (8480/3).

Example 3: Code infiltrating ductal carcinoma with DCIS, solid, cribriform, and comedo type to the invasive infiltrating ductal carcinoma (8500/3).

Use a **combination code** if the diagnosis is either ductal carcinoma OR lobular carcinoma mixed with another type of carcinoma. Look for the words "and" or "mixed" in the diagnosis.

Code duct carcinoma mixed with another type of carcinoma (excluding lobular) to 8523/_.

Example 1: Code duct carcinoma **and** tubular carcinoma to 8523/3.

Example 2: Code DCIS **and** cribriform carcinoma in situ to 8523/2.

Code lobular carcinoma mixed with another type of carcinoma (excluding ductal) to 8524_.

Example 1: Code lobular **and** adenoid cystic carcinoma to 8524/3.

Example 2: Code tubular carcinoma **and** lobular carcinoma as 8524/3.

Code the **infiltrating ductal subtype** even if the code is numerically lower than infiltrating ductal (8500/_) when the following terms are used:
Type: Duct carcinoma, _____ type
Predominantly: Duct carcinoma, predominantly _____
With features of: Duct carcinoma with features of _____
Subtype: Infiltrating ductal, _____ subtype
Variant: Duct carcinoma, _____ variant
Other terms that indicate the majority of tumor

Example 1: Duct carcinoma, tubular type. Code the histology as tubular carcinoma, 8211/3.

Example 2: Duct carcinoma with apocrine features. Code the histology as apocrine carcinoma 8401/3.

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

Example 1: Duct carcinoma, cribriform and comedo types. Code the histology to 8523/3.

Example 2: Duct carcinoma in situ showing both solid and cribriforming subtypes. Code the histology as 8523/2.

Separate Tumors of Different Histologies in One Breast

If different histologies occur in **separate tumors in the same breast**, use the multiple primary rules to determine if there is one primary or more. If, according to the rules, there are two primaries, abstract and stage separately. If, according to the rules, there is one primary, abstract and stage as one primary. Use a combination code for combinations of duct and lobular or combinations of duct and Paget disease.

Example 1: Lobular carcinoma in situ in the upper inner quadrant of the right breast and duct carcinoma in the lower inner quadrant of the right breast. Code the histology as 8522/3.

Example 2: Paget disease of nipple and intraductal carcinoma, upper outer quadrant. Code the histology as 8543/3.

Grade

Priority Rules for Grading Breast Cancer

Code the tumor grade using the following priority order:

Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table below)
Bloom Richardson grade (low, intermediate, high)
Nuclear grade only
Terminology Differentiation (well differentiated, moderately differentiated, etc)
Histologic grade
Grade i, grade ii, grade iii, grade iv

Bloom-Richardson (BR)

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

BR may be expressed in **scores** (range 3-9)
The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells)
Use the following table to convert the score into SEER code

BR may be expressed as a **grade** (low, intermediate, high)
BR grade is derived from the BR score
For cases diagnosed 1996 and later, use the following table to convert the BR grade into SEER code (Note that the conversion of low, intermediate, and high is different from the conversion used for all other tumors)

Convert BR Score to ICD-0-3 Morphology 6th Digit Code

Use the table below to convert BR **score** to **ICD-0-3 Morphology 6th Digit Code**.

BR Combined Score	Differentiation	Grade	ICD-0-3 Morphology 6th Digit Code
3, 4, 5	Well differentiated	I	1
6, 7	Moderately differentiated	II	2
8, 9	Poorly differentiated	III	3

Convert BR Grade to SEER Code

Use the table below to convert BR **grade** to SEER code.

BR Grade	Differentiation	Grade	ICD-0-3 Morphology 6th Digit Code
BR low grade	Well differentiated	I	1
BR intermediate grade	Moderately differentiated	II	2
BR high grade	Poorly differentiated	III	3

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table above). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the table below to convert the grade to SEER codes.

Term	Grade	ICD-0-3 Morphology 6th Digit Code
1/3, 1/2	Low grade	2
2/3	Intermediate grade	3
3/3, 2/2	High grade	4

Laterality

Laterality must be coded for all subsites.

Tumor Markers

Estrogen and progesterone receptors (ERA and PRA) are positive in most breast cancers. A positive ERA and PRA indicates a better prognosis and response to estrogen therapy.

Size of Primary Tumor

General Coding Guidelines

If **multiple masses** are present, code the diameter of the **largest invasive mass.** Ignore the in situ even if it is larger than the invasive.

If the patient had **neoadjuvant** treatment, code the **largest** tumor size **documented** prior to the start of treatment.

Tumors That Are Purely Invasive or Purely In situ

For purely invasive or purely in situ tumors, record the size of tumor based on the following priority of reports.

Priority in which to use Reports to Code Tumor Size

1. **Pathology** report
2. **Operative** report
3. Physical examination
4. Imaging (**mammography**)
5. Imaging (**ultrasound**)

Single Tumors with Both Invasive and In situ Components

Record the **size** of the **invasive** component, if given.
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 37 mm mixed in situ and invasive adenocarcinoma. Pathology documents that 14 mm is invasive. *Record tumor size as 014.*

Characteristics of Isolated Tumor Cells versus Micrometastases (CS Lymph Nodes)

Isolated tumor cells do not usually show proliferation or stromal reaction—in other words, no evidence of malignant activity (CS Lymph Nodes code 00).
Micrometastatic disease represents implantation of tumor cells in the involved organ (node) with extravasation, proliferation, and often a stromal reaction—in other words, malignant activity (positive lymph nodes).

General Staging Guidelines

DO NOT USE the following to determine tumor extension:

A. Dimpling of the skin, tethering, nipple retraction, nipple involvement or skin changes other than those listed in CS extension code 51 (See also CS Extension, Note 1)
B. **Micro**scopic satellite skin nodules
(**macro**scopic or **gross** nodules in skin of primary breast **are** used in staging)
C. Microscopically proven invasion of lymphatic vessels within the breast

Collaborative Staging Codes
Breast
C50.0-C50.6, C50.8-C50.9
C50.0 Nipple
C50.1 Central portion of breast
C50.2 Upper-inner quadrant of breast
C50.3 Lower-inner quadrant of breast
C50.4 Upper-outer quadrant of breast
C50.5 Lower-outer quadrant of breast
C50.6 Axillary Tail of breast
C50.8 Overlapping lesion of breast
C50.9 Breast, NOS
Note: Laterality must be coded for this site

Breast
CS Tumor Size
Note 1: For tumor size, some breast cancers cannot be sized pathologically.
Note 2: When coding pathologic size, code the measurement of the invasive component. For example, if there is a large in situ component (e.g., 4 cm) and a small invasive component see Site-Specific Factor 6 to code more information about the reported tumor size. If the size of invasive component is not given, code the size of the entire tumor and record what it represents in Site-Specific Factor 6.
Note 3: Microinvasion is the extension of cancer cells beyond the basement membrane into the adjacent tissues with no focus more than 0.1 cm in greatest dimension. When there are multiple foci of microinvasion, the size of only the largest focus is used to classify the microinvasion. (Do not use the sum of all the individual foci.)

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microinvasion; microscopic focus or foci only, no size given; described as less than 1 mm
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
996	Mammographic/xerographic diagnosis only, no size given; clinically not palpable
997	Paget's Disease of nipple with no demonstrable tumor

998	Diffuse
999	Unknown; size not stated Not documented in patient record

Breast

CS Extension

Note 1: Changes such as dimpling of the skin, tethering, and nipple retraction are caused by tension on Cooper's ligament(s), not by actual skin involvement. They do not alter the classification.

Note 2: Consider adherence, attachment, fixation, induration, and thickening as clinical evidence of extension to skin or subcutaneous tissue, code '20'.

Note 3: Consider "fixation, NOS" as involvement of pectoralis muscle, code '30'.

Note 4: If extension code is 00, then Behavior code must be 2; if extension code is 05 or 07, then behavior code may be 2 or 3; and, if extension code is 10, then behavior code must be 3.

Note 5: Inflammatory Carcinoma. AJCC includes the following text in the 6th edition Staging Manual (p. 225-6), "Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse erythema and edema (peau d'orange) of the breast, often without an underlying palpable mass. These clinical findings should involve the majority of the skin of the breast. Classically, the skin changes arise quickly in the affected breast. Thus the term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease. On imaging, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor emboli within dermal lymphatics, which may or may not be apparent on skin biopsy. The tumor of inflammatory carcinoma is classified T4d. It is important to remember that inflammatory carcinoma is primarily a clinical diagnosis. Involvement of the dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings. In addition to the clinical picture, however, a biopsy is still necessary to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself."

Note 6: For Collaborative Staging, the abstractor should record a stated diagnosis of inflammatory carcinoma, and also record any clinical statement of the character and extent of skin involvement in the text area. Code 71 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% of the breast. Code 73 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% (majority) of the skin of the breast. Cases with a stated diagnosis of inflammatory carcinoma but no such clinical description should be coded 71. A clinical description of inflammation, erythema, edema, peau d'orange, etc. without a stated diagnosis of inflammatory carcinoma should be coded 51 or 52, depending on described extent of the condition.

Code	Description	TNM	SS77	SS2000
00	In situ: noninfiltrating; intraepithelial Intraductal WITHOUT infiltration Lobular neoplasia	Tis	IS	IS
05	Paget Disease of nipple (WITHOUT underlying tumor)	Tis	**	**
07	Paget Disease of nipple (WITHOUT underlying invasive carcinoma pathologically)	Tis	**	**

10	Confined to breast tissue and fat including nipple and/or areola Localized, NOS	*	L	L
20	Invasion of subcutaneous tissue Local infiltration of dermal lymphatics adjacent to primary tumor involving skin by direct extension Skin infiltration of primary breast including skin of nipple and/or areola	*	RE	RE
30	Attached or fixation to pectoral muscle(s) or underlying tissue Deep fixation Invasion of (or fixation to) pectoral fascia or muscle	*	RE	RE
40	Invasion of (or fixation to): Chest wall Intercostal or serratus anterior muscle(s) Rib(s)	T4a	RE	RE
51	Extensive skin involvement, including: Satellite nodule(s) in skin of primary breast Ulceration of skin of breast Any of the following conditions described as involving not more than 50% of the breast, or amount or percent of involvement not stated: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
52	Any of the following conditions described as involving more than 50% of the breast WITHOUT a stated diagnosis of inflammatory carcinoma: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
61	(40) + (51)	T4c	RE	RE
62	(40) + (52)	T4b	RE	RE
71	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'organge, etc., involving not more than 50% of the skin of the breast, or percent of involvement not stated, WITH or	T4b	RE	RE

71 cont'd	WITHOUT dermal lymphatic infiltration. Inflammatory carcinoma, NOS			
72	OBSOLETE – Description: Diagnosis of inflammatory WITH a clinical diagnosis of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the breast, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS NOTE: Code 72 has been combined with code 71. Any cases coded to 72 should be re-coded to 71.	T4b	RE	RE
73	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the skin of the breast, WITH or WITHOUT dermal lymphatic infiltration	T4d	RE	RE
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 20, and 30 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site.

** For codes 05 and 07 ONLY, summary stage is assigned based on the value of Behavior Code ICD-0-3 as shown in the Extension Behavior Table for this site.

Breast

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field. Use code 60 in the absence of other information about regional nodes.

Note 3: If no lymph nodes were removed surgically, then use only the following codes for clinical evaluation of axillary nodes: 00 - Clinically negative 50 - Fixed/matted nodes, 60 - Clinically positive axillary nodes 99 - Unknown/not stated.

Note 4: If pre-surgical therapy was given and there is a clinical evaluation (positive or negative) of lymph nodes, then use only the following codes for clinical evaluation of axillary nodes: 00 - Clinically negative 50 - Fixed/matted nodes 60 - Clinically positive axillary nodes AND Code a '5' in the nodes evaluation field. If there is no clinical evaluation of nodes, use the information from the pathologic evaluation and code a '6' in the nodes evaluation field.

Note 5: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters not greater than 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction). Lymph nodes with ITCs only are not considered positive lymph nodes.

Note 6: Codes 13-50 are used for positive axillary nodes without internal mammary nodes.

Code	Description	TNM	SS77	SS2000
**00	None; no regional lymph node involvement, or ITCs detected by immunohistochemistry or molecular methods ONLY. (See Note 5 and Site-specific Factors 4 and 5.)	*	NONE	NONE
**05	None: no regional lymph nodes(s) but with (ITC's) detected on routing H and E stains. (See Note 5)	N0(i+)	NONE	NONE
13	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected by immunohistochemical (IHC) means ONLY (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm)	N1mi	RN	RN
15	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected or verified on H&E (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm) Micrometastasis, NOS	N1mi	RN	RN
25	Movable axillary lymph node(s), ipsilateral, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm)	**	RN	RN
26	Stated as N1, NOS	**	RN	RN
28	Stated as N2, NOS	**	RN	RN
50	Fixed/matted ipsilateral axillary nodes, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm) Fixed/matted ipsilateral axillary nodes, NOS	**	RN	RN
60	Axillary/regional lymph node(s), NOS Lymph nodes NOS	**	RN	RN
71	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	**	RN	RN
72	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITH axillary lymph node(s), ipsilateral	**	RN	RN
73	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	**	RN	RN

74	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N2b	RN	RN
75	Infraclavicular lymph node(s) (subclavicular)	N3a	D	RN
76	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITH axillary lymph node(s), ipsilateral, codes 15 to 60 WITH or WITHOUT infraclavicular lymph node(s)	N3b	RN	RN
77	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N2b	RN	RN
78	(75) + (77)	N3a	D	RN
79	Stated as N3, NOS	N3NOS	RN	RN
80	Supraclavicular node(s)	N3c	D	D
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For code 00 ONLY, the N category is assigned based on the coding of Site-Specific Factors 4 and 5 using the IHC MOL Table for this site.
**For codes 25, 26, 28, 50, 60, 71, 72, and 73 ONLY, the N category is assigned based on the value of Site-Specific Factor 3, Number of Positive Ipsilateral Axillary LymphNodes. See Lymph Nodes Positive Axillary Nodes Table
**Updated July 1, 2005

Breast
Reg LN Pos
Note 1: Record this field even if there has been preoperative treatment.
Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastastases are > 0.2mm and code the lymph nodes as positive in this field.
Note 3: Record all positive regional lymph nodes in this field. Record the number of positive regional axillary nodes separately in the appropriate Site-Specific Factor field.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified

98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Breast
Reg LN Exam
SEE STANDARD TABLE

Breast
CS Mets at Dx
Note: Supraclavicular (transverse cervical) is moved to CS Lymph Nodes.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Cervical, NOS Contralateral/bilateral axillary and/or internal mammary Other than above Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
42	Further contiguous extension: Skin over: Axilla Contralateral (opposite) breast Sternum Upper abdomen	M1	D	D
44	Metastasis: Adrenal (suprarenal) gland Bone, other than adjacent rib Contralateral (opposite) breast - if stated as metastatic Lung Ovary Satellite nodule(s) in skin other than primary breast	M1	D	D
50	(10) + any of [(40) to (44)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Breast
C500–C509
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction, NOS

No specimen was sent to **pathology** for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

20 Partial mastectomy, NOS; less than total mastectomy, NOS
21 Partial mastectomy WITH nipple resection
22 Lumpectomy or excisional biopsy
23 Reexcision of the biopsy site for gross or microscopic residual disease
24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded **20–24** remove **the gross primary tumor** and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

Lymph node dissection is not part of the equation for surgery codes 20-24.

Example: Lumpectomy with axillary lymph node dissection would be coded to surgery code 22.

30 Subcutaneous mastectomy
A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin

[***SEER Note:*** This procedure is rarely used to treat malignancies]

40 **Total** (simple) **mastectomy**, NOS
41 WITHOUT removal of uninvolved contralateral breast
43 Reconstruction, NOS
44 Tissue
45 Implant
46 Combined (Tissue and implant)
42 WITH removal of uninvolved contralateral breast
47 Reconstruction, NOS
48 Tissue
49 Implant

75 Combined (Tissue and implant)

[***SEER Notes:*** If axillary lymph nodes are present in the specimen, code the Surgery of Primary Site field to 51. If there are no axillary lymph nodes present in the specimen, code the Surgery of Primary Site field to 41. Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment.]

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294)
If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

50 Modified radical mastectomy
51 WITHOUT removal of uninvolved contralateral breast
53 Reconstruction, NOS
54 Tissue
55 Implant
56 Combined (Tissue and Implant)
52 WITH removal of uninvolved contralateral breast
57 Reconstruction, NOS
58 Tissue
59 Implant

63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.
If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item Surgical Procedure/Other Site (NAACCR Item # 1294)

[***SEER Notes:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment. Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy.]

60 **Radical** mastectomy, NOS
61 WITHOUT removal of uninvolved contralateral breast

64 Reconstruction, NOS
65 Tissue
66 Implant
67 Combined (Tissue and Implant)

62 WITH removal of uninvolved contralateral breast
68 Reconstruction, NOS
69 Tissue

73 Implant

74 Combined (Tissue and Implant)

[***SEER Notes:*** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

70 Extended radical mastectomy
71 WITHOUT removal of uninvolved contralateral breast
72 WITH removal of uninvolved contralateral breast

[***SEER Note:*** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection.]

80 Mastectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Vulva (incl. Skin of Vulva)
[excl. Melanoma of Vulva, Kaposi Sarcoma of vulva, Mycosis Fungiodes of vulva, Sezary Disease of vulva, and Other Lymphomas of vulva]
C51.0-C51.2, C51.8-C51.9
C51.0 Labium majus
C51.1 Labium minus
C51.2 Clitoris
C51.8 Overlapping lesion of vulva
C51.9 Vulva, NOS
Note: This schema is NOT used for Malignant Melanoma, Kaposi's Sarcoma, Mycosis Fungoides, Sezary Disease, or Other Lymphomas. Each of these diseases has a separate schema

Vulva (incl. Skin of Vulva)
CS Tumor Size
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Extension
Note 1: FIGO Stage 1, 1A and 1B are defined by size of tumor (less than or equal to 2 cm), involvement of vulva or vulva and perineum, and depth of stromal invasion as defined in codes 10, 11, 12, 30, 40, 41, and 42. FIGO Stage II is greater than 2 cm, but would be coded in the same range of codes.
Note 2: The depth of invasion is defined as the measurement of the tumor from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.

Code	Description	TNM	SS77	SS2000
00	In situ: Noninvasive; intraepithelial Bowen's disease, intraepidermal; preinvasive carcinoma FIGO Stage 0	Tis	IS	IS
10	Invasive cancer confined to: Musculature Submucosa Vulva including skin	*	L	L
11	Vulva only: Stromal invasion less than or equal to 1 mm	**	L	L
12	Vulva only: Stromal invasion greater than 1 mm	***	L	L
30	Localized, NOS	*	L	L
40	Vulva and perineum, level of invasion in mm not stated	*	RE	RE
41	Vulva and perineum, stromal invasion less than or equal to 1 mm	**	RE	RE

42	Vulva and perineum, stromal invasion greater than 1 mm	***	RE	RE
60	Anus Perianal skin Urethra (See code 75 for upper urethral mucosa) Vagina FIGO Stage III	T3	RE	RE
62	Bladder wall or bladder, NOS excluding mucosa Rectal wall or rectum, NOS excluding mucosa	T3	D	RE
70	Perineal body Rectal mucosa	T4	D	D
75	Bladder mucosa Fixed to pubic bone Upper urethral mucosa FIGO Stage IVA	T4	D	RE
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 30, and 40 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 1 for this site.
** For Extension codes 11 and 41 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 2 for this site.
*** For Extension codes 12 and 42 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 3 for this site.

Vulva (incl. Skin of Vulva)

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Unilateral regional lymph nodes: Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph node(s), NOS (unilateral)	N1	RN	RN

	FIGO Stage III			
50	Bilateral or contralateral regional lymph nodes: Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph node(s), NOS (bilateral or contralateral) FIGO Stage IVA	N2	RN	RN
60	Regional lymph node(s), NOS (not stated if unilateral, bilateral or contralateral)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Vulva (incl. Skin of Vulva)
Reg LN Pos
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
Reg LN Exam
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph node(s): External iliac	M1	RN	D
12	Distant lymph node(s): Internal iliac (hypogastric) Obturator Pelvic, NOS	M1	D	D
13	Distant lymph node(s) other than code 11 and 12, including common iliac	M1	D	D
40	Distant metastases other than distant lymph node(s) (codes	M1	D	D

40 cont'd	10 to 13) Distant metastasis, NOS Carcinomatosis			
50	(40) + any of [(10) to (13)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Vagina
C52.9
C52.9 Vagina, NOS

Vagina
CS Tumor Size
SEE STANDARD TABLE

Vagina
CS Extension
Note: According to AJCC, pelvic wall is defined as muscle, fascia, neurovascular structures, or skeletal portions of the bony pelvis.

Code	Description	TNM	SS77	SS2000
00	In situ: Noninvasive; intraepithelial FIGO Stage 0	Tis	IS	IS
10	Invasive cancer confined to Submucosa (stroma) (vagina) FIGO Stage I	T1	L	L
20	Musculature involved	T1	L	L
30	Localized, NOS	T1	L	L
40	Cervix Paravaginal soft tissue Rectovaginal septum Vesicovaginal septum Vulva FIGO Stage II	T2	RE	RE
50	Cul de sac (rectouterine pouch) FIGO Stage II	T2	RE	RE
52	Extension to bladder wall or bladder, NOS excluding mucosa Rectal wall or rectum, NOS excluding mucosa	T3	D	RE
60	Extension to pelvic wall Described clinically as "frozen pelvis", NOS FIGO Stage III	T3	D	RE
70	Extension to bladder mucosa (excluding bullous edema) or rectal mucosa FIGO Stage IVA	T4	D	D

80	Extension beyond true pelvis Extension to urethra FIGO Stage IVA, not further specified	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Vagina

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	All parts of vagina, regional nodes: Pelvic lymph nodes: Iliac, NOS: Common External Internal (hypogastric) Obturator Middle sacral (promontorial) (Gerota's node)	N1	RN	RN
20	Lower third of vagina, regional nodes: Ipsilateral: Inguinal, NOS: Superficial inguinal (femoral)	N1	D	RN
30	Lower third of vagina, regional nodes: Bilateral: Inguinal, NOS: Superficial inguinal (femoral)	N1	D	RN
40	Upper two-thirds of vagina, regional nodes: Pelvic lymph node(s), NOS	N1	D	RN
50	Regional lymph node(s), unknown whether primary is in upper or lower vagina Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated	NX	U	U

99 cont'd	Regional lymph node(s) cannot be assessed Not documented in patient record			

Vagina
Reg LN Pos
SEE STANDARD TABLE

Vagina
Reg LN Exam
SEE STANDARD TABLE

Vagina
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Inguinal (for primary in upper two-thirds of vagina only) Retroperitoneal, NOS	M1	D	D
12	Distant lymph node(s) other than code 11	M1	D	D
40	Distant metastases except distant lymph node(s) (codes 10 to 12) FIGO Stage IVB Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) to (12)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, **C510–C519, C529,** C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed d uring the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Cervix Uteri
C53.0-C53.1, C53.8-C53.9
C53.0 Endocervix
C53.1 Exocervix
C53.8 Overlapping lesion of cervix
C53.9 Cervix uteri

Cervix Uteri
CS Tumor Size
SEE STANDARD TABLE

Cervix Uteri
CS Extension
Note 1: Involvement of anterior and/or posterior septum is coded as involvement of the vaginal wall.
Note 2: Record positive pelvic or peritoneal washings as information only. Not to be coded as metastatic disease.

Code	Description	TNM	SS77	SS2000
00	In situ: Preinvasive; noninvasive; intraepithelial Cancer in situ WITH endocervical gland involvement FIGO Stage 0	Tis	IS	IS
01	CIN (Cervical intraepithelial neoplasia) Grade III	Tis	IS	IS
11	Minimal microscopic stromal invasion less than or equal to 3 mm in depth and less than or equal to 7 mm in horizontal spread FIGO Stage IA1	T1a1	L	L
12	"Microinvasion" Tumor WITH invasive component greater than 3 mm and less than or equal to 5 mm in depth, taken from the base of the epithelium, and less than or equal to 7 mm in horizontal spread FIGO Stage IA2	T1a2	L	L
20	Invasive cancer confined to cervix and tumor larger than that in code 12 FIGO Stage IB	*	L	L
25	Invasive cancer confined to cervix and clinically visible lesion	*	L	L
30	Localized, NOS Confined to cervix uteri or uterus, NOS, except corpus uteri, NOS (Not clinically visible or unknown if clinically visible.)	*	L	L

31	FIGO Stage I, not further specified	*	L	L
35	Corpus uteri, NOS	T1NOS	RE	RE
36	Code (35) + (11)	T1a1	RE	RE
37	Code (35) + (12)	T1a2	RE	RE
38	Code (35) + [(20) or (25)]	*	RE	RE
39	Code (35) + [(30) or (31)]	*	RE	RE
40	Extension to: Cul de sac (rectouterine pouch) Upper 2/3's of vagina including fornices Vagina, NOS Vaginal wall, NOS FIGO Stage IIA FIGO Stage II, NOS	T2a	RE	RE
50	Extension to: Ligament(s): Broad Cardinal Uterosacral Parametrium (paracervical soft tissue) FIGO Stage IIB	T2b	RE	RE
60	Extension to: Bladder wall Bladder, NOS excluding mucosa Bullous edema of bladder mucosa Lower 1/3 of vagina Rectal wall Rectum, NOS excluding mucosa FIGO Stage IIIA	T3a	RE	RE
62	Extension to: Ureter, intra- and extramural Vulva FIGO Stage IIIA	T3a	D	RE
63	Tumor causes hydronephrosis or nonfunctioning kidney FIGO Stage IIIB	T3b	RE	RE
65	Extension to pelvic wall(s) (Described clinically as "frozen pelvis", NOS) FIGO Stage IIIB	T3b	D	RE
68	Extension to:	T3NOS	D	RE

68 cont'd	Fallopian tube Ovary(ies) Urethra FIGO Stage III, NOS			
70	Extension to rectal or bladder mucosa (Note: for bullous edema of bladder mucosa, see code 60.) FIGO Stage IVA	T4	D	D
80	Further contiguous extension beyond true pelvis Sigmoid colon Small intestine FIGO Stage IVA, not further specified	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 20, 25, 30, 31, 38 and 39, the T category is assigned based on the CS Tumor Size, as shownin the Extension Size Table for this site.

Cervix Uteri

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.

Note 3: If either exploratory or definitive surgery is done with no mention of lymph nodes, assume nodes are negative, code 00.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Paracervical Parametrial Pelvic, NOS Sacral, NOS: Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral	N1	RN	RN

	Uterosacral Regional lymph node(s), NOS			
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Cervix Uteri
Reg LN Pos
SEE STANDARD TABLE

Cervix Uteri
Reg LN Exam
SEE STANDARD TABLE

Cervix Uteri
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) including: Aortic (para-, peri-, lateral) Inguinal (femoral) Mediastinal Distant lymph node(s), NOS **FIGO Stage IV	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Updated July 1, 2005

Site-Specific Surgery Codes
Cervix Uteri
C530–C539
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

[***SEER Note:*** **For invasive cancers,** dilation and curettage is NOT coded as Surgery of Primary Site]

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Loop Electrocautery Excision Procedure (LEEP)
16 Laser ablation
17 Thermal ablation

No specimen sent to **pathology** from surgical events 10–17

20 **Local** tumor **excision**, NOS
26 Excisional biopsy, NOS
27 Cone biopsy
24 Cone biopsy WITH gross excision of lesion
29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

21 Electrocautery
22 Cryosurgery
23 Laser ablation or excision

[***SEER Note:*** Codes 21 to 23 above combine 20 Local tumor excision, 24 Cone biopsy WITH gross excision of lesion, 26 Excisional biopsy, NOS, 27 Cone biopsy or 29 Trachelectomy, removal of cervical stump; cervicectomy with 21 Electrocautery, 22 Cryosurgery, 23 Laser ablation or excision]

25 Dilatation and curettage; endocervical curettage (for insitu only)
28 Loop electrocautery excision procedure (LEEP)

[***SEER Notes:*** Margins of resection may have microscopic involvement.
Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional

biopsy, laser ablation, thermal ablation.]

Specimen sent to **pathology** from surgical events 20–29

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
51 Modified radical hysterectomy
52 Extended hysterectomy
53 Radical hysterectomy; Wertheim procedure
54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
61 WITHOUT removal of tubes and ovaries
62 WITH removal of tubes and ovaries

70 Pelvic exenteration
71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site].

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Corpus Uteri; Uterus, NOS (excluding Placenta)
C54.0-C54.3, C54.8-C54.9, C55.9
C54.0 Isthmus uteri
C54.1 Endometrium
C54.2 Myometrium
C54.3 Fundus uteri
C54.8 Overlapping lesion of corpus uteri
C54.9 Corpus uteri
C55.9 Uterus, NOS

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Tumor Size
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Extension
Note 1: According to the AJCC, extension to the bowel or bladder mucosa must be proven by biopsy in order to rule out bullous edema.
Note 2: Since "cancer cells in ascites or in peritoneal washings" was not specifically categorized in the 1977 Summary Stage Guide, is unclear to which stage previous cases may have been coded

Code	Description	TNM	SS77	SS2000
00	In situ: preinvasive; noninvasive; intraepithelial Cancer in situ FIGO Stage 0	Tis	IS	IS
10	FIGO Stage I not further specified Invasive cancer confined to corpus uteri	T1NOS	L	L
11	Confined to endometrium (stroma) FIGO Stage IA	T1a	L	L
12	Tumor invades less than one-half of myometrium Invasion of inner half of myometrium FIGO Stage IB	T1b	L	L
13	Tumor invades one-half or more of myometrium Invasion of outer half of myometrium FIGO Stage IC	T1c	L	L
14	Invasion of myometrium, NOS	T1NOS	L	L
**16	Tunica serosa of visceral peritoneum (serosa covering the corpus)	T1NOS	L	L
40	Localized, NOS	T1NOS	L	L

50	Cervix uteri, NOS, but not beyond uterus FIGO Stage II, NOS	T2NOS	RE	RE
51	Endocervical glandular involvement only FIGO Stage IIA	T2a	RE	RE
52	Cervical stromal invasion FIGO Stage IIB	T2b	RE	RE
60	Extension or metastasis within true pelvis: Adnexa Fallopian tube(s) Ligaments: Broad, round, uterosacral Ovary(ies) Parametrium Pelvic serosa **Tunica serosa (parietal living of the pelvis or abdominal cavity) FIGO Stage IIIA FIGO Stage III, NOS	T3a	RE	RE
61	Cancer cells in ascites Cancer cells in peritoneal washings FIGO Stage IIIA	T3a	RE	RE
62	Ureter and vulva	T3a	D	RE
64	Extension or metastasis to vagina FIGO Stage IIIB	T3b	D	RE
65	Extension or metastasis to pelvic wall(s) Described clinically as "frozen pelvis", NOS FIGO Stage IIIB	T3b	RE	RE
66	Extension or metastasis to: Bladder wall Bladder, NOS excluding mucosa Rectal wall Rectum, NOS excluding mucosa FIGO Stage IIIB	T3b	RE	RE
67	[(65) or (66)] and [(62) or (64)]	T3b	D	RE
70	Extension to bowel mucosa or bladder mucosa (excluding bullous edema) FIGO Stage IVA FIGO Stage IV, NOS	T4	D	D

80	Further contiguous extension Abdominal serosa (peritoneum) Cul de sac Sigmoid colon Small intestine	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Updated July 1, 2005

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes includes bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Paracervical Parametrial Pelvic, NOS Sacral, NOS: Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Uterosacral	N1	RN	RN
20	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic	N1	RN	RN
50	Regional lymph node(s):	N1	RN	RN

50 cont'd	FIGO Stage IIIC, NOS			
80	Regional lymph node(s), NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Corpus Uteri; Uterus, NOS (excluding Placenta)
Reg LN Pos
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
Reg LN Exam
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s): Superficial inguinal	M1	RN	D
12	Distant lymph node(s) other than code 11: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph node(s) (codes 11-12) Distant metastasis, NOS Carcinomatosis Stage IVB Stage IV, NOS	M1	D	D
50	(40) + any of [(11) or (12)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Corpus Uteri
C540–C559
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

[***SEER Note:*** **For invasive cancers,** dilation and curettage is NOT coded as Surgery of Primary Site]

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Loop Electrocautery Excision Procedure (LEEP)
16 Thermal ablation

No specimen sent to **pathology** from surgical events 10–16

20 Local tumor excision, NOS; simple excision, NOS
24 Excisional biopsy
25 Polypectomy
26 Myomectomy

Any **combination** of **20** or **24–26** WITH

21 Electrocautery
22 Cryosurgery
23 Laser ablation or excision

[***SEER Note:*** Codes 21 to 23 above combine 20 Local tumor excision, 24 Excisional biopsy, 25 Polypectomy, or 26 Myomectomy with 21 Electrocautery, 22 Cryosurgery or 23 Laser ablation or excision]

Specimen sent to **pathology** from surgical events 20–26

[***SEER Note:*** Margins of resection may have microscopic involvement]

30 **Subtotal** hysterectomy/**supracervical hysterectomy/fundectomy** WITH or WITHOUT removal of tube(s) and ovary(ies)
31 WITHOUT tube(s) and ovary(ies)
32 WITH tube(s) and ovary(ies)

[***SEER Note:*** For these procedures, the cervix is left in place]

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 **Modified radical** or **extended** hysterectomy; radical hysterectomy; **extended radical** hysterectomy
61 Modified radical hysterectomy
62 Extended hysterectomy
63 Radical hysterectomy; Wertheim procedure
64 Extended radical hysterectomy

[***SEER Note:*** Use code 63 for "Type III" hysterectomy]

65 **Hysterectomy, NOS**, WITH or WITHOUT removal of tube(s) and ovary(ies)
66 WITHOUT removal of tube(s) and ovary(ies)
67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration
76 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

77 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

78 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

79 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Ovary
C56.9
C56.9 Ovary
Note: Laterality must be coded for this site

Ovary
CS Tumor Size
SEE STANDARD TABLE

Ovary
CS Extension
Note 1: Ascites WITH malignant cells changes FIGO stages I and II to IC and IIC, respectively. Ascites, NOS is considered negative.
Note 2: "Both extension to and discontinuous metastasis to any of the following pelvic organs is considered FIGO Stage II and coded in the range 50-65: adnexae, NOS; bladder, bladder serosa; broad ligament (mesovarium); cul-de-sac; fallopian tubes; parametrium; pelvic peritoneum; pelvic wall; rectum; sigmoid colon; sigmoid mesentery; ureter; uterus; uterine serosa.
Note 3: Peritoneal implants outside the pelvis (codes 70-73) must be microscopically confirmed. Peritoneal implants may also be called seeding, salting, talcum powder appearance, or studding.
Note 4: If implants are mentioned, determine whether they are in the pelvis or in the abdomen and code appropriately (60-64) or (70-73). If the location is not specified, code as 75.
Note 5: Both extension to and discontinuous metastasis to any of the following abdominal organs is considered FIGO Stage III and coded in the range 70-75: abdominal mesentery; diaphragm; gallbladder; infracolic omentum; kidneys; large intestine except rectum and sigmoid colon; liver (peritoneal surface); omentum; pancreas; pericolic gutter; peritoneum, NOS; small intestine; spleen; stomach; ureters.
Note 6: Excludes parenchymal liver nodules, which are coded in CS Mets at DX
Note 7: Since "cancer cells in ascites or in peritoneal washings" was not specifically categorized in the 1977 Summary Stage Guide, it is unclear to which stage previous cases may have been coded.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	Tis	IS	IS
10	Tumor limited to one ovary, capsule intact, no tumor on ovarian surface, no malignant cells in ascites or peritoneal washings FIGO Stage IA	T1a	L	L
20	Tumor limited to both ovaries, capsule(s) intact, no tumor on ovarian surface, no malignant cells in ascites or peritoneal washings FIGO Stage IB	T1b	L	L
30	Tumor limited to ovaries, unknown if capsule(s) ruptured or if one or both ovaries involved Localized, NOS	T1NOS	L	L

30 cont'd	FIGO Stage I, NOS			
35	Tumor limited to ovary(ies), capsule(s) ruptured FIGO Stage 1C	T1c	L	RE
36	Tumor on ovarian surface FIGO Stage 1C	T1c	D	RE
41	Tumor limited to ovary(ies) WITH malignant cells in ascites or peritoneal washings FIGO Stage IC	T1c	RE	RE
43	(35) + (41) FIGO Stage IC	T1c	RE	RE
44	(36) + any of [(35) or (41)] FIGO Stage 1C	T1c	D	RE
50	Extension to or implants on (but no malignant cells in ascites or peritoneal washings): Adnexa, NOS, ipsilateral or NOS Fallopian tube(s), ipsilateral or NOS FIGO Stage IIA	T2a	RE	RE
52	Extension to or implants on (but no malignant cells in ascites or peritoneal washings): Adnexa, NOS, contralateral Fallopian tube(s), contralateral Uterus FIGO Stage IIA	T2a	D	RE
60	Extension to or implants on other pelvic structures (but no malignant cells in ascites or peritoneal washings): Pelvic tissue: Adjacent peritoneum Ligament(s): Broad, ipsilateral, NOS Ovarian Round Suspensory Mesovarium, ipsilateral, NOS Pelvic wall FIGO Stage IIB	T2b	RE	RE
61	Extension to or implants on other pelvic structures (but no malignant cells in ascites or peritoneal washings): Broad ligament(s), contralateral Mesovarium, contralateral	T2b	D	RE

61 cont'd	FIGO Stage IIB			
**62	[(50) and/or (60)] WITH malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	RE	RE
**63	[(52) and/or (60)] WITH malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	D	RE
64	(61) WITH malignant cells in ascites or peritoneal washings FIGO IIC	T2c	D	RE
65	Tumor involves one or both ovaries with pelvic extension, NOS FIGO Stage II, NOS	T2NOS	RE	RE
70	Microscopic peritoneal implants beyond pelvis, including peritoneal surface/capsule of liver FIGO Stage IIIA (See Note 5)	T3a	D	D
71	Macroscopic peritoneal implants beyond pelvis, less than or equal to 2 cm in diameter, including peritoneal surface of liver FIGO Stage IIIB (See Note 5)	T3b	D	D
72	Peritoneal implants beyond pelvis, greater than 2 cm in diameter, including peritoneal surface of liver (liver capsule) FIGO Stage IIIC (See Note 5)	T3c	D	D
73	Tumor involves one or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis, NOS FIGO Stage III, NOS (See Note 5)	T3NOS	D	D
75	Peritoneal implants, NOS (See Note 5)	T3NOS	D	D
80	Further contiguous extension	T3NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Updated July 1, 2005

Ovary
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved, code "00".
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes includes bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric), NOS Obturator Pelvic, NOS	N1	RN	RN
12	Regional lymph node(s): Lateral sacral (laterosacral)	N1	D	RN
20	Regional lymph node(s): Aortic (para-, peri-, lateral) Retroperitoneal, NOS	N1	RN	RN
30	Regional lymph node(s): Inguinal	N1	D	RN
40	(10) + (20)	N1	RN	RN
42	[(12) or (30)] + [(10) or (20)]	N1	D	RN
50	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Ovary
Reg LN Pos
SEE STANDARD TABLE

Ovary
Reg LN Exam
SEE STANDARD TABLE

Ovary
CS Mets at Diagnosis

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10), including: Liver parenchymal metastasis Pleural effusion WITH positive cytology Distant metastasis, NOS Carcinomatosis Stage IV, NOS	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Ovary
C569
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

17 Local tumor destruction, NOS

No specimen sent to **pathology** from surgical event 17

25 **Total removal** of **tumor** or (single) **ovary**, NOS
26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
27 WITHOUT hysterectomy
28 WITH hysterectomy

Specimen sent **to pathology** from surgical events 25–28

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
36 WITHOUT hysterectomy
37 WITH hysterectomy

[***SEER Note:*** Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy]

50 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
51 WITHOUT hysterectomy
52 WITH hysterectomy

[***SEER Note:*** Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy]

55 Unilateral or bilateral (salpingo-) **oophorectomy** WITH **OMENTECTOMY**, NOS; partial or total; **unknown** if **hysterectomy** done
56 WITHOUT hysterectomy
57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
61 WITH colon (including appendix) and/or small intestine resection (not incidental)
62 WITH partial resection of urinary tract (not incidental)
63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of

multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

[***SEER Note:*** Debulking or cytoreductive surgery is implied by the following phrases (This is not intended to be a complete list. Other phrases may also imply debulking).

Adjuvant treatment pending surgical reduction of tumor
Ovaries, tubes buried in tumor
Tumor burden
Tumor cakes
Very large tumor mass

Do not code multiple biopsies alone as debulking or cytoreductive surgery. Do not code debulking or cytoreductive surgery based only on the mention of "multiple tissue fragments" or "removal of multiple implants." Multiple biopsies and multiple specimens confirm the presence or absence of metastasis].

70 Pelvic exenteration, NOS

71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

80 (Salpingo-) oophorectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Fallopian Tube
C57.0
C57.0 Fallopian tube
Note: Laterality must be coded for this site

Fallopian Tube
CS Tumor Size
SEE STANDARD TABLE

Fallopian Tube
CS Extension
Note 1: Positive regional lymph nodes (FIGO Stage IIIC) are coded in the CS Lymph Nodes field.
Note 2: Codes 13 and 71: Since "malignant ascites or malignant peritoneal washings" was not specifically categorized in the 1977 Summary Staging Guide, it is unclear to which stage previous cases may have been coded.
Note 3: Liver capsule metastases are coded to 75-78 in the Extension field; liver parenchymal metastases are coded in the Mets at DX field.

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive, intraepithelial Limited to tubal mucosa FIGO Stage 0	Tis	IS	IS
10	Confined to fallopian tube, NOS FIGO Stage I	T1NOS	L	L
11	Confined to one fallopian tube WITHOUT penetrating serosal surface; no ascites FIGO Stage IA	T1a	L	L
12	Confined to both fallopian tubes WITHOUT penetrating serosal surface; no ascites FIGO Stage IB	T1b	L	L
13	Extension onto or through tubal serosa Malignant ascites Malignant peritoneal washings FIGO Stage IC	T1c	L	L
30	Localized, NOS FIGO Stage 1	T1NOS	L	L

35	Pelvic extension, NOS with no malignant cells in peritoneal washings FIGO Stage II	T2NOS	RE	RE
40	Extension or metastasis to: Corpus uteri Ovary, ipsilateral Uterus, NOS FIGO Stage IIA	T2a	RE	RE
50	Extension or metastasis to: Broad ligament, ipsilateral Mesosalpinx, ipsilateral Peritoneum FIGO Stage IIB	T2b	RE	RE
60	Ovary, contralateral FIGO Stage IIA	T2a	D	RE
65	Extension or metastasis to: Cul de sac (rectouterine pouch) Rectosigmoid Sigmoid Small intestine FIGO IIB	T2b	D	RE
70	Extension or metastasis to: Omentum FIGO Stage IIB	T2b	D	RE
71	Pelvic extension (codes 35 to 70) with malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	D	RE
75	Peritoneal implants outside the pelvis, NOS FIGO Stage III	T3NOS	D	D
76	Microscopic peritoneal metastasis outside the pelvis FIGO Stage IIIA	T3a	D	D
77	Macroscopic peritoneal metastasis less than or equal to 2 cm outside the pelvis FIGO Stage IIIB	T3b	D	D
78	Peritoneal metastases greater than 2 cm FIGO Stage IIIC	T3c	D	D

80	Further contiguous extension FIGO Stage III	T3NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Fallopian Tube
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes includes bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Pelvic, NOS	N1	RN	RN
12	Regional lymph node(s): Lateral sacral (laterosacral) Presacral	N1	D	RN
20	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Retroperitoneal, NOS	N1	RN	RN
22	(12) + (20)	N1	D	RN
30	Regional lymph node(s): Inguinal	N1	D	RN
50	Regional lymph node(s), NOS	N1	RN	RN

80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Fallopian Tube
Reg LN Pos
SEE STANDARD TABLE

Fallopian Tube
Reg LN Exam
SEE STANDARD TABLE

Fallopian Tube
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10), including: Liver parenchymal metastasis Pleural effusion WITH positive cytology Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Broad and Round Ligaments, Parametrium, Uterine Adnexa
C57.1-C57.4
C57.1 Broad ligament
C57.2 Round ligament
C57.3 Parametrium
C57.4 Uterine adnexa
Note: AJCC does not define TNM staging for this site.

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Tumor Size
SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Confined to tissue or organ of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Corpus uteri Ovary, ipsilateral Uterus, NOS	NA	RE	RE
50	Fallopian tube for ligaments Mesosalpinx, ipsilateral Peritoneum	NA	RE	RE
70	Cervix uteri Cul de sac (rectouterine pouch) Omentum Ovary, contralateral Rectosigmoid Sigmoid Small intestine	NA	D	D
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Iliac, NOS: Common External Internal (hypogastric): Obturator Inguinal Lateral sacral (laterosacral) Pelvic, NOS Retroperitoneal, NOS Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Broad and Round Ligaments, Parametrium, Uterine Adnexa
Reg LN Pos
SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa
Reg LN Exam
SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D

40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, **C570–C579**, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Other and Unspecified Female Genital Organs
C57.7-C57.9
C57.7 Other specified parts of female genital organs
C57.8 Overlapping lesion of female genital organs
C57.9 Female genital tract, NOS
Note: AJCC does not define TNM staging for this site.

Other and Unspecified Female Genital Organs
CS Tumor Size
SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (See definition in General Instructions)	NA	RE	RE
60	Adjacent organs/structures: Female genital organs: Adnexa Broad ligament(s) Cervix uteri Corpus uteri Fallopian tube(s) Ovary(ies) Parametrium Round ligament(s) Uterus, NOS Vagina	NA	RE	RE
80	Further contiguous extension: Other organs of pelvis	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Female Genital Organs
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Female Genital Organs
Reg LN Pos
SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
Reg LN Exam
SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Codes
Placenta
C58.9
C58.9 Placenta
Note 1: This schema correlates to the AJCC's Gestational Trophoblastic Tumors scheme. In most cases, gestational trophoblastic tumors (ICD-O-3 morphology codes 9100-9105) are coded to placenta, C58.9.
Note 2: If a trophoblastic tumor is not associated with a pregnancy and arises in another site, such as ovary, use the primary site code and Collaborative Staging schema for that site.

Placenta
CS Tumor Size
SEE STANDARD TABLE

Placenta
CS Extension
Note 1: Substaging of gestational trophoblastic tumors are determined by the value coded in the Prognostic Scoring Index Table, using Site Specific Factor 1. See note in Site Specific Factor 1, Prognostic Index Table to determine the prognostic index score.
Note 2: For this schema, according to AJCC, involvement of genital structures may be either by direct extension or metastasis and is still T2. For Collaborative Staging, metastasis to genital structures should be coded 70 in CS Extension and not coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ: Noninvasive; intraepithelial FIGO Stage 0	Tis	IS	IS
10	Confined to placenta FIGO Stage I	T1	L	L
30	Localized, NOS FIGO Stage 1	T1	L	L
40	Adjacent connective tissue, NOS FIGO Stage II	T2	RE	RE
60	Other genital structures by direct extension or NOS: Broad ligament Cervix Corpus uteri Fallopian tube(s) Genital structures, NOS Ovary(ies) Uterus, NOS Vagina	T2	RE	RE

60 cont'd	FIGO Stage II			
70	Other genital structures, by metastasis: Broad ligament Cervix Corpus uteri Fallopian tube(s) Genital structures, NOS Ovary(ies) Uterus, NOS Vagina FIGO Stage II	T2	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Note: For codes 10-80, the substaging is determined by using the Risk Scores in the Prognostic Scoring Index in Site Specific Factor 1Table.

Placenta
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Placenta
Reg LN Pos

Code	Description
99	Not applicable

Placenta
Reg LN Exam

Code	Description
99	Not applicable

Placenta

CS Mets at Diagnosis

Note 1: All lymph node involvement is considered M1 in TNM, so all lymph node involvement, whether regional or distant nodes, is coded in the field Mets at DX.

Note 2: According to AJCC, metastasis to genital structures is considered T2 and not M1 for GTT. For this Collaborative Staging schema, metastasis to genital structures is coded 70 in CS Extension and not coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Metastasis to lung(s) only, NOS FIGO III	M1a	D	D
20	Regional lymph nodes: Iliac, NOS: Common External Internal (hypogastric), NOS Obturator Parametrial Pelvic, NOS Sacral, NOS: Lateral Presacral Promontory (Gerota's) Uterosacral	M1b	RN	RN
30	Regional lymph nodes: Aortic, NOS: Lateral Para-aortic Periaortic	M1b	RN	RN
35	(20) + (30)	M1b	RN	RN
40	Regional lymph node(s), NOS	M1b	RN	RN
50	Distant lymph node(s), NOS	M1b	D	D
51	Distant lymph node(s): Superficial inguinal (femoral)	M1b	D	D
52	Specified distant lymph node(s) other than in code 51	M1b	D	D
60	Lymph nodes, NOS	M1b	D	D
70	Distant metastases, other than lymph node(s) or lung	M1b	D	D

70 cont'd	Distant metastasis, NOS Carcinomatosis			
80	(70) + any of [(10) to (60)]	M1b	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, **C570–C579, C589**, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
C60.0-C60.2, C60.8-C60.9
C60.0 Prepuce
C60.1 Glans penis
C60.2 Body of penis
C60.8 Overlapping lesion of penis
C60.9 Penis, NOS
Note: This schema is NOT used for Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, or Other Lymphomas. Each of these diseases has a separate schema.

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Tumor Size
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; Bowen disease; intraepithelial	Tis	IS	IS
05	Noninvasive verrucous carcinoma	Ta	IS	IS
10	Invasive tumor limited to subepithelial connective tissue, but not involving corpus spongiosum or cavernosum If primary is skin: invasive tumor limited to skin of penis, prepuce (foreskin) and/or glans	T1	L	L
30	Localized, NOS	T1	L	L
35	For body of penis ONLY: Corpus cavernosum Corpus spongiosum Tunica albuginea of corpus spongiosum	T2	L	L
40	Corpus cavernosum except for tumor in body of penis Corpus spongiosum except for tumor in body of penis Tunica albuginea of corpus spongiosum except for tumor in body of penis	T2	RE	RE
50	Satellite nodule(s) on prepuce or glans	T1	RE	RE
60	Urethra Prostate	T3	RE	RE

70	Adjacent structures: Muscle, NOS: Bulbospongiosus Ischiocavernosus Superficial transverse perineal Skin: Abdominal Perineum Pubic Scrotal	T4	RE	RE
80	Further contiguous extension Testis	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.

Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	SINGLE superficial inguinal (femoral) regional lymph node	N1	RN	RN
20	Multiple OR bilateral superficial inguinal (femoral) regional lymph nodes	N2	RN	RN
30	Regional lymph nodes: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal)	N3	RN	RN
40	Regional lymph nodes: External iliac Internal iliac (hypogastric)	N3	RN	RN

40 cont'd	Obturator Pelvic nodes, NOS			
50	Regional Lymph Node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
Reg LN Pos
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas
Reg LN Exam
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas
CS Mets at Diagnosis
SEE STANDARD TABLE

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, **C600–C609**, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
PROSTATE
C61.9

Equivalent or Equal Terms

- Acinar adenocarcinoma, adenocarcinoma (For prostate primaries only)
- Adenocarcinoma, glandular carcinoma

Histology

About 95% of all prostate cancers are acinar adenocarcinoma. The term acinar refers to the fact that the adenocarcinoma originates in the prostatic acini. Acinar adenocarcinoma is not a specific histologic type when referring to the prostate; therefore, code to adenocarcinoma (8140).

Priority Rules for Grading Prostate Cancer

Code the tumor grade using the following priority order.

1. Gleason's grade (Use the table to convert Gleason's grade information into the appropriate code)
2. Terminology
   Differentiation (well differentiated, moderately differentiated, etc)
3. Histologic grade
   Grade I, grade II, grade III, grade IV
4. Nuclear grade only

Gleason's Pattern

Prostate cancers are commonly graded using Gleason's score or pattern. Gleason's grading is based on a 5-component system, meaning it is based on 5 histologic patterns. The pathologist will evaluate the primary (majority) and secondary patterns for the tumor. The pattern is written as a range, with the majority pattern appearing first and the secondary pattern as the last number

> **Example:** A Gleason pattern of 2 + 4 means that the primary pattern is 2 and the secondary pattern is 4.

Gleason's Score

The patterns are added together to create a score.

> **Example**: If the pattern is 2 + 4, the pattern score is 6 (the sum of 2 and 4).

a. If the pathology report contains only **one number**, and that number is **less than or equal to 5,** it is a pattern.

b. If the pathology report contains only **one number**, and that number is **greater than 5**, it is a score.

c. If the pathology report specifies a specific **number out of a total of 10**, the first number given is the score.

Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.

d. If there are **two numbers other than 10**, assume they refer to two patterns. The first number is the primary pattern and the second is the secondary pattern.

Example: If the pathology report says "Gleason's 3 + 5," the Gleason's score would be 8, the sum of 3 and 5.

Use the following table to convert Gleason's pattern or score into ICD-0-3 Morphology 6th Digit Code:

Gleason Conversion Table

Gleason's Score	Gleason's Pattern	Histologic Grade	Terminology	ICD-0-3 Morphology 6th Digit Code
2, 3, 4	1, 2	I	Well differentiated	1
5, 6	3	II	Moderately differentiated	2
7, 8, 9, 10	4, 5	III	Poorly differentiated	3

Note: Code 7 was moved from moderately differentiated to poorly differentiated with cases diagnosed on or after 01/01/2003.

Collaborative Staging Codes
Prostate
C61.9
C61.9 Prostate gland
Note: Transitional cell carcinoma of the prostatic urethra is to be coded to primary site C68.0, Urethra, and assigned Collaborative Stage codes according to the urethra scheme.

Prostate
CS Tumor Size
SEE STANDARD TABLE

Prostate
CS Tumor Extension-Clinical Extension
****Note 1:** This field and Site-Specific Factor 3, CS Extension – Pathologic Extension, must both be coded, whether or not a prostatectomy was performed. Information from prostatectomy is EXCLUDED from this field and coded only in Site-Specific Factor 3.
****Note 2:**
A. Codes 10-15: CODES 10 to 15 are used only for clinically inapparent tumor not palpable or visible by imaging and incidentally found microscopic carcinoma (latent, occult) in one or both lobes. Within this range, give priority to codes 13-15 over code 10. When tumor is found in one lobe, both lobes or in prostatic apex by needle biopsy but is not palpable or visible by imaging, use code 15.
B. CODES 20 to 24 are used only for clinically/radiographically apparent tumor, i.e., that which is palpable or visible by imaging. Codes 21 and 22 have precedence over code 20. Code 20 has precedence over code 24.
C. CODE 30 is used for localized cancer when it is unknown if clinically or radiographically apparent. An example would be when a diagnosis is made prior to admission for a prostatectomy with no details provided on clinical findings prior to admission.
**D. CODES 31, 33 and 34 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the "T" classification.
E. CODES 41 to 49 are used for extension beyond the prostate.
****Note 3:** Prostate Apex Involvement: This field and Site-Specific Factor 4, Prostate Apex Involvement, are both coded whether or not a prostatectomy was performed.
****Note 4:** Use codes 13-14 when a TURP is done, not for a biopsy only. Do not use code 15 when a TURP is done.
****Note 5:** Involvement of the prostatic urethra does not alter the extension code.
****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 60.
****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.
****Note 8:** This schema includes evaluation of other pathologic tissue such as a biopsy of the rectum.
****Note 9:** For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c,

p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Eval, and Site-Specific Factor 3. If the value of Site-Specific Factor 3 (Pathologic Extension) is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT. If Site-Specific Factor 3 (Pathologic Extension) code is 95 or greater (meaning that prostatectomy was not performed, or it was performed but the information is not usable for staging), the mapping values are taken from the CS Extension (Clinical Extension) mapping, and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 (Pathologic Extension) code is 000 (in situ), and if CS Extension code (Clinical Extension) is greater than 00 and less than 95 (not in situ), the mapping values are taken from the CS Extension (Clinical Extension) mapping and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 code is 000 (in situ) and CS Extension code is 00 (in situ) or greater than 94, the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT.

Prostate

CS Extension-Clinical Extension

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial	Tis	IS	IS
10	Clinically inapparent tumor, number of foci or percent involved tissue not specified Stage A, NOS	T1NOS	L	L
13	Incidental histologic finding in 5% or less of tissue resected (clinically inapparent)	T1a	L	L
14	Incidental histologic finding more than 5% of tissue resected (clinically inapparent)	T1b	L	L
15	Tumor identified by needle biopsy, e.g., for elevated PSA (clinically inapparent)	T1c	L	L
20	Involvement in one lobe, NOS (clinically apparent only)	T2NOS	L	L
21	Involves one half of one lobe or less (clinically apparent only)	T2a	L	L
22	Involves more than one half of one lobe, but not both lobes (clinically apparent only)	T2b	L	L
23	Involves both lobes (clinically apparent only)	T2c	L	L
24	Clinically apparent tumor confined to prostate, NOS Stage B, NOS	T2NOS	L	L
30	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Not stated if Stage A or B, T1 or T2,	T2NOS	L	L

30 cont'd	clinically apparent or inapparent			
31	**OBSOLETE - Into prostatic apex/arising in prostatic apex, NOS (See Notes 2,3 and Site-Specific Factor 4)	T2NOS	L	L
33	**OBSOLETE – Arising in prostatic apex (See Notes 2,3 and Site-Specific Factor 4)	T2NOS	L	L
34	**OBSOLETE – Extending into prostatic apex (See Notes 2,3 and Site-Specific Factor 4)	T2NOS	L	L
41	Extension to periprostatic tissue (Stage C1) Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3NOS	RE	RE
42	Unilateral extracapsular extension	T3a	RE	RE
43	Bilateral extracapsular extension	T3a	RE	RE
45	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
49	Periprostatic extension, NOS (Unknown if seminal vesicle(s) involved) Stage C, NOS	T3NOS	RE	RE
50	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
52	Levator muscles Skeletal muscle, NOS Ureter(s)	T4	D	RE
60	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 6)	T4	D	D
70	Further contiguous extension (Stage D2) including to: Bone Other organs Penis Sigmoid colon Soft tissue other than periprostatic	T4	D	D
95	No evidence of primary tumor	T0	U	U

99	Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Updated July 1, 2005

Prostate
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional nodes, including contralateral or bilateral lymph nodes: Iliac, NOS External Internal (hypogastric), NOS: Obturator Pelvic, NOS Periprostatic Sacral, NOS Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed	NX	U	U

Prostate
Reg LN Pos
SEE STANDARD TABLE

Prostate
Reg LN Exam
SEE STANDARD TABLE

Prostate
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s), NOS	M1a	RN	D

	Common iliac			
12	Distant lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Cervical Inguinal, NOS Deep, NOS Node of Coquet or Rosenmuller (highest deep inguinal) Superficial (femoral) Retroperitoneal, NOS Scalene (inferior deep cervical) Supraclavicular (transverse cervical) Distant lymph node(s), NOS	M1a	D	D
30	Metastasis in bone(s)	M1b	D	D
35	(30) + [(11) or (12)]	M1b	D	D
40	Distant metastasis, other than distant lymph nodes (codes 11 or 12) or bone(s) Carcinomatosis	M1c	D	D
45	Distant metastasis, NOS Stage D2, NOS	M1NOS	D	D
50	(40) + any of [(11) or (12)]	M1c	D	D
55	(40) + any of [(30) or (35)]	M1c	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Prostate

CS Site-Specific Factor 3 CS Extension - Pathologic Extension

Note 1: Include information from prostatectomy in this field and not in CS Extension - Clinical Extension. Use all histologic 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 margin, or bladder neck margin is involved and there is no extracapsular extension, use code 040.

**Note 5: Codes 031, 033 and 034 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the "T" classification.

**Note 6: 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 7: "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 8: 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 9: For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c,p,y, or a indicator are assigned based on the values in CS Extension, CS TS/Eval, and Site-Specific Factor 3. If the value of Site-Specific Factor 3 (Pathologic Extension) is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT. If Site-Specific Factor 3 (Pathologic Extension) code is 095 or greater (meaning that prostatectomy was not performed, or it was performed but the information is not usable for staging), the mapping values are taken from the CS Extension (Clinical Extension) mapping, and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 (Pathologic Extension) code is 000 (in situ), and if CS Extension code (Clinical Extension) is greater than 00 and less than 95 (not in situ), the mapping values are taken from the CS Extension (Clinical Extension) mapping, and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 code is 000 (in situ) and CS Extension code is 00 (in situ) or greater than 94, the mapping values are taken from the Site-Specific Factor 3 mapping and the T category is identified as a pT.

**Note 10: Code 045, extension to seminal vesicle(s) (Stage C2), takes priority over Code 048, extracapsular extension and margins involved, if both are present.

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	OBSOLETE – Into prostatic apex/arising in prostatic apex, NOS (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L

032	Invasion into (but not beyond) prostatic capsule	T2NOS	L	L
**033	OBSOLETE – Arising in prostatic apex (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
**034	OBSOLETE – Extending into prostatic apex (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
**040	No extracapsular extension but margins involved (See Note 4)	T2NOS	L	RE
041	Extension to periprostatic tissue (Stage C1): Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3a	RE	RE
042	Unilateral extracapsular extension	T3a	RE	RE
043	Bilateral extracapsular extension	T3a	RE	RE
045	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
**048	Extracapsular extension and margins involved (Excluding seminal vesicle margins—See Code 045)	T3a	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 performed, but not considered first course of treatment because of, for example, disease progression.	TX	U	U
099	Prostatectomy done: Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Updated July 1, 2005

Site-Specific Surgery Codes
Prostate
C61.9
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item "Hematologic Transplant and Endocrine Procedures" (NAACCR Item # 3250).

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (**TURP**), NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003)

10 **Local** tumor **destruction**, [or excision] NOS
14 Cryoprostatectomy
15 Laser ablation
16 Hyperthermia
17 Other method of local tumor destruction

No specimen sent to **pathology** from surgical events 10–17

[***SEER Notes:*** Code Transurethral Microwave Thermotherapy (TUMT) as 16
Code High Intensity Focused Ultrasonography (HIFU) as 17
Code Transurethral Needle Ablation (TUNA) as 17]

20 **Local** tumor **excision**, NOS
21 Transurethral resection (TURP), NOS22 TURP—cancer is incidental finding during surgery for benign disease
23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH

24 Cryosurgery

25 Laser

26 Hyperthermia

[***SEER Note:*** Codes 24 to 26 above combine 20 Local tumor excision, NOS, 21 TURP, NOS, 22 TURP incidental or 23 TURP suspected/known cancer with 24 Cryosurgery, 25 Laser or 26 Hyperthermia]

Specimen sent to **pathology** from surgical events 20–26

30 **Subtotal, segmental, or simple prostatectomy**, which may leave all or part of the capsule intact

50 **Radical** prostatectomy, NOS; **total** prostatectomy, NOS

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck

70 **Prostatectomy** WITH resection in continuity with **other organs**; pelvic **exenteration**

Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Prostatectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Testis
C62.0-C62.1, C62.9
C62.0 Undescended testis
C62.1 Descended testis
C62.9 Testis, NOS

Testis
CS Tumor Size
SEE STANDARD Table

Testis
CS Extension
Note 1: Laterality must be coded for this site.
Note 2: According to AJCC, "Except for pTis and pT4, extent of primary tumor for TNM is classified by radical orchiectomy. TX is used for other categories in the absence of radical orchiectomy." For Collaborative Staging, this means that the categories of T1, T2, and T3 are derived only when Site Specific Factor 4 indicates that a radical orchiectomy was performed. See the Extension Orchiectomy table for details.

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial Intratubular germ cell neoplasia	Tis	IS	IS
10	Invasive tumor WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion or NOS Body of testis Rete testis Tunica albuginea	*	L	L
15	Invasive tumor WITH vascular/lymphatic invasion Body of testis Rete testis Tunica albuginea	*	L	L
20	Tunica vaginalis involved Surface implants	*	L	L
30	Localized, NOS	*	L	L
31	Tunica, NOS	TX	L	L
40	Epididymis involved WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion not stated	*	RE	RE
45	Epididymis involved WITH vascular/lymphatic invasion	*	RE	RE

50	Spermatic cord, ipsilateral Vas deferens	*	RE	RE
60	Dartos muscle, ipsilateral Scrotum, ipsilateral	T4	RE	RE
70	Extension to scrotum, contralateral Ulceration of scrotum	T4	D	D
75	Penis	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For extension codes 10, 15, 20, 30, 40, 45, and 50, the T category is assigned based on the values of CS Extension and Site-Specific Factor 4 (Radical Orchiectomy Performed), using the Extension/Orchiectomy extra table.

Testis

CS Lymph Nodes

Note 1: Regional nodes in codes 10-30 include contralateral and bilateral nodes.

Note 2: Involvement of inguinal, pelvic, or external iliac lymph nodes in the absence of previous scrotal or inguinal surgery is coded in CS Mets at DX, as distant lymph node involvement.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) (bilateral and contralateral): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Preaortic Retroaortic Retroperitoneal, NOS Spermatic vein	*	RN	RN
20	Regional lymph node(s) (bilateral and contralateral): Pericaval, NOS: Interaortocaval Paracaval Precaval Retrocaval	*	D	RN

30	Regional lymph node(s) (bilateral and contralateral): Pelvic, NOS External iliac WITH previous scrotal or inguinal surgery	*	RN	RN
40	Inguinal nodes, NOS: Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITH previous scrotal or inguinal surgery	*	D	D
50	Regional lymph node(s), NOS	*	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10, 20, 30, 40, 50, and 80 the N category is assigned from the Number Positive Lymph Nodes and Size of Metastasis in Lymph Nodes extra table using the values of Site Specific Factor 5 (Size of Metastasis in Lymph Nodes) and Reg LN Pos.

Testis
Reg LN Pos
SEE STANDARD TABLE

Testis
Reg LN Exam
SEE STANDARD TABLE

Testis
CS Mets at Dx
Note: Involvement of inguinal, pelvic, or external iliac lymph nodes after previous scrotal or inguinal surgery is coded under CS Lymph Nodes, as regional node involvement.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s): Pelvic, NOS External iliac WITHOUT previous scrotal or inguinal surgery, or unknown if previous scrotal or inguinal surgery	M1a	RN	RN
12	Distant lymph node(s): Inguinal nodes, NOS: Deep, NOS	M1a	D	D

12 cont'd	Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITHOUT previous scrotal or inguinal surgery, or unknown if previous scrotal or inguinal surgery			
13	Specified distant lymph node(s), other than code (11) or (12) Distant lymph node(s), NOS	M1a	D	D
20	Distant metastasis to lung	M1a	D	D
25	Distant metastases to lung and lymph nodes (20) + any of [(10) to (13)]	M1a	D	D
40	Metastasis to other distant sites (WITH or WITHOUT metastasis to lung and/or distant lymph node(s)) Carcinomatosis	M1b	D	D
45	Distant metastasis, NOS	M1NOS	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Collaborative Staging Codes
Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
C63.0-C63.1, C63.7-C63.9
C63.0 Epididymis
C63.1 Spermatic cord
C63.7 Other specified parts of male genital organs
C63.8 Overlapping lesion of male genital organs
C63.9 Male genital organs, NOS
Note 1: AJCC does not define TNM staging for this site.
Note 2: Laterality must be coded for C63.0-C63.1.
Note 3: Carcinoma of the scrotum is included in the scrotum schema. Melanoma (M-8720-8790) of scrotum is included in the melanoma skin schema. Mycosis fungoides (M-9700) or Sezary disease (M-9701) of scrotum is included in the mycosis fungoides schema. Melanoma, mycosis fungoides, or Sezary disease of any other site listed is coded using this schema. Kaposi sarcoma of all sites is included in the Kaposi sarcoma schema, and lymphomas of all sites are included in the lymphoma schema.

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Tumor Size
SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial	NA	IS	IS
10	Confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (See definition of connective tissue in the general instructions)	NA	RE	RE
60	Adjacent organs/structures: Male genital organs: Penis Prostate Testis Sites in this schema which are not the primary	NA	RE	RE

80	Further contiguous extension Other organs and structures in male pelvis: Bladder Rectum Urethra	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s) Iliac, NOS: External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Pelvic, NOS Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed	NA	U	U

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
Reg LN Pos
SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
Reg LN Exam
SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Codes
Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
C63.2 Scrotum, NOS
Note: Melanoma (M-8720-8790) of scrotum is included in the melanoma schema. Mycosis Fungoides (M-9700) or Sezary disease (M-9701) of scrotum is included in the Mycosis Fungoides schema. Kaposi sarcoma of the scrotum is included in the Kaposi Sarcoma schema. Lymphoma of the scrotum is included in the lymphoma schema.

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Tumor Size
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Tumor Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepidermal	Tis	IS	IS
10	Confined to scrotum	*	L	L
30	Localized, NOS	*	L	L
40	Adjacent connective tissue (See definition of connective tissue in general instructions)	*	RE	RE
60	Adjacent organs/structures Male genital organs: Epididymis Penis Prostate Spermatic cord Testis	T4	RE	RE
80	Further contiguous extension Other organs and structures in male pelvis: Bladder Rectum Urethra	T4	D	D
95	No evidence of primary tumor	T0	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For CS Extension codes 10, 30 and 40 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size table for this site.

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Iliac, NOS: External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep inguinal, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
Reg LN Pos
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
Reg LN Exam
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Mets at DX
SEE STANDARD TABLE

Site-Specific Surgery Codes
Testis
C620-C629
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

12 Local tumor destruction, NOS

No specimen sent to **pathology** from surgical event 12

20 **Local** or **partial** excision of **testicle**

Specimen sent to **pathology** from surgical event 20

30 Excision of testicle, WITHOUT cord

[***SEER Note:*** Orchiectomy not including spermatic cord]

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

[***SEER Note:*** Orchiectomy with or without spermatic cord]

80 **Orchiectomy, NOS** (unspecified whether partial or total testicle removed)

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** only

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, **C630–C639,** C680–C689, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
KIDNEY, RENAL PELVIS, AND URETER
Kidney C649, Renal Pelvis C659, Ureter C669

Equivalent or Equal Terms

- Flat transitional cell, flat urothelial, in situ transitional cell, and in situ urothelial
- Urothelial and transitional
- Urothelium and transitional epithelium
- Intramucosal and in situ

Laterality

Laterality is required for sites C64.9, C65.9, and C66.9.

Priority Rules for Grading Kidney Cancer

1. Fuhrman grade
2. Nuclear grade
3. Terminology (well diff, mod diff)
4. Histologic grade (grade 1, grade 2)

These prioritization rules do not apply to Wilm's tumor (8960).

Collaborative Staging Codes
Kidney (Renal Parenchyma)
C64.9
C64.9 Kidney, NOS (Renal parenchyma)
Note: Laterality must be coded for this site.

Kidney (Renal Parenchyma)
CS Tumor Size
SEE STANDARD TABLE

Kidney (Renal Parenchyma)
CS Extension
Note: The parenchyma of the kidney includes the following structures: cortex (outer layer of kidney) and renal columns; medulla, medullary rays, renal pyramids, and renal papillae; nephrons (renal corpuscle, loops of Henle, proximal and distal tubules, collecting duct), glomerulus, and Bowman's capsule. The most common site for renal parenchymal cancer to develop is in the proximal convoluted tubule. Tumor extension from one of these structures into another would be coded to 10 unless there were further signs of involvement.

Code	Description	TNM	SS77	SS2000
00	In situ	Tis	IS	IS
10	Invasive cancer confined to kidney cortex and/or medulla	*	L	L
20	Invasion of renal capsule Renal pelvis or calyces involved Separate focus of tumor in renal pelvis/calyx	*	L	L
30	Localized, NOS	*	L	L
39	Stated as T3, NOS	T3NOS	RE	RE
40	Adrenal (suprarenal) gland, ipsilateral Perirenal (perinephric) tissue/fat Renal (Gerota's) fascia Renal sinus fat Retroperitoneal soft tissue	T3a	RE	RE
60	Blood vessels: Extrarenal portion of renal vein or segmental branches Hilar blood vessel Inferior vena cava below diaphragm Perirenal vein Renal artery Renal vein, NOS Tumor thrombus in a renal vein, NOS	T3b	RE	RE

62	Vena cava above diaphragm or invades the wall of the vena cava	T3c	RE	RE
65	Extension beyond Gerota's fascia to: Ascending colon from right kidney Descending colon from left kidney Diaphragm Duodenum from right kidney Peritoneum Tail of pancreas Ureter, including implant(s), ipsilateral	T4	RE	RE
67	Extension beyond Gerota's fascia to: Psoas muscle	T4	D	RE
70	Ribs	T4	D	D
75	Liver Spleen Stomach	T4	D	D
80	Further contiguous extension Aorta Contralateral Adrenal (suprarenal) gland Kidney Ureter Other direct extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For codes 10, 20, and 30 ONLY, the T category is assigned based on the value of tumor size, as shown in the Extension Size Table for this site.

Kidney (Renal Parenchyma)

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Single regional lymph node: Aortic, NOS: Lateral (lumbar) Para-aortic	N1	RN	RN

10 cont'd	Periaortic Renal hilar Retroperitoneal, NOS Regional lymph node(s), NOS			
11	Single regional lymph node: Paracaval	N1	D	RN
15	(10) + (11) including: Single regional lymph node as specified in code 10 PLUS single paracaval node	N2	D	RN
40	More than one regional lymph node (including contralateral or bilateral nodes) other than as defined in code 15	N2	D	RN
70	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Kidney (Renal Parenchyma)
Reg LN Pos
SEE STANDARD TABLE

Kidney (Renal Parenchyma)
Reg LN Exam
SEE STANDARD TABLE

Kidney (Renal Parenchyma)
CS Mets at Diagnosis
SEE STANDARD TABLE

Site-Specific Surgery Codes
Kidney, Renal Pelvis, and Ureter
Kidney C649, Renal Pelvis C659, Ureter C669
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Thermal ablation

No specimen sent to **pathology** from this surgical event 10–15

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 **Partial** or **subtotal nephrectomy** (kidney or renal pelvis) or **partial ureterectomy** (ureter)

Procedures coded 30 include, but are not limited to:
Segmental resection
Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma
Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter

50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter

70 **Any nephrectomy** (simple, subtotal, complete, partial, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Nephrectomy, NOS
Ureterectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Renal Pelvis and Ureter
C65.9, C66.9
C65.9 Renal pelvis
C66.9 Ureter
Note: Laterality must be coded for this site.

Renal Pelvis and Ureter
CS Tumor Size
SEE STANDARD TABLE

Renal Pelvis and Ureter
CS Extension
Note: If Extension code is 00 or 05, Behavior Code must be 2. If CS Extension code is 10, Behavior Code must be 3.

Code	Description	TNM	SS77	SS2000
00	Carcinoma in situ, NOS Non-invasive, intraepithelial	Tis	IS	IS
05	Papillary noninvasive carcinoma	Ta	IS	IS
10	Subepithelial connective tissue (lamina propria, submucosa) invaded	T1	L	L
20	Muscularis invaded	T2	L	L
30	Localized, NOS	T1	L	L
*35	Extension to ureter from renal pelvis	T2	RE	RE
40	Extension to adjacent (connective) tissue: Peripelvic/periureteric tissue Retroperitoneal soft/connective tissue	T3	RE	RE
60	For renal pelvis only: Ipsilateral kidney parenchyma and kidney, NOS	T3	RE	RE
**62	OBSOLETE: Extension to ureter from renal pelvis Note: cases coded to 35, 40 or 60	T2	RE	RE
63	Psoas muscle from ureter	T4	RE	RE
65	Extension to bladder from ureter Implants in ureter	T4	RE	RE
66	Extension to major blood vessel(s): Aorta	T4	RE	RE

66 cont'd	Renal artery/vein Vena cava (inferior) Tumor thrombus in a renal vein, NOS			
67	Adrenal (suprarenal) gland from renal pelvis	T4	RE	RE
68	Duodenum from right renal pelvis or right ureter	T4	RE	RE
70	Extension to: Ascending colon from right renal pelvis Bladder (wall or mucosa) from renal pelvis Colon, NOS Descending colon from left renal pelvis Ipsilateral kidney parenchyma from ureter Liver Pancreas Perinephric fat via kidney Spleen	T4	D	D
75	Ascending colon from right ureter Descending colon from left ureter	T4	RE	D
80	Further contiguous extension, including: For ureter: Prostate Uterus	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

**Updated July 1, 2005

Renal Pelvis and Ureter
CS Lymph nodes
Note: Measure the size of the metastasis in the lymph node to determine codes 10-30, not the size of the lymph node itself.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Single regional lymph node, less than or equal to 2 cm: Renal pelvis: Aortic, NOS: Lateral (lumbar) Para-aortic	N1	RN	RN

10 cont'd	Periaortic Paracaval Renal hilar Retroperitoneal, NOS Regional lymph node(s), NOS Ureter: Iliac, NOS: Common External Internal (hypogastric), NOS Obturator Lateral aortic (lumbar) Paracaval Pelvic, NOS Periureteral Renal hilar Retroperitoneal, NOS Regional lymph node(s), NOS			
20	Regional lymph nodes as listed in code 10 Single regional lymph node greater than 2 - 5 cm OR multiple regional nodes, none greater than 5 cm	N2	RN	RN
30	Regional lymph nodes as listed in code 10 Regional lymph node(s), at least one greater than 5 cm	N3	RN	RN
50	Regional lymph node(s), NOS (size and/or number not stated)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Renal Pelvis and Ureter
Reg LN Pos
SEE STANDARD TABLE

Renal Pelvis and Ureter
Reg LN Exam
SEE STANDARD TABLE

Renal Pelvis and Ureter
CS Mets at Dx
SEE STANDARD TABLE

Site-Specific Surgery Codes
Kidney, Renal Pelvis, and Ureter
Kidney C649, **Renal Pelvis C659, Ureter C669**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Thermal ablation

No specimen sent to **pathology** from this surgical event 10–15

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 **Partial** or **subtotal nephrectomy** (kidney or renal pelvis) or **partial ureterectomy** (ureter)

Procedures coded 30 include, but are not limited to:
Segmental resection
Wedge resection

40 Complete/total/simple nephrectomy—for kidney parenchyma

Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter

50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter

70 **Any nephrectomy** (simple, subtotal, complete, partial, total, radical) in continuity with the resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

80 Nephrectomy, NOS
Ureterectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
BLADDER
C67.0–C67.9

Primary Site

C670 **Trigone** of bladder
Base of bladder
Floor

C671 **Dome** of bladder
Fundus
Vertex
Roof
Vault

C672 **Lateral wall** of bladder
Right wall
Left wall
Lateral to ureteral orifice
Sidewall

C673 **Anterior wall** of bladder

C674 **Posterior wall** of bladder

C675 Bladder **neck**
Vesical neck
Internal urethral orifice

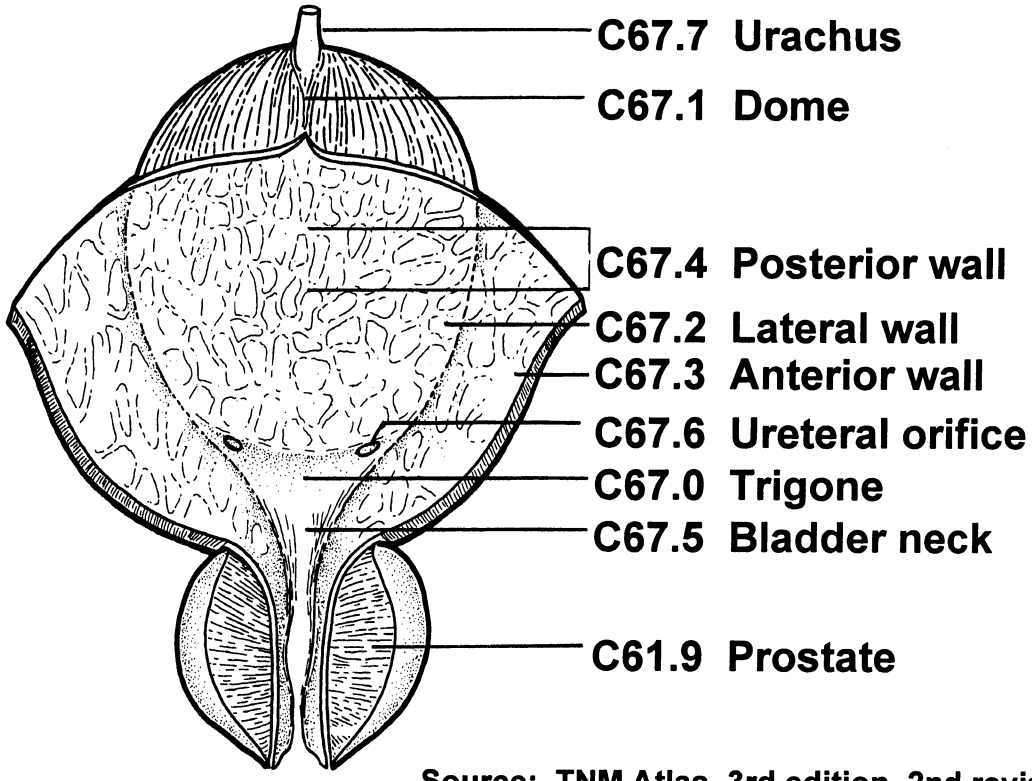
C676 **Ureteric orifice**
Just above ureteric orifice

C677 **Urachus**
Mid umbilical ligament

C678 **Overlapping** lesion of bladder
Lateral-posterior wall (hyphen)

C679 **Bladder, NOS**
Lateral posterior wall (no hyphen)

Bladder Anatomy and ICD-O-3



Source: TNM Atlas, 3rd edition, 2nd revision

Figure 1

Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Equivalent or Equal Terms

- Flat transitional cell, flat urothelial, in situ transitional cell, and in situ urothelial
- Urothelial and transitional
- Urothelium and transitional epithelium
- Intramucosal and in situ

Bladder Wall Pathology

The bladder wall is composed of three layers. There may be "sub layers" within the major layers of the bladder.

Bladder Layer	Sub layer	Synonyms	Staging	Description
Mucosa		Epithelium, transitional epithelium, urothelium, mucosal surface, transitional mucosa	No blood vessels, in situ/noninvasive	First layer on inside of bladder Lines bladder, ureters, and urethra
	Basement membrane		No invasion of basement membrane is in situ Invasion/penetration of basement membrane is invasive	Single layer of cells that lies beneath the mucosal layer separating the epithelial layer from the lamina propria
	Submucosa	Submucous coat, lamina propria, areolar connective tissue	Invasive	Areolar connective tissue interlaced with the muscular coat Contains blood vessels, nerves, and in some regions, glands
Lamina propria	Submucosa, Suburothelial connective tissue, subepithelial tissue, stroma, muscularis mucosa, transitional epithelium		Invasive	
Muscle	Bladder wall	Muscularis, muscularis propria, muscularis externa, smooth muscle	Invasive	

The following terms are used when the tumor has extended **through the bladder wall** (invades regional tissue):

Serosa (Tunica serosa): The outermost serous coat is a reflection of the peritoneum that covers the superior surface and the upper parts of the lateral surfaces of the urinary bladder.
The serosa is part of visceral peritoneum. The serosa is reflected from these bladder surfaces onto the abdominal and pelvic walls.
Perivesical fat
Adventitia: Some areas of the bladder do not have a serosa. Where there is no serosa, the connective tissue of surrounding structures merges with the connective tissue of the bladder and is called adventitia.

Multifocal Tumors

Invasive tumor in more than one subsite

Assign site code **C679** when the tumor is **multifocal** (separate tumors in more than one subsite of the bladder).

If the TURB or pathology proves **invasive** tumor in **one subsite** and **in situ tumor** in all **other** involved subsites, code to the subsite involved with **invasive** tumor.

HISTOLOGY

More than 90% of bladder tumors are transitional cell carcinoma.
About 6-8% of bladder tumors are squamous cell carcinomas.
About 2% of bladder tumors are adenocarcinoma. Adenocarcinomas tend to occur in the urachus or, frequently, the trigone of the bladder.

Other bladder histologic types include sarcoma, lymphoma, and small cell carcinoma. Rhabdomyosarcoma occurs in children.

Behavior Code

If the only surgery performed is a transurethral resection of the bladder (TURB) and if it is documented that depth of invasion cannot be measured because there is no muscle in the specimen, code the behavior as malignant /3, not in situ /2.

Three-Grade System (Nuclear Grade)

There are several sites for which a three-grade system is used. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into three rather than four categories (see comparison table below). The expected outcome

is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to ICD-0-3 Morphology 6th Digit Code.

Term	Grade	ICD-0-3 Morphology 6th Digit Code
1/3 1/2	Low grade	2
2/3	Intermediate grade	3
3/3 2/2	High grade	4

FIRST COURSE TREATMENT

TREATMENT MODALITIES (most common treatments)

TURB with fulguration
TURB with fulguration followed by intravesical BCG (bacillus Calmette-Guerin)
Usually used for patients with multiple tumors or for high-risk patients
TURB with fulguration followed by intravesical chemotherapy
Thiotepa
Mitomycin
Doxorubicin
Segmental cystectomy (rare)
Radical cystectomy in selected patients with extensive or refractory superficial tumor
Interstitial irradiation with or without external-beam irradiation
Implantation of radioisotopes

Treatments under clinical investigation (code under Other Treatment)

Photodynamic therapy after intravenous hematoporphyrin derivative

Intravesical interferon alfa-2a (papillary and in situ)
Chemoprevention agents to prevent recurrence
Chemotherapy administered prior to cystectomy or in conjunction with external-beam irradiation

Multiple Primaries

Note: For cases diagnosed on or after 1/1/2007, refer to Appendix O.

For cases diagnosed on or after 1/1/1995:
When a patient is diagnosed with invasive transitional cell carcinoma and/or invasive papillary transitional carcinoma of the bladder (8120-8130), code all subsequent occurrences of transitional cell carcinoma and/or papillary carcinoma as a recurrence.

> ***Exception**: When the first occurrence of transitional cell or papillary transitional carcinoma is in situ and a subsequent occurrence is invasive, code the invasive occurrence as a second primary.*

Collaborative Staging Codes
Bladder
C67.0-C67.9
C67.0 Trigone of bladder
C67.1 Dome of bladder
C67.2 Lateral wall of bladder
C67.3 Anterior wall of bladder
C67.4 Posterior wall of bladder
C67.5 Bladder neck
C67.6 Ureteric orifice
C67.7 Urachus
C67.8 Overlapping lesion of bladder
C67.9 Bladder, NOS

Bladder
CS Tumor Size
SEE STANDARD TABLE

Bladder
CS Extension
Note 1: DISTINGUISHING NONINVASIVE AND INVASIVE BLADDER CANCER The two main types of bladder cancer are the flat (sessile) variety and the papillary type. Only the flat (sessile) variety is called in situ when tumor has not penetrated the basement membrane. Papillary tumor that has not penetrated the basement membrane is called non-invasive, and pathologists use many different descriptive terms for noninvasive papillary transitional cell carcinoma. Frequently, the pathology report does not contain a definite statement of noninvasion; however, noninvasion can be inferred from the microscopic description. The more commonly used descriptions for noninvasion are listed below in Notes 2 and 3. Careful attention must be given to the use of the term "confined to mucosa" for urinary bladder. Historically, carcinomas described as "confined to mucosa" were coded as localized. However, pathologists use this designation for non-invasion as well.
In order to rule out the possibility of coding noninvasive tumors in this category, abstractors should determine:
1) If the tumor is confined to the epithelium, then it is noninvasive.
2) If the tumor has penetrated the basement membrane to invade the lamina propria, then it is invasive. The terms lamina propria, submucosa, stroma, and subepithelial connective tissue are used interchangeably.
3) Only if this distinction cannot be made should the tumor be coded to "confined to mucosa."
Note 2: For **Bladder Cases Only, Definite Statements of Non-invasion (Extension code 01) include:** Non-infiltrating; Non-invasive; No evidence of invasion; No extension into lamina propria; No stromal invasion; No extension into underlying supporting tissue; Negative lamina propria and superficial muscle; Negative muscle and (subepithelial) connective tissue; No infiltrative behavior/component.
Note 3: For Bladder Cases Only, Inferred Descriptions of Non-invasion (Extension code 03) include: No involvement of muscularis propria and no mention of subepithelium/submucosa; No statement of invasion (microscopic description present); (Underlying) Tissue insufficient to judge depth of invasion; No invasion of bladder wall; No involvement of muscularis propria; Benign deeper

tissue; Microscopic description problematic for pathologist (non-invasion versus superficial invasion); Frond surfaced by transitional cells; No mural infiltration; No evidence of invasion (no sampled stroma).

Note 4: The lamina propria and submucosa tend to merge when there is no muscularis mucosae, so these terms will be used interchangeably.

Note 5: The meaning of the terms "invasion of mucosa, grade 1" and "invasion of mucosa, grade 2" varies with the pathologist who must be queried to determine whether the carcinoma is noninvasive" or "invasive."

Note 6: If Extension code is 00-06, Behavior Code must be 2. If Extension code is 10, Behavior Code may be 2 or 3. If Extension code is 15 or greater, Behavior Code must be 3.

Note 7: Statements meaning Confined to Mucosa, NOS (code 10): Confined to mucosal surface Limited to mucosa, no invasion of submucosa and muscularis No infiltration/invasion of fibromuscular and muscular stroma Superficial, NOS.

Note 8: If a tumor is described as confined to mucosa (or the equivalents in Note 5) AND as papillary, use extension code 01 or 03. Use code 10 (confined to mucosa) only if the tumor is described as confined to mucosa but is not described as papillary.

Note 9: Periureteral in code 40 refers only to that portion of the ureter that is intramural to the bladder. All other periureteral involvement would be coded to 60.

Code	Description	TNM	SS77	SS2000
01	PAPILLARY transitional cell carcinoma, stated to be noninvasive papillary non-infiltrating TNM/AJCC Ta (See Note 1.) Jewett-Strong-Marshall Stage 0	Ta	IS	IS
03	PAPILLARY transitional cell carcinoma, with inferred description of non-invasion (See Note 3.)	Ta	IS	IS
06	Sessile (flat) (solid) carcinoma in situ Carcinoma in situ, NOS Transitional cell carcinoma in situ TNM/AJCC Tis Jewett-Strong-Marshall CIS	Tis	IS	IS
10	Confined to mucosa, NOS	Tis	L	L
15	Invasive tumor confined to subepithelial connective tissue (tunica propria, lamina propria, submucosa, stroma) TNM/AJCC T1 Jewett-Strong-Marshall Stage A	T1	L	L
20	Muscle (muscularis) invaded, NOS	T2NOS	L	L
21	Muscle (muscularis) invaded: Superficial muscle--inner half	T2a	L	L

22	Muscle (muscularis) invaded: Deep muscle--outer half	T2b	L	L
23	Extension through full thickness of bladder wall	T3a	L	L
30	Localized, NOS	T1	L	L
40	Adventitia Extension to/through serosa (mesothelium) Peritoneum Periureteral fat/tissue Perivesical fat/tissue, NOS	T3NOS	RE	RE
41	Extension to perivesical fat (microscopic)	T3a	RE	RE
42	Extension to perivesical fat (macroscopic) Extravesical mass	T3b	RE	RE
45	Stated as T4, NOS	T4NOS	RE	RE
60	Prostate Ureter Urethra, including prostatic urethra	T4a	RE	RE
65	Parametrium Rectovesical/Denonvilliers' fascia Vas deferens; seminal vesicle	T4a	RE	RE
67	Uterus Vagina	T4a	RE	RE
70	Bladder is FIXED	T4b	RE	RE
75	Abdominal wall Pelvic wall	T4b	D	D
80	Further contiguous extension, including: Pubic bone Rectum, male Sigmoid	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Bladder
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: Measure the size of the metastasis in the lymph node to determine codes 10-30, not the size of the lymph node itself.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes (including contralateral or bilateral nodes): Perivesical Iliac: Internal (hypogastric) Obturator External Iliac, NOS Sacral (lateral, presacral, sacral promontory (Gerota's), or NOS) Pelvic, NOS Regional lymph node(s), NOS Single regional lymph node less than or equal to 2 cm	N1	RN	RN
20	Single regional lymph node greater than 2 cm and less than or equal to 5 cm OR multiple regional nodes, none greater than 5 cm	N2	RN	RN
30	Regional lymph node(s), at least one greater than 5 cm	N3	RN	RN
50	Regional lymph node(s), NOS (size and/or number not stated)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Bladder
Reg LN Pos
SEE STANDARD TABLE

Bladder
Reg LN Exam
SEE STANDARD TABLE

Bladder
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s): Common iliac	M1	D	D
11	Distant lymph node(s), NOS Specified distant lymph node(s) other than code (10)	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10 or 11) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) or (11)]	M1	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site-Specific Surgery Codes
Bladder
C67.0-C67.9
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser
15 Intravesical therapy
16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

No specimen sent to **pathology** from surgical events 10–16

[***SEER Note:*** Code BCG as both surgery and immunotherapy]

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

[***SEER Note:*** Code TURB as 27]

Combination of 20 or 26–27 WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)

[***SEER Note:*** This code is used only for men. It involves removal of bladder and prostate, with or without urethrectomy. The procedure is also called cystoprostatectomy. If a radical cystectomy is the procedure for a woman, use code 71.]

61 Radical cystectomy PLUS ileal conduit
62 Radical cystectomy PLUS continent reservoir or pouch, NOS
63 Radical cystectomy PLUS abdominal pouch (cutaneous)
64 Radical cystectomy PLUS in situ pouch (orthotopic)

70 Pelvic exenteration, NOS
71 Radical cystectomy (**female** only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra

72 Posterior exenteration
73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes

The lymph node dissection should also be coded under Scope of Regional Lymph Node Surgery (NAACCR item # 1292).

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

80 **Cystectomy, NOS**

90 **Surgery, NOS**

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Urethra
C68.0
C68.0 Urethra
Note: Transitional cell carcinoma of the prostatic ducts and prostatic urethra are to be coded to urethra (C68.0) according to this schema.

Urethra
CS Tumor Size
SEE STANDARD TABLE

Urethra
CS Extension
Note: If Extension code is 00 or 05, Behavior Code must be 2. If CS Extension code is 10, Behavior Code must be 3.

Code	Description	TNM	SS77	SS2000
00	Carcinoma in situ, NOS	Tis	IS	IS
01	Carcinoma in situ, involvement of prostatic urethra	Tispu	IS	IS
02	Carcinoma in situ, involvement of prostatic ducts	Tispd	IS	IS
05	Noninvasive papillary, polypoid, or verrucous carcinoma **Note:** Code 05 does not apply to transitional cell carcinoma of prostatic urethra or prostatic ducts	Ta	IS	IS
10	Subepithelial connective tissue (lamina propria, submucosa) invaded	T1	L	L
20	Muscularis invaded	T2	L	L
30	Localized, NOS	T1	L	L
40	Corpus spongiosum Periurethral muscle (sphincter) Prostate	T2	RE	RE
60	Beyond the prostatic capsule Bladder neck Corpus cavernosum Vagina, anterior or NOS	T3	RE	RE
70	Other adjacent organs, including Bladder (excluding bladder neck) Seminal vesicle(s)	T4	D	D
80	Further contiguous extension	T4	D	D

95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Urethra

CS Lymph Nodes

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: Measure the size of the metastasis in the lymph node to determine codes 10-30, not the size of the lymph node itself.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes (including contralateral or bilateral nodes): Iliac, NOS: Common External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) Pelvic, NOS Sacral, NOS Presacral Regional lymph node(s), NOS Single regional lymph node less than or equal to 2 cm	N1	RN	RN
20	Single regional lymph node greater than 2 - 5 cm OR multiple regional nodes, none greater than 5 cm	N2	RN	RN
30	Regional lymph node(s), at least one greater than 5 cm	N2	RN	RN
50	Regional lymph node(s), NOS (size and/or number not stated)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record	NX	U	U

Urethra
Reg LN Pos
SEE STANDARD TABLE

Urethra
Reg LN Exam
SEE STANDARD TABLE

Urethra
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs C68.1, C68.8-C68.9
C68.1 Paraurethral gland
C68.8 Overlapping lesion of urinary organs
C68.9 Urinary system, NOS
Note: AJCC does not define TNM staging for this site.

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs CS Tumor Size
SEE STANDARD TABLE

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs CS Extension
Note: If CS Extension code is 00 or 05, Behavior code must be 2. If CS Extension code is 10, Behavior Code must be 3.

Code	Description	TNM	SS77	SS2000
00	Carcinoma in situ, NOS (See Note)	NA	IS	IS
05	Noninvasive papillary, polypoid, or verrucous carcinoma (See Note)	NA	IS	IS
10	Subepithelial connective tissue (lamina propria, submucosa) invaded (See Note)	NA	L	L
20	Muscularis invaded	NA	L	L
30	Localized, NOS	NA	L	L
40	Corpus spongiosum Periurethral muscle (sphincter) Prostate	NA	RE	RE
60	Beyond the prostatic capsule Bladder neck Corpus cavernosum Vagina, anterior or NOS	NA	RE	RE
70	Other adjacent organs, including Bladder (excluding bladder neck) Seminal vesicle(s)	NA	D	D
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99 99 cont'd	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	NA	NONE	NONE
10	Regional lymph nodes (including contralateral or bilateral nodes): Iliac, NOS: Common External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) Pelvic, NOS Sacral, NOS Presacral Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs Reg LN Pos

SEE STANDARD TABLE

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs Reg LN Exam

SEE STANDARD TABLE

Paraurethral Gland, Overlapping Lesion of Urinary Organs, and Unspecified Urinary Organs
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, **C680–C689**, C690–C699, C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Collaborative Staging Codes
Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
C69.0
C69.0 Conjunctiva
Note: Laterality must be coded for this site.

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
CS Tumor Size
SEE STANDARD TABLE

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Tumor confined to conjunctiva	*	L	L
30	Localized, NOS	*	L	L
40	Intraocular extension	T3	L	L
50	Adjacent extraocular extension, excluding orbit Eyelid	T3	RE	RE
70	Orbit, NOS	T4NOS	RE	RE
71	Orbital soft tissues without bone invasion	T4a	RE	RE
72	Bone of orbit	T4b	RE	RE
78	Adjacent paranasal sinuses	T4c	RE	RE
79	Brain	T4d	D	D
80	Further contiguous extension	T4NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

For Extension codes 10 and 30 ONLY, T category is assigned based on value of CS Tumor Size, as shown in Extension Size Table. Tumors 5mm or less are T1. Tumors more than 5mm are T2.

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
Reg LN Pos
SEE STANDARD TABLE

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
Reg LN Exam
SEE STANDARD TABLE

Conjunctiva [excl. Retinoblastoma, Malignant Melanoma, Kaposi Sarcoma, and Lymphoma]
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Malignant Melanoma of Conjunctiva
C69.0
(M-8720-8790)
C69.0 Conjunctiva
Note: Laterality must be coded for this site.

Malignant Melanoma of Conjunctiva
CS Tumor Size
Note: Record the size of the tumor in the CS Tumor Size table below, not depth or thickness. Depth or thickness is recorded in Site Specific Factor 1 in the Measured Thickness (Depth), Breslow's Measurement table.

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

Malignant Melanoma of Conjunctiva
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ	Tis	IS	IS
10	Tumor(s) of bulbar conjunctiva confined to the epithelium occupying more one quadrant or less	T1	L	L
12	Tumor(s) of bulbar conjunctiva confined to the epithelium occupying more than one quadrant	T1	L	L

15	Tumor(s) of bulbar conjunctiva, NOS	T1	L	L
30	Localized, NOS	T1	L	L
40	Tumor of bulbar conjunctiva, thickness not stated, WITH invasion of substantia propria (or with corneal extension, NOS)	T2	RE	RE
41	Tumor of bulbar conjunctiva, not more than 0.8 mm in thickness, WITH invasion of substantia propria (or with corneal extension, NOS)	T2	RE	RE
42	Tumor of bulbar conjunctiva, more than 0.8 mm in thickness, WITH invasion of substantia propria (or with corneal extension, NOS)	T3	RE	RE
44	Tumor involves: Caruncle Conjunctival fornix Palpebral conjunctiva	T3	L	L
46	(44) + any of [(40) or (42)]	T3	RE	RE
70	Extension to: Eyelid Globe Orbit	T4	RE	RE
80	Further contiguous extension, including: Central nervous system Sinuses	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Malignant Melanoma of Conjunctiva
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical Mandibular, NOS: Submandibular (submaxillary)	N1	RN	RN

10 cont'd	Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS			
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Malignant Melanoma of Conjunctiva
Reg LN Pos
SEE STANDARD TABLE

Malignant Melanoma of Conjunctiva
Reg LN Exam
SEE STANDARD TABLE

Malignant Melanoma of Conjunctiva
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
C69.1-C69.4, C69.8-C69.9
C69.1 Cornea, NOS
C69.2 Retina
C69.3 Choroid
C69.4 Ciliary body
C69.8 Overlapping lesion of eye and adnexa
C69.9 Eye, NOS
Note 1: Laterality must be coded for this site.
Note 2: AJCC does not define TNM staging for this site.
Note 3: AJCC includes primary site C69.8 (Overlapping lesions of eye and adnexa) in its chapter 46, Sarcoma of the Orbit. Collaborative Staging excludes melanomas and retinoblastomas from this schema. All other histologies are included with this schema.

Collaborative Staging Codes
Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
CS Tumor Size
SEE STANDARD TABLE

Collaborative Staging Codes
Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ	NA	IS	IS
10	Tumor confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Intraocular extension	NA	L	L
70	Adjacent extraocular extension: Eyelid Orbit	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Codes
Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
CS Lymph Nodes
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph nodes Cervical Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record	NA	U	U

Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
Reg LN Pos
SEE STANDARD TABLE

Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
Reg LN Exam
SEE STANDARD TABLE

Collaborative Staging Codes
Cornea, Retina, Choroid, Ciliary Body (Iris, Lens, Sclera, Uveal Tract), Eyeball, Overlapping and Other Eye [Excluding Melanoma and Retinoblastoma]
CS Mets at Dx

Code	Description	TNM	SS77	SS2000

00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Code
Malignant Melanoma of Iris and Ciliary Body
C69.4
(M-8720-8790)
C69.4 Ciliary Body and Iris
Note: Laterality must be coded for these sites

Malignant Melanoma of Iris and Ciliary Body
CS Tumor Size
SEE STANDARD TABLE

Malignant Melanoma of Iris and Ciliary Body
CS Extension
Note 1: AJCC 6th Edition states that when basal dimension and apical height do not fit this classification, the largest diameter should be used for classification. In clinical practice the tumor base may be estimated in optic disc diameters (dd) (average: 1 dd = 1.5mm). The elevation may be estimated in diopters (average: 3 diopters = 1 mm). Other techniques, such as ultrasonography and computerized stereometry, may provide a more accurate measurement.
Note 2: Iris and ciliary body are both included in the ICD-O-3 site code of C69.4, so they are in the same Collaborative Staging schema. However, they are staged with different criteria by AJCC. Many of the extension codes below are marked as applicable to either iris or ciliary body only. Any code not so marked may be used for either site.

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	FOR IRIS PRIMARY ONLY: Confined to iris, NOS	T1NOS	L	L
11	FOR IRIS PRIMARY ONLY: Limited to iris not more than 3 clock hours in size, WITHOUT melanomalytic glaucoma, or not stated if melanomalytic glaucoma	T1a	L	L
13	FOR IRIS PRIMARY ONLY: Limited to iris more than 3 clock hours in size, WITHOUT melanomalytic glaucoma, or not stated if melanomalytic glaucoma	T1b	L	L
14	FOR IRIS PRIMARY ONLY: Limited to iris WITH melanomalytic glaucoma	T1c	L	L

21	FOR CILIARY BODY PRIMARY ONLY: Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), not stated if extraocular extension present (See Note 1.)	T1NOS	L	L
22	FOR CILIARY BODY PRIMARY ONLY: Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITHOUT microscopic or macroscopic extraocular extension. (See Note 1.)	T1a	L	L
23	FOR CILIARY BODY PRIMARY ONLY: Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITH microscopic extraocular extension. (See Note 1.)	T1b	L	L
24	FOR CILIARY BODY PRIMARY ONLY: Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITH macroscopic extraocular extension. (See Note 1.)	T1c	L	L
30	Localized, NOS Diameter and/or thickness in clock hours or mm not stated	T1NOS	L	L
41	FOR IRIS PRIMARY ONLY: Tumor confluent with or extending into the ciliary body and/or choroid WITHOUT melanomalytic glaucoma, or not stated if melanomalytic glaucoma	T2NOS	L	L
42	FOR IRIS PRIMARY ONLY: Tumor confluent with or extending into the ciliary body and/or choroid WITH melanomalytic glaucoma	T2a	L	L
51	FOR CILIARY BODY PRIMARY ONLY: Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), not stated if extraocular extension present (See Note 1.)	T2NOS	L	L
52	FOR CILIARY BODY PRIMARY ONLY: Tumor greater than 10 mm but not more than 16 mm in	T2a	L	L

52 cont'd	greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITHOUT microscopic or macroscopic extraocular extension present. (See Note 1.)			
53	FOR CILIARY BODY PRIMARY ONLY: Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITH microscopic extraocular extension present. (See Note 1.)	T2b	RE	RE
54	FOR CILIARY BODY PRIMARY ONLY: Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITH macroscopic extraocular extension present. (See Note 1.)	T2c	RE	RE
60	FOR IRIS PRIMARY ONLY: Tumor confluent with or extending into the ciliary body and/or choroid WITH scleral extension, WITHOUT melanomalytic glaucoma, or not stated if melanomalytic glaucoma	T3NOS	L	L
61	FOR IRIS PRIMARY ONLY: Tumor confluent with or extending into the ciliary body and/or choroid WITH scleral extension, AND melanomalytic glaucoma	T3a	L	L
65	FOR IRIS PRIMARY ONLY: Extraocular extension	T4	RE	RE
71	FOR CILIARY BODY PRIMARY ONLY: Tumor more than 16 mm in greatest basal diameter and/or greater than 10 mm in maximum height (thickness), WITHOUT extraocular extension or not stated if extraocular extension present. (See Note 1.)	T3NOS	L	L
75	FOR CILIARY BODY PRIMARY ONLY: Tumor more than 16 mm in greatest basal diameter and/or greater than 10 mm in maximum height (thickness), WITH extraocular extension. (See Note 1.)	T4	RE	RE
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Malignant Melanoma of Iris and Ciliary Body
CS Tumor Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical Parotid (preauricular) Submandibular Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Malignant Melanoma of Iris and Ciliary Body
Reg LN Pos
SEE STANDARD TABLE

Malignant Melanoma of Iris and Ciliary Body
Reg LN Exam
SEE STANDARD TABLE

Malignant Melanoma of Iris and Ciliary Body
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Malignant Melanoma of Choroid
C69.3
(M-8720-8790)
C69.3 Choroid
Note: Laterality must be coded for these sites

Malignant Melanoma of Choroid
CS Tumor Size
SEE STANDARD TABLE

Malignant Melanoma of Choroid
CS Extension
Note: AJCC 6th Edition states that when basal dimension and apical height do not fit this classification, the largest diameter should be used for classification. In clinical practice the tumor base may be estimated in optic disc diameters (dd) (average: 1 dd = 1.5mm). The elevation may be estimated in diopters (average: 3 diopters = 1 mm). Other techniques, such as ultrasonography and computerized stereometry, may provide a more accurate measurement.

Code	Description	TNM	SS77	SS2000
00	In situ	Tis	IS	IS
22	Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), AND extraocular invasion unknown	T1NOS	L	L
24	Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITHOUT microscopic extraocular extension	T1a	L	L
26	Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITH microscopic extraocular extension	T1b	L	L
28	Tumor 10 mm or less in greatest diameter and 2.5 mm or less in greatest height (thickness), WITH macroscopic extraocular extension	T1c	L	L
30	Localized, NOS	T1NOS	L	L
42	Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), AND extraocular invasion unknown	T2NOS	L	L

44	Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITHOUT microscopic extraocular invasion	T2a	L	L
46	Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITH microscopic extraocular invasion	T2b	RE	RE
48	Tumor greater than 10 mm but not more than 16 mm in greatest basal diameter and between 2.5 mm and 10 mm in maximum height (thickness), WITH macroscopic extraocular invasion	T2c	RE	RE
*66	Tumor greater than 16 mm in greatest diameter and/or greater than 10 mm in maximum height (thickness) WITHOUT extraocular extension	T3	RE	RE
*68	Tumor greater than 16 mm in greatest diameter and/or greater than 10 mm in maximum height (thickness) WITH extraocular extension	T4	RE	RE
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

** Updated July 1, 2005

Malignant Melanoma of Choroid
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical Parotid (preauricular) Submandibular Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated	NX	U	U

99 cont'd	Regional lymph node(s) cannot be assessed Not documented in patient record			

Malignant Melanoma of Choroid
Reg LN Pos
SEE STANDARD TABLE

Malignant Melanoma of Choroid
Reg LN Exam
SEE STANDARD TABLE

Malignant Melanoma of Choroid
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Malignant Melanoma of Other Eye
C69.1, C69.2, C69.5, C69.8-C69.9
(M-8720-8790)
C69.1 Cornea
C69.2 Retina
C69.5 Lacrimal gland
C69.8 Overlapping lesion of eye and adnexa
C69.9 Eye, NOS
Excludes 69.0 Conjunctiva, C69.3 Choroid, and C69.4 Ciliary Body
Note 1: Laterality must be coded for these sites
Note 2: AJCC includes primary site C69.8 (Overlapping lesions of eye and adnexa) in its chapter 46, Sarcoma of the Orbit. This schema includes only melanomas of the sites listed above.

Malignant Melanoma of Other Eye
CS Tumor Size
SEE STANDARD TABLE

Malignant Melanoma of Other Eye
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	NA	IS	IS
10	Tumor limited to other part of eye with or without intraocular extension	NA	L	L
30	Localized, NOS	NA	L	L
70	Adjacent extraocular extension	NA	RE	RE
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Malignant Melanoma of Other Eye
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph nodes Cervical Parotid (preauricular) Submandibular Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Malignant Melanoma of Other Eye
Reg LN Pos
SEE STANDARD TABLE

Malignant Melanoma of Other Eye
Reg LN Exam
SEE STANDARD TABLE

Malignant Melanoma of Other Eye
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Codes
Lacrimal Gland
C69.5
C69.5 Lacrimal gland
Note: Laterality must be coded for this site.

Lacrimal Gland
CS Tumor Size
SEE STANDARD TABLE

Lacrimal Gland
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Tumor confined to lacrimal gland/duct	*	L	L
30	Localized, NOS	*	L	L
40	Invading periosteum of fossa of lacrimal gland/duct	**	RE	RE
60	Extension to any of the following WITHOUT bone invasion: Globe (eyeball) Optic nerve Orbital soft tissues	T4	RE	RE
70	Adjacent bone	T4	RE	RE
75	Brain	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension codes 10 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in Extension Size Table. Tumors 2.5 cm or less are T1, and tumors between 2.6 and 5 cm are T2.
**For Extension code 40 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in Extension Size Table 2. Tumors 5 cm or less are T3a, and tumors more than 5 cm are T3b.

Lacrimal Gland
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Lacrimal Gland
CS Reg LN Pos
SEE STANDARD TABLE

Lacrimal Gland
CS Reg LN Exam
SEE STANDARD TABLE

Lacrimal Gland
CS Mets at Dx
SEE STANDARD TABLE

Collaborative Staging Codes
Orbit
C69.6
C69.6 Orbit, NOS
Note 1: Laterality must be coded for this site.
Note 2: AJCC uses this scheme only for sarcomas of the orbit.

Orbit
CS Tumor Size
SEE STANDARD TABLE

Orbit
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepithelial	Tis	IS	IS
10	Tumor confined to orbit Localized, NOS	*	L	L
40	Diffuse invasion of orbital tissues and/or bony walls	T3	RE	RE
60	Extension to: Adjacent paranasal sinuses Cranium	T4	RE	RE
70	Central nervous system	T4	D	D
80	Further contiguous extension	T4	L	L
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

*For Extension code 10 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Orbit
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Cervical	N1	RN	RN

10 cont'd	Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Regional lymph node(s), NOS			
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Orbit
Reg LN Pos
SEE STANDARD TABLE

Orbit
Reg LN Exam
SEE STANDARD TABLE

Orbit
CS Mets at Diagnosis
SEE STANDARD TABLE

Collaborative Staging Codes
Retinoblastoma
C69.0-C69.6, C69.8-C69.9
(9510-9514)
C69.0 Conjunctiva
C69.1 Cornea, NOS
C69.2 Retina
C69.3 Choroid
C69.4 Ciliary Body
C69.5 Lacrimal Gland
C69.6 Orbit, NOS
C69.8 Overlapping lesion of eye and adnexa
C69.9 Eye, NOS
Note 1: Laterality must be coded for this site.
Note 2: Code all retinoblastomas using this scheme, including conjunctiva, uvea and other parts of eye.

Retinoblastoma
CS Tumor Size
SEE STANDARD TABLE

Retinoblastoma
CS Extension
****Note 1:** For correct calculation of derived staging fields for this schema, CS Extension and Site-Specific Factor 1, Extension Evaluated at Enucleation, must both be coded, whether or not an enucleation was performed. Information from enucleation is EXCLUDED from CS Extension and coded only in Site-Specific Factor 1.
****Note 2:** For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c, p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 1. If the value of Site-Specific Factor 1 is a valid code between 030 and 080 (i.e., enucleation was done and extension information is available for staging), the mapping values are taken from the Site-Specific Factor 1 mapping, and the T category is identified as a pT. Otherwise (i.e., Site-Specific Factor 1 code is not between 030 and 080, or is invalid or blank, meaning that enucleation was not performed, or it was performed but the information is not useable for staging), the mapping values are taken from the CS Extension mapping, and the c, p, y, or a indicator is taken from th TS/Ext Eval mapping.

Code	Description	TNM	SS77	SS2000
11	Any eye in which the largest tumor is less than or equal to 3 mm in height AND no tumor is located closer than 1 DD (1.5 mm) to the optic nerve or fovea	T1a	L	L
13	All other eyes in which the tumor(s) are confined to retina regardless of location or size (up to half the volume of the	T1b	L	L

13 cont'd	eye) AND no vitreous seeding AND no retinal detachment or subretinal fluid greater than 5 mm from the base of the tumor			
31	Tumor confined to retina (no vitreous seeding or significant retinal detachment), NOS	T1NOS	L	L
41	Minimal tumor spread to vitreous and/or subretinal space. Fine local or diffuse vitreous seeding and/or serous retinal detachment up to total detachment may be present but no clumps, lumps, snowballs, or avascular masses are allowed in the vitreous or subretinal space. Calcium flecks in the vitreous or subretinal space are allowed. Tumor may fill up to 2/3 the volume of the eye.	T2a	L	L
43	Massive tumor spread to vitreous and/or subretinal space. Vitreous seeding and/or subretinal implantation may consist of lumps, clumps, snowballs, or avascular tumor masses. Retinal detachment may be total. Tumor may fill up to 2/3 the volume of the eye.	T2b	L	L
45	Unsalvageable intraocular disease. Tumor fills more than 2/3 the eye No possibility of visual rehabilitation. One or more of the following are present: Tumor-associated glaucoma, either neovascular or angle closure Anterior segment extension of tumor Ciliary body extension of tumor Hyphema (significant) Massive vitreous hemorrhage Tumor in contact with lens Orbital cellulitis-like clinical presentation	T2c	L	L
47	Tumor with contiguous spread to adjacent tissues or spaces (vitreous or subretinal space), NOS	T2NOS	L	L
59	Invasion of optic nerve and/or optic coats, NOS	T3	RE	RE
75	Extraocular tumor	T4	RE	RE
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Note: If enucleation done (i.e., SSF1 coe 030 to 080) the T category is derived form Site-Specific Factor 1 and assigned "pT". Else: [no enucleation done] the T category is derived from CS Extension and assigned based on CS TX/Ext-Eval field.
**Updated July 1, 2005

Retinoblastoma
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Submandibular Parotid (preauricular) Cervical Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Retinoblastoma
Reg LN Pos
SEE STANDARD TABLE

Retinoblastoma
Reg LN Exam
SEE STANDARD TABLE

Retinoblastoma
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s)	*	D	D
30	Distant metastasis to bone marrow only	*	D	D
40	Distant metastasis except distant lymph node(s) (10) or bone marrow (30) Distant metastasis, NOS	*	D	D

40 cont'd	Carcinomatosis			
50	(10) + any of [(30) or (40)] Distant lymph node(s) plus other distant metastases	*	D	D
55	Stated as M1, NOS	*	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

*For Mets at DX codes 10, 30, 40, 50 and 55 ONLY, the M category is assigned based on the value of CS Mets at DX and CS Mets Eval, as shown in the table CS Mets at DX, Mets Eval for this site.

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, **C690–C699,** C740–C749, C750–C759
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Seer Site-Specific Coding Guidelines
BRAIN [and other parts of central nervous system]
Meninges C700-C709, Brain C710–C719,
Spinal Cord, Cranial Nerves and
Other Parts of Central Nervous System C720–C729
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Grade

Astrocytoma

Grade astrocytomas (M-9383, 9400, 9401, 9410-9412, 9420, 9421) according to ICD-O-3 rules.

Term	Grade	ICD-0-3 Morphology 6th Digit
Well differentiated	Grade 1	1
Intermediate differentiation	Grade II	2
Poorly differentiated	Grade III	3
Anaplastic	Grade IV	4

Use the **conversion table** in the Grade, Differentiation, or Cell Indicator section general instructions to code low grade, intermediate grade, and high grade

Code the Grade, Differentiation field to 9 [Cell type not determined, not stated or not applicable] in the absence of a stated grade on the pathology report. If a grade is stated, code the stated grade.
If **no grade** is given, code unknown, 9

Always code the Grade, Differentiation field to for 4 [Grade IV] for "anaplastic" tumors. Anaplastic is synonymous with undifferentiated.

Do not automatically code **glioblastoma multiforme** as grade IV. If no grade is given, code to unknown, 9.

For primary tumors of the brain and spinal cord (C710-C729) do not use the **WHO grade, Anne/Mayo, or Kemohan grades** to code this field.

The use of World Health Organization coding of aggressiveness is reserved for assignment of grade for staging.

Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is reportable. Record as 9421/3 in the registry.

Collaborative Staging Codes
Brain and Cerebral Meninges
C70.0, C71.0-C71.9
C70.0 Cerebral meninges
C71.0 Cerebrum
C71.1 Frontal lobe
C71.2 Temporal lobe
C71.3 Parietal lobe
C71.4 Occipital lobe
C71.5 Ventricle, NOS
C71.6 Cerebellum, NOS
C71.7 Brain stem
C71.8 Overlapping lesion of brain
C71.9 Brain, NOS
Note 1: This scheme is compatible with the AJCC fourth edition scheme TNM for brain. The AJCC opted not to recommend a TNM scheme in the sixth edition.
Note 2: AJCC does not define TNM staging for this site.

Brain and Cerebral Meninges
CS Tumor Size
SEE STANDARD TABLE

Brain and Cerebral Meninges
CS Extension
Note: C71.0 is SUPRAtentorial, except the following subsites coded to C 71.0 are INFRAtentorial: hypothalamus, pallium, thalamus. C71.1-C71.5 are SUPRAtentorial. C71.6-C71.7 are INFRAtentorial. The following subsites coded to C71.8 are SUPRAtentorial: corpus callosum, tapetum. The following sites coded to C71.9 are SUPRAtentorial: anterior cranial fossa, middle cranial fossa, suprasellar. The following subsites coded to C71.9 are INFRAtentorial: posterior cranial fossa.

Code	Description	TNM	SS77	SS2000
05	Benign or borderline brain tumors	NA	NA	NA
10	Supratentorial tumor confined to: CEREBRAL HEMISPHERE (cerebrum) or MENINGES of CEREBRAL HEMI-SPHERE on one side: Frontal lobe Occipital lobe Parietal lobe Temporal lobe	NA	L	L
11	Infratentorial tumor confined to: CEREBELLUM or MENINGES of CEREBELLUM on one side: Vermis:	NA	L	L

11 cont'd	Lateral lobes Median lobe of cerebellum			
12	Infratentorial tumor confined to: BRAIN STEM or MENINGES of BRAIN STEM on one side: Medulla oblongata Midbrain (mesencephalon) Pons Hypothalamus Thalamus	NA	L	L
15	Confined to brain, NOS Confined to meninges, NOS	NA	L	L
20	Infratentorial tumor: Both cerebellum and brain stem involved with tumor on one side	NA	L	L
30	Confined to ventricles Tumor invades or encroaches upon ventricular system	NA	L	L
**40	Tumor crosses the midline Tumor involves contralateral hemisphere Tumor involves corpus callosum (including splenium)	NA	RNOS	RNOS
**50	Supratentorial tumor extends infratentorially to involve cerebellum or brain stem	NA	RNOS	RNOS
**51	Infratentorial tumor extends supratentorially to involve cerebrum (cerebral hemisphere)	NA	RNOS	RNOS
**60	Tumor invades: Bone (skull) Major blood vessel(s) Meninges (dura) Nerves, NOS Cranial nerves Spinal cord/canal	NA	RNOS	RNOS
70	Circulating cells in cerebral spinal fluid (CSF) Nasal cavity Nasopharynx Posterior pharynx Outside central nervous system (CNS)	NA	D	D
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

**Updated July 1, 2005

Brain and Cerebral Meninges
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Brain and Cerebral Meninges
Reg LN Pos

Code	Description	Staging Basis
99	Not applicable	NA

Brain and Cerebral Meninges
Reg LN Exam

Code	Description
99	Not applicable

Brain and Cerebral Meninges
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant metastases	NA	D	D
85	"Drop" metastases	NA	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	NA	U	U

Collaborative Staging Codes
Other Parts of Central Nervous System
C70.1, C70.9, C72.0-C72.5, C72.8-C72.9
C70.1 Spinal meninges
C70.9 Meninges, NOS
C72.0 Spinal cord
C72.1 Cauda equina
C72.2 Olfactory nerve
C72.3 Optic nerve
C72.4 Acoustic nerve
C72.5 Cranial nerve, NOS
C72.8 Overlapping lesion of brain and central nervous system
C72.9 Nervous system, NOS
Note: This schema is compatible with the AJCC fourth edition TNM for spinal cord. AJCC does not define TNM staging for this site in the sixth edition.

Other Parts of Central Nervous System
CS Tumor Size
SEE STANDARD TABLE

Other Parts of Central Nervous System
CS Extension

Code	Description	TNM	SS77	SS2000
05	Benign or borderline brain and other parts of the CNS tumors	NA	NA	NA
10	Tumor confined to tissue or site of origin	NA	L	L
30	Localized, NOS	NA	L	L
**40	Meningeal tumor infiltrates nerve Nerve tumor infiltrates meninges (dura)	NA	RNOS	RNOS
**50	Adjacent connective/soft tissue Adjacent muscle	NA	RNOS	RNOS
**60	Brain, for cranial nerve tumors Major blood vessel(s) Sphenoid and frontal sinuses (skull)	NA	RNOS	RNOS
70	Brain except for cranial nerve tumors Bone, other than skull Eye	NA	D	D
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U

99 99 cont'd	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

**Updated July 1, 2005

Other Parts of Central Nervous System
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Other Parts of Central Nervous System
Reg LN Pos

Code	Description
99	Not applicable.

Other Parts of Central Nervous System
Reg LN Exam

Code	Description
99	Not applicable.

Other Parts of Central Nervous System
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
BRAIN [and other parts of central nervous system]
Meninges C700-C709, Brain C710–C719,
Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C720–C729
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code laminectomies for spinal cord primaries

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Tumor **destruction**, NOS

[***SEER Note:*** Local tumor destruction, NOS]

No specimen sent to **pathology** from surgical event 10
Do not record stereotactic radiosurgery as tumor destruction. It should be recorded in the radiation treatment item.

20 Local excision (biopsy) of lesion or mass

Specimen sent to **pathology** from surgical event 20

40 Partial resection

[***SEER Note:*** Partial resection, NOS]

55 Gross total resection

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
THYROID GLAND
C739

Coding Hormone Therapy

Hormones as Replacement Therapy – Do Not Code as Treatment

The thyroid gland produces hormones that influence essentially every organ, tissue and cell in the body. When the thyroid is partially or totally removed, it is no longer able to secrete these essential hormones and the patient is placed on hormone replacement therapy. Do not code replacement therapy as treatment.

Hormone Treatment for Follicular Thyroid Cancer – Code in the Hormone Field

The growth of follicular cell cancer depends on thyroid stimulating hormone. Suppression of these hormones is thought to deprive the cells of a growth-promoting influence. Patients with follicular cell-derived cancers have been treated with supraphysiologic doses of thyroid hormone to suppress serum thyroid-stimulating hormones. This treatment has been an industry standard for more than forty years. Record the delivery of these hormones in the Hormone treatment field.

Generic Thyroid Drug Names:
Levothyroxine /L-thyroxine
Liothyronine
Liotrix
Methimazole
Natural Thyroid
Propylthiouracil / PTU
Thyrotropin alfa

Thyroid Drugs Brand Names:
Armour Thyroid
Cytomel
Levothroid
Levoxyl
Naturethroid
Synthroid
Tapazole
Thyrogen
Thyrolar
Unithroid
Westhroid

Collaborative Staging Codes
Thyroid Gland
C73.9
C73.9 Thyroid gland

Thyroid Gland
CS Tumor Size
SEE STANDARD TABLE

Thyroid Gland
CS Extension
Note: AJCC considers all anaplastic carcinomas to be T4. Collaborative Staging has implemented this as follows: If histology is equal to 8020 or 8021 and if CS Extension is equal to 00, 10, 20, 30, 40, 45, or 48, then T category is equal to T4a. For these histologies, if CS Extension is equal to 50, 52, 60, 62, 70, 72, or 80, then T category is equal to T4b. If CS Extension is equal to 95 or 99, the T category is T4NOS. For all other histologies, follow the rules as shown in the tables.

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive	Tis	IS	IS
10	Single invasive tumor confined to thyroid	*	L	L
20	Multiple foci confined to thyroid	*	L	L
30	Localized, NOS	*	L	L
40	Into thyroid capsule, but not beyond	*	L	L
45	Minimal extrathyroid extension including: Strap muscle(s): Omohyoid Sternohyoid Sternothyroid	T3	RE	RE
48	Pericapsular soft/connective tissue	T3	RE	RE
50	Parathyroid Nerves: Recurrent laryngeal Vagus	T4a	RE	RE
52	Cricoid cartilages Esophagus Larynx Sternocleidomastoid muscle	T4a	RE	RE
60	Thyroid cartilage Tumor is described as "FIXED to adjacent tissues"	T4b	RE	RE

62	Blood vessel(s) (major): Carotid artery Jugular vein Thyroid artery or vein	T4b	RE	RE
70	Bone Skeletal muscle, other than strap or sternocleidomastoid muscle	T4b	D	D
72	Trachea	T4a	D	D
80	Further contiguous extension Mediastinal tissues Prevertebral fascia	T4b	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 20, 30, and 40 ONLY, the T category is assigned based on value of CS Tumor Size from Extension Size Table.

Thyroid

CS Lymph Nodes

****Note 1:** Code only regional nodes and nodes, NOS in this field. Distant nodes are coded in the field Mets at DX.

****Note 2:** This field includes all lymph nodes defined as Levels I-VI and other by AJCC. The complete definitions are provided in the General Instructions for head and neck cancers.

****Note 3:** Codes 12-15 include ipsilateral, bilateral, contralateral, and midline lymph nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
**10	OBSOLETE: Ipsilateral regional lymph nodes: Anterior deep cervical (laterotracheal) (recurrent laryngeal): Paralaryngeal Paratracheal Prelaryngeal Pretracheal Cervical, NOS Internal jugular, NOS: Deep cervical, NOS: Lower, NOS Jugulo-omohyoid (supraomohyoid) Middle	N1a	RN	RN

**10 cont.	Retropharyngeal Spinal accessory (posterior cervical) Note Review and recode in 12-15			
**11	OBSOLETE: Regional lymph nodes: Delphian node Mediastinal, NOS Posterior mediastinal (tracheoesphageal) Upper anterior mediastinal Supraclavicular (transverse cervical) Note: Review and recode in 12-15	N1b	D	RN
**12	Level VI nodes (central compartment of the neck) Anterior deep cervical Laterotracheal Paralaryngeal Paratracheal Prelaryngeal/Delphian Pretracheal Recurrent laryngeal Stated as N1a, NOS	N1a	RN	RN
**13	Cervical nodes (other than those in central compartment) Levels I-III and Levels IV-V (except supraclavicular nodes, see code 14) Level I node Submandibular (submaxillary Submental Level II node Jugulodigastric (subdigastric) Upper Deep Cervical Upper jugular Level III node Middle deep cervical Mid jugular Level IV node Jugulo-omohyoid (supraomohyoid Lower deep cervical Lower jugular Level V node Posterior cervical Posterior triangle (spinal accessory and transverse cervical) Other Groups Paraphayrngeal Retropharyngeal Sub-occipital	N1b	RN	RN

**13 cont'd	Cervical, NOS Deep cervical, NOS Internal jugular, NOS Mandibular, NOS Stated as N1b, NOS			
**14	Supraclavicular nodes (transverse cervical)	N1b	D	RN
**15	Level VII node Posterior mediastinal (tracheoesophageal Superior mediastinal nodes Upper anterior mediastinal nodes Upper mediastinal nodes Mediastinal, NOS	N1b	D	RN
**20	OBSOLETE - Regional lymph nodes as listed in code 10 Bilateral, contralateral or midline cervical nodes NOTE: Review and recode in 12-15	N1a	RN	RN
**21	OBSOLETE - Regional lymph nodes as listed in code 11 Bilateral, contralateral, or midline nodes NOTE: Review and recode in 12-15	N1b	D	RN
**30	OBSOLETE - Tracheoesophageal (posterior mediastinal) NOTE: Review and recode in 15	N1b	D	RN
**31	OBSOLETE - Mediastinal, NOS Upper anterior mediastinal NOTE: Review and recode in 15	N1b	D	RN
50	Regional lymph node(s), NOS	N1N0S	RN	RN
80	Lymph nodes, NOS	N1NOS	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

**Updated July 1, 2005

Thyroid
Reg LN Pos
SEE STANDARD TABLE

Thyroid
Reg LN Exam
SEE STANDARD TABLE

Thyroid
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
**10	OBSOLETE - Mandibular (facial) node. NOTE: Review and recode in CS Lymph Nodes	M1	D	D
**11	OBSOLETE - Level I nodes. NOTE: Review and recode in CS Lymph Nodes	M1	D	D
**12	Distant lymph node(s), NOS	M1	D	D
**40	Distant metastases except distant lymph node(s) (code 12) Carcinomatosis Distant metastasis, NOS	M1	D	D
**50	OBSOLETE - Description: (40) + or any of [(10) to (12)] Distant lymph node(s) plus other distant metastasis NOTE : Review and recode to 40 or to 51 and appropriate code in CS Lymph Nodes	M1	D	D
**51	(12) + (40) (Distant lymph node(s) plus other distant metastasis)	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

**Updated July 1, 2005

Collaborative Staging Codes
Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
C37.9, C74.0-C74.1, C74.9, C75.0-C75.5, C75.8-C75.9
Note: Laterality must be coded for sites C74.0, C74.1, C74.9, and C75.4.
C37.9 Thymus
C74.0 Cortex of adrenal gland
C74.1 Medulla of adrenal gland
C74.9 Adrenal gland, NOS
C75.0 Parathyroid gland
C75.1 Pituitary gland
C75.2 Craniopharyngeal duct
C75.3 Pineal gland
C75.4 Carotid body
C75.5 Aortic body and other paraganglia
C75.8 Overlapping lesion of endocrine glands and related structures
C75.9 Endocrine gland, NOS
Note: AJCC does not define TNM staging for this site.

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
CS Tumor Size
SEE STANDARD TABLE

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
CS Extension

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
05	For C75.1 pituitary gland, C75.2 craniopharyngeal duct and C75.3 pineal gland ONLY: Benign or borderline tumors	NA	NA	NA
10	Invasive carcinoma confined to gland of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (See definition in General Instructions)	NA	RE	RE
60	Adjacent organs/structures Thymus and aortic body: Organs/structures in mediastinum Adrenal (suprarenal): Kidney Retroperitoneal structures Parathyroid Thyroid	NA	RE	RE

60 cont'd	Thyroid cartilage Pituitary and craniopharyngeal duct: Cavernous sinus Infundibulum Pons Sphenoid body and sinuses Pineal: Infratentorial and central brain Carotid body: Upper neck			
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: Use code 99, not applicable, for the following sites: Pituitary gland (C75.1), Craniopharyngeal duct (C75.2), and Pineal gland (C75.3)

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph nodes Cervical for carotid body and parathyroid only Mediastinal for aortic body and thymus only Retroperitoneal for adrenal (suprarenal) gland only	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record For Pituitary gland (C75.1), Craniopharyngeal duct (C75.2), and Pineal gland (C75.3): Not applicable	NA	U	U

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
Reg LN Pos
SEE STANDARD TABLE

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
Reg LN Exam
SEE STANDARD TABLE

Thymus, Adrenal (Suprarenal) Gland, and Other Endocrine Glands
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Site-Specific Surgery Codes
Thyroid Gland
C739
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

13 Local tumor destruction, NOS

No specimen sent to **pathology** from surgical event 13

25 Removal of **less than a lobe**, NOS
26 Local surgical excision
27 Removal of a partial lobe ONLY

Specimen sent to **pathology** from surgical events 25–27

20 Lobectomy and/or isthmectomy
21 Lobectomy ONLY
22 Isthmectomy ONLY
23 Lobectomy WITH isthmus

30 Removal of a **lobe** and **partial** removal of the **contralateral lobe**

40 **Subtotal** or **near total** thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Site-Specific Surgery Codes
All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, **C379,** C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, C630–C639, C680–C689, C690–C699, **C740–C749, C750–C759**
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs

[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
KAPOSI SARCOMA OF ALL SITES
(M-9140)

Primary Site

Kaposi sarcoma is **coded to the site in which it arises**. If Kaposi sarcoma arises in skin and another site simultaneously, code to skin (C44_). If no primary site is stated, code to **skin (C44_).**

Collaborative Staging Codes
Kaposi Sarcoma of All Sites
(M-9140)
Note: This scheme cannot be compared to either the Historic Stage or the 1977 Summary Stage schemes

Kaposi Sarcoma of All Sites
CS Tumor Size

Code	Description
888	Not applicable

Kaposi Sarcoma of All Sites
CS Extension

Code	Description	TNM	SS77	SS2000
11	Single lesion: Skin	NA	U	L
12	Single lesion: Mucosa (e.g., oral cavity, anus, rectum, vagina, vulva)	NA	U	L
13	Single lesion: Viscera (e.g., pulmonary, gastrointestinal tract, spleen, other)	NA	U	L
21	Multiple lesions: Skin	NA	U	L
22	Multiple lesions: Mucosa (e.g., oral cavity, anus, rectum, vagina, vulva)	NA	U	L
23	Multiple lesions: Viscera (e.g., pulmonary, gastrointestinal tract, spleen, other)	NA	U	L
24	(21) + (22)	NA	U	RE
25	(21) + (23)	NA	U	RE
26	(22) + (23)	NA	U	RE
27	(21) + (22) + (23)	NA	U	D
29	Multiple lesions, NOS	NA	U	U
95	No evidence of primary tumor	NA	U	U

99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Kaposi Sarcoma of All Sites
CS Lymph Nodes
Note: For this site, code all lymph node involvement in this field.

Code	Description	TNM	SS77	SS2000
00	No lymph node involvement (No clinical adenopathy and either pathologically negative or no pathological statement)	NA	U	NONE
10	Clinically enlarged palpable lymph node(s) (adenopathy), and either pathologically negative nodes or no pathological statement	NA	U	RN
20	No clinically enlarged palpable lymph node(s) (adenopathy) but pathologically positive lymph node(s)	NA	U	RN
30	Both clinically enlarged palpable lymph node(s) (adenopathy) and pathologically positive lymph node(s) Lymph nodes, NOS	NA	U	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Kaposi Sarcoma of All Sites
Reg LN Pos
SEE STANDARD TABLE

Kaposi Sarcoma of All Sites
Reg LN Exam
SEE STANDARD TABLE

Kaposi Sarcoma of All Sites
CS Mets at DX

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Site-Specific Surgery Codes
Skin
C440-C449
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

10 Local tumor destruction, NOS
11 Photodynamic therapy (PDT)
12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
13 Cryosurgery
14 Laser ablation

No specimen sent to **pathology** from surgical events 10–14

20 **Local** tumor **excision**, NOS
26 Polypectomy
27 Excisional biopsy

Any **combination** of **20** or **26–27** WITH

21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

[***SEER Note:*** Codes 21 to 25 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, 24 Laser ablation, or 25 Laser excision]

Specimen sent to **pathology** from surgical events 20–27

[***SEER Notes:*** Code UVB phototherapy for mycosis fungoides primaries under Surgery of Primary Site for skin. Assign code 11 if there is no pathology specimen. Assign code 21 if there is a pathology specimen. Codes 20-27 include shave and wedge resection]

30 **Biopsy** of primary tumor **followed by** a **gross excision** of the lesion (does not have to be done under the same anesthesia)
31 Shave biopsy followed by a gross excision of the lesion
32 Punch biopsy followed by a gross excision of the lesion
33 Incisional biopsy followed by a gross excision of the lesion

34 Mohs surgery, NOS
35 Mohs with 1-cm margin or less
36 Mohs with more than 1-cm margin

[***SEER Note:*** Codes 30 to 33 include less than a wide excision, less than 1 cm margin or margins are unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30. Code 45 represents a wide excision in which it is known that the margins of excision are greater than 1 cm.]

45 **Wide excision** or **reexcision** of lesion or **minor** (local) **amputation** with margins more than 1 cm, NOS. Margins MUST be microscopically negative.

46 WITH margins more than 1 cm and less than or equal to 2 cm
47 WITH margins greater than 2 cm
If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code, 20-36.

60 Major amputation

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

SEER Site-Specific Coding Guidelines
LYMPH NODES
Lymph Nodes C770–C779

Primary Site - Nodal vs. Extra-nodal

1. When multiple lymph node chains are involved at the time of diagnosis, do not simply code the lymph node chain that was biopsied.
    a. If it is possible to determine where the disease originated, code the primary site to that lymph node chain.
    b. If multiple lymph node chains are involved and it is not possible to determine the lymph node chain where the disease originated, code the primary site to C778, lymph nodes of multiple regions.
2. If a lymphoma is extranodal, code the organ of origin.

    Example: Pathology from stomach resection shows lymphoma. No other pathologic or clinical disease identified. Code the primary site as stomach, NOS (C169).

3. If a lymphoma is present both in an extranodal site and in that organ's regional lymph nodes, code the extralymphatic organ as the primary site. The only exception would be if the lymphoma in the extranodal site were a direct extension from the regional nodes. Lymphomas can spread from the regional lymph nodes into an extranodal site only by direct extension.

    Example 1: Lymphoma is present in the spleen and splenic lymph nodes. Code the primary site to spleen (C422).

    Example 2: Lymphoma is present in the stomach and the gastric lymph nodes. Code the primary site to stomach, NOS (C169).

4. If the lymphoma is present in extralymphatic organ(s) and non-regional lymph nodes, consult the physician to determine a primary site. If a site cannot be determined, code Lymph Node, NOS (C779).
5. If the primary site is unknown or not given:
    a. Code retroperitoneal lymph nodes if described as retroperitoneal mass
    b. Code inguinal lymph nodes if described as inguinal mass
    c. Code mediastinal lymph nodes if described as mediastinal mass
    d. Code mesenteric lymph nodes if described as mesenteric mass
    e. If the primary site is unknown code Lymph Nodes, NOS (C779)

    Exception: *Code unknown primary site (C809) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma*

Code **mycosis fungoides** and **cutaneous lymphomas** to Skin (C44_).

Grade
DO NOT code the descriptions "high grade," "low grade," or "intermediate grade" in the Grade, Differentiation or Cell Indicator field. FOR LYMPHOMA ONLY, the terms "high grade," "low grade," and "intermediate grade" refer to the Working Formulation of lymphoma diagnoses. The Working Formulation is not a grade or differentiation.

DO NOT code the descriptions "Grade 1," "Grade 2," or "Grade 3" in the Grade, Differentiation or Cell Indicator field. FOR LYMPHOMA ONLY, the terms "Grade 1," "Grade 2," and "Grade 3" represent lymphoma types, rather than differentiation.

The designation of **T-cell, B-cell, null cell**, or **NK cell** has precedence over any statement of grading or differentiation. Code ANY statement of T-cell, B-cell, null cell, or NK cell. Code information on cell type from any source, whether or not marker studies are documented in the patient record

> **Example:** The history portion of the medical record documents that the patient has a T-cell lymphoma. There are no marker studies in the chart. Code the grade as T-cell.

Additional Terms to be Coded

T-cell (code 5)
T-cell phenotype
T-precursor
Pre-T
Gamma-Delta T

B-Cell (code 6)
B-cell phenotype
B-precursor
Pre-B

Null-Cell; Non-T-non-B (code 7)
Null-cell
Non T-non-B
Common cell

NK (natural killer) cell (code 8)
Nasal NK/T cell lymphoma
Combined T and B cell

Cell type not determined, not stated, not applicable (code 9)
Combined T and B cell

. Regional Lymph Nodes Positive and Regional Lymph Nodes Examined

These two fields are always coded '99' for both nodal and extranodal lymphomas

Collaborative Staging Codes
Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl. Mycosis Fungoides and Sezary Disease)
(ICD-O-3 M-959-972 EXCEPT 9700/3 and 9701/3

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
CS Tumor Size

Code	Description
888	Not applicable

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
CS Extension
Note 1: For Hodgkin Lymphoma an E lesion is defined as disease that involves extralymphatic site(s). Extralymphatic means other than lymph nodes and other lymphatic structures. These lymphatic structures include spleen, thymus gland, Waldeyer's ring (tonsils), Peyer's patches (ileum) and lymphoid nodules in the appendix. Any lymphatic structure is to be coded the same as a lymph node region.
Note 2: S equals Spleen involvement.
Note 3: If there is no mention of extranodal involvement but several diagnostic procedures were done, including laparotomy, interpret as no involvement.
Note 4: Involvement of adjacent soft tissue does not alter the classification.

Code	Description	TNM	SS77	SS2000
10	Involvement of a single lymph node region Stage I	*	L	L
11	Localized involvement of a single extralymphatic organ/ site in the absence of any lymph node involvement Multifocal involvement of one extralymphatic organ/site Stage IE	*	L	L
12	Involvement of spleen only Stage IS	*	L	L
20	Involvement of two or more lymph node regions on the SAME side of the diaphragm Stage II	*	RNOS	RNOS
21	Localized involvement of a single extralymphatic organ/site WITH involvement of its regional lymph node(s) or WITH or WITHOUT involvement of other lymph node(s) on the SAME side of the diaphragm Direct extension to adjacent organs or tissues	*	RNOS	RNOS

21 cont'd	Stage IIE			
22	Involvement of spleen PLUS lymph node(s) BELOW the diaphragm Stage IIS	*	RNOS	RNOS
23	Involvement of spleen PLUS involvement of a single extralymphatic organ/site BELOW the diaphragm WITH/WITHOUT involvement of lymph node(s) BELOW the diaphragm Stage IIES	*	RNOS	RNOS
30	Involvement of lymph node regions on BOTH sides of the diaphragm Stage III	*	D	D
31	Involvement of an extralymphatic organ/site PLUS involvement of lymph node(s) on the OPPOSITE side of the diaphragm Stage IIIE	*	D	D
32	Involvement of the spleen PLUS lymph node(s) ABOVE the diaphragm Involvement of the spleen PLUS lymph node(s) on both sides of the diaphragm Stage IIIS	*	D	D
33	(31) + (32) OR Involvement of the spleen PLUS a single extralymphatic site ABOVE the diaphragm WITH/WITHOUT involvement of lymph node(s) Involvement of the spleen PLUS involvement of lymph node region(s)ABOVE the diaphragm PLUS involvement of a single extralymphatic organ/site on either side of the diaphragm Stage IIIES	*	D	D
80	Diffuse or disseminated (multifocal) involvement of ONE OR MORE extralymphatic organ(s)/site(s) WITH or WITHOUT associated lymph node involvement Multifocal involvement of MORE THAN ONE extralymphatic organ/site Involvement of isolated extralymphatic organ in absence of involvement of adjacent lymph nodes, but in conjunction with disease in distant sites Metastasis/involvement: Bone marrow	*	D	D

80 cont'd	Liver Nodular involvement of lung(s) Stage IV			
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	*	U	U

* AJCC stage group for this site is derived directly from the extension code, as shown in the Extension Stage Table. For extension codes 10-80, the AJCC Stages Groups I-IV are subdivided into A and B based on presence or absence of symptoms as shown in the Symptom Stage Subgroup Table

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
Reg LN Pos

Code	Description
99	Not applicable for this site

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
Reg LN Exam

Code	Description
99	Not applicable

Hodgkin and Non-Hodgkin Lymphomas of All Sites (excl Mycosis Fungoides and Sezary Disease)
CS Mets at Dx

Code	Description	TNM	SS77	SS2000
88	Not applicable for this site	NA	U	U

***Lymph node chains are subsites of lymph node regions. Use information pertaining to lymph node chains to code lymph node surgery; use lymph node region information to code stage.**

Site-Specific Surgery Codes
Lymph Nodes
C770-C779
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003)

15 Local tumor destruction, NOS

No specimen sent to **pathology** from surgical event 15

25 **Local** tumor **excision**, NOS

Less than a full chain; includes a **lymph node biopsy**

30 Lymph node dissection, NOS
31 One chain
32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
41 One chain
42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51 One chain
52 Two or more chains

60 **Lymph node dissection**, NOS and partial/total removal of **adjacent organ(s)** PLUS **splenectomy** (Includes staging laparotomy for lymphoma)
61 One chain
62 Two or more chains

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

[***SEER Note:*** Lymph node chains are subsites of lymph node regions. Use information pertaining to lymph node **chains** to code lymph node surgery; use lymph node **region** information to code stage.]

Collaborative Staging Codes
Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
(M-9731-9734, 9740-9742, 9750-9758, 9760-9762, 9764-9769, 9800-9801, 9805, 9820, 9823, 9826-9827, 9831-9837, 9840, 9860-9861, 9863, 9866-9867, 9870-9876, 9891, 9895-9897, 9910, 9920, 9930-9931, 9940, 9945-9946, 9948, 9950, 9960-9964, 9970, 9975, 9980, 9982-9987, 9989)
Note: This list includes only preferred terms from ICD-O-3

9731 Plasmacytoma, NOS	9866 Acute promyelocytic leukemia
9732 Multiple myeloma	9867 Acute myelomonocytic leukemia
9733 Plasma cell leukemia	9870 Acute basophilic leukemia
9734 Plasmacytoma, extramedullary	9871 Acute myeloid leukemia with abnormal marrow, eosinophils
9740 Mast cell sarcoma	9872 Acute myeloid leukemia, minimal differentiation
9741 Malignant mastocytosis	9873 Acute myeloid leukemia without maturation
9742 Mast cell leukemia	9874 Acute myeloid leukemia with maturation
9750 Malignant histiocytosis	9875 Chronic myelogenous leukemia, BCR/ABL positive
9751 Langerhans cell histiocytosis, NOS*	9876 Atypical chronic myeloid leukemia BCR/ABL negative
9752 Langerhans cell histiocytosis, unifocal*	9891 Acute monocytic leukemia
9753 Langerhans cell histiocytosis, multifocal*	9895 Acute myeloid leukemia with multilineage dysplasia
9754 Langerhans cell histiocytosis disseminated	9896 Acute myeloid leukemia, t(8;21)(q22;q22)
9755 Histiocytic sarcoma	9897 Acute myeloid leukemia, 11q23 abnormalities
9756 Langerhans cell sarcoma	9910 Acute megakaryoblastic leukemia
9757 Interdigitating dendritic cell sarcoma	9920 Therapy-related acute myeloid leukemia, NOS
9758 Follicular dendritic cell sarcoma	9930 Myeloid sarcoma
9760 Immunoproliferative disease, NOS	9931 Acute panmyelosis with myelofibrosis
9761 Waldenstrom macroglobulinemia	9940 Hairy cell leukemia
9762 Heavy chain disease, NOS	9945 Chronic myelomonocytic leukemia, NOS
9764 Immunoproliferative small intestinal disease	9946 Juvenile myelomonocytic leukemia
9765 Monoclonal gammopathy of undetermined significance*	9948 Aggressive NK-cell leukemia
9766 Angiocentric immunoproliferative lesion*	9950 Polycythemia (rubra) vera
9767 Angioimmunoblastic lymphadenopathy*	9960 Chronic myeloproliferative disease, NOS
9768 T-gamma lymphoproliferative disease*	9961 Myelosclerosis with myeloid metaplasia
9769 Immunoglobulin deposition disease*	9962 Essential thrombocythemia
9800 Leukemia, NOS	
9801 Acute leukemia, NOS	
9805 Acute biphenotypic leukemia	
9820 Lymphoid leukemia, NOS	
9823 B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma	
9826 Burkitt cell leukemia	
9827 Adult T-cell leukemia/lymphoma	

(HTLV-1 positive) 9831 T-cell large granular lymphocytic leukemia* 9832 Prolymphocytic leukemia, NOS 9833 Prolymphocytic leukemia, B-cell type 9834 Prolymphocytic leukemia, T-cell type 9835 Precursor cell lymphoblastic leukemia, NOS 9836 Precursor B-cell lymphoblastic leukemia 9837 Precursor T-cell lymphoblastic leukemia 9840 Acute myeloid leukemia, M6 type 9860 Myeloid leukemia, NOS 9861 Acute myeloid leukemia, NOS 9863 Chronic myeloid leukemia *Usually considered of uncertain/borderline behavior 9964 Hypereosinophilic syndrome	9963 Chronic neutrophilic leukemia 9970 Lymphoproliferative disorder, NOS* 9975 Myeloproliferative disease, NOS* 9980 Refractory anemia, NOS 9982 Refractory anemia with sideroblasts 9983 Refractory anemia with excess blasts 9984 Refractory anemia with excess blasts in transformation 9985 Refractory cytopenia with multilineage dysplasia 9986 Myelodysplastic syndrome with 5q deletion (5q-) syndrome 9987 Therapy-related myelodysplastic syndrome, NOS 9989 Myelodysplastic syndrome, NOS

Collaborative Staging Codes
Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
Note: AJCC does not define TNM staging for this site.

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
CS Tumor Size

Code	Description
888	Not applicable

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
CS Extension

Code	Description	TNM	SS77	SS2000
10	Localized disease: (single/solitary/unifocal/isolated/mono-ostotic) may be coded for: Plasmacytoma, NOS (M-9731/3) (solitary myeloma) Plasmacytoma, extramedullary (M-9734/3) (not occurring in bone Mast cell sarcoma (M-9740) Malignant histiocytosis (M-9750) Histiocytic sarcoma (M-9755) Langerhans cell sarcoma (M-9756) Dendritic cell sarcoma (M-9757, M-9758) Myeloid sarcoma (M-9930)	NA	L	L
80	Systemic disease (poly-ostotic):	NA	D	D

	All histologies including those in 10			
99	Unknown	NA	D	D

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
Reg LNS Pos

Code	Description	TNM	SS77	SS2000
99	Not applicable	NA	U	U

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
Reg LNS Exam

Code	Description	TNM	SS77	SS2000
99	Not applicable	NA	U	U

Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms
CS Mets at DX

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Site-Specific Surgery Codes
Hematopoietic/Reticuloendothelial/
Immunoproliferative/Myeloproliferative Disease
C420, C421, C423, C424 (with any histology)
or
M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989 (with any site)

Codes

98 **All** hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease **sites** and/or **histologies**, WITH or WITHOUT surgical treatment

Surgical procedures for hematopoietic, reticuloendothelial, immunoproliferative, myeloproliferative primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item # 1294)

[***SEER Note***: 99 Death certificate only]

Collaborative Staging Codes
Other and Ill-Defined Sites, Unknown Primary Site
C42.0-C42.4, C76.0-C76.5, C76.7-C76.8, C77.0-C77.5, C77.8-C77.9, C80.9
Note: C42._ and C77._, Other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms, Hodgkin and non-Hodgkin lymphomas, and Kaposi sarcoma
C42.0 Blood
C42.1 Bone marrow
C42.2 Spleen
C42.3 Reticuloendothelial system, NOS
C42.4 Hematopoietic system, NOS
C76.0 Head, face or neck, NOS
C76.1 Thorax, NOS
C76.2 Abdomen, NOS
C76.3 Pelvis, NOS
C76.4 Upper limb, NOS
C76.5 Lower limb, NOS
C76.7 Other ill-defined sites
C76.8 Overlapping lesion of ill-defined sites
C77.0 Head, face and neck
C77.1 Intrathoracic
C77.2 Intra-abdominal
C77.3 Axilla or arm
C77.4 Inguinal region or leg
C77.5 Pelvis
C77.8 Lymph nodes of multiple regions
C77.9 Lymph nodes, NOS
C80.9 Unknown primary site
Note: AJCC does not define TNM staging for this site.

Other and Ill-Defined Sites, Unknown Primary Site
CS Tumor Size
SEE STANDARD TABLE

Other and Ill-Defined Sites, Unknown Primary Site
CS Extension

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Other and Ill-Defined Sites, Unknown Primary Site
CS Lymph Nodes

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Other and Ill-Defined Sites, Unknown Primary Site
Reg LN Pos

Code	Description
99	Not applicable.

Other and Ill-Defined Sites, Unknown Primary Site
Reg LN Exam

Code	Description
99	Not applicable.

Other and Ill-Defined Sites, Unknown Primary Site
CS Mets at DX

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Site-Specific Surgery Codes
Unknown and Ill-Defined Primary Sites
C760-C768, C809
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

98 **All** unknown and ill-defined disease sites, **WITH** or **WITHOUT surgical treatment**
Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item Surgical Procedure/Other Site (NAACCR Item #1294)

[***SEER Note:*** 99 Death certificate only]

Site-Specific Surgery Codes
SPLEEN
C42.2
(EXCEPT FOR M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

CODES

00	None; no cancer directed surgery of primary site; autopsy ONLY
19	Local tumor destruction, NOS
21	Partial splenectomy
22	Total splenectomy
80	Splenectomy, NOS
90	Surgery, NOS
99	Unknown if cancer directed surgery performed; death certificate ONLY

Site-Specific Surgery Codes
Lymph Nodes
C770-C779
(Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; **no surgery** of primary site; **autopsy** ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to **pathology** for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003)

15 Local tumor destruction, NOS

No specimen sent to **pathology** from surgical event 15

25 **Local** tumor **excision**, NOS

Less than a full chain; includes a **lymph node biopsy**

30 Lymph node dissection, NOS
31 One chain
32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
41 One chain
42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
51 One chain
52 Two or more chains

60 **Lymph node dissection**, NOS and partial/total removal of **adjacent organ(s)** PLUS **splenectomy** (Includes staging laparotomy for lymphoma)
61 One chain
62 Two or more chains

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

[***SEER Note:*** Lymph node chains are subsites of lymph node regions. Use information pertaining to lymph node **chains** to code lymph node surgery; use lymph node **region** information to code stage.]

THE LAW

Chapter 82, Health and Safety Code
(Amended September 1, 2001)

Section 82.001. Short Title

This Chapter may be cited as the Texas Cancer Incidence Reporting Act.

Section 82.002. Definition

In this chapter:

(1) Cancer includes:
  (A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;
  (B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;
  (C) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and
  (D) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.
(2) Clinical laboratory means an accredited facility in which:
  (A) tests are performed identifying findings of anatomical changes; and
  (B) specimens are interpreted and pathological diagnoses are made.
(3) Health care facility means:
  (A) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);
  (B) an ambulatory surgical center licensed under Chapter 243;
  (C) an institution licensed under Chapter 242; or
  (D) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.
(4) Health care practitioner means:
  (A) a physician as defined by Section 151.002, Occupations Code; or
  (B) a person who practices dentistry as described by Section 251.003, Occupations Code.

Section 82.003. Applicability of Chapter

This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.

Section 82.004. Registry Required

The board shall maintain a cancer registry for the state.

Section 82.005. Content of Registry

(a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.
(b) The cancer registry must include:
  (1) a record of the cases of cancer that occur in the state; and
  (2) information concerning cancer cases as the board considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Section 82.006. Board Powers

To implement this chapter, the board may:

(1) adopt rules that the board considers necessary;
(2) execute contracts that the board considers necessary;
(3) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;
(4) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;
(5) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;
(6) receive and use gifts made for the purpose of this chapter; and
(7) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Section 82.007. Annual Report

(a) The department shall publish an annual report to the legislature of the information obtained under this chapter.
(b) The department, in cooperation with other cancer reporting organizations and research institutions may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Section 82.008. Data From Medical Records

(a) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the board or its representative, on request, data the board considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster.

(b) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by the department and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

(c) The data required to be furnished under this section must include patient identification and diagnosis.

(d) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

(e) The board shall adopt procedures that ensure adequate notice is given to the healthcare facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

(f) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

(g) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(h) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Section 82.009. Confidentiality

(a) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

(b) Medical or epidemiological information may be released:
   (1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;
   (2) with the consent of each person identified in the information; or
   (3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the board to ensure confidentiality as required by state and federal laws.

(c) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

(d) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008 (h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Section 82.010. Immunity From Liability

The following persons subject to this chapter that act in compliance with this chapter are not civilly or criminally liable for furnishing the information required under this chapter:

(1) a health care facility or clinical laboratory;
(2) an administrator, officer, or employee of a health care facility or clinical laboratory
(3) a health care practitioner or employee of a health care practitioner; and
(4) an employee of the department.

Section 82.011. Examination and Supervision Not Required

This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the board or its representatives.

This Act takes effect September 1, 2001.

The following rules are pending final adoption. The estimated final publication date is June 26, 2006 with final adoption expected in mid-July, 2006.

THE RULES

Texas Administrative Code
Title 25, Health Services
Part 1, Department of State Health Services
Chapter 91, Cancer
Subchapter A, Cancer Registry
Effective Date: July 9, 2006

§91.1. Purpose.

These sections implement the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82, concerning the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code §§280e to 280e-4. Nothing in these sections shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

(2) Branch--Cancer Epidemiology and Surveillance Branch of the department.

(3) Cancer--Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

(4) Cancer reporting handbook--The branch's manual for cancer reporters that documents reporting procedures and format.

(5) Clinical laboratory--An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted and pathological diagnoses are made.

(6) Department--Department of State Health Services.

(7) Health care facility--A general or special hospital as defined by the Health and Safety Code, Chapter 241; an ambulatory surgical center licensed under the Health and

(8) Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

(9) Health care practitioner--A physician as defined by Occupations Code, §151.002 or a person who practices dentistry as described by the Occupations Code, §251.003.

(10) Personal cancer data--Information that includes items that may identify an individual.

(11) Quality assurance--Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

(12) Report--Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

(13) Research--A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(14) Statistical data--Aggregate presentation of individual records on cancer cases excluding patient identifying information.

(15) Texas Cancer Registry--The cancer incidence reporting system administered by the Cancer Epidemiology and Surveillance Branch.

§91.3. Who Reports, Access to Records.

(a) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4-91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

(b) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

(c) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

(d) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and
(2) the facility reported the same data the practitioner would be required to report.

(e) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

(a) Reportable conditions.

(1) The cases of cancer to be reported to the branch are as follows:

(A) All neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the branch as non-reportable in the cancer reporting handbook; and

(B) All benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

(2) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which correspond to the branch's reportable list are specified in the cancer reporting handbook.

(b) Reportable information.

(1) The data required to be reported for each cancer case shall include:

(A) name, address, zip code, and county of residence;

(B) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is

available from the medical record;

(C) information on industrial or occupational history, to the extent such information is available from the medical record;

(D) diagnostic information including the cancer site and laterality, cell type, tumor behavior, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

(E) first course of cancer-related treatment, including dates and types of procedures;

(F) text information to support cancer diagnosis, stage and treatment codes, unless another method acceptable to the branch is used to confirm these codes;

(G) Health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

(H) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

(2) Each report shall:

(A) be electronically readable and contain all data items required in paragraph (1) of this subsection;

(B) be fully coded and in a format prescribed by the branch;

(C) meet all quality assurance standards utilized by the branch;

(D) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

(E) be submitted to the branch electronically; and

(F) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

(a) All reports shall be submitted to the department within six months of the patient's

admission, initial diagnosis or treatment for cancer.

(b) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

(c) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

(d) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

(a) Facilities with an annual caseload greater than 400 shall submit their reports of cancer via the Internet using TCR or other acceptable software assuring security of case information.

(b) Reports of cancer from facilities with an annual caseload less than 400 shall be submitted to the branch using one of the following methods:

(1) three and one half inch disk;

(2) compact disc; or

(3) the Internet.

§91.7. Where to Report.

Data reports should be submitted to the branch as specified in the cancer reporting handbook.

§91.8. Compliance.

(a) Each health care facility, clinical laboratory or health care practitioner that reports to the department, by methods specified in §§91.4-91.7 of this title (relating to Cancer Registry), is considered compliant.

(b) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

(c) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the

information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

(1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

(2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

(3) A health care facility, clinical laboratory or health care practitioner may request the department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

(d) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

(a) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of the Act.

(b) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

(c) Any requests for confidential or statistical data shall be made in accordance with §§91.11 or 91.12 of this title (relating to Cancer Registry).

(d) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports,

Access to Records). The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R §164.512(a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete and accurate data. The department will provide:

(1) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

(2) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

(3) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

(a) Statistical cancer data previously analyzed and printed are available upon written or oral request to the branch. All other requests for statistical data shall be in writing and directed to: Cancer Epidemiology and Surveillance Branch, Department of State Health Services, 1100 West 49th Street, Austin Texas 78756-3199.

(b) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

(1) name, address, and telephone number of the person requesting the information;

(2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998-2002); and

(3) name and address of person(s) to whom data and billings are to be sent (if applicable).

§91.12. Requests and Release of Personal Cancer Data.

(a) Data requests for research.

(1) Requests for personal cancer data shall be in writing and directed to: Department of State Health Services, Institutional Review Board (IRB), 1100 West 49th Street, Austin, Texas 78756-3199.

(2) Written requests for personal data shall meet the submission requirements of the department's IRB before release.

(3) The branch may release personal cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

(4) The branch may release personal cancer data to private agencies, organizations, and associations if approved by the IRB.

(5) The branch may release personal cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB.

(b) Data requests for non-research purposes.

(1) The branch may provide reports containing personal data back to the respective reporting entity from records previously submitted to the branch from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

(2) The branch may release personal data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled "Confidential" and will follow established departmental internal protocols and procedures.

(3) The branch may release personal cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

(4) The branch may release personal cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

(5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

FIPS COUNTY CODES - TEXAS COUNTIES

Anderson	001	Comal	091	Grayson	181
Andrews	003	Comanche	093	Gregg	183
Angelina	005	Concho	095	Grimes	185
Aransas	007	Cooke	097	Guadalupe	187
Archer	009	Coryell	099	Hale	189
Armstrong	011	Cottle	101	Hall	191
Atascosa	013	Crane	103	Hamilton	193
Austin	015	Crockett	105	Hansford	195
Bailey	017	Crosby	107	Hardeman	197
Bandera	019	Culberson	109	Hardin	199
Bastrop	021	Dallam	111	Harris	201
Baylor	023	Dallas	113	Harrison	203
Bee	025	Dawson	115	Hartley	205
Bell	027	Deaf Smith	117	Haskell	207
Bexar	029	Delta	119	Hays	209
Blanco	031	Denton	121	Hemphill	211
Borden	033	De Witt	123	Henderson	213
Bosque	035	Dickens	125	Hidalgo	215
Bowie	037	Dimmitt	127	Hill	217
Brazoria	039	Donley	129	Hockley	219
Brazos	041	Duval	131	Hood	221
Brewster	043	Eastland	133	Hopkins	223
Briscoe	045	Ector	135	Houston	225
Brooks	047	Edwards	137	Howard	227
Brown	049	Ellis	139	Hudspeth	229
Burleson	051	El Paso	141	Hunt	231
Burnet	053	Erath	143	Hutchinson	233
Caldwell	055	Falls	145	Irion	235
Calhoun	057	Fannin	147	Jack	237
Callahan	059	Fayette	149	Jackson	239
Cameron	061	Fisher	151	Jasper	241
Camp	063	Floyd	153	Jeff Davis	243
Carson	065	Foard	155	Jefferson	245
Cass	067	Fort Bend	157	Jim Hogg	247
Castro	069	Franklin	159	Jim Wells	249
Chambers	071	Freestone	161	Johnson	251
Cherokee	073	Frio	163	Jones	253
Childress	075	Gaines	165	Karnes	255
Clay	077	Galveston	167	Kaufman	257
Cochran	079	Garza	169	Kendall	259
Coke	081	Gillespie	171	Kenedy	261
Coleman	083	Glasscock	173	Kent	263
Collin	085	Goliad	175	Kerr	265
Collingsworth	087	Gonzales	177	Kimble	267
Colorado	089	Gray	179	King	269

Kinney	271	Panola	365	Upshur	459
Kleberg	273	Parker	367	Upton	461
Knox	275	Parmer	369	Uvalde	463
Lamar	277	Pecos	371	Val Verde	465
Lamb	279	Polk	373	Van Zandt	467
Lampasas	281	Potter	375	Victoria	469
La Salle	283	Presidio	377	Walker	471
Lavaca	285	Rains	379	Waller	473
Lee	287	Randall	381	Ward	475
Leon	289	Reagan	383	Washington	477
Liberty	291	Real	385	Webb	479
Limestone	293	Red River	387	Wharton	481
Lipscomb	295	Reeves	389	Wheeler	483
Live Oak	297	Refugio	391	Wichita	485
Llano	299	Roberts	393	Wilbarger	487
Loving	301	Robertson	395	Willacy	489
Lubbock	303	Rockwall	397	Williamson	491
Lynn	305	Runnels	399	Wilson	493
McCulloch	307	Rusk	401	Winkler	495
McLennan	309	Sabine	403	Wise	497
McMullen	311	San Augustine	405	Wood	499
Madison	313	San Jacinto	407	Yoakum	501
Marion	315	San Patricio	409	Young	503
Martin	317	San Saba	411	Zapata	505
Mason	319	Schleicher	413	Zavala	507
Matagorda	321	Scurry	415	**County unknown and resident outside the State of Texas**	**998**
Maverick	323	Shackelford	417		
Medina	325	Shelby	419		
Menard	327	Sherman	421		
Midland	329	Smith	423	**Unknown**	**999**
Milam	331	Somervell	425		
Mills	333	Starr	427		
Mitchell	335	Stephens	429		
Montague	337	Sterling	431		
Montgomery	339	Stonewall	433		
Moore	341	Sutton	435		
Morris	343	Swisher	437		
Motley	345	Tarrant	439		
Nacogdoches	347	Taylor	441		
Navarro	349	Terrell	443		
Newton	351	Terry	445		
Nolan	353	Throckmorton	447		
Nueces	355	Titus	449		
Ochiltree	357	Tom Green	451		
Oldham	359	Travis	453		
Orange	361	Trinity	455		
Palo Pinto	363	Tyler	457		

DETERMINING MULTIPLE PRIMARIES SOLID MALIGNANT TUMORS

Every effort should be made to identify separate primary tumors. The determination of the number of primary tumors a patient has is a medical decision, but operational rules are needed in order to ensure consistency of reporting by all institutions. Factors to consider include the site of origin, the date of diagnosis, the histologic type, the behavior of the neoplasm (in situ vs. invasive), and laterality. It is important to remember that in some cases different histologic terms are used to describe progressive stages of the same disease process.

Refer to specific guidelines in *Appendix E* for hematopoietic primaries and pages 13–16 in this appendix for specific guidelines for benign and borderline primary intracranial and central nervous system tumors (CNS).

Terms:

The words "**tumor**," "**neoplasm**," "**mass**," and "**lesion**" are used interchangeably throughout this manual.

The terms "**original**" and "**initial**" are synonymous.

Definitions:

Focal: Limited to one specific area

Foci/focus: The starting point of a disease process, a single cell

Laterality: the right or left side of the body or the right or left of a paired organ such as the right kidney or the left kidney. Unilateral describes a single organ/side. Bilateral describes both organs/sides.

Metachronous tumors: multiple tumors or lesions that occur greater than two months from the original/initial diagnosis

Multicentric: A primary tumor with satellites in surrounding tissue

Multifocal: Multiple tumors arising in two or more locations

Multiple primaries: two or more independent primary reportable neoplasms

Non-synchronous (Metachronous) tumors: multiple masses or lesions that occur greater than two months from the original/initial diagnosis

Paired Organ: two separate organs, a right and a left; for example: right breast and left breast

Primary site: the anatomical portion of the body where the cancer originated

Simultaneous tumors: multiple tumors identified at the time of diagnosis

Synchronous tumors: multiple tumors diagnosed within two months of the original/initial diagnosis

Single primary: one distinct reportable cancer

Single Tumor: a single lesion. A single tumor may **invade regional** organs by traveling along the mucosa or extending through the organ wall into **regional** tissue or organs. A single tumor may have **multiple or mixed** histologies.

Examples:

a. Colon primary: a large tumor originating in the ascending colon with *intramucosal* spread into the transverse colon. Abstract as a single primary and record the primary site as ascending colon.

b. The patient has multiple papillary urothelial bladder tumors with in situ spread into the ureters. Abstract as a single primary and record the primary site as bladder. (Mucosal spread of a urinary tract tumor may be called "field effect" or "regional diathesis").

HOW TO DETERMINE SAME VS. DIFFERENT PRIMARY SITE (BASED ON ICD-O-3 TOPOGRAPHY CODE)

1. The **third numeric digit** after the 'C' describes a subsite of the organ; it is **not used** to define individual (different) sites, other than the exceptions listed.

   Example:

   C50_ is the code for breast and the third numeric digit, C505 describes a subsite of the breast, the lower-outer quadrant.

   EXCEPTION: *For the following sites, a difference in the third numeric digit designates a different primary site:*

   Colon (C18_)
   Anus and anal canal (C21_)
   Bones, joints, and articular cartilage (C40_ –C41_)
   Melanoma of skin (C44_)
   Peripheral nerves and autonomic nervous system (C47_)
   Connective, subcutaneous and other soft tissues (C49_)

Examples:

a. The patient has a melanoma on the skin of the scalp (C444) and another melanoma on the calf of the right leg (C447). These are two different primary sites because the third numeric digit of the site code is different.

b. The patient has an invasive adenocarcinoma in the cecum (C180) and a separate invasive adenocarcinoma in the sigmoid colon (C187). Do not code to colon (C189). These are two different primaries and two separate abstracts must be submitted.

2. If the **first two numeric digits** after the C are **identical**, it is the **same site**.

Example:

If there is a tumor in the lower outer quadrant of the right breast (C505) and a separate tumor in the upper outer quadrant of the right breast, (C504), it is the same site.

***Possible EXCEPTION: Paired organ**: There are specific rules for paired organs. See the Multiple Primary Rules on page D7–D9.*

3. If there is **any difference** in the first two numeric digits after the C, it is a **different** site.

Example:

Stomach, NOS (C169) and small intestine, NOS (C179) are different sites because the second numeric digit is not identical.

***EXCEPTION: ICD-O-2/ICD-O-3 groupings**: The second edition of the International Classification of Diseases for Oncology (ICD-O-2) split several site codes into categories having differences in the second numeric digit after the C. The second and third edition ICD-O topography codes are identical. When a patient has **multiple independent** tumors, any combination of site codes within the same row in the table are the same primary site. Use this table for in situ and/or invasive tumors diagnosed prior to 2007. (Do not use this table for a single tumor with extension into another site).*

SEER Site Grouping Table

The purpose of this table is to show which group sites are treated as a single site when abstracting a case. **Do not use for cases diagnosed on or after 1/1/2007.**

ICD-O-3 CODE	SITE GROUPINGS	CODE TO
C01 C02	Base of tongue Other and unspecified parts of tongue	C029 Tongue, NOS
C05 C06	Palate Other and unspecified parts of mouth	C069 Mouth, NOS
C07 C08	Parotid gland Other and unspecified major salivary glands	C089 Major salivary glands, NOS
C09 C10	Tonsil Oropharynx	C109 Oropharynx, NOS
C12 C13	Pyriform sinus Hypopharynx	C139 Hypopharynx, NOS
C23 C24	Gallbladder Other and unspecified parts of the biliary tract	C249 Biliary tract, NOS
C30 C31	Nasal cavity and middle ear Accessory sinuses	C319 Accessory sinuses, NOS
C33 C34	Trachea Bronchus and lung	C349 Lung, NOS
C37 C380 C381–3 C388	Thymus Heart Mediastinum Overlapping lesion of heart, mediastinum, and pleura	C383 Mediastinum, NOS
C51 C52 C577 C578–9	Vulva Vagina Other specified female genital organs Unspecified female genital organs	C579 Female genital, NOS
C569 C570 C571 C572 C573 C574	Ovary Fallopian tube Broad ligament Round ligament Parametrium Uterine adnexa	Code C569 (ovary) when ovary is one of the involved sites Code C579 (female genital, NOS) when only non-ovarian sites are involved.
C60 C63	Penis Other and unspecified male genital organs	C639 Male genital, NOS

ICD-O-3 CODE	SITE GROUPINGS	CODE TO
C64 C65 C66 C68	Kidney Renal pelvis Ureter Other and unspecified urinary organs	Code C649 when one of the involved organs is kidney Code C689 (Urinary system, NOS) when only non-kidney sites are involved
C74 C75	Adrenal gland Other endocrine glands and related structures	C759 Endocrine gland, NOS

***Note:** This table is **not** identical to the table in ICD-O-3. Two combinations of sites are listed in the ICD-O-3 but not in the SEER table: C19 (rectosigmoid) and C20 (rectum) and C40 (bones of limbs) and C41 (bones of other sites). Multiple tumors in the rectosigmoid and rectum are different sites. Multiple tumors in C40 and C41 are different sites.*

HOW TO DETERMINE SAME VS. DIFFERENT HISTOLOGY (BASED ON ICD-O-3 HISTOLOGY CODES)

1. If the **first three digits of the ICD-O-3 histology codes are the same,** it is the same histology.

***EXCEPTION:** The ICD-O-3 histology code for non-small cell carcinoma (8046) is a separate morphology group from the small cell histologies (codes 8040 – 8045). Even though the first three digits are the same, they are different histologies.*

MULTIPLE PRIMARY RULES FOR SOLID TUMORS

Definitions:

Simultaneous tumors: identified at the same time of diagnosis.

Synchronous tumors: diagnosed within two months of the original/initial diagnosis.

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

Use the following rules to determine whether to report a single primary or multiple primaries. Coding rules for the data items mentioned such as primary site, histology, laterality, etc. are not described in detail in this section; refer to the instructions for coding each data item elsewhere in this manual.

Rules for Single Tumor:

Rule 1: A single lesion composed of one histologic type is a single primary, even if the lesion crosses site boundaries.

Examples:

a. A single lesion involving the tongue and floor of mouth is one primary.

b. A single, large mucinous adenocarcinoma involving the sigmoid and descending colon segments is one primary.

Rule 2: A single lesion composed of multiple (different) histologic types is a single primary even if it crosses site boundaries.

The most frequent combinations of histologic types are listed in ICD-O-3. For example, combination terms such as "adenosquamous carcinoma (8560/3)" or "small cell-large cell carcinoma (8045/3)" are included. A single lesion composed of mixed or multiple histologies is a single primary.

Examples:

a. A single lesion containing both embryonal cell carcinoma and teratoma is a single primary and would be coded to 9081/3, mixed embryonal carcinoma and teratoma.

b. A single lesion of the liver composed of neuroendocrine carcinoma (8246/3) and hepatocellular carcinoma (8170/3) is a single primary and would be coded to the more specific histology, neuroendocrine carcinoma 8246/3.

Rules for Multiple Tumors:

Rule 3a: Simultaneous multiple lesions of the same histologic type within the same site (in other words, multi*focal* tumors in a single organ or site) are a single primary. If one lesion has a behavior code of in situ /2 and the other lesion has a behavior code of malignant /3, this is a single primary whose behavior is malignant /3.

Examples:

a. At nephrectomy, two separate, distinct foci of renal cell carcinoma are found in the specimen, in addition to the 3.5 cm primary renal cell carcinoma. Abstract as a single primary.

b. At mastectomy for removal of a 2 cm invasive ductal carcinoma, an additional 5 cm area of intraductal carcinoma was noted. Abstract as one invasive primary.

Rule 3b: If a new cancer of the same histology as an earlier one is diagnosed in the same site within two months, this is a single primary cancer.

Example:

Adenocarcinoma in adenomatous polyp (8210) in sigmoid colon removed by polypectomy in December 2005. At segmental resection in January 2006, an adenocarcinoma in a tubular adenoma (8210) adjacent to the previous polypectomy site was removed. *Count as one primary.*

Rule 4: If both sides of a paired organ are involved with the same histologic type within two months of the initial diagnosis

1. It is one primary if the physician states the tumor in one organ is metastatic from the other.

   a. Code the laterality to the side where the primary originated

   b. Code the laterality as 4 if it is unknown in which side the primary originated

2. Code as multiple primaries if the physician states these are independent primaries or when there is no physician statement that one is metastatic from the other.

EXCEPTION: *Simultaneous bilateral involvement of the* ***ovaries*** *with the same histology is one primary and laterality is coded 4 when it is unknown which ovary was the primary site.*

EXCEPTION: *Bilateral* ***retinoblastomas*** *are a single primary with laterality of 4.*

EXCEPTION: *Bilateral* ***Wilms*** *tumors are always a single primary with laterality of 4.*

Rule 5: If a tumor with the same histology is identified in the same site at least two months after the initial/original diagnosis **(metachronous),** this is a **separate primary.**

EXCEPTION: *This is a single primary only when the physician documents that the initial/original tumor gave rise to the later tumor.*

Examples:

a. Infiltrating duct carcinoma of the upper outer quadrant of the right breast diagnosed March 2005 and treated with lumpectomy. Previously unidentified mass in lower inner quadrant right breast noted in July 2005 mammogram. This was removed and found to be infiltrating duct carcinoma. Abstract the case as two primaries.

b. During the workup for a squamous cell carcinoma of the vocal cord, a second squamous cell carcinoma is discovered in the tonsillar fossa. Abstract as two primaries.

EXCEPTION: *Effective with cases diagnosed January 1995 and later, if an in situ tumor is followed by an invasive cancer in the same site more than two months apart, report as two primaries even if stated to be a recurrence. The invasive primary should be reported with the date of the invasive diagnosis. (**Note:** The purpose of this guideline is to ensure that the case is counted as an incident case (i.e., invasive) when incidence data are analyzed.)*

EXCEPTION: *Report as a single primary and prepare a single abstract for the first invasive lesion:*

- Multiple invasive adenocarcinomas of the prostate (C619)
- Multiple invasive bladder cancers (C670–C679) with histology codes 8120–8130

Examples:

a. Urothelial bladder tumor removed by transurethral resection of the bladder (TURB). At three month check-up, a new urothelial tumor is removed. Abstract as one primary of the bladder.

b. Patient has elevated PSA and a needle biopsy that shows adenocarcinoma in the right lobe of the prostate. Patient and clinician opt for "watchful waiting." Four months later, PSA is higher and patient has a second biopsy, which shows adenocarcinoma in the left lobe. Abstract as one primary of the prostate.

EXCEPTION: *Kaposi sarcoma (9140) is reported only once and is coded to the site in which it arises. Code the primary site to skin (C44_) when Kaposi sarcoma arises in skin and another site simultaneously. If no primary site is stated, code the primary site to skin, NOS (C449).*

Rule 6: Multiple synchronous lesions of different histologic types within a single paired or unpaired organ are separate primaries.

Example:

A patient undergoes a partial gastrectomy for adenocarcinoma of the body of the stomach. In the resected specimen, the pathologist finds both adenocarcinoma and nodular non-Hodgkin lymphoma. Abstract two primaries.

EXCEPTION: *Multiple lesions in a single site occurring within two months: if one lesion is carcinoma, NOS, adenocarcinoma, NOS, sarcoma, NOS, or melanoma, NOS and the second lesion is more specific, such as large cell carcinoma, mucinous adenocarcinoma, spindle cell sarcoma, or superficial spreading melanoma, abstract as a single primary and code the histology to the more specific term.*

EXCEPTIONS: *For colon and rectum tumors:*

a. *When an adenocarcinoma (8140/_; in situ or invasive) arises in the same segment of the colon or rectum as an adenocarcinoma in a polyp (8210/_, 8261/_, 8263/_), abstract a single primary and code the histology as adenocarcinoma (8140/_).*

b. *When there is familial adenomatous polyposis (FAP) (8220) with malignancies arising in polyps in the same or multiple segments of the colon or rectum, abstract as a single primary.*

EXCEPTION: *There are certain sites in which multiple foci of tumor and multiple histologic types are commonly found together. These multifocal, multi-histologic tumors occur most frequently in the thyroid (papillary and follicular), bladder (papillary and transitional cell) and breast (combinations of ductal and lobular and combinations of Paget disease and ductal/intraductal). They are abstracted as a single primary with a mixed histology. In such cases, consult ICD-O-3 for a list of the most frequent histologic combinations.*

Examples:

a. A thyroid specimen contains two separate carcinomas— one papillary and the other follicular. Abstract one primary with the histology as papillary and follicular (8340).

b. Abstract one primary when **multiple bladder** tumors are **papillary urothelial** (8130) and/or **transitional** cell (8120).

c. A left mastectomy specimen shows lobular carcinoma in the upper inner quadrant and intraductal carcinoma in the lower inner quadrant. Abstract one primary with histology as lobular and ductal (8522/3).

d. A right mastectomy specimen shows Paget's disease in the nipple and a separate underlying ductal carcinoma. Abstract one primary. Assign the combination code 8543 (Ductal and Paget disease).

Rule 7: Multiple synchronous lesions of different histologic types in paired organs are multiple primaries. If one histologic type is reported in one side of a paired organ and a different histologic type is reported in the other paired organ, these are two primaries unless there is a statement to the contrary.

Example:

If a ductal tumor occurs in one breast and a lobular tumor occurs in the opposite

breast, these are two separate primaries.

Rule 8: Multiple metachronous lesions of different histologic types within a single site are separate primaries.

Rule 9: Multiple lesions of different histologic types occurring in different sites are separate primaries whether occurring simultaneously or at different times.

Examples:

a. In 2005, the patient had a mucin-producing carcinoma of the transverse colon. In 2006, the patient was diagnosed with an astrocytoma of the frontal lobe of the brain. Abstract as separate primaries.

b. During the workup for a transitional cell carcinoma of the bladder, the patient has a TURP that shows adenocarcinoma of the prostate. Abstract as separate primaries.

Rule 10: Multiple lesions of the same histologic type occurring in different sites are separate primaries unless stated to be metastatic.

Table of Rules to Determine Multiple Primaries for Solid Tumors :

RULE	TUMORS	SITE(S)	HISTOLOGY	VARIABLES	TIMING	SINGLE VS. MULTIPLE PRIMARY
1	Single	NA	NA		NA	Single
2	Single	NA	Different		NA	Single
3a	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
3b	Multiple	Same	Same	Non-paired or only one side of paired organ	Simultaneous or synchronous	Single
4	Multiple	Same (bilateral)	Same	Both sides of paired organ involved	Simultaneous or synchronous	Multiple unless physician states one is metastatic. ***EXCEPTION:*** Bilateral tumors: Ovary (same histology), retinoblastoma, or Wilms tumor are a single primary
5	Multiple	Same	Same		Synchronous	Multiple unless physician states recurrent or metastatic ***EXCEPTIONS:*** 1. Report as a **single** primary: a. Invasive prostate with histology (8140) b. Invasive bladder with histologies (8120–8130) c. Kaposi sarcoma (9140) 2. For all sites: Report as multiple primaries: In situ followed by invasive **even if stated to be recurrence.**

RULE	TUMORS	SITE(S)	HISTOLOGY	VARIABLES	TIMING	SINGLE VS. MULTIPLE PRIMARY
6	Multiple	Same	Different	Single paired or unpaired organ	Simultaneous or synchronous	Multiple ***EXCEPTIONS:*** The following are single primaries: 1. One histology is a more specific histology than the other (NOS and specific). 2. Colon: a. (Adeno) carcinoma and (adeno) carcinoma arising in a polyp. b. Familial adenomatous polyposis (FAP) with malignancies arising in polyps. 3. Histology combinatio commonly found together a. Thyroid (follicular and papillary) b. Bladder (transitional and papillary) 4. Breast: if two lesions in one breast are: a. Lobular and ductal b. Paget disease and ductal or intraductal
7	Multiple	Same	Different	Both sides of paired organ	Simultaneous or synchronous	Multiple ***EXCEPTION:*** Report as single: 1. If stated to be metastatic

RULE	TUMORS	SITE(S)	HISTOLOGY	VARIABLES	TIMING	SINGLE VS. MULTIPLE PRIMARY
8	Multiple	Same	Different		More than 2 months after original/initial tumor	Multiple
9	Multiple	Different	Different		NA	Multiple
10	Multiple	Different	Same		NA	Multiple unless stated to be metastatic ***EXCEPTION:*** Wilms tumor

DETERMINING MULTIPLE PRIMARIES FOR BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS (C70.0–C72.9, C75.1–C75.3):

Definitions:

Same site: the first two numeric digits of the ICD-O-3 topography code are identical.

Different site: the first two numeric digits of the ICD-O-3 topography code are different.

Timing: the amount of time between the original and subsequent tumors is not used to determine multiple primaries because the natural biology of non-malignant tumors is that of expansive, localized growth.

HOW TO DETERMINE SAME VS DIFFERENT HISTOLOGIES (BASED ON HISTOLOGIC GROUPINGS):

When there are **multiple tumors**, use the following table to determine if the tumors are the same histology or different histologies.

Histologic groupings to determine same histology for non-malignant brain tumors:

Choroid Plexus neoplasms	9390/0, 9390/1
Ependyomas	9383, 9394, 9444
Neuronal and neuronal-glial neoplasms	9384, 9412, 9413, 9442, 9505/1, 9506
Neurofibromas	9540/0, 9540/1, 9541, 9550, 9560/0
Neurinomatosis	9560/1
Neurothekeoma	9562
Neuroma	9570
Perineurioma, NOS	9571/0

Instructions for Using Histologic Group Table

1. **Both** histologies are listed **in** the **table**

   a. Histologies that are in the same **grouping** or row in the table are the **same histology**.

   b. Histologies listed in **different groupings** in the table are **different histologies**.

2. One or both of the **histologies** is **not** listed **in** the **table**

   a. If the **ICD-O-3 codes** for both histologies have the identical first three digits, the histologies are the same.

   b. If the first three digits of the **ICD-O-3** histology codes are different, the histology types are different.

MULTIPLE PRIMARY RULES FOR BENIGN AND BORDERLINE PRIMARY INTRACRANIAL AND CNS TUMORS:

The multiple primary rules are presented in two formats, text and table. Note that the rule numbers in both formats are identical.

Use the following rules to determine whether to report a single primary or multiple primaries. Coding rules for the data items mentioned, such as primary site, histology, laterality, etc., are not described in detail here; refer to the instructions in the Cancer Information section of the handbook.

***Note:** If there is a **single tumor**, it is always a **single** primary.*

Rule 1: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and **same side** (laterality) as the original tumor are recurrences (single primary) even after many years.

Example:

Patient had a desmoplastic infantile astrocytoma (9412/1) of the cerebellum (C716) diagnosed on 2/1/04 and a glanglioglioma (9505/1) of the brain stem (C717) diagnosed on 5/12/06.

Rationale: Because 9412/1 and 9505/1 are both in the same group on the nonmalignant histologic group table they are considered the same histology. The first two numeric digits of the ICD-O-3 topography codes for the sites, cerebellum and brain stem, are identical so the sites are the same. The two sites are not divided into sides so the laterality is the same. Because the sites, histologies and laterality are the same regardless of when the recurrence occurred, the tumors are considered one

primary and one abstract is completed.

Rule 2: Multiple non-malignant tumors of the **same histology** that recur in the **same site** and it is unknown if it is the same side (laterality) as the original tumor are recurrences (single primary) even after 20 years.

Example:

An acoustic neuroma (9560/0) was diagnosed in the right acoustic nerve (C724) on 1/15/04. A schwannoma (9560/0) of the acoustic nerve, NOS (9560/0), was diagnosed on 12/22/05.

Rationale: Acoustic Neuroma and schwannoma have the same histology code. Both tumors occurred in the acoustic nerve, which is considered the same site even though the laterality of the second tumor is unknown. This is one primary, regardless of when the recurrence was diagnosed.

Rule 3: Multiple non-malignant tumors of the same histology in **different sites** of the CNS are separate (multiple) primaries.

Example:

A dysembryoplastic neuroepithelial (9413/0) tumor of the hypoglossal nerve (C725) was diagnosed on 3/1/04, and a medullocytoma (9506/1) of the cerebellum (C716) was diagnosed on 4/12/04.

Rationale: The histologies are the same because they are found in the same group on the nonmalignant CNS histologic group table. However, the sites are different because there is a difference in the first two numeric digits of the ICD-O-3 topography codes. Because there is a difference in the sites of the two tumors, they are considered two primaries and two abstracts must be completed.

Rule 4: Multiple non-malignant tumors of the same histology in **different sides** (laterality) of the CNS are separate (multiple) primaries.

Example:

A meningioma (9530/0) of the right cerebral meninges (C700) is diagnosed 1/10/04. A meningioma (95300) of the left cerebral meninges (C700) is diagnosed the same day.

Rationale: The histologies and sites are the same, but the laterality is different. These are two different primaries and two abstracts should be completed.

Rule 5: Multiple non-malignant tumors of different histologies are separate (multiple) primaries.

Example:

A patient was diagnosed with subependymoma (9383/1) of the ventricle (C715) on 7/3/04. On 10/1/05 patient was diagnosed with subependymal giant cell astrocytoma (9384/1) of the cerebellum (C716).

Rationale: Because the two histologies are in different groups on the nonmalignant histologic group table, the histologies are different and these are two separate primary tumors. An abstract for each primary should be completed.

Table of Rules to Determine Multiple Primaries for Benign and Borderline Primary Intracranial and CNS Tumors:

RULE #	SITE	LATERALITY	HISTOLOGY	PRIMARY(IES)
1	Same	Same	Same	Single
2	Same	Unknown	Same	Single
3	Different	Any	Same	Multiple
4	Same	Different sides of the same site in the CNS	Same	Multiple
5	Any	Any	Different	Multiple

CRITERIA FOR DETERMINING MULTIPLE PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

Note: The new 2007 multiple primary and histology rules (Appendix O) do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors.

The following rules are to be used as a guide for identifying lymphomas and leukemias with second primaries. Note that the rules refer to general headings followed by the ICD-O morphology codes included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular" and "granulocytic," check the ICD-O Alphabetic Index to determine into which general category a specific term falls. Complete instructions for determining subsequent primaries in lymphatic and hematopoietic diseases are available in both the SEER Program Code Manual 2004 and the FORDS.

Note: *Different histologic terms are sometimes used to describe progressive stages or phases of the same disease process.*

Lymphoma Codes: Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. The following rules will be helpful in choosing the correct ICD-O-3 code for the histologic type:

1. The current preferred terminology is the World Health Organization Classification of Tumors of the Hematopoietic and Lymphoid Tissues.

2. If this terminology is not what is stated in the diagnosis, the following guidelines from older classifications apply:

   a. When the terms "diffuse" and "nodular" (follicular) are both mentioned in a diagnosis, ignore the term "diffuse" in coding, because most nodular tumors progress to diffuse or have some diffuse aspects.

   b. If neither diffuse nor nodular (follicular) is mentioned, presume the lymphoma is diffuse.

   c. The terms lymphoma, malignant lymphoma, and non-Hodgkin's lymphoma may be used interchangeably.

   d. Avoid using non-specific or unclassified lymphoma terms if there are specific diagnoses that can be coded.

   e. Some terms have equivalent meanings, for example:
      i. Centroblastic = non-cleaved
      ii. Centrocytic = cleaved
      iii. Follicular = nodular
      iv. Histiocytic = large (cell)
      v. Lymphocytic = small (cell)
      vi. Mixed lymphocytic and histiocytic = mixed small and large (cell)

f. When the term "mixed cellularity" is used with non-Hodgkin's lymphoma, it means mixed lymphocytic-histiocytic lymphoma.

DEFINITIONS OF SINGLE AND SUBSEQUENT PRIMARIES FOR HEMATOLOGIC MALIGNANCIES BASED ON ICD-O-3 REPORTABLE MALIGNANCIES, EFFECTIVE WITH DIAGNOSES 01/01/2001 AND AFTER

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one disease into another.

The following chart was prepared by Seer Program, NCI, and provided to aid the registrar in determining single versus subsequent primary.

The following guidelines are employed:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.

2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or Myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.

3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.

4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In

the cell at the intersection of the first diagnosis row and the second diagnosis column, a "S" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a "D" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note: *If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma.*

Note: *The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the International Classification of Diseases, Third Edition (ICD-O-3) for a complete list of related terms and synonyms.*

Complete Diagnostic Terms for Table (Based on ICD-O-3):

1. 9590 Malignant lymphoma, NOS
2. 9591 Malignant lymphoma, non-Hodgkin, NOS
3. 9596 Composite Hodgkin and non-Hodgkin lymphoma
4. 9650-9667 Hodgkin lymphoma (all subtypes)
5. 9670-9671 Malignant lymphoma, small B lymphocytic
6. 9673 Mantle cell lymphoma
7. 9675-9684 Malignant lymphoma, diffuse large B-cell
8. 9687 Burkitt lymphoma
9. 9689, 9699 Marginal zone B-cell lymphoma
10. 9690-9698 Follicular lymphoma
11. 9700-9701 Mycosis fungoides and Sezary syndrome
12. 9702-9719 T/NK-cell non-Hodgkin lymphoma
13. 9727 Precursor cell lymphoblastic lymphoma, NOS
14. 9728 Precursor B -cell lymphoblastic lymphoma
15. 9729 Precursor T -cell lymphoblastic lymphoma
16. 9731 -9734 Plasma cell tumors
17. 9740 -9742 Mast cell tumors
18. 9750 -9756 Histiocytosis/Langerhans cell histiocytosis
19. 9757 -9758 Dendritic cell sarcoma
20. 9760 Immunoproliferative disease, NOS
21. 9761 Waldenstrom macroglobulinemia
22. 9762 Heavy chain disease, NOS
23. 9764 Immunoproliferative small intestinal disease
24. 9800 -9801 Leukemia, NOS/Acute leukemia, NOS
25. 9805 Acute biphenotypic leukemia
26. 9820 Lymphoid leukemia, NOS
27. 9823 B -cell chronic lymphocytic leukemia/small lymphocytic lymphoma

28. 9826 Burkitt cell leukemia
29. 9827 Adult T -cell leukemia/lymphoma (HTLV-1 positive)
30. 9832 Prolymphocytic leukemi a, NOS
31. 9833 Prolymphocytic leukemia, B -cell type
32. 9834 Prolymphocytic leukemia, T -cell type
33. 9835 Precursor cell lymphoblastic leukemia, NOS
34. 9836 Precursor B -cell lymphoblastic leukemia
35. 9837 Precursor T -cell lymphoblastic leukemia
36. 9840 -9910 Myeloid leukemias
37. 9920 Therapy related acute myelogenous leukemia
38. 9930 Myeloid sarcoma
39. 9931 Acute panmyelosis with myelofibrosis
40. 9940 Hairy cell leukemia
41. 9945 Chronic myelomonocytic leukemia, NOS
42. 9946 Juvenile myelomonocytic leukemia
43. 9948 Aggressive NK -cell leukemia
44. 9950 Polycythemia vera
45. 9960 Chronic myeloproliferative disease, NOS
46. 9961 Myelosclerosis with myeloid metaplasia
47. 9962 Essential thrombocythemia
48. 9963 Chroni c neutrophilic leukemia
49. 9964 Hypereosinophilic syndrome
50. 9980 -9986 Refractory anemias
51. 9987 Therapy related myelodysplastic syndrome, NOS
52. 9989 Myelodysplastic syndrome, NOS

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 1 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	**S**	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	**S**	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	**S**	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	**S**	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	**S**	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	**S**	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	**S**	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	**S**	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	**S**	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	**S**
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lymblas lymph NOS	14. 9728 Precurs lymblas lymph B-cl	15. 9729 Precurs lymblas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	**S**	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	**S**	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	**S**	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	**S**	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	**S**	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	**S**	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	**S**	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	**S**	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	**S**
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary

SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	**S**	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	**S**	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	**S**	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	**S**	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	**S**	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	**S**	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	**S**	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	**S**	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	**S**	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	**S**
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	**S**	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	**S**	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	**S**	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	**S**	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	**S**	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	**S**	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	**S**	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	**S**	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	**S**	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	**S**	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	**S**
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	**S**	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	**S**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	**S**	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	**S**	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	**S**	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	**S**	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	**S**	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	**S**

Codes: S--one primary only; D--presumably a subsequent primary

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DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: (MMDDYYYY)	(2460) PHYSICIAN MANAGING:
(550) REGISTRY NUMBER:	(2470) PHYSICIAN FOLLOW UP:
(540) REPORTING FACILITY NUMBER:	(2410) FACILITY REFERRED FROM:
(500) REPORTING SOURCE:	(2420) FACILITY REFERRED TO:
(2300) MEDICAL RECORD #:	(560) SEQUENCE NUMBER:
(610) CLASS OF CASE:	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME:	
(2240) FIRST NAME:	
(2250) MIDDLE NAME:	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX:
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: (MMDDYYYY)
(2330) STREET ADDRESS:	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001:
(70) CITY:	(400) PRIMARY SITE:
(80) STATE:	(440) GRADE OF TUMOR:
(100) ZIP CODE:	(410) LATERALITY:
(90) FIPS COUNTY CODE AT DX:	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN:	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH:	
(250) PLACE OF BIRTH:	
(160) RACE 1:	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2:	
(162) RACE 3:	
(163) RACE 4:	
(164) RACE 5:	(490) DIAGNOSTIC CONFIRMATION:
(190) SPANISH/HISPANIC ORIGIN:	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX:	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION:	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

(2800) (2004 and >) CS TUMOR SIZE:	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION:	
(2830) CS LYMPH NODES:	
(820) REGIONAL LYMPH NODES POSITIVE:	(1400) HORMONE CODE:
(830) REGIONAL LYMPH NODES EXAMINED:	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX:	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE:
(2600) SUMMARY STAGE DOCUMENTATION:	(3250) RX SUMM-TRANSPLANT/ENDOCRINE:
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE:
(1292) RX SUMM-SCOPE OF REG LN SURGERY:	(1250) DATE OTHER TREATMENT STARTED: (MMDDYYYY)
(1200) RX DATE-SURGERY: (MMDDYYYY)	(1420) OTHER TREATMENT CODE:
(1290) SURG RX CODE:	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY:	
(1294) RX SUMM-SURG OTHER/DIST RX CODE:	
(2610) RX TEXT-SURGERY	(1750) DATE OF LAST CONTACT OR DEATH: (MMDDYYYY)
	(1760) VITAL STATUS:
(1210) DATE RADIATION STARTED: (MMDDYYYY)	(2090) DATE ABSTRACTED: (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE:	(570) ABSTRACTOR INITIALS:
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE:	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE:	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: (MMDDYYYY)	(2460) PHYSICIAN MANAGING: 2006
(550) REGISTRY NUMBER:	(2470) PHYSICIAN FOLLOW UP: 2006
(540) REPORTING FACILITY NUMBER:	(2410) FACILITY REFERRED FROM: 2001
(500) REPORTING SOURCE:	(2420) FACILITY REFERRED TO: 2001
(2300) MEDICAL RECORD #:	(560) SEQUENCE NUMBER:
(610) CLASS OF CASE: 1998	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME:	
(2240) FIRST NAME:	
(2250) MIDDLE NAME:	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 2007
(2280) ALIAS NAME: 2007	(390) DATE OF INITIAL DX: (MMDDYYYY)
(2330) STREET ADDRESS:	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL: 2006	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 2001
(70) CITY:	(400) PRIMARY SITE:
(80) STATE:	(440) GRADE OF TUMOR:
(100) ZIP CODE:	(410) LATERALITY: 1995
(90) FIPS COUNTY CODE AT DX:	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN:	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH:	
(250) PLACE OF BIRTH: 1998	
(160) RACE 1:	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 2001	
(162) RACE 3: 2001	
(163) RACE 4: 2001	
(164) RACE 5: 2001	(490) DIAGNOSTIC CONFIRMATION:
(190) SPANISH/HISPANIC ORIGIN:	(780) TUMOR SIZE (MM): 1998 DX PRIOR TO 2004
(220) SEX:	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION:	(759) SUMMARY STAGE 2000: 2001

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

(2800) (2004 and >) CS TUMOR SIZE: 2004	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION: 2004	
(2830) CS LYMPH NODES: 2004	
(820) REGIONAL LYMPH NODES POSITIVE: 1998	(1400) HORMONE CODE: 1995
(830) REGIONAL LYMPH NODES EXAMINED: 1998	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 2004	
(2880) CS SITE-SPECIFIC FACTOR 1: 2004	
(2900) CS SITE-SPECIFIC FACTOR 3: 2004	(1410) IMMUNOTHERAPY CODE: 1995
(2600) SUMMARY STAGE DOCUMENTATION:	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 2003
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 2006
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 2001	(1250) DATE OTHER TREATMENT STARTED: 1995 (MMDDYYYY)
(1200) RX DATE-SURGERY: 1995 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 1995
(1290) SURG RX CODE: 1995	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 2006	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 1998	
(2610) RX TEXT-SURGERY	(1750) DATE OF LAST CONTACT OR DEATH: 1995 (MMDDYYYY)
	(1760) VITAL STATUS: 1998
(1210) DATE RADIATION STARTED: 1995 (MMDDYYYY)	(2090) DATE ABSTRACTED: (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 2003	(570) ABSTRACTOR INITIALS:
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 2006	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 2003 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 1995	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 1

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 01192007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX888888
(550) REGISTRY NUMBER: 2007000022	(2470) PHYSICIAN FOLLOW UP: TX777777
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 00002009811	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: BROWN	
(2240) FIRST NAME: CHARLES	
(2250) MIDDLE NAME: L	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 20
(2280) ALIAS NAME: Brown Charlie	(390) DATE OF INITIAL DX: 01192007 (MMDDYYYY)
(2330) STREET ADDRESS: 91264 READY LN	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 94713
(70) CITY: NACOGDOCHES	(400) PRIMARY SITE: C719
(80) STATE: TX	(440) GRADE OF TUMOR: 9
(100) ZIP CODE: 75964	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 347	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 422222222	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 02232000	DESMOPLASTIC NODULAR MEDULLABLASTOMA
(250) PLACE OF BIRTH: 999	
(160) RACE 1: 01	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	POSTERIOR FOSSA BRAIN
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 1	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: Patient is a white male child	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 1

(2800) (2004 and >) CS TUMOR SIZE: 060	(2640) RX TEXT-CHEMO 2/9/07- Cisplatin, Vincristine
(2810) CS EXTENSION: 70	
(2830) CS LYMPH NODES: 88	
(820) REGIONAL LYMPH NODES POSITIVE: 99	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 99	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 1/19/07 MRI: Large 4x4x6cm solid midline post fossa tumor causing obstructive hydrocephalus; spine MRI: Nodular enhancement of leptomeninges of lower spinal cord, worrisome for drop mets. 1/19/07 Resection posterior fossa tumor: Medulloblastoma w/focal nodular/desmoplastic features; CSF: hemorrhagic fluid w/clusters of medulloblastoma cells.	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 3
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 9	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 01192007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 55	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 1/19/07 Total resection posterior fossa tumor	(1750) DATE OF LAST CONTACT OR DEATH: 02172007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 05252007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: XYX
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 02092007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 03	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 2

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 01212007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX12345
(550) REGISTRY NUMBER: 2007000001	(2470) PHYSICIAN FOLLOW UP: TX54321
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 00000809436	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: DOE	
(2240) FIRST NAME: JANE	
(2250) MIDDLE NAME: E	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 10
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 01222007 (MMDDYYYY)
(2330) STREET ADDRESS: 1110 E MARINA DR	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 81403
(70) CITY: WOODKING	(400) PRIMARY SITE: C504
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 78613	(410) LATERALITY: 1
(90) FIPS COUNTY CODE AT DX: 516	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 777888999	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 08131943	ADENOCARCINOMA, MD
(250) PLACE OF BIRTH: 999	
(160) RACE 1: 01	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	UOQ RIGHT BREAST
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 2	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 63 YOWF	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

EXAMPLE 2

(2800) (2004 and >) CS TUMOR SIZE: 022	(2640) RX TEXT-CHEMO 2/28/07 Adriamycin and Cytoxan
(2810) CS EXTENSION: 10	
(2830) CS LYMPH NODES: 00	
(820) REGIONAL LYMPH NODES POSITIVE: 98	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 00	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 1/21/07 H&P: 1.5cm mass UOQ right breast, no skin changes, no axillary lymphadenopathy 1/21/07 U/S Rt breast: 2.2cm mass 1/22/07 FNA: adenocarcinoma, md 1/26/07 lumpectomy: infiltrating adenoca, md, margins free	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 3
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 0	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 01262007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 22	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 1/26/07 Right breast lumpectomy	(1750) DATE OF LAST CONTACT OR DEATH: 06012007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 04282007 (MMDDYYYY)	(2090) DATE ABSTRACTED: 06122007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 20	(570) ABSTRACTOR INITIALS: MYN
(2620, 2630) RX TEXT-RADIATION 4/28/07 External Beam Radiation	(50) NAACCR RECORD VERSION: 11
	FOR CRD USE ONLY
(1380) RX SUMM-SURG/RAD SEQUENCE: 3	
(3230) RX DATE-SYSTEMIC: 02282007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 03	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 3

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 09092007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX4321
(550) REGISTRY NUMBER: 200700100	(2470) PHYSICIAN FOLLOW UP: TX9991
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 00A123	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 2	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: ENDEAVOR	
(2240) FIRST NAME: PATIENCE	
(2250) MIDDLE NAME: X	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 99
(2280) ALIAS NAME: Endeavor Patti	(390) DATE OF INITIAL DX: 09022007 (MMDDYYYY)
(2330) STREET ADDRESS: 321 Elsewhere Cr	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL: Garden State Apartments	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 81403
(70) CITY: Sandcrab	(400) PRIMARY SITE: C187
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 99999	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 481	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 999999999	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 01011955	Adenocarcinoma, MD
(250) PLACE OF BIRTH: 001	
(160) RACE 1: 02	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	Sigmoid Colon
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 2	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 52 YOBF	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 3

(2800) (2004 and >) CS TUMOR SIZE: 050	(2640) RX TEXT-CHEMO 10/15/07 Patient started chemo, type not documented in chart
(2810) CS EXTENSION: 40	
(2830) CS LYMPH NODES: 10	
(820) REGIONAL LYMPH NODES POSITIVE: 01	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 14	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 9/2/07 Colonoscopy: apple core lesion in sigmoid colon consistent w/adenoca. 9/4/07 CT Abdomen & Pelvis: essentially neg. 9/9/07 Sigmoid colectomy Path report: MD adenoca, 5.0cm, extends through muscularis propria, extensively involves subserosal adipose tissue, surgical margins free, 1/14 pericolic LNs	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 3
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 5	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 09092007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 30	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 9/9/07 Sigmoid colectomy	(1750) DATE OF LAST CONTACT OR DEATH: 10302007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 02012008 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: UTO
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
	FOR CRD USE ONLY
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	
(3230) RX DATE-SYSTEMIC: 10152007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 01	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 4

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 01292007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX101010
(550) REGISTRY NUMBER: 2007000029	(2470) PHYSICIAN FOLLOW UP: TX00001
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 00000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 000000138398	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: REYNAS	
(2240) FIRST NAME: CORNELIO	
(2250) MIDDLE NAME: E	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 63
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 01292007 (MMDDYYYY)
(2330) STREET ADDRESS: 3021 Ranchero St	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 84803
(70) CITY: Bay City	(400) PRIMARY SITE: C187
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 77414	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 312	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 799129999	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 02101926	MD Mucinous Adenoca
(250) PLACE OF BIRTH: 230	
(160) RACE 1: 01	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	Sigmoid Colon
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 1	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 1	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 80 YOWM	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 4

(2800) (2004 and >) CS TUMOR SIZE: 040	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION: 42	
(2830) CS LYMPH NODES: 00	
(820) REGIONAL LYMPH NODES POSITIVE: 00	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 08	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 1/29/07 Colon Bx at 25cm: MD Adenoca 1/30/07 Sigmoid colon: Mucinous adenoca, MD, 4cm, 0/8 LNs, tumor invades into adipose tissue	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 0
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 5	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 01302007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 40	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 1/30/07 Hemicolectomy	(1750) DATE OF LAST CONTACT OR DEATH: 08062007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 08142007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: XXY
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 00000000 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 00	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 5

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 04072007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX3333
(550) REGISTRY NUMBER: 2007000234	(2470) PHYSICIAN FOLLOW UP: TX3334
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 0000013422	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: LADY	
(2240) FIRST NAME: LUCKY	
(2250) MIDDLE NAME: D	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 10
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 04072007 (MMDDYYYY)
(2330) STREET ADDRESS: 711 Dice Row	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 80703
(70) CITY: Rolling Hills	(400) PRIMARY SITE: C343
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 78777	(410) LATERALITY: 2
(90) FIPS COUNTY CODE AT DX: 516	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 123987675	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 07111977	MD Squamous Cell Carcinoma
(250) PLACE OF BIRTH: 077	
(160) RACE 1: 03	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 01	LLL Lung
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 2	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 29 YO White & American Indian Female	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 5

(2800) (2004 and >) CS TUMOR SIZE: 102	(2640) RX TEXT-CHEMO 4/17/07 ARA-C
(2810) CS EXTENSION: 40	
(2830) CS LYMPH NODES: 10	
(820) REGIONAL LYMPH NODES POSITIVE: 98	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 00	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 99	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 4/7/07 CT Lung: 10.2cm mass in LLL, suspicious for malignancy; enlarged hilar LNs, probably atelectasis 4/8/07 LLL Bx: MD Squamous Cell Carcinoma	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 0
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 0	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 00000000 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 00	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 1	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY	(1750) DATE OF LAST CONTACT OR DEATH: 06302007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 06012007 (MMDDYYYY)	(2090) DATE ABSTRACTED: 08152007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 20	(570) ABSTRACTOR INITIALS: YME
(2620, 2630) RX TEXT-RADIATION 6/1/07 External Beam Radiation	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 04172007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 03	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 6

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 01122007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX00001
(550) REGISTRY NUMBER: 200700001	(2470) PHYSICIAN FOLLOW UP: TX00005
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 0000A1	(560) SEQUENCE NUMBER: 00
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: DILLYDALLY	
(2240) FIRST NAME: FREDERICK	
(2250) MIDDLE NAME: Z	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 99
(2280) ALIAS NAME: Dillydally Freddy	(390) DATE OF INITIAL DX: 01122007 (MMDDYYYY)
(2330) STREET ADDRESS: 111 Unknown Rd	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 96803
(70) CITY: Anywhere	(400) PRIMARY SITE: C770
(80) STATE: TX	(440) GRADE OF TUMOR: 6
(100) ZIP CODE: 11111	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 481	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 700555000	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 02141975	Large B-cell Lymphoma
(250) PLACE OF BIRTH: 001	
(160) RACE 1: 02	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	Cervical Lymph Nodes
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 1	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 31 YOBM	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 6

(2800) (2004 and >) CS TUMOR SIZE: 888	(2640) RX TEXT-CHEMO 1/14/2007 Pt started on CHOP and Rituxan
(2810) CS EXTENSION: 10	
(2830) CS LYMPH NODES: 88	
(820) REGIONAL LYMPH NODES POSITIVE: 99	(1400) HORMONE CODE: 01
(830) REGIONAL LYMPH NODES EXAMINED: 99	(2650) RX TEXT-HORMONE 1/14/07 CHOP
(2850) CS METS AT DX: 88	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 1/10/07 CT Neck & Abdomen: rt cervical lymphadenopathy, no other suspicious areas 1/12/07 Cervical LN excision Bx: c/w large B-cell lymphoma	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 3
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 9	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 01222007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 25	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 1/12/07 Cervical LN excisional BX	(1750) DATE OF LAST CONTACT OR DEATH: 01152007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 05012007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: CLW
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 01142007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 03	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 7

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 02132007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX1234
(550) REGISTRY NUMBER: 200700001	(2470) PHYSICIAN FOLLOW UP: TX1234
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 0000B1	(560) SEQUENCE NUMBER: 60
(610) CLASS OF CASE: 2	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: ALVAREZ	
(2240) FIRST NAME: GABRIELLE	
(2250) MIDDLE NAME: R	
(2390) MAIDEN NAME: MACHADO	(630) PRIMARY PAYER AT DX: 60
(2280) ALIAS NAME: Alvarez Ruby	(390) DATE OF INITIAL DX: 02012007 (MMDDYYYY)
(2330) STREET ADDRESS: 123 Heavenly Ln	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL: Paradise Hills Retirement Home	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 95300
(70) CITY: Paradise	(400) PRIMARY SITE: C700
(80) STATE: TX	(440) GRADE OF TUMOR: 9
(100) ZIP CODE: 22222	(410) LATERALITY: 2
(90) FIPS COUNTY CODE AT DX: 481	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 664664664	(2590) MORPHOLOGY/BEHAVIOR AND GRADE:
(240) DATE OF BIRTH: 06021913	Meningioma
(250) PLACE OF BIRTH: 001	
(160) RACE 1: 01	(2580) PRIMARY SITE AND LATERALITY:
(161) RACE 2: 88	Cerebral Meninges, Lt.
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 6	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 2	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 93 YO Hispanic White Female	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

EXAMPLE 7

(2800) (2004 and >) CS TUMOR SIZE: 023	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION: 05	
(2830) CS LYMPH NODES: 88	
(820) REGIONAL LYMPH NODES POSITIVE: 99	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 99	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 2/1/07 CT Brain: 2.3cm non-glial tumor in left cerebral meninges 2/13/07 Gross total resection: Meningioma of lt cerebral meninges	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 0
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 9	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 02132007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 55	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 2/13/07 Gross total resection of meningioma; no further treatment recommende	(1750) DATE OF LAST CONTACT OR DEATH: 02172007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 06012007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: SOE
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 00000000 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 00	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 8

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 05252007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX1111
(550) REGISTRY NUMBER: 200700004	(2470) PHYSICIAN FOLLOW UP: TX1234
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 0000C1	(560) SEQUENCE NUMBER: 02
(610) CLASS OF CASE: 2	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE) Adenocarcinoma of colon, 2000
(2230) LAST NAME: ALF	
(2240) FIRST NAME: D	
(2250) MIDDLE NAME: L	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 10
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 05012007 (MMDDYYYY)
(2330) STREET ADDRESS: 222 Everywhere Dr	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 81403
(70) CITY: Anytown	(400) PRIMARY SITE: C619
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 00001	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 481	FINAL DIAGNOSIS (2580, 2590) (2590) MORPHOLOGY/BEHAVIOR AND GRADE: Adenocarcinoma, Gleason score 5 (2580) PRIMARY SITE AND LATERALITY: Prostate
(2320) SSN: 100100001	
(240) DATE OF BIRTH: 11271950	
(250) PLACE OF BIRTH: 999	
(160) RACE 1: 01	
(161) RACE 2: 88	
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 3	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 1	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 56 YO Cuban Woman	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 8

(2800) (2004 and >) CS TUMOR SIZE: 999	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION: 15	
(2830) CS LYMPH NODES: 00	
(820) REGIONAL LYMPH NODES POSITIVE: 00	(1400) HORMONE CODE: 00
(830) REGIONAL LYMPH NODES EXAMINED: 17	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3: 022	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 5/1/07 Prostate Bx due to elevated PSA: Adenoca, Gleason score 5 5/25/07 Radical Prostatectomy: PD infiltrating adenoca, Gleason 5/10, in about 75% of lt lobe, no tumor in rt lobe. Tumor limited to prostate, no ext through capsule or into periprostatic fat, seminal vesicles free; 0/17 rt and lt LNs	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 0
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 5	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 05252007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 50	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 5/25/07 Radical prostatectomy	(1750) DATE OF LAST CONTACT OR DEATH: 05252007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 00000000 (MMDDYYYY)	(2090) DATE ABSTRACTED: 09252007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 00	(570) ABSTRACTOR INITIALS: ONO
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 00000000 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 00	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 9

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 02132007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TZ010101
(550) REGISTRY NUMBER: 2007000054	(2470) PHYSICIAN FOLLOW UP: TX000222
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0000000000
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 00000000100	(560) SEQUENCE NUMBER: 02
(610) CLASS OF CASE: 2	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE) Bladder Carcinoma, 2000
(2230) LAST NAME: SNOWMAN	
(2240) FIRST NAME: FROSTY	
(2250) MIDDLE NAME: T	
(2390) MAIDEN NAME:	(630) PRIMARY PAYER AT DX: 20
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 02092007 (MMDDYYYY)
(2330) STREET ADDRESS: 654 Icy Ln	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 81403
(70) CITY: Burr	(400) PRIMARY SITE: C619
(80) STATE: TX	(440) GRADE OF TUMOR: 2
(100) ZIP CODE: 77488	(410) LATERALITY: 0
(90) FIPS COUNTY CODE AT DX: 481	FINAL DIAGNOSIS (2580, 2590) (2590) MORPHOLOGY/BEHAVIOR AND GRADE: Adenocarcinoma, MD (2580) PRIMARY SITE AND LATERALITY: Prostate
(2320) SSN: 123123123	
(240) DATE OF BIRTH: 01011910	
(250) PLACE OF BIRTH: 077	
(160) RACE 1: 03	
(161) RACE 2: 88	
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 1	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 97 YO American Indian Male	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

EXAMPLE 9

(2800) (2004 and >) CS TUMOR SIZE: 999	(2640) RX TEXT-CHEMO
(2810) CS EXTENSION: 30	
(2830) CS LYMPH NODES: 10	
(820) REGIONAL LYMPH NODES POSITIVE: 14	(1400) HORMONE CODE: 01
(830) REGIONAL LYMPH NODES EXAMINED: 18	(2650) RX TEXT-HORMONE 2/28/07 Lupron
(2850) CS METS AT DX: 00	
(2880) CS SITE-SPECIFIC FACTOR 1:	
(2900) CS SITE-SPECIFIC FACTOR 3: 097	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 2/9/07 TURP: Adenoca, md 2/10/07 Bone scan: neg Pelvic LN Dissection: 14/18 adenoca	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 3
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 5	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 02092007 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 00
(1290) SURG RX CODE: 21	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 0	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY 2/9/07 TURP 2/13/07 Pelvic LN dissection	(1750) DATE OF LAST CONTACT OR DEATH: 07152007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 03152007 (MMDDYYYY)	(2090) DATE ABSTRACTED: 07282007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 54	(570) ABSTRACTOR INITIALS: XYZ
(2620, 2630) RX TEXT-RADIATION 3/15/07 Brachytherapy, Interstitial, HDR	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 3	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 02282007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 00	

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 10

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 02152007 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: TX999999
(550) REGISTRY NUMBER: 2007000167	(2470) PHYSICIAN FOLLOW UP: TX121314
(540) REPORTING FACILITY NUMBER: 998	(2410) FACILITY REFERRED FROM: 0099999999
(500) REPORTING SOURCE: 1	(2420) FACILITY REFERRED TO: 0000000000
(2300) MEDICAL RECORD #: 00000004567	(560) SEQUENCE NUMBER: 02
(610) CLASS OF CASE: 1	(2200) OTHER PRIMARY TUMORS: (SITE,MORPHOLOGY, and DATE) Melanoma, Skin of face, 1985
(2230) LAST NAME: RIVERS	
(2240) FIRST NAME: FLOW	
(2250) MIDDLE NAME: BLUE	
(2390) MAIDEN NAME: WILD	(630) PRIMARY PAYER AT DX: 99
(2280) ALIAS NAME:	(390) DATE OF INITIAL DX: 02152007 (MMDDYYYY)
(2330) STREET ADDRESS: 666 Wingding Ln	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL:	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 90503
(70) CITY: Cedar Park	(400) PRIMARY SITE: C384
(80) STATE: TX	(440) GRADE OF TUMOR: 3
(100) ZIP CODE: 78613	(410) LATERALITY: 2
(90) FIPS COUNTY CODE AT DX: 516	FINAL DIAGNOSIS (2580, 2590) (2590) MORPHOLOGY/BEHAVIOR AND GRADE: Malignant Mesothelioma, PD
(2320) SSN: 766999000	
(240) DATE OF BIRTH: 01011948	
(250) PLACE OF BIRTH: 077	
(160) RACE 1: 01	(2580) PRIMARY SITE AND LATERALITY: Left Pleura
(161) RACE 2: 88	
(162) RACE 3: 88	
(163) RACE 4: 88	
(164) RACE 5: 88	(490) DIAGNOSTIC CONFIRMATION: 1
(190) SPANISH/HISPANIC ORIGIN: 0	(780) TUMOR SIZE (MM): DX PRIOR TO 2004
(220) SEX: 2	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 59 YOWF	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM EXAMPLE 10

(2800) (2004 and >) CS TUMOR SIZE: 999	(2640) RX TEXT-CHEMO 3/1/07 Cisplatin, adriamycin
(2810) CS EXTENSION: 50	
(2830) CS LYMPH NODES: 00	
(820) REGIONAL LYMPH NODES POSITIVE: 98	(1400) HORMONE CODE: 99
(830) REGIONAL LYMPH NODES EXAMINED: 00	(2650) RX TEXT-HORMONE
(2850) CS METS AT DX: 99	
(2880) CS SITE-SPECIFIC FACTOR 1: 030	
(2900) CS SITE-SPECIFIC FACTOR 3:	(1410) IMMUNOTHERAPY CODE: 00
(2600) SUMMARY STAGE DOCUMENTATION: 2/15/07 Lt Lung Bx: PD Malignant neoplasm c/w mesothelioma 3/1/07 CT Chest: Large lt pleural effusion, large lobulated fluid collection lt hemithorax w/assoc loss of volume and interstitial lung infil, most likely basis of mets	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 00
	(2660) RX TEXT-IMMUNOTHERAPY
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 0
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 0	(1250) DATE OTHER TREATMENT STARTED: 00000000 (MMDDYYYY)
(1200) RX DATE-SURGERY: 99999999 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 0
(1290) SURG RX CODE: 99	(2670) RX TEXT-OTHER
(1340) REASON FOR NO SURGERY: 9	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 0	
(2610) RX TEXT-SURGERY	(1750) DATE OF LAST CONTACT OR DEATH: 05052007 (MMDDYYYY)
	(1760) VITAL STATUS: 1
(1210) DATE RADIATION STARTED: 99999999 (MMDDYYYY)	(2090) DATE ABSTRACTED: 06152007 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 99	(570) ABSTRACTOR INITIALS: POP
(2620, 2630) RX TEXT-RADIATION	(50) NAACCR RECORD VERSION: 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 0	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 03012007 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 03	

SEER GEOCODES
ALPHABETICAL LIST

A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
580 African Coastal Islands (previously included in 540)
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
265 America, Latin
260 America, North (use a more specific term; see also North America)
300 America, South
121 American Samoa
611 Anatolia
641 Andaman Islands
443 Andorra
520 Anglo -Egyptian Sudan
543 Angola
245 Anguilla
665 Annam
750 Antarctica
245 Antigua
245 Antilles, NOS
245 Antilles, Netherlands
625 Arab Palestine (former)
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
611 Armenia (Turkey)
633 Armenia (U.S.S.R.)
245 Aruba
600 Asia, NOS
680 Asia, East
640 Asia, Mid-East
611 Asia Minor, NOS
610 Asia, Near-East
650 Asia, Southeast
620 Asian Arab Countries
634 Asian Republics of the former U.S.S.R.
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaijan
633 Azerbaizhan S.S.R.
445 Azores

B

247 Bahamas, The
629 Bahrain
443 Balearic Islands
463 Baltic Republic(s), NOS
463 Baltic States, NOS
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
457 Belarus
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
539 Bioko (Fernando Poo)
452 Bohemia
355 Bolivia
545 Bophuthatswana
673 Borneo
453 Bosnia-Herzogovina
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
245 British West Indies, NOS
671 Brunei
454 Bulgaria
520 Burkina Faso (Upper Volta)
649 Burma (see Myanmar)
579 Burundi
457 Byelorussian S.S.R.

C

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean, NOS

245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the former U.S.S.R.
245 Cayman Islands
500 Central Africa, NOS
539 Central African Republic
250 Central America
499 Central Europe, NOS
060 Central Midwest States
647 Ceylon (see Sri Lanka)
520 Chad
401 Channel Islands (British)
361 Chile
681 China, NOS
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskei
665 Cochin China
711 Cocos (Keeling) Islands
381 Colombia
083 Colorado
580 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo, NOS
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
541 Congo Kinshasa
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
539 Cote d'Ivoire (Ivory Coast)
471 Crete
453 Croatia
241 Cuba
245 Curacao
495 Cyprus
517 Cyrenaica
452 Czechoslovakia
452 Czech Republic

D

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
499 Eastern Europe, NOS
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
122 Enterbury Islands
500 Equatorial Africa, NOS
539 Equatorial Guinea (Spanish Guinea)
585 Eritrea
458 Estonia
458 Estonian S.S.R. (Estonia)
585 Ethiopia
499 Europe, NOS
470 Europe, other mainland

F

425 Faroe (Faeroe) Islands
381 Falkland Islands
431 Federal Republic of Germany
123 Federated States of Micronesia
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
441 France
545 Free State (Orange Free State)
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
530 French West Africa, NOS
245 French West Indies
721 Futuna

G

539 Gabon
345 Galapagos Islands
539 Gambia, The
631 Gaza Strip
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
431 German Democratic Republic
430 Germanic Countries
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
122 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadaloupe
126 Guam
251 Guatamala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau (Portuguese Guinea)
539 Guinea, Equatorial Guinea, New (see New Guinea)
539 Guinea, Portuguese
331 Guyana

H

242 Haiti
099 Hawaii
432 Holland
253 Honduras
252 Honduras, British
683 Hong Kong
475 Hungary

I

421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
620 Iraq-Saudi Arabian Neutral Zone
410 Ireland (Eire)
410 Ireland, NOS
404 Ireland, Northern
410 Ireland, Republic of
401 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
634 Kazakhstan
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
122 Kiribati
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait
634 Kyrgystan
634 Kyrgyz

L

221 Labrador
661 Laos
420 Lapland, NOS
265 Latin America, NOS
459 Latvia
459 Latvian S.S.R. (Latvia)
623 Lebanon
245 Leeward Island, NOS
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
122 Line Islands, Southern
461 Lithuania
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali
491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
580 Mauritius
580 Mayotte
490 Mediterranean Islands, Other
721 Melanesian Islands
610 Mesopotamia, NOS
230 Mexico
041 Michigan
123 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
249 Miquelon
039 Mississippi
063 Missouri
456 Moldavia
456 Moldavian S.S.R.
456 Moldova
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat
649 Myanmar (see Burma)

N

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada
245 Nevis
221 New Brunswick
725 New Caledonia
001 New England

673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
510 North Africa, NOS
260 North America, NOS (use more specific term if possible)
240 North American Islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
499 Northern Europe, NOS
404 Northern Ireland
129 Northern Mariana Islands
050 Northern Midwest States
549 Northern Rhodesia

711 Norfolk Island
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
227 Nunavut
551 Nyasaland

O

720 Oceanía
043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney Islands

P

120 Pacific area, U.S. possessions
720 Pacific Islands
123 Pacific Islands, Trust Territory of the (code to specific islands if possible)
090 Pacific Coast States
639 Pakistan
645 Pakistan, East
639 Pakistan, West
139 Palau (Trust Territory of the Pacific Islands)
625 Palestine, Arab
631 Palestine, Jewish
631 Palestine, NOS
631 Palestinian National Authority--PNA
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
629 Persian Gulf States, NOS
351 Peru
675 Philippine Islands
675 Philippines
122 Phoenix Islands
725 Pitcairn Islands
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prairie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

Q

629 Qatar
222 Quebec

R

684 Republic of China
545 Republic of South Africa
580 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language Countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia, NOS
457 Russia, White
455 Russian Federation (former U.S.S.R.)
455 Russian S.F.S.R.
577 Rwanda
134 Ryukyu Islands (Japan)

S

520 Sahara, Western (Spanish)
121 Samoa, American
725 Samoa, Western
245 St. Christopher-Nevis
580 St. Helena
245 St. Kitts
245 St. Lucia
249 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia

403 Scotland
539 Senegal
453 Serbia
580 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic Countries
453 Slavonia
452 Slovak Republic
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland
583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
380 South American Islands
026 South Carolina
055 South Dakota
695 South Korea
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
499 Southern Europe, NOS
122 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen
Soviet Union (see individual Republics)
443 Spain
520 Spanish Sahara
647 Sri Lanka (see Ceylon)
520 Sudan (Anglo-Egyptian Sudan)
520 Sudanese Countries
673 Sumatra
332 Suriname
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

T

634 Tadzhik S.S.R.
684 Taiwan
634 Tajikistan
571 Tanzania
571 Tanganyika
571 Tanzanyika
031 Tennessee
077 Texas
651 Thailand (Siam)
685 Tibet
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Trans-Jordan
545 Transkei
545 Transvaal
449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
634 Turkmenistan
245 Turks Islands
125 Tuvalu

U

573 Uganda
456 Ukraine
456 Ukranian S.S.R.
404 Ulster
545 Union of South Africa
Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbekistan
634 Uzbek S.S.R.

V

721 Vanuatu
447 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

W

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington D.C.
530 West Africa, NOS
539 West African Countries, other
631 West Bank
431 West Germany
245 West Indies, NOS (see also individual islands)
639 West Pakistan
024 West Virginia
499 Western Europe, NOS
520 Western (Spanish) Sahara
725 Western Samoa
457 White Russia
245 Windward islands
051 Wisconsin
082 Wyoming

Y

629 Yemen
629 Yemen, People's Democratic Republic of

453 Yugoslavia (former Yugoslavia region)
225 Yukon Territory

Z

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

COMPARISON OF DATA SETS

Definitions:

Required Data Set (R): Commission-approved programs must record the required data set items using the codes and definitions specified in the FORDS manual.

Supplementary Data Set (S): The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.

Surveillance, Epidemiology, and End Results Program (SEER): Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.

National Program of Cancer Registries (NPCR): Required and recommended data elements for state cancer registries participating in the National Program of Cancer Registries of the Centers for Disease Control and Prevention.

Commission on Cancer (CoC): Refers to requirements and recommendations of the Commission on Cancer of ACoS.

Texas Cancer Registry (TCR): Refers to the requirements and recommendations of the Texas Cancer Registry.

Codes for Recommendations:

Left blank indicates that this data field is not currently collected by the TCR and other entities.

R = Required
RH = Historically collected and currently transmitted
RC = Collected by SEER from CoC-approved hospitals
RS = Required, site specific
S = Supplementary/recommended
D = Derived
T = Required status to be determined based upon implementation date of CS (see note on the first page of Chapter IX)
*** = When available**
^ = These texts may be met with one or several text block fields
• = Not in the data set but available
 # = Central registries may code using 1998 SEER or COC
C - Collect = These data items are collected
T – Transmit =These data items are collected and transmitted

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	10	Record Type	•	R	•	R	•	R	NAACCR
	20	Patient ID Number	•	R	•	•	R	R	Reporting Registry
	21	Patient System ID-Hosp		•	•	•	•	•	NAACCR
	30	Registry Type	•	•	•	•	•	•	NAACCR
	35	FIN Coding System	•	•	•	•	•	•	NAACCR
	37	Reserved 00		•	•	•	•	•	
	40	Registry ID		R	•	•	R	R	NAACCR
New	45	NPI—Registry ID		•	•	•	R*	•	NAACCR
	50	NAACCR Record Version	R	R	•	R	•	•	NAACCR
	60	Tumor Record Number		•	•	•	S	S	NAACCR
	70	Addr at DX--City	R	R	R	R	R	•	COC
	80	Addr at DX--State	R	R	R	R	R	•	COC
	90	County at DX	R	R	R	R	R	R	FIPS/SEER
	100	Addr at DX--Postal Code	R	R	R	R	R	•	COC
	110	Census Tract 1970/80/90	D	RH*	•	•	RH	RH	SEER
	120	Census Cod Sys 1970/80/90	D	RH*	•	•	RH	RH	SEER
	130	Census Tract 2000	D	R	•	•	R	R	NAACCR
Retired	140	Census Tract Cod Sys--Alt							
	150	Marital Status at DX		•	•	•	R	R	SEER
	160	Race 1	R	R	R	R	R	R	SEER/COC
	161	Race 2	R	R	R	R	R	R	SEER/COC
	162	Race 3	R	R	R	R	R	R	SEER/COC
	163	Race 4	R	R	R	R	R	R	SEER/COC
	164	Race 5	R	R	R	R	R	R	SEER/COC
	170	Race Coding Sys--Current		•	R	R	•	•	NAACCR
	180	Race Coding Sys--Original		•	R	R	•	•	NAACCR
	190	Spanish/Hispanic Origin	R	R	R	R	R	R	SEER/COC
Revised	191	NHIA Derived Hisp Origin		D	•	•	D	R	NAACCR
	192	IHS Link		R*	•	•	•	R	NPCR
Revised	200	Computed Ethnicity		R	•	•	D	R	SEER
	210	Computed Ethnicity Source		R	•	•	R	R	SEER
	220	Sex	R	R	R	R	R	R	SEER/COC
	230	Age at Diagnosis	•	R	R	R	R	R	SEER/COC
	240	Birth Date	R	R	R	R	R	R	SEER/COC
	250	Birthplace	R	R*	R	R	R	R	SEER/COC
	260	Religion		•	•	•	•	•	Varies
	270	Occupation Code--Census		R*	•	•	•	•	Census/ NPCR
	280	Industry Code--Census		R*	•	•	•	•	Census/ NPCR
	290	Occupation Source		R*	•	•	•	•	NPCR
	300	Industry Source		R*	•	•	•	•	NPCR
	310	Text--Usual Occupation	•	R*	•	•	•	•	NPCR
	320	Text--Usual Industry	•	R*	•	•	•	•	NPCR

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	330	Occup/Ind Coding System	•	R*	•	•	•	•	NPCR
	340	Tobacco History		•	•	•	•	•	Varies
	350	Alcohol History		•	•	•	•	•	Varies
	360	Family History of Cancer		•	•	•	•	•	Varies
	362	Census Tract Block Group	D	•	•	•	•	•	Census
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH	SEER
	365	Census Tr Certainty 2000	D	R	•	•	R	R	NAACCR
Revised	366	GIS Coordinate Quality		R*	•	•	S	•	NAACCR
	370	Reserved 01		•	•	•	•	•	
	380	Sequence Number--Central	•	R	•	•	R	R	SEER
	390	Date of Diagnosis	R	R	R	R	R	R	SEER/COC
	400	Primary Site	R	R	R	R	R	R	SEER/COC
	410	Laterality	R	R	R	R	R	R	SEER/COC
	419	Morph--Type&Behav ICD-O-2							
	420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	SEER/COC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	SEER/COC
	440	Grade	R	R	R	R	R	R	SEER/COC
Revised	442	Ambiguous Terminology DX		•	R	R	R	R	SEER
Revised	443	Date of Conclusive DX		•	R	R	R	R	SEER
Revised	444	Mult Tum Rpt as One Prim		•	R	R	R	R	SEER
Revised	445	Date of Multiple Tumors		•	R	R	R	R	SEER
Revised	446	Multiplicity Counter		•	R	R	R	R	SEER
	447	Number of Tumors/Hist		•	•	•	•	•	NAACCR
	450	Site Coding Sys--Current	•	R	R	R	•	•	NAACCR
	460	Site Coding Sys--Original		•	R	R	•	•	NAACCR
	470	Morph Coding Sys--Current	•	R	R	R	•	•	NAACCR
	480	Morph Coding Sys--Originl		•	R	R	•	•	NAACCR
	490	Diagnostic Confirmation	R	R	R	R	R	R	SEER/COC
	500	Type of Reporting Source	R	R	•	•	R	R	SEER
Revised	501	Casefinding Source		•	•	•	R	R	NAACCR
	510	Screening Date		•	•	•	•	•	NAACCR
	520	Screening Result		•	•	•	•	•	NAACCR
	521	Morph--Type&Behav ICD-O-3							
	522	Histologic Type ICD-O-3	R	R	R	R	R	R	SEER/COC
	523	Behavior Code ICD-O-3	R	R	R	R	R	R	SEER/COC
	530	Reserved 02		•	•	•	•	•	
Retired	535	Reserved 25		•	•	•	•	•	
Retired	538	Reporting Hospital FAN							
	540	Reporting Hospital	R	R	R	R	R	•	COC
New	545	NPI—Reporting Facility		R*	R*	R*	R*	•	NAACCR
	550	Accession Number--Hosp	R	•	R	R	R	•	COC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	560	Sequence Number--Hospital	R	•	R	R	R	•	COC
	570	Abstracted By	R	•	R	R	R	•	COC
	580	Date of 1st Contact	R	R	R	R	•	•	COC
	590	Date of Inpatient Adm		•	•	•	•	•	NAACCR
	600	Date of Inpatient Disch		•	•	•	•	•	NAACCR
	610	Class of Case	R	R	R	R	RC	•	COC
	615	Reserved 26		•	•	•	•	•	
Retired	620	Year First Seen This CA							
Revised	630	Primary Payer at DX	R*	R*	R	R	R	R	COC
Retired	635	Reserved 27	•	•	•	•	•	•	
Retired	640	Inpatient/Outpt Status							
Retired	650	Presentation at CA Conf							
Retired	660	Date of CA Conference							
	670	RX Hosp--Surg Prim Site		•	R	R	R	•	COC
	672	RX Hosp--Scope Reg LN Sur		•	R	R	R	•	COC
	674	RX Hosp--Surg Oth Reg/Dis		•	R	R	R	•	COC
	676	RX Hosp--Reg LN Removed		•	•	RH	•	•	COC
	680	Reserved 03		•	•	•	•	•	
Revised	690	RX Hosp—Radiation		•	•	•	RH	•	SEER/COC
	700	RX Hosp--Chemo		•	R	R	R	•	COC
	710	RX Hosp--Hormone		•	R	R	R	•	COC
	720	RX Hosp--BRM		•	R	R	R	•	COC
	730	RX Hosp--Other		•	R	R	R	•	COC
	740	RX Hosp--DX/Stg Proc		•	R	R	•	•	COC
	741	Reserved 28		•	•	•	•	•	
Retired	742	RX Hosp--Screen/BX Proc1							
Retired	743	RX Hosp--Screen/BX Proc2							
Retired	744	RX Hosp--Screen/BX Proc3							
Retired	745	RX Hosp--Screen/BX Proc4							
	746	RX Hosp—Surg Site 98-02		•	•	RH	RH	•	COC
	747	RX Hosp—Scope Reg 98-02		•	•	RH	RH	•	COC
	748	RX Hosp—Surg Oth 98-02		•	•	RH	RH	•	COC
	750	Reserved 04		•	•	•	•	•	
Revised	759	SEER Summary Stage 2000	D	RH	RH	RH	•	S	SEER
	760	SEER Summary Stage 1977	RH	RH	RH	RH	•	S	SEER
	765	Reserved 29		•	•	•	•	•	
Retired	770	Loc/Reg/Distant Stage							
	779	Extent of Disease 10-Dig							
	780	EOD--Tumor Size	RH	•	RH	RH	RH	RH	SEER/COC
	790	EOD--Extension		•	•	•	RH	RH	SEER
	800	EOD--Extension Prost Path		•	•	•	RH	RH	SEER
	810	EOD--Lymph Node Involv		•	•	•	RH	RH	SEER
	820	Regional Nodes Positive	R	•	R	R	R	R	SEER/COC
	830	Regional Nodes Examined	R	•	R	R	R	R	SEER/COC
	840	EOD--Old 13 Digit		•	•	•	RH	RH	SEER

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	850	EOD--Old 2 Digit		•	•	•	RH	RH	SEER
	860	EOD--Old 4 Digit		•	•	•	RH	RH	SEER
	870	Coding System for EOD		•	•	•	RH	RH	SEER
	880	TNM Path T		•	R	R	•	•	AJCC
	890	TNM Path N		•	R	R	•	•	AJCC
	900	TNM Path M		•	R	R	•	•	AJCC
	910	TNM Path Stage Group		•	R	R	•	•	AJCC
	920	TNM Path Descriptor		•	R	R	•	•	COC
	930	TNM Path Staged By		•	R	R	•	•	COC
	940	TNM Clin T		•	R	R	•	•	AJCC
	950	TNM Clin N		•	R	R	•	•	AJCC
	960	TNM Clin M		•	R	R	•	•	AJCC
	970	TNM Clin Stage Group		•	R	R	•	•	AJCC
	980	TNM Clin Descriptor		•	R	R	•	•	COC
	990	TNM Clin Staged By		•	R	R	•	•	COC
	995	Reserved 30	•	•	•	•	•	•	
Retired	1000	TNM Other T							
Retired	1010	TNM Other N							
Retired	1020	TNM Other M							
Retired	1030	TNM Other Stage Group							
Retired	1040	TNM Other Staged By							
Retired	1050	TNM Other Descriptor							
	1060	TNM Edition Number		•	R	R	•	•	COC
	1065	Reserved 31		•	•	•	•	•	
Retired	1070	Other Staging System							
	1080	Date of 1st Positive BX		•	•	•	•	•	NAACCR
	1090	Site of Distant Met 1		•	•	RH	•	•	COC
	1100	Site of Distant Met 2		•	•	RH	•	•	COC
	1110	Site of Distant Met 3		•	•	RH	•	•	COC
	1120	Pediatric Stage		•	•	•	•	•	COC
	1130	Pediatric Staging System		•	•	•	•	•	COC
	1140	Pediatric Staged By		•	•	•	•	•	COC
	1150	Tumor Marker 1		•	•	RH	RH	RH	SEER
	1160	Tumor Marker 2		•	•	RH	RH	RH	SEER
	1170	Tumor Marker 3		•	•	RH	RH	RH	SEER
	1180	Reserved 05		•	•	•	•	•	
	1190	Reserved 06		•	•	•	•	•	
	1200	RX Date--Surgery	R	•	R	R	S	•	COC
	1210	RX Date--Radiation	R	•	R	R	S	•	COC
	1220	RX Date--Chemo		•	•	•	•	•	NAACCR
	1230	RX Date--Hormone		•	•	•	•	•	NAACCR
	1240	RX Date--BRM		•	•	•	S	•	NAACCR
	1250	RX Date--Other	R	•	R	R	S	•	COC
	1260	Date of Initial RX--SEER	D	R#	•	•	R	R	SEER
	1270	Date of 1st Crs RX--COC		R#	R	R	•	•	COC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	1280	RX Date--DX/Stg Proc		•	R	R	•	•	COC
	1290	RX Summ--Surg Prim Site	R	R	R	R	R	R	SEER/COC
	1292	RX Summ—Scope Reg LN Sur	R	R	R	R	R	R	SEER/COC
	1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	R	R	SEER/COC
Revised	1296	RX Summ—Reg LN Examined	R	•	•	RH	RH	RH	SEER/COC
	1300	Reserved 07		•	•	•	•	•	
	1310	RX Summ--Surgical Approch		•	•	RH	•	•	COC
	1320	RX Summ--Surgical Margins		•	R	R	•	•	COC
	1330	RX Summ--Reconstruct 1st		•	•	•	RH	RH	SEER
	1340	Reason for No Surgery	R	R	R	R	R	R	SEER/COC
	1350	RX Summ--DX/Stg Proc		•	R	R	•	•	COC
	1355	Reserved 22		•	•	•	•	•	
Revised	1360	RX Summ--Radiation		•	•	•	R	R	SEER
	1370	RX Summ--Rad to CNS		•	•	•	R	R	SEER/COC
	1380	RX Summ--Surg/Rad Seq	R	R	R	R	R	R	SEER/COC
	1390	RX Summ--Chemo	R	R	R	R	R	R	SEER/COC
	1400	RX Summ--Hormone	R	R	R	R	R	R	SEER/COC
	1410	RX Summ--BRM	R	R	R	R	R	R	SEER/COC
	1420	RX Summ--Other	R	R	R	R	R	R	SEER/COC
	1430	Reason for No Radiation		•	R	R	•	•	COC
	1435	Reserved 32		•	•	•	•	•	
Retired	1440	Reason for No Chemo							
Retired	1450	Reason for No Hormone							
	1460	RX Coding System--Current	•	R	R	R	•	RH	NAACCR
	1465	Reserved 33		•	•	•	•	•	
Retired	1470	Protocol Eligibility Stat							
Retired	1480	Protocol Participation							
Retired	1490	Referral to Support Serv							
	1500	First Course Calc Method		•	•	•	•	•	NAACCR
	1510	Rad--Regional Dose: cGy		•	R	R	•	•	COC
	1520	Rad--No of Treatment Vol		•	R	R	•	•	COC
Retired	1530	Rad--Elapsed RX Days							
	1535	Reserved 34		•	•	•	•	•	
	1540	Rad--Treatment Volume		•	R	R	•	•	COC
	1550	Rad--Location of RX		•	R	R	•	•	COC
	1555	Reserved 35		•	•	•	•	•	
Retired	1560	Rad—Intent of Treatment							
	1570	Rad--Regional RX Modality	R	R	R	R	RC	•	COC
Retired	1580	Rad-- RX Completion Status							
Retired	1590	Rad--Local Control Status							
Retired	1600	Chemotherapy Field 1							
Retired	1610	Chemotherapy Field 2							

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
Retired	1620	Chemotherapy Field 3							
Retired	1630	Chemotherapy Field 4							
	1635	Reserved 23		•	•	•	•	•	
Revised	1639	RX Summ—Systemic/Surg Seq	R	R	R	R	R	R	COC
	1640	RX Summ--Surgery Type		•	•	•	RH	RH	SEER
	1641	Reserved 36		•	•	•	•	•	
Retired	1642	RX Summ--Screen/BX Proc1							
Retired	1643	RX Summ--Screen/BX Proc2							
Retired	1644	RX Summ--Screen/BX Proc3							
Retired	1645	RX Summ--Screen/BX Proc4							
	1646	RX Summ—Surg Site 98-02		•	RH	RH	RH	RH	SEER/COC
	1647	RX Summ—Scope Reg 98-02		•	RH	RH	RH	RH	SEER/COC
	1648	RX Summ—Surg Oth 98-02		•	RH	RH	RH	RH	SEER/COC
	1650	Reserved 08		•	•	•	•	•	
	1660	Subsq RX 2nd Course Date		•	•	•	•	•	COC
	1670	Subsq RX 2nd Course Codes							
	1671	Subsq RX 2nd Course Surg		•	•	•	•	•	COC
	1672	Subsq RX 2nd Course Rad		•	•	•	•	•	COC
	1673	Subsq RX 2nd Course Chemo		•	•	•	•	•	COC
	1674	Subsq RX 2nd Course Horm		•	•	•	•	•	COC
	1675	Subsq RX 2nd Course BRM		•	•	•	•	•	COC
	1676	Subsq RX 2nd Course Oth		•	•	•	•	•	COC
	1677	Subsq RX 2nd--Scope LN SU		•	•	•	•	•	COC
	1678	Subsq RX 2nd--Surg Oth		•	•	•	•	•	COC
	1679	Subsq RX 2nd--Reg LN Rem		•	•	•	•	•	COC
	1680	Subsq RX 3rd Course Date		•	•	•	•	•	COC
	1690	Subsq RX 3rd Course Codes							
	1691	Subsq RX 3rd Course Surg		•	•	•	•	•	COC
	1692	Subsq RX 3rd Course Rad		•	•	•	•	•	COC
	1693	Subsq RX 3rd Course Chemo		•	•	•	•	•	COC
	1694	Subsq RX 3rd Course Horm		•	•	•	•	•	COC
	1695	Subsq RX 3rd Course BRM		•	•	•	•	•	COC
	1696	Subsq RX 3rd Course Oth		•	•	•	•	•	COC
	1697	Subsq RX 3rd--Scope LN Su		•	•	•	•	•	COC
	1698	Subsq RX 3rd--Surg Oth		•	•	•	•	•	COC
	1699	Subsq RX 3rd--Reg LN Rem		•	•	•	•	•	COC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	1700	Subsq RX 4th Course Date		•	•	•	•	•	COC
	1710	Subsq RX 4th Course Codes							
	1711	Subsq RX 4th Course Surg		•	•	•	•	•	COC
	1712	Subsq RX 4th Course Rad		•	•	•	•	•	COC
	1713	Subsq RX 4th Course Chemo		•	•	•	•	•	COC
	1714	Subsq RX 4th Course Horm		•	•	•	•	•	COC
	1715	Subsq RX 4th Course BRM		•	•	•	•	•	COC
	1716	Subsq RX 4th Course Oth		•	•	•	•	•	COC
	1717	Subsq RX 4th--Scope LN Su		•	•	•	•	•	COC
	1718	Subsq RX 4th--Surg Oth		•	•	•	•	•	COC
	1719	Subsq RX 4th--Reg LN Rem		•	•	•	•	•	COC
Retired	1720	Subsq RX 5th Course Date							
	1725	Reserved 37		•	•	•	•	•	
	1726	Reserved 38		•	•	•	•	•	
Retired	1730	Subsq RX 5th Course Codes							
Retired	1731	Subsq RX 5th Course Surg							
Retired	1732	Subsq RX 5th Course Rad							
Retired	1733	Subsq RX 5th Course Chemo							
Retired	1734	Subsq RX 5th Course Horm							
Retired	1735	Subsq RX 5th Course BRM							
Retired	1736	Subsq RX 5th Course Oth							
Retired	1737	Subsq RX 5th--Scope LN Su							
Retired	1738	Subsq RX 5th--Surg Oth							
Retired	1739	Subsq RX 5th--Reg LN Rem							
	1740	Reserved 09		•	•	•	•	•	
	1741	Subsq RX--Reconstruct Del		•	•	•	•	•	COC
	1750	Date of Last Contact	R	R	R	R	R	R	SEER/COC
	1760	Vital Status	R	R	R	R	R	R	SEER/COC
	1770	Cancer Status		•	R	R	•	•	COC
	1780	Quality of Survival		•	•	•	•	•	COC
	1790	Follow-Up Source		•	R	R	•	•	COC
	1791	Follow-up Source Central		R	•	•	•	•	NAACCR
	1800	Next Follow-Up Source		•	R	•	•	•	COC
	1810	Addr Current--City		•	R	•	R	•	COC
	1820	Addr Current--State		•	R	•	R	•	COC
	1830	Addr Current--Postal Code		•	R	•	R	•	COC
	1835	Reserved 10		•	•	•	•	•	
	1840	County--Current		•	•	•	•	•	NAACCR
	1842	Follow-Up Contact--City		•	•	•	R	•	SEER
	1844	Follow-Up Contact--State		•	•	•	R	•	SEER
	1846	Follow-Up Contact--Postal		•	•	•	R	•	SEER
	1850	Unusual Follow-Up Method		•	•	•	•	•	COC
	1860	Recurrence Date--1st		•	R	R	RC	•	COC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
Retired	1870	Recurrence Distant Sites							
	1871	Recurrence Distant Site 1		•	•	•	•	•	NAACCR
	1872	Recurrence Distant Site 2		•	•	•	•	•	NAACCR
	1873	Recurrence Distant Site 3		•	•	•	•	•	NAACCR
	1880	Recurrence Type--1st		•	R	R	RC	•	COC
Retired	1890	Recurrence Type--1st--Oth							
	1895	Reserved 39		•	•	•	•	•	
	1900	Reserved 11		•	•	•	•	•	
	1910	Cause of Death	•	R	•	•	R	R	SEER
	1920	ICD Revision Number	•	R	•	•	R	R	SEER
	1930	Autopsy		•	•	•	•	•	NAACCR
	1940	Place of Death		R	•	•	•	•	NPCR
Retired	1950	Reserved 12		•	•	•	•	•	
	1960	Site (73-91) ICD-O-1		•	•	•	RH	RH	SEER
	1970	Morph (73-01) ICD-O-1							
	1971	Histology (73-91) ICD-O-1		•	•	•	RH	RH	SEER
	1972	Behavior (73-91) ICD-O-1		•	•	•	RH	RH	SEER
	1973	Grade (73-91) ICD-O-1		•	•	•	RH	RH	SEER
	1980	ICD-O-2 Conversion Flag		•	R	R	R	R	SEER
	1981	Over-ride SS/NodesPos		•	•	•	•	•	NAACCR
	1982	Over-ride SS/TNM-N		•	•	•	•	•	NAACCR
	1983	Over-ride SS/TNM-M		•	•	•	•	•	NAACCR
	1984	Over-ride SS/DisMet1		•	•	•	•	•	NAACCR
	1985	Over-ride Acsn/Class/Seq		•	R	R	•	•	COC
	1986	Over-ride HospSeq/DxConf		•	R	R	•	•	COC
	1987	Over-ride COC-Site/Type	•	•	R	R	•	•	COC
	1988	Over-ride HospSeq/Site		•	R	R	•	•	COC
	1989	Over-ride Site/TNM-StgGrp		•	R	R	•	•	COC
	1990	Over-ride Age/Site/Morph	•	R	R	R	R	R	SEER
	2000	Over-ride SeqNo/DxConf	•	R	•	•	R	R	SEER
	2010	Over-ride Site/Lat/SeqNo	•	R	•	•	R	R	SEER
	2020	Over-ride Surg/DxConf	•	R	R	R	R	R	SEER
	2030	Over-ride Site/Type	•	R	R	R	R	R	SEER
	2040	Over-ride Histology	•	R	R	R	R	R	SEER
	2050	Over-ride Report Source	•	R	•	•	R	R	SEER
	2060	Over-ride Ill-define Site	•	R	•	•	R	R	SEER
	2070	Over-ride Leuk, Lymphoma	•	R	R	R	R	R	SEER
	2071	Over-ride Site/Behavior	•	R	R	R	R	R	SEER
	2072	Over-ride Site/EOD/DX Dt	•	•	•	•	R	R	SEER
	2073	Over-ride Site/Lat/EOD	•	•	•	•	R	R	SEER
	2074	Over-ride Site/Lat/Morph	•	R	R	R	R	R	SEER
Retired	2080	Reserved 13							
	2081	CRC CHECKSUM		•	•	•	S	S	NAACCR
	2082	Reserved 24		•	•	•	•	•	
	2090	Date Case Completed	•	•	•	•	•	•	NAACCR

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	2100	Date Case Last Changed	•	•	•	•	•	•	NAACCR
	2110	Date Case Report Exported	•	R	•	R	•	•	NPCR
	2111	Date Case Report Received	•	R	•	•	•	•	NPCR
	2112	Date Case Report Loaded	•	R	•	•	•	•	NPCR
	2113	Date Tumor Record Availbl		R	•	•	•	•	NPCR
Retired	2114	Future Use Timeliness 1							
Retired	2115	Future Use Timeliness 2							
	2116	ICD-O-3 Conversion Flag		R	R	R	R	R	SEER/COC
	2120	SEER Coding Sys--Current		•	•	•	•	R	NAACCR
	2130	SEER Coding Sys--Original		•	•	•	•	R	NAACCR
	2140	COC Coding Sys--Current		•	R	R	•	•	COC
	2150	COC Coding Sys--Original		•	R	R	•	•	COC
Retired	2160	Subsq Report for Primary							
Retired	2161	Reserved 20							
	2170	Vendor Name	•	•	•	R	•	•	NAACCR
	2180	SEER Type of Follow-Up		•	•	•	R	R	SEER
	2190	SEER Record Number		•	•	•	•	R	SEER
	2200	Diagnostic Proc 73-87		•	•	•	RH	RH	SEER
Retired	2210	Reserved 14							
	2220	State/Requestor Items		•	•	•	•	•	Varies
	2230	Name--Last	R	R	R	•	R	•	NAACCR
	2240	Name--First	R	R	R	•	R	•	NAACCR
	2250	Name--Middle	R	R	R	•	R	•	COC
	2260	Name--Prefix		•	•	•	•	•	SEER
	2270	Name--Suffix		•	•	•	R	•	SEER
	2280	Name--Alias	R	R	•	•	R	•	SEER
	2290	Name--Spouse/Parent		•	•	•	•	•	NAACCR
	2300	Medical Record Number	R	R	R	•	R	•	COC
	2310	Military Record No Suffix		•	R	•	•	•	COC
	2320	Social Security Number	R	R	R	•	R	•	COC
	2330	Addr at DX--No & Street	R	R	R	•	R	•	COC
Revised	2335	Addr at DX--Supplementl	R	R	R	•	R	•	COC
	2350	Addr Current--No & Street		•	R	•	R	•	COC
	2352	Latitude	D	R*	•	•	S	•	NAACCR
	2354	Longitude	D	R*	•	•	S	•	NAACCR
	2355	Addr Current--Supplementl		•	R	•	R	•	COC
	2360	Telephone		•	R	•	R	•	COC
Retired	2370	DC State							
Retired	2371	Reserved 21							
Revised	2380	DC State File Number		R	•	•	R*	•	State
	2390	Name--Maiden	R*	R	•	•	R	•	SEER
	2392	Follow-Up Contact--No&St		•	•	•	R	•	SEER
	2393	Follow-Up Contact--Suppl		•	•	•	R	•	SEER
	2394	Follow-Up Contact--Name		•	•	•	R	•	SEER
Retired	2400	Reserved 16							

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	2410	Institution Referred From	R	•	R	•	•	•	COC
New	2415	NPI—Inst Referred From		•	R*	•	•	•	NAACCR
	2420	Institution Referred To	R	•	R	•	•	•	COC
New	2425	NPI—Inst Referred To		•	R*	•	•	•	NAACCR
Retired	2430	Last Follow-Up Hospital							
	2435	Reserved 40		•	•	•	•	•	
	2440	Following Registry		•	R	•	R	•	COC
New	2445	NPI—Following Registry		•	•	•	R*	•	NAACCR
Retired	2450	Reserved 17							
	2460	Physician--Managing	R	•	•	•	•	•	NAACCR
New	2465	NPI—Physician--Managing		•	•	•	•	•	NAACCR
	2470	Physician--Follow-Up	R	•	R	•	R	•	COC
New	2475	NPI—Physician—Follow-Up		•	R*	R*	R*	•	NAACCR
	2480	Physician--Primary Surg		•	R	•	•	•	COC
New	2485	NPI—Physician—Primary Surg		•	R*	R*	•	•	NAACCR
	2490	Physician 3		•	R	•	•	•	COC
New	2495	NPI—Physician 3		•	R*	R*	•	•	NAACCR
	2500	Physician 4		•	R	•	•	•	COC
New	2505	NPI—Physician 4		•	R*	R*	•	•	NAACCR
	2520	Text—DX Proc--PE		R^	•	•	R	•	NPCR
	2530	Text—DX Proc--X-ray/scan		R^	•	•	R	•	NPCR
	2540	Text—DX Proc--Scopes		R^	•	•	R	•	NPCR
	2550	Text—DX Proc--Lab Tests		R^	•	•	R	•	NPCR
	2560	Text—DX Proc--Op		R^	•	•	R	•	NPCR
	2570	Text—DX Proc--Path		R^	•	•	R	•	NPCR
	2580	Text--Primary Site Title	R	R^	•	•	R	•	NPCR
	2590	Text--Histology Title	R	R^	•	•	R	•	NPCR
	2600	Text--Staging	R	R^	•	•	R	•	NPCR
	2610	RX Text--Surgery	R	R^	•	•	R	•	NPCR
	2620	RX Text--Radiation (Beam)	R	R^	•	•	R	•	NPCR
	2630	RX Text--Radiation Other	R	R^	•	•	R	•	NPCR
	2640	RX Text--Chemo	R	R^	•	•	R	•	NPCR
	2650	RX Text--Hormone	R	R^	•	•	R	•	NPCR
	2660	RX Text--BRM	R	R^	•	•	R	•	NPCR
	2670	RX Text--Other	R	R^	•	•	R	•	NPCR
	2680	Text--Remarks		•	•	•	R	•	NPCR
	2690	Place of Diagnosis		•	•	•	•	•	NPCR
	2700	Reserved 19		•	•	•	•	•	
	2800	CS Tumor Size	R	•	R	R	R	R	AJCC
	2810	CS Extension	R	R	R	R	R	R	AJCC
	2820	CS Tumor Size/Ext Eval		•	R	R	•	•	AJCC
	2830	CS Lymph Nodes	R	R	R	R	R	R	AJCC
	2840	CS Reg Nodes Eval		•	R	R	•	•	AJCC
	2850	CS Mets at DX	R	R	R	R	R	R	AJCC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	2860	CS Mets Eval		•	R	R	•	•	AJCC
	2880	CS Site-Specific Factor 1	RS	RS	R	R	R	R	AJCC
	2890	CS Site-Specific Factor 2		•	R	R	R	R	AJCC
	2900	CS Site-Specific Factor 3	RS	RS	R	R	R	R	AJCC
	2910	CS Site-Specific Factor 4		•	R	R	R	R	AJCC
	2920	CS Site-Specific Factor 5		•	R	R	R	R	AJCC
	2930	CS Site-Specific Factor 6		•	R	R	R	R	AJCC
	2935	CS Version 1st		R	R	R	R	R	AJCC
	2936	CS Version Latest		R	R	R	R	R	AJCC
	2940	Derived AJCC T		•	D	D	D	D	AJCC
	2950	Derived AJCC T Descriptor		•	D	D	•	•	AJCC
	2960	Derived AJCC N		•	D	D	D	D	AJCC
	2970	Derived AJCC N Descriptor		•	D	D	•	•	AJCC
	2980	Derived AJCC M		•	D	D	D	D	AJCC
	2990	Derived AJCC M Descriptor		•	D	D	•	•	AJCC
	3000	Derived AJCC Stage Group		•	D	D	D	D	AJCC
	3010	Derived SS1977	D	D	D	D	D	D	AJCC
	3020	Derived SS2000	D	D	D	D	D	D	AJCC
	3030	Derived AJCC--Flag		•	R	R	D	D	AJCC
	3040	Derived SS1977--Flag	^	•	R	R	D	D	AJCC
	3050	Derived SS2000--Flag	^	D	R	R	D	D	AJCC
	3100	Archive FIN		•	R	R	•	•	COC
New	3105	NPI—Archive FIN		•	R*	R*	•	•	NAACCR
	3110	Comorbid/Complication 1		•	R	R	•	•	COC
	3120	Comorbid/Complication 2		•	R	R	•	•	COC
	3130	Comorbid/Complication 3		•	R	R	•	•	COC
	3140	Comorbid/Complication 4		•	R	R	•	•	COC
	3150	Comorbid/Complication 5		•	R	R	•	•	COC
	3160	Comorbid/Complication 6		•	R	R	•	•	COC
	3161	Comorbid/Complication 7		•	R	R	•	•	COC
	3162	Comorbid/Complication 8		•	R	R	•	•	COC
	3163	Comorbid/Complication 9		•	R	R	•	•	COC
	3164	Comorbid/Complication 10		•	R	R	•	•	COC
	3165	ICD Revision Comorbid		•	R	R	•	•	COC
	3170	RX Date--Most Defin Surg		•	R	R	•	•	COC
	3180	RX Date--Surgical Disch		•	R	R	•	•	COC
	3190	Readm Same Hosp 30 Days		•	R	R	•	•	COC
	3200	Rad--Boost RX Modality		•	R	R	RC	•	COC
	3210	Rad--Boost Dose cGy		•	R	R	•	•	COC
	3220	RX Date--Radiation Ended		•	R	R	•	•	COC
Revised	3230	RX Date--Systemic	R	•	R	R	S	•	COC
	3250	RX Summ--Transplnt/Endocr	R	R	R	R	R	R	COC
Retired	3260	Pain Assessment							
	3270	RX Summ--Palliative Proc		•	R	R	•	•	COC

	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		SOURCE OF STANDARD
					C	T	C	T	
	3280	RX Hosp--Palliative Proc		•	R	R	•	•	COC
	3300	RuralUrban Continuum 1993		D	•	•	•	•	NAACCR
	3310	RuralUrban Continuum 2000		D	•	•	•	•	NAACCR

REPORTABLE LIST

This listing provides documentation of all conditions the TCR considers reportable. Note the following changes:

- Reportable conditions from both the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* and the *Third Edition (ICD-O-3)* are included in the listing.
- Newly reportable conditions and terms with behavior changed from /1 (borderline) in *ICD-O-2* to /3 (malignant) in *ICD-O-3* are identified in **bold** print. These conditions are reportable only when diagnosed on or after January 1, 2001.
- Several terms changed behavior from /3 (malignant) in *ICD-O-2* to /1 (borderline) in *ICD-O-3*. These conditions are reportable only when diagnosed prior to January 1, 2001, and are identified in *[brackets and italics].*
- New terms and synonyms for existing ICD-O codes were added.

Adamantinoma (long bones, malignant, tibial only)
Adenoacanthoma
Adenocarcinofibroma
Adenocarcinoma
Adenofibroma (malignant endometrioid only)
Adenoma (carcinoid bronchial and cylindroid bronchial only)
Adenosarcoma
AIN III (anal intraepithelial neoplasia, grade III)
Ameloblastoma (malignant only)
Androblastoma (malignant only)
Anemia, refractory
Angioendotheliomatosis
Angiomyosarcoma
Angiosarcoma
Argentaffinoma (malignant only)
Arrhenoblastoma (malignant only)
Astroblastoma
Astrocytoma
Astroglioma
Blastoma
Cancer
Carcinoid, **malignant** (exclude benign tumor of appendix, strumal, argentaffin tumor NOS, **enterochromaffin-like cell NOS, and tubular**)
Carcinofibroma
Carcinoma
Carcinomatosis
Carcinosarcoma
CASTLE (Carcinoma showing thymus-like element)
Chloroma
Cholangiocarcinoma
Chondroblastoma
Chondrosarcoma
Chordoma
Choriocarcinoma
Chorioepithelioma
Chorionepithelioma
Class IV cytology
Class V cytology
Comedocarcinoma
CPNET (central primitive neuroectodermal, NOS)
Cylindroma (exclude eccrine dermal, and skin)
Cyst (dermoid with malignant transformation only **or dermoid with secondary tumor**)
Cystadenocarcinofibroma
Cystadenocarcinoma
Cystadenofibroma (malignant endometrioid only)
[Cystadenoma (diagnosis date prior to

January 1, 2001);
(mucinous, borderline malignancy papillary, borderline malignancy papillary mucinous, borderline malignancy papillary pseudomucinous, borderline malignancy papillary serous, borderline malignancy pseudomucinous, borderline malignancy serous, borderline malignancy only)]
Cystosarcoma phyllodes (malignant only)
Cytopenia, refractory with multilineage dysplasia
Dermatofibrosarcoma
Diktyoma **(exclude benign)**
DIN III (ductal intraepithelial neoplasia, grade III)
Disease (include only:
alpha heavy chain
Bowen
Chronic Myeloproliferative
Di Guglielmo
Franklin
gamma heavy chain
Heavy chain NOS
Hodgkin
immunoproliferative [NOS and small intestinal only]
Letterer-Siwe
mast cell, systemic tissue
Mu heavy chain
Myeloproliferative, chronic, NOS
Paget [exclude of bone]
Sezary
Disorder, myeloproliferative, chronic
Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
Dysgerminoma
Ectomesenchymoma
Endometriosis, stromal
Enteroglucagonoma (malignant only)
Ependymoblastoma
Ependymoma (exclude myxopapillary)
Epithelioma (NOS, basal cell, malignant, and squamous cell only)
Erythremia (acute and chronic only)
Erythroleukemia
Erythroplasia, Queyrat
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Fibrochondrosarcoma
Fibrodentinosarcoma
Fibroepithelioma, of Pinkus type or NOS
Fibroliposarcoma
Fibromyxosarcoma
Fibro-odontosarcoma
Fibrosarcoma
Fibroxanthoma (malignant only)
Gangliocytoma
Ganglioglioma
Ganglioneuroblastoma
Ganglioneuroma
Gastrinoma (malignant only)
Gemistocytoma
Germinoma
GIST-Gastrointestinal stromal tumor (malignant only)
Glioblastoma
Glioma
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glucagonoma (malignant only)
Granuloma (Hodgkin only)
Hemangioblastoma
Hemangioendothelioma (malignant only)
Hemangiopericytoma (malignant only)
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocholangiocarcinoma
Hepatoma (exclude benign)
Hidradenocarcinoma
Hidradenoma (malignant only)
Histiocytoma (malignant fibrous only)
Histiocytosis (malignant, and acute progressive X only)
Histiocytosis, Langerhans cell, disseminated or generalized
Hutchinson melanotic freckle (melanoma In situ only)

Hypernephroma
Immunocytoma
Insulinoma (malignant only)
LCIS, NOS (lobular carcinoma in situ)
Leiomyosarcoma
Lentigo maligna
Leukemia (**exclude granular lymphocytic)**
Linitis plastica
Liposarcoma (**exclude well differentiated liposarcoma, superficial)**
LN2 (of breast also called lobular neoplasia, grade 2 only)
Lymphangioendothelioma (malignant only)
Lymphangiosarcoma
Lymphoblastoma
Lymphoepithelioma
Lymphoma
Lymphosarcoma
Macroglobulinemia, Waldenstrom
Malignancy
Malignant
Mastocytoma (malignant only)
Mastocytosis (malignant only)
Medulloblastoma
Medulloepithelioma
Medullomyoblastoma
Melanocytoma, meningeal
Melanoma (exclude juvenile)
Melanomatosis, meningeal
Melanosis (precancerous only)
Meningioma
Mesenchymoma (malignant only)
Mesonephroma (exclude benign)
Mesothelioma (exclude benign and cystic)
Metaplasia, agnogenic myeloid
Microglioma
MPNST, NOS (malignant peripheral nerve sheath tumor)
Multiple neurofibromatosis
Mycosis fungoides
Myelofibrosis (acute, **chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease** only)
Myeloma
Myelomatosis
Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)
Myelosis
Myoblastoma (malignant granular cell only)
Myoepithelioma (malignant only)
Myosarcoma
Myosis, stromal NOS or endolymphatic stromal
Myxoliposarcoma
Myxosarcoma
Neoplasia, **ductal intraepithelial, grade 3 (of breast, also called DIN III)**
Neoplasia, intratubular germ cell
Neoplasia, lobular, grade 2 of breast only (also called LN2)
Neoplasia, **squamous** intraepithelial, grade 3 (of **anus**, vulva and vagina only- also called, **AIN III**, VIN III and VAIN III)
Neoplasm(malignant only, **except in C70.0-C72.9, C75.1-C75.3)**
Nephroblastoma
Nephroma (exclude mesoblastic)
Neurilemmoma
Neurilemmosarcoma
Neuroblastoma
Neurocytoma, olfactory
Neuroepithelioma
Neurofibrosarcoma
Neurosarcoma
Nevus (malignant blue only)
Odontosarcoma
Oligoastrocytoma, mixed
Oligodendroblastoma
Oligodendroglioma
Orchioblastoma
Osteochondrosarcoma
Osteoclastoma (malignant only)Osteofibrosarcoma
Osteosarcoma
Pancreatoblastoma
Panmyelosis, acute only
Papilloma, choroid plexus
Papulosis, lymphomatoid
Paraganglioma (malignant only)
Paragranuloma, Hodgkin
Perineural MPNST
Perineurioma (malignant only)

Pheochromoblastoma
Pheochromocytoma (malignant only)
Pilomatrixoma (malignant only)
Pinealoma
Pineoblastoma
Pineocytoma
Pituitary Adenoma
Plasmacytoma
PNET (primitive neuroectodermal tumor)
Pneumoblastoma
Polycythemia (proliferative, rubra vera, or vera)
Polyembryoma
Polyposis (malignant lymphomatous only)
Porocarcinoma
Poroma, eccrine (malignant only)
PPNET (peripheral primitive neuroectodermal tumor)
Preleukemia
Prolactinoma
Pseudomyxoma peritonei
Queyrat erythroplasia
Rathke Pouch Tumor
Reticuloendotheliosis
Reticulosarcoma
Reticulosis (histiocytic medullary, malignant, **pagetoid,** and polymorphic only)
Retinoblastoma
Rhabdomyosarcoma
Rhabdosarcoma
Sarcoma (**exclude well differentiated liposarcoma, superficial**)
Sarcomatosis (meningeal only)
Schwannoma
Seminoma
SETTLE (spindle epithelial tumor with thymus-like element)
Somatostatinoma (malignant only)
Spermatocytoma
Spiradenoma (malignant only)
Spongioblastoma
Spongioneuroblastoma
Stromatosis, endometrial
Struma (malignant ovarii and Wuchernde Langhans only)
Subependymoma
Subependymoma-ependymoma, mixed
Sympathicoblastoma
Syndrome,
5q deletion with myelodysplastic syndrome
Hypereosinophilic
Myelodysplastic
NOS
with 5q deletion syndrome
therapy-related, NOS
therapy-related, alkylating agent related
therapy-related, epidopophyllotoxin related
Preleukemic
Sezary
Synovioma (NOS and malignant only)
Syringoma chondroid, (malignant only)
Teratoblastoma, malignant
Teratocarcinoma
Teratoma (embryonal, immature, malignant, and with malignant transformation only)
Thecoma (malignant only)
Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)
Thymoma (malignant or **type C** only)
Tumor (include only):
adenocarcinoid
adrenal cortical (malignant only)
alpha cell (malignant only)
Askin
Bednar
beta cell (malignant only)
Brenner (malignant only)
Burkitt
carcinoid, NOS (except of appendix)
carcinoid (malignant only)
desmoplastic small round cell
embolus
endodermal sinus
epithelial (malignant only)
Ewing
fibrous, solitary (malignant only)
follicular dendritic cell
fusiform cell type (malignant only)
G cell (malignant only)

Tumor (cont'd)
gastrin cell (malignant only)
gastrointestinal stromal (malignant only)
germ cell
giant cell (malignant only)
glomus (malignant only)
granular cell (malignant only)
granulosa cell (malignant or **sarcomatoid** only)
Grawitz
interstitial cell (malignant only)
intravascular bronchial alveolar
Klatskin
Krukenberg
Leydig cell (malignant only)
malignant **(any type)**
mast cell (malignant only)
Merkel cell
mesenchymal (malignant only)
mesodermal, mixed
metastatic
mixed pineal
mixed salivary gland type (malignant only)
[mucinous, of low malignant potential; *diagnosis date prior to January 1, 2001]*
mucocarcinoid
Mullerian mixed
neuroectodermal (exclude melanotic)
nonencapsulating sclerosing
odontogenic (malignant only)
olfactory, neurogenic
Pancoast
[papillary mucinous, of low malignant potential; diagnosis date prior to January 1, 2001]
[papillary serous, of low malignant potential; diagnosis date prior to January 1, 2001]
peripheral neuroectodermal **or peripheral primitive neuroectodermal, NOS**
peripheral nerve sheath (malignant only)
phyllodes (malignant only)

Tumor (cont'd)
pineal parenchymal of intermediate differentiation
Pinkus
plasma cell
polyvesicular vitelline
primitive neuroectodermal
rhabdoid, NOS
rhabdoid/teratoid, atypical
round cell, desmoplastic, small
Schminke
secondary
[serous, NOS, of low malignant potential serous, papillary, of low malignant potential; diagnosis date prior to January 1, 2001]
Sellar region granular cell tumor
Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)
sinus, endodermal
small cell type (malignant only)
soft tissue (malignant only)
spindle cell type (malignant only)
spindle epithelial with thymus-like element or thymus-like differentiation
steroid cell (malignant only)
sweat gland (malignant only)
teratoid/rhabdoid, atypical
transitional pineal
triton, malignant
trophoblastic, epithelioid
vitelline, polyvesicular
Wilm
yolk sac
Ulcer, rodent
VAIN III (vaginal intraepithelial neoplasia, grade 3)
VIN III (vulvar intraepithelial neoplasia, grade 3)
Vipoma (**malignant only**)
Xanthoastrocytoma, pleomorphic

Resource: NAACCR Procedure Guidelines for Cancer Registries Series IV: Appendix D February 2002

COMMON ACCEPTABLE ABBREVIATIONS
(In Order of Terms)

When abbreviating words in an address, refer to the Address Abbreviations section of the *National Zip Code and Post Office Directory*, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult the SEER Program *Self Instructional Manual for Tumor Registrars: Book 8--Antineoplastic Drugs, 3rd Edition.*

Abdomen	ABD
Abdominal Perineal	AP
Abnormal	ABN
Above Knee Amputation	AK(A)
Acid Phosphatase	ACID PHOS
Acquired Immunodeficiency Syndrome	AIDS
Activities of Daily Living	ADL
Acute Granulocytic Leukemia	AGL
Acute Lymphocytic Leukemia	ALL
Acute Myelogenous Leukemia	AML
Adenocarcinoma	ADENOCA
Adjacent	ADJ
Admission; Admit	ADM
Against Medical Advice	AMA
Aids Related Complex	ARC
Alcohol	ETOH
Alkaline Phosphatase	ALK PHOS
Alpha-fetoprotein	AFP
Also Known As	AKA
Ambulatory	AMB
Anaplastic	ANAP
Angiography	ANGIO
Anterior	ANT
Anteroposterior	AP
Appendix	APP
Approximately	APPROX
Arterial Blood Gas	ABG
Arteriovenous	AV
Aspiration	ASP
Auscultation & Percussion	A&P
Autopsy	AUT
Axilla(ry)	AX
Bacillus Calmette-Guerin	BCG
Barium	BA
Barium Enema	BE
Bartolin's, Urethral, and Skene's Glands	BUS
Below Knee (Amputation)	BK(A)
Benign Prostatic Hypertrophy/Hyperplasia	BPH
Bilateral	BIL
Bilateral Salpingo-oophorectomy	BSO
Bile Duct	BD
Biopsy	BX, Bx
Blood Urea Nitrogen	BUN
Bone Marrow	BM
Bone Scan	BSC
Bowel Movement	BM
Bowel Sounds	BS
Breath Sounds	BS, BRS
Bright Red Blood (per Rectum)	BRB(PR)
Calcium	CA, Ca, ca
Cancer, Carcinoma	CA
Carcinoembryonic Antigen	CEA
Carcinoma In-situ	CIS
CAT Scan	CT, CT SC
Centimeter	cm
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cervical Intraepithelial Neoplasia	CIN
Cervical Vertebra	C1-C7
Cervix	CX
Cesium	CS
Chemotherapy	CHEMO
Chest X-ray	CXR
Chief Complaint	CC
Chronic Granulocytic Leukemia	CGL
Chronic Lymphocytic Leukemia	CLL
Chronic Myelogenous Leukemia	CML
Cigarettes	CIG
Clear	CLR
Collaborative Stage	CS
Ascending Colon	A-COLON
Descending Colon	D-COLON
Sigmoid Colon	S-COLON

Transverse Colon	T-COLON
Common Bile Duct	CBD
Complaining of	C/O
Complete Blood Count	CBC
Computerized Axial Tomography	CT, CAT SCAN
Consistent with	C/W
Continue	Cont
Contralateral	Contra
Costal Margin	CM
Creatine Phosphokinase	CPK
Cubic Centimeter	CC
Cystoscopy	CYSTO
Cytology	CYTO
Cytomegalovirus	CMV
Date of Birth	DOB
Dead on Arrival	DOA
Decreased	DECR (or <)
Dermatology	DERM
Diagnosis	DX
Diameter	DIAM
Differentiated	DIFF
Digital Rectal Exam	DRE
Dilatation & Curettage	D&C
Discharge	DIS, DISCH, DS
Discontinued	DC
Disease	DZ, DIS
Doctor	DR, MD
Dorsalis Pedis	DP
Ductal Carcinoma Insitu	DCIS
Ears, Nose & Throat	ENT
Electroencephalogram	EEG
Electromyogram	EMG
Emergency Room	ER
Endoscopic Retrograde Cholangiopancreatography	ERCP
Enlarged	ENL
Esophagogastroduodenoscopy	EGD
Estrogen Receptor (Assay)	ERA)
Evaluation	EVAL
Examination	EXAM
Examination under Anesthesia	EUA
Excision	exc
Exploratory Laparotomy	EXP LAP
Extend	EXT
Extended Care Facility	ECF
Extension	EXT
External	EXT
Extremity	EXT
Eyes, Ears, Nose, & Throat	EENT
Family (Medical) History	F(M)H
Fever Unknown Origin	FUO
Fine Needle Aspiration	FNA
Finger breadth	FB
Floor of Mouth	FOM
Follow-up	FU
Fracture	Fx
Frozen Section	FS
Gallbladder	GB
Gastroenterostomy	GE
Gastroesophageal	GE
Gastrointestinal	GI
Genitourinary	GU
Grade	GR
Gram	gm
Gynecology	GYN
Head, Eyes, Ears, Nose, and Throat	HEENT
Hematocrit	HCT
Hemoglobin	Hb, Hgb
History	Hx
History & Physical	H&P
History of	HO
History of Present Illness	HPI
Hormone	HORM
Hospital	HOSP
Hour, Hours	Hr, Hrs
Human Chorionic Gonadotropin	HCG
Human Immunodeficiency Virus	HIV
Human Papilloma Virus	HPV
Human T-Lymphotrophic Virus Type III	HTLV-III
Hysterectomy	HYST
Immunoglobulin	Ig
Impression	IMP
Includes, Including	INCL
Increase	INCR (or >)
Inferior Vena Cava	IVC
Infiltrating	INFILT
Inpatient	IP
Intercostal Margin (Space)	ICM(S)
Internal Mammary Artery	IMA
Intrathecal	IT
Intravenous	IV

Intravenous Pyelogram	IVP
Intravenous Urography	IVU
Invade(s)/invading/invasion	INV
Involve(s)/involvement	INVL
Ipsilateral	IPSI
Irregular	IRREG
Iodine	I
Jugular Venous Distention	JVD
Kidneys, Ureters, Bladder	KUB
Kilogram	kg
Kilovolt	KV
Laparotomy	LAP
Large	LG
Last Menstrual Period	LMP
Lateral	lat
Left	lt
Left Costal Margin	LCM
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Salpingo-oophorectomy	LSO
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Liter	l
Liver, Kidney, Spleen (Bladder)	LKS(B)
Local M.D.	LMD
Lower Extremity	LE
Lower Inner Quadrant	LIQ
Lower Outer Quadrant	LOQ
Lumbar Puncture	LP
Lumbar Vertebra	L1-L5
Lumbosacral	LS
Lymphadenopathy-Associated Virus	LAV
Lymph Node(s)	LN, LNS
Lymph Node Dissection	LND
Magnetic Resonance Imaging	MRI
Malignant	MALIG
Mandible	MAND
Mastectomy	MAST
Maxillary	MAX
Maximum	MAX
Medical Doctor	DR, MD
Medicine	MED
Metastatic, Metastasis	MET, METS
Microscopic	MICRO
Midclavicular Line	MCL
Middle Lobe	ML
Millicurie (hours)	MC(H)
Milligram (hours)	MG(H)
Milliliter	ml
Millimeter	mm
Million Electron Volts	MEV
Minimum	MIN
Moderate	MOD
Moderately Differentiated	MD, MOD DIFF
Modified Radical Mastectomy	MRM
Month	mo
Multiple	MULT
Nausea & Vomiting	N&V
Neck Vein Distention	NVD
Negative	NEG (or -)
Neurology	NEURO
No Evidence of Disease	NED
No Evidence of Metastatic Disease	NEMD
Normal	NL
No Significant Findings	NSF
Not Applicable	NA
Not Otherwise Specified	NOS
Not Recorded	NR
Obstructed (-ing, -ion)	OBST
Operating Room	OR
Operation	OP
Operative Report	OP RPT
Ounce	oz
Outpatient	OP
Packs Per Day	PPD
Palpated (-able)	PALP
Papanicolaou Smear	Pap
Papillary	PAP
Past Medical History	PMH
Pathology	PATH
Patient	PT
Pelvic Inflammatory Disease	PID
Percussion & Auscultation	P&A
Percutaneous	PERC
Personal (Primary) Medical Doctor	PMD
Physical Examination	PE
Platelets	PLT
Poorly Differentiated	PD, POOR DIFF
Positive	POS (or +)

Positron Emission Tomography	PET
Possible	POSS
Posterior	POST
Posteroanterior	PA
Postmortem Examination	POST
Postoperative (-ly)	PO, POSTOP
Postoperative Day	POD
Preoperative (-ly)	PREOP
Present Illness	PI
Prior to Admission	PTA
Probable (-ly)	PROB
Progesterone Receptor (Assay)	PR(A)
Pulmonary	PULM
Pulmonary Artery	PA
Radiation	RAD
Radiation Absorbed Dose	RAD
Radiation Therapy	RT
Radical	RAD
Radioimmunoassay	RIA
Radium	RA
Red Blood Cells	RBC
Resection	RESEC
Respiratory	RESP
Review of Outside Films	ROF
Review of Outside Slides	ROS
Review of Systems	ROS
Right	rt
Right Costal Margin	RCM
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Right Salpingo-oophorectomy	RSO
Right Upper Extremity	RUE
Right Upper Lobe	RUL
Right Upper Quadrant	RUQ
Rule Out	RO, R/O
Sacral Vertebra	S1-S5
Salpingo-oophorectomy	SO
Sequential Multiple Analysis (Biochem Profile)	SMA
Serum Glutamic Oxaloacetic Transaminase	SGOT
Serum Glutamic Pyruvic Transaminase	SGPT
Shortness of Breath	SOB
Skilled Nursing Facility	SNF
Specimen	SPEC
Split Thickness Skin Graft	STSG
Small	SM, SML
Small Bowel	SB, SML BWL
Cervical Spine	C-SPINE
Lumbar Spine	L-SPINE
Sacral Spine	S-SPINE
Thoracic Spine	T-SPINE
Squamous	SQ, SQUAM
Squamous Cell Carcinoma	SCC
Status Post	S/P
Subcutaneous	subq, SQ
Superior Vena Cava	SVC
Surgery, Surgical	SURG
Suspicious/suspected	SUSP
Symptoms	sx
Thoracic	T
Thoracic Vertebra	T1-T12
Total Abdominal Hysterectomy-Bilateral Salpingo-oophorectomy	TAH-BSO
Total Parenteral Nutrition	TPN
Total Vaginal Hysterectomy	TVH
Transitional Cell Carcinoma	TCC
Transurethral Resection	TUR
Transurethral Resection Bladder (Tumor)	TURB (T)
Transurethral Resection of Prostate	TURP
Treatment	Rx, Tx
Tumor Size	TS
Ultrasound	US
Undifferentiated	UNDIFF
Unknown	Unk
Upper Extremity	UE
Upper Gastrointestinal	UGI
Upper Inner Quadrant	UIQ
Upper Outer Quadrant	UOQ
Vagina, Vaginal	VAG
Vaginal Hysterectomy	VAG HYST
Vaginal Intraepithelial Neoplasia	VAIN
Vascular	VASC
Vulvar Intraepithelial Neoplasia	VIN
Well Differentiated	WD, WELL DIFF
White Blood Cells	WBC
With	W/

Within Normal Limits	WNL
Without	W/O
Work-up	W/U
X-ray	XR
Year	YR

SYMBOLS

At	@
Comparison	/
Decrease, Less than	<
Equals	=
Increase, More than	>
Negative	-
Number*	#
Positive	+
Pounds**	#
Times	x

*If it appears before a numeral.
**If it appears after a numeral.

Multiple Primary and Histology Coding Rules

January 01, 2007

National Cancer Institute
Surveillance Epidemiology and End Results Program
Bethesda, MD

Multiple Primary and Histology Coding Manual

The 2007 Multiple Primary and Histology (MP/H) coding rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles. The Appendix O of the 2007 Texas Cancer Registry (TCR) Reporting Handbook contains only the text format. The flowchart and matrix formats can be downloaded from the TCR's website www.dshs.state.tx.us/tcr/reporting.shtm#HB. The terms, definitions and coding rules have been incorporated into their respective sites; therefore the page numbers are not sequential.

The TCR will not collect the following data items:

- Date of Conclusive Terminology
- Multiplicity Counter
- Date of Multiple Tumors
- Type of Multiple Tumors Reported as One Primary

Multiple Primary and Histology Coding Rules
Table of Contents

The 2007 Multiple Primary and Histology Coding Rules

Carol Johnson, BS, CTR, Steve Peace, BS, CTR, Peggy Adamo, RHIT, CTR,
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III. Preface

The 2007 Multiple Primary and Histology (MP/H) Coding Rules present the first site-specific multiple primary and histology rules developed to promote consistent and standardized coding by cancer registrars. This project was sponsored by the National Cancer Institute (NCI) Surveillance Epidemiology and End Results (SEER) Program. In January 2003, the Multiple Primary and Histology Task Force was formed to tackle problems identified in existing rules. The MP/H Task Force was a diverse group with membership from all but two SEER regions, the American College of Surgeons (ACoS) Commission on Cancer (CoC), the American Joint Committee on Cancer (AJCC), the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR), the National Cancer Registrars Association (NCRA), North American Association of Central Cancer Registries (NAACCR), 15 central registry representatives, and Canadian Cancer Registries. Physician guidance by specialty pathologists and clinicians was integral to the review and revision process. Regular consultation with the editors of ICD-O-3 clarified ICD-O-3 codes and ensured that the new rules accurately reflect the ICD-O-3 editors' intent and purpose.

The 2007 MP/H Rules include site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant brain. A separate set of rules addresses the specific and general rules for malignant solid tumors originating in all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology coding instructions. For example, there are instructions and guidance for identifying histologic lineages, differentiating between general (NOS) terms and specific histologic types, and correctly assigning mixed and combination codes.

The rules are available in three formats: flowchart, matrix and text. The different formats were developed to meet the needs of registrars who have different learning styles.

The MP/H Task Force also developed three new data items that complement these rules, Multiplicity Counter, Date of Multiple Tumors, and Type of Multiple Tumors Reported as One Primary.

The rules are available in this stand-alone manual and also in the *2007 SEER Coding and Staging Manual.*

A cadre of instructors has been trained to provide in-person education on using the new rules to registrars. Web-based cancer registrar education is available on the SEER training website, http://seer.cancer.gov/. Multiple primary and histology issues are covered in several modules, and a 2007 MP/H rules module will be added. Continuing education units can be requested from the National Cancer Registrars Association. Recorded training webcasts will be available for viewing and provide another option for mass training of registrars who cannot attend an in-person workshop.

IV.
Multiple Primary and Histology Rules General Instructions

Multiple Primary and Histology Coding Rules
General Instructions

EQUIVALENT OR EQUAL TERMS

Multicentric, multifocal
Tumor, mass, lesion, neoplasm

DEFINITIONS

Note: Use these terms and definitions for all reportable cases except lymphoma and leukemia primaries (M9590-9989).

Bilateral: Relating to the right **and** left sides of the body or of a body structure; bilaterality is **not** an indication of single or multiple primaries.

Clinical Diagnosis: A diagnosis that is not microscopically confirmed. It may be based on information from diagnostic imaging or the clinician's expertise.

Contiguous tumor: A single tumor that involves, invades, or bridges adjacent or connecting sites or subsites.

Focal: An adjective meaning limited to one specific area. A focal cancer is limited to one specific area or organ. The area may be microscopic **or** macroscopic.

Foci: Plural of focus.

Focus: A term used by pathologists to describe a group of cells that can be **seen only by a microscope**. The cells are noticeably different from the surrounding tissue either by their appearance, chemical stain, or other testing.

Laterality: Indication of which side of a **paired organ/site** a tumor is located. (See Paired organ/site)

Most representative specimen: The pathologic specimen from the surgical procedure that removed the most **tumor** tissue.

Multiple primaries: More than one reportable case.

Overlapping tumor: The involved sites are adjacent (next to each other) and the tumor is contiguous.

Paired organ/site: There are two sides, one on the left side of the body and one on the right side of the body. (See Laterality)

Recurrence: This term has two meanings:

1. The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy.
2. A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer.

Single primary: One reportable case.

Unilateral: Relating to one side of the body or one side of a body structure.

DETERMINING MULTIPLE PRIMARIES FOR SOLID MALIGNANT TUMORS

Note: The rules do not apply to hematopoietic primaries (lymphoma and leukemia) of any site or to the reportable benign or borderline intracranial or CNS tumors..

A. General Information

1. Use these rules to determine the number of reportable primaries. Do **not** use these rules to determine case reportablility, stage, or grade.
2. The 2007 multiple primary and histology coding rules **replace all previous** multiple primary and histology coding **rules**.
3. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
4. Read the **General Instructions** and the **site-specific Equivalent Terms and Definitions** before using the multiple primary rules.
5. The multiple primary and histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the rules in the format that is easiest for you to follow.
6. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
7. **Do not use** a physician's statement to decide whether the patient has a recurrence of a previous cancer or a new primary. Use the multiple primary rules as written **unless** a **pathologist compares** the present tumor to the "original" tumor and states that this tumor is a recurrence of cancer from the previous primary.
8. Use the Determining Multiple Primaries: Hematopoietic Primaries (Lymphoma and Leukemia) rules and table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" to determine single versus multiple primaries for lymphoma and leukemia cases.

B. How to Use the Multiple Primary Rules

1. **Use** the **Multiple Primary** rules to **make a decision on the number of primary malignancies** to be abstracted for reportable solid malignant tumors.
2. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast

- Colon
- Head and neck
- Kidney
- Lung
- Malignant melanoma of the skin
- Renal pelvis, ureter, bladder, and other urinary

3. Use the **Other Sites rules** for solid malignant tumors that occur in primary sites not covered by the site-specific rules.
4. Each module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors) is an independent, complete set of coding rules. To determine which set of primary site rules to use:

a.. When there is no tumor in the primary site, only metastatic lesions are present:

I. Use the primary site documented by a physician and use the multiple primary and histology coding rules for that primary site.

II. If no primary site is documented, code the primary site as unknown and use the general multiple primary and histology coding rules. Use the "Unknown if Single or Multiple Tumors" module to determine multiple primaries and the "Single Tumor" module for coding histology.

b. To choose the appropriate module (Unknown if Single or Multiple Tumors, Single Tumor, Multiple Tumors),

I. Use the multiple primary and histology coding rules for the primary site

II. Determine the number of tumors

i. Do not count metastatic lesions

ii. When the tumor is only described as multicentric or multifocal and the number of tumors is not mentioned, use the "Unknown if Single or Multiple Tumors" module

iii. When there is a tumor or tumors with separate microscopic foci, ignore the separate microscopic foci and use the "Single Tumor" or "Multiple Tumor" modules as appropriate

iv. When the patient has a single tumor, use the "Single Tumor" module.

v. If there are multiple tumors, use the "Multiple Tumor" module.

III. See the Equivalent Terms and Definitions for Head and Neck for guidance in coding the primary site

IV. Use the primary site documented by the physician on the medical record

5. If a **single primary**, prepare **one abstract**.
6. If there are **multiple primaries**, prepare **two or more abstracts**.
7. Rules are in hierarchical order within each module (Unknown if Single or Multiple Tumors, Single Tumor, and Multiple Tumors). Use the first rule that applies and

STOP

Histologic Type ICD-O-3

Item Length: 4
NAACCR Item #: 522
NAACCR Name: Histologic Type ICD-O-3

The data item Histologic Type ICD-O-3 describes the microscopic composition of cells and/or tissue for a specific primary. The tumor type or histology is a basis for staging and determination of treatment options. It affects the prognosis and course of the disease.

The *International Classification of Diseases for Oncology*, Third Edition (ICD-O-3) is the standard reference for histology codes for tumors diagnosed in 2001 and later. Do not record the 'M' that precedes the histology code. See sections *Coding Guidelines for Topography and Morphology.* and *Summary of Principal Rules for Using the ICD-O*, Third Edition for guidance in using the ICD-O-3.

Information about the 2007 Histology Coding Rules
Note: Do not use these rules to determine case reportability.

1. The 2007 multiple primary rules **replace all previous** multiple primary **rules**.
2. The rules are **effective** for cases **diagnosed January 1, 2007** and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
3. The histology coding rules are available in **three formats**: flowchart, text, and matrix. The **rules are identical**, only the formats differ. Use the set of rules in the format that is easiest for you to follow.
4. **Notes** and **examples** are included with some of the rules to **highlight key points** or to add **clarity** to the rules.
5. Rules are in **hierarchical** order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary).

How to Use the Rules

1. Read the **General Instructions**.
2. Read the **site-specific Equivalent Terms and Definitions**.
3. Use these rules to make a decision on coding the histology for all reportable solid malignant tumors.
4. Use the multiple primary rules to determine whether the patient has a single or multiple primaries before coding the histology.
5. Code the histology for **each** primary in a **separate abstract**.
6. Use the **site-specific rules** for the following primary sites:
   - Brain, malignant (intracranial and CNS)
   - Breast
   - Colon
   - Head and neck
   - Kidney
   - Lung
   - Malignant melanoma of the skin

- Renal pelvis, ureter, bladder, and other urinary

7. Use the **Other Sites rules** for all solid malignant tumors that occur in primary sites **not included** in the site-specific rules.
8. Determine whether the patient has a single tumor or multiple tumors that will be abstracted as a single primary
    a. Do not count metastatic tumors
    b. When the tumor is described as multifocal or multicentric, use the Multiple Tumors module
    c. When there is a tumor or tumors with separate foci of tumor do not count the foci
    d. Only count the tumors that will be used to prepare that abstract. For example, when there are two tumors that will be abstracted as multiple primaries, you would use the Single Tumor modules to determine the histology code for each of the abstracts..
9. **Each section** (Single Tumor and Multiple Tumors Abstracted as a Single Primary) is an independent, **complete set of coding rules**. For example, if the patient has multiple tumors, that will be abstracted as a single primary start with the first rule under the heading Multiple Tumors Abstracted as a Single Primary. Do not use any of the rules under the header Single Tumor.
10. Use the first rule that applies and

STOP

Priority order for using Documents to Code Histology

Medical records frequently include multiple pathology reports and references to histologic diagnosis. Use the following instructions to identify which reports best represent the histology to be coded.

1. Pathology report:
    a. From the **most representative** tumor specimen examined
    b. From the **final diagnosis**
        Note 1: Use information from **addenda** and **comments** associated with the final diagnosis to code the histology.
        Note 2: A **revised/amended diagnosis** replaces the original final diagnosis. Code the histology from the revised/amended diagnosis.
        Note 3: The new rules **limit** the information **to the final diagnosis**. The old rules allowed coding from information in the microscopic description. You will only use information from the microscopic portion of the pathology report when instructed to do so in one of the site-specific rules.
2. Cytology report.
3. When you do not have either a pathology report or cytology report:
    a. Documentation in the medical record that references pathology or cytology findings
    b. From mention of type of cancer (histology) in the medical record

Ambiguous Terms Used to Code Histology

When any of the ambiguous terms are used to describe a more specific histology, code the more specific histology.

Ambiguous terms that are characteristic (used to code histology)
- Apparent(ly)
- Appears
- Comparable with
- Compatible with
- Consistent with
- Favor(s)
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)
- Typical (of)

Example: Non-small cell carcinoma, most likely adenocarcinoma. Code adenocarcinoma.

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Guidelines for Head and Neck

The head and neck rules cover the following sites: Lip C000-C009, Oral Cavity C019-C069, Salivary Gland C079-C089, Tonsil C090-C099, Oropharynx C100-C109, Nasopharynx C110-C119, Pyriform Sinus C129, Hypopharynx C130-C139, Other and Ill-defined Sites in Lip, Oral cavity and Pharynx C140-C148, Nasal Cavity C300, Middle Ear C301, Accessory Sinuses C310-C319, and Larynx C320-C329.

Head and neck tumors frequently extend into adjacent anatomic sites, or overlap multiple contiguous sites. The workup for these tumors often includes physical examinations, imaging, scans, endoscopies, biopsies and surgical observations. Each of these diagnostic tools provides a unique view of the tumor. More than one anatomic location may be involved with tumor and reports may contain conflicting information regarding the primary site.

Coding the Primary Site

Code the site where the tumor **originated**; do not simply code the biopsy site.

When there are multiple biopsies and the primary site is not documented, or when there is discrepant information, code the primary site using the following priority order.

Priority Order

1. Tumor board
   a. Specialty
   b. General
2. Staging physician's site assignment
   a. AJCC staging form
   b. TNM statement in medical record

If neither 1 nor 2 are available, the priority order for using information depends upon whether the patient had a surgical resection of the primary tumor.

3. Total (complete) resection of primary tumor
   Note: The primary tumor is completely removed. The surgical margins may be microscopically positive.
   a. Surgeon's statement from operative report
   b. Final diagnosis from pathology report

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

4. No resection (biopsy only):
   Documentation from:
   a. Endoscopy (physical exam with scope)
   b. Radiation oncologist
   c. Diagnosing physician
   d. Primary care physician
   e. Other physician
   f. Radiologist impression from diagnostic imaging
   g. Physician statement based on physical exam (clinical impression)

When the point of origin **cannot be determined**, use a topography code for overlapping sites:

- C02.8 Overlapping lesion of tongue
- C08.8 Overlapping lesion of major salivary glands
- C14.8 Overlapping lesion of lip, oral cavity, and pharynx.

Equivalent or Equal Terms

- In situ, noninvasive, intraepithelial
- Squamous cell carcinoma, squamous cell epithelioma, epidermoid carcinoma
- Tumor, mass, lesion, neoplasm
- Contiguous, continuous

Definitions

In Situ: A tumor that is confined to the epithelium without penetration of the basement membrane

Invasive: A tumor that penetrates the basement membrane and involves at least the lamina propria

Most invasive: The tumor with the greatest continuous extension (see focal and foci definitions in the general instructions). The least to the greatest extension for mouth and oral cavity:

- epithelium
- lamina propria, submucosa (not found in gum and hard palate)
- muscularis propria (not found in gum and hard palate)

Table 1 –Paired Sites
Table Instructions: Use this table to determine multiple primary status for sites listed in Column 1.

Column 1: Paired Sites	**Column 2: Code**
Parotid Glands	C079
Major Salivary Glands	C080; C081
Tonsils	C090; C091; C098, C099
Nasal Cavity	C300
Accessory Sinuses	C310; C312
Middle Ear	C301

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

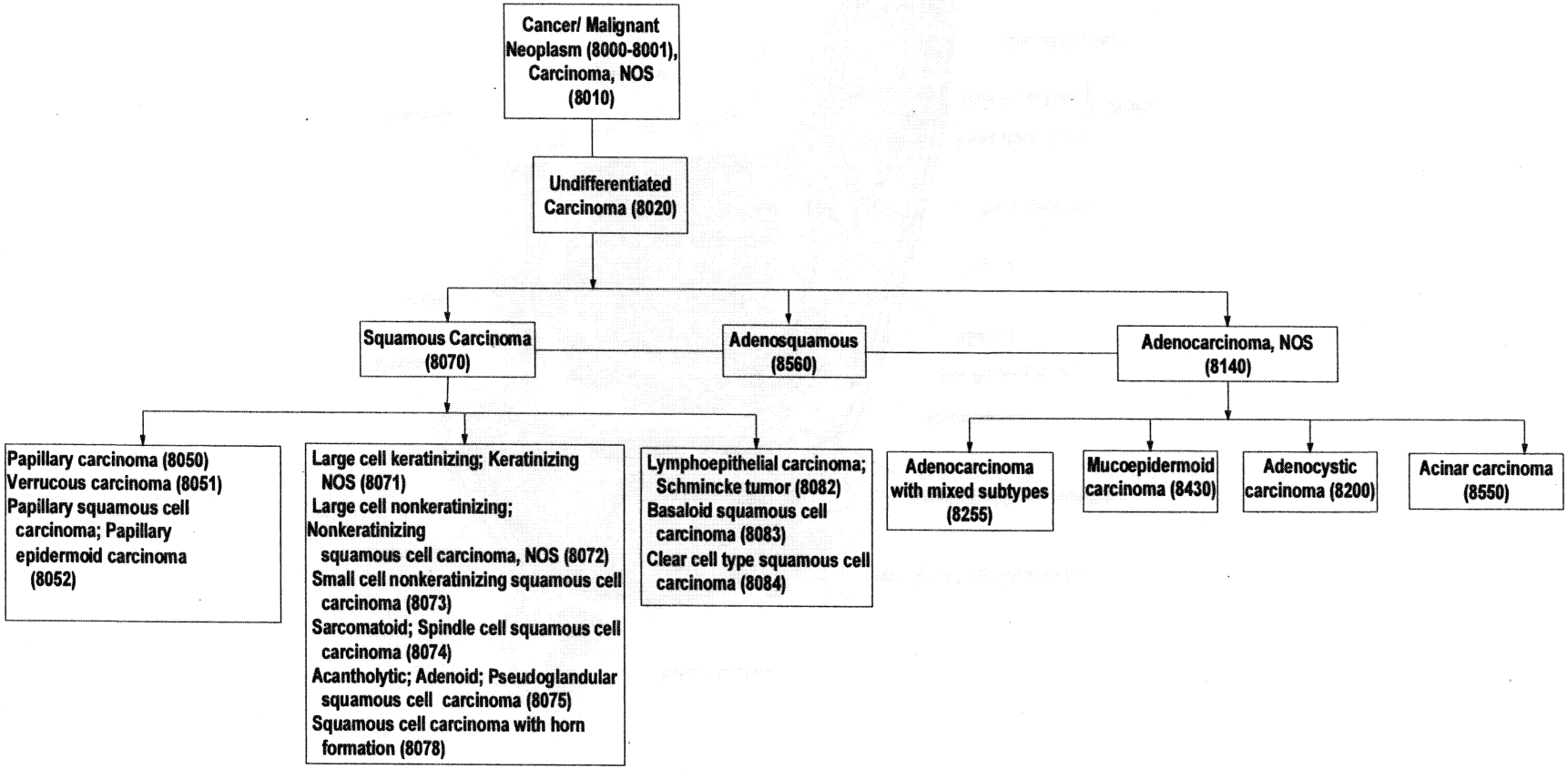
Code	Site Groupings
C01 C02	Base of tongue Other and unspecified parts of tongue
C05 C06	Palate Other and unspecified parts of mouth
C07 C08	Parotid gland Other and unspecified major salivary glands
C09 C10	Tonsil Oropharynx
C12 C13	Pyriform sinus Hypopharynx
C30 C31	Nasal cavity and middle ear Accessory sinuses

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

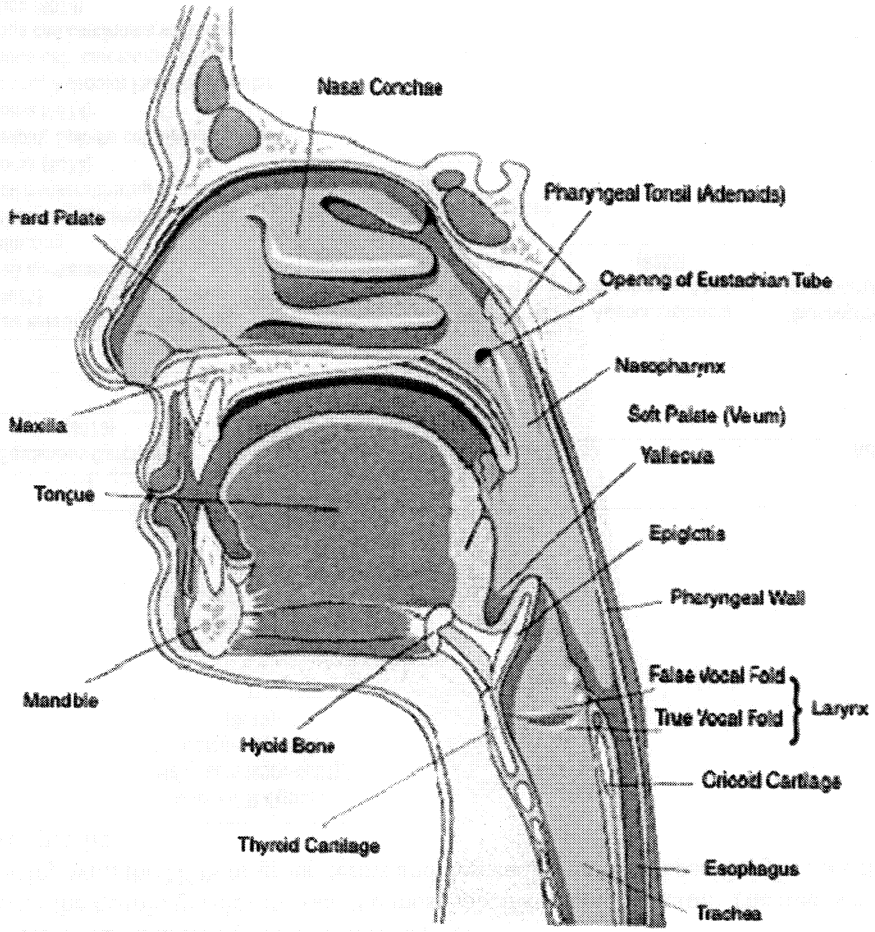
Chart 1 – Head and Neck Histology Groups and Specific types

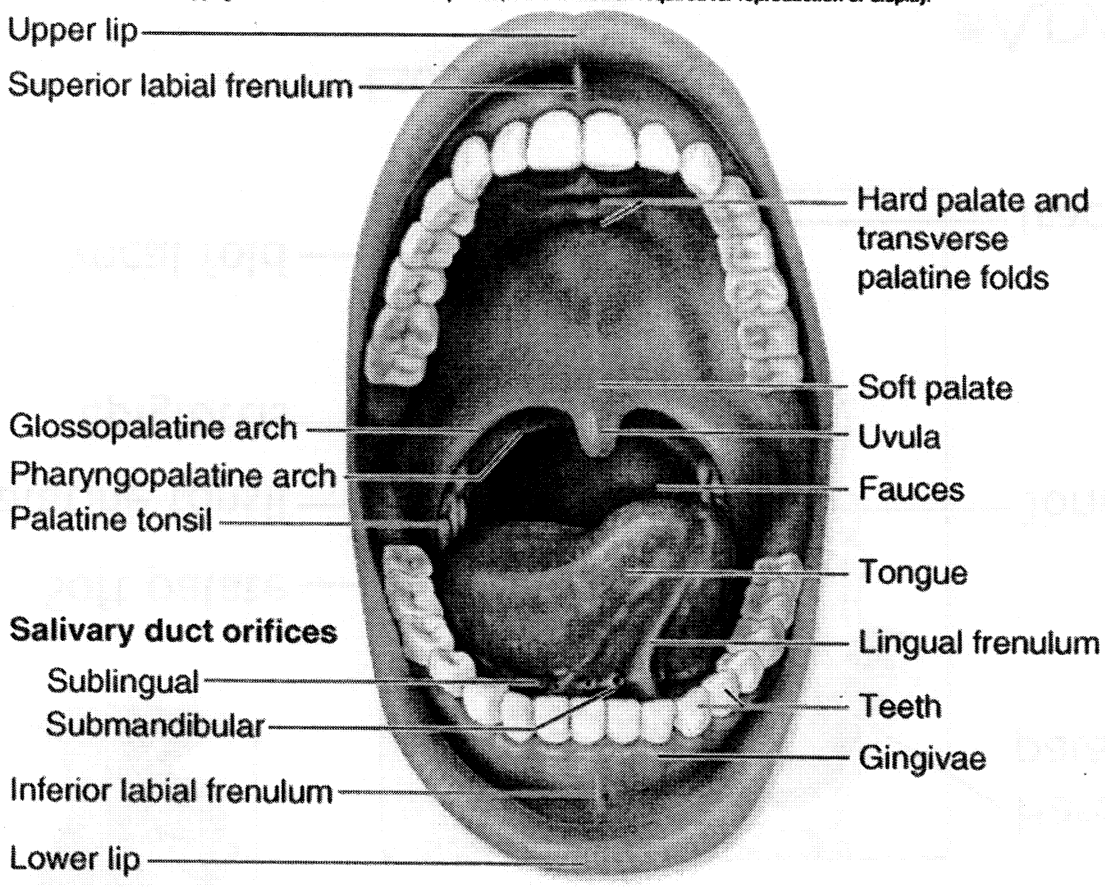
Note: Greater than 85% of cancers in the Head and Neck are squamous cell carcinoma

Chart Instructions: Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.



Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)





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Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
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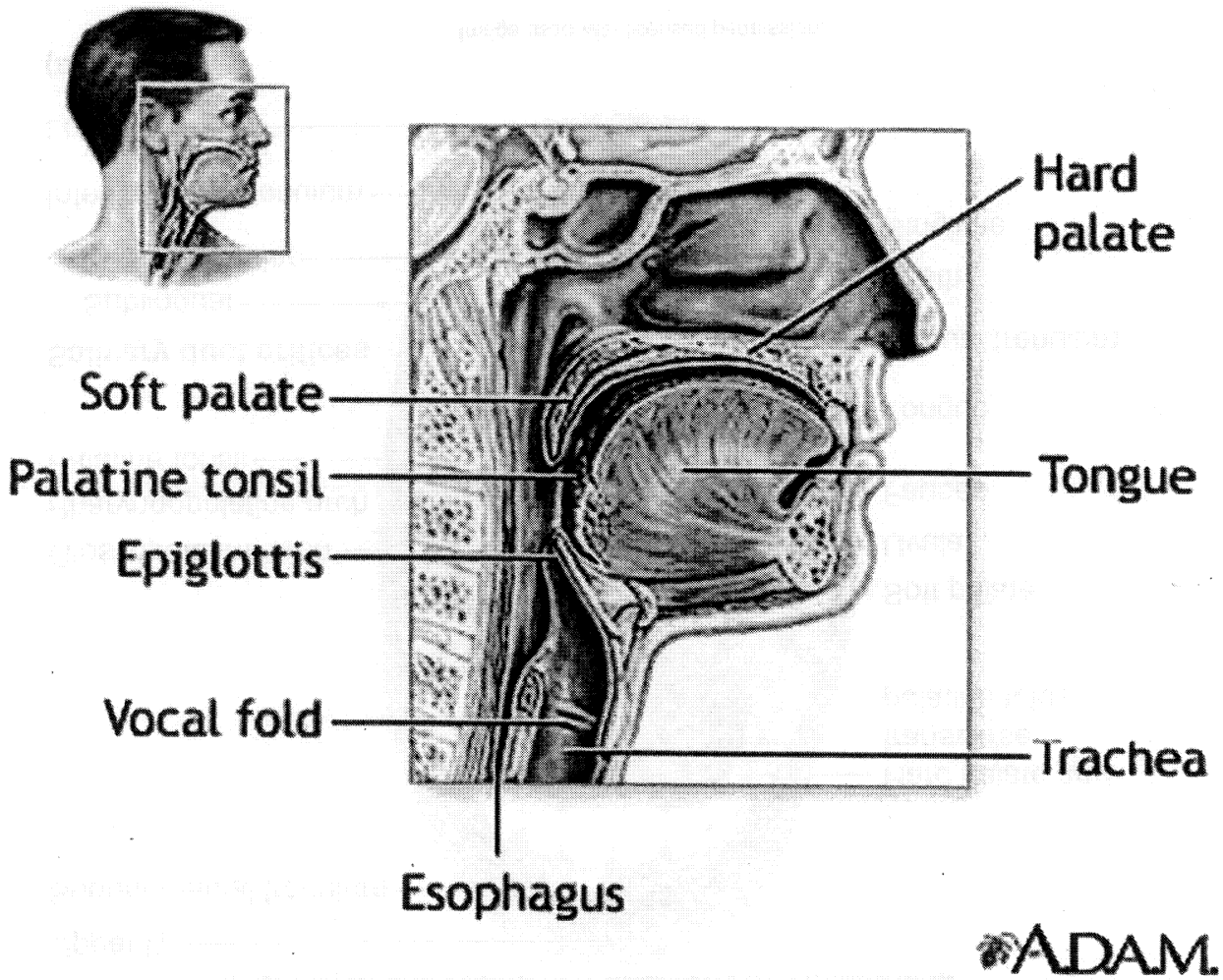
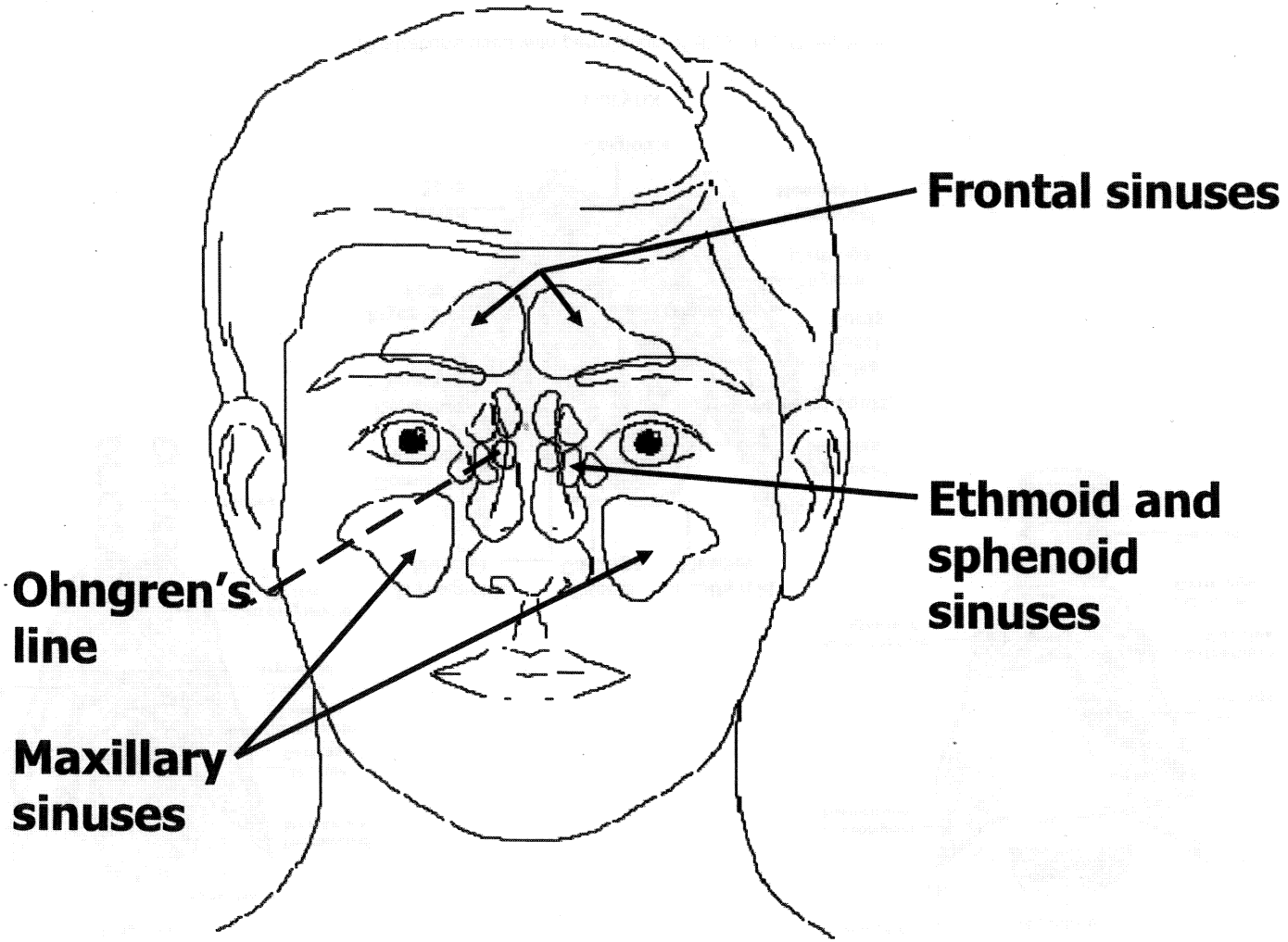
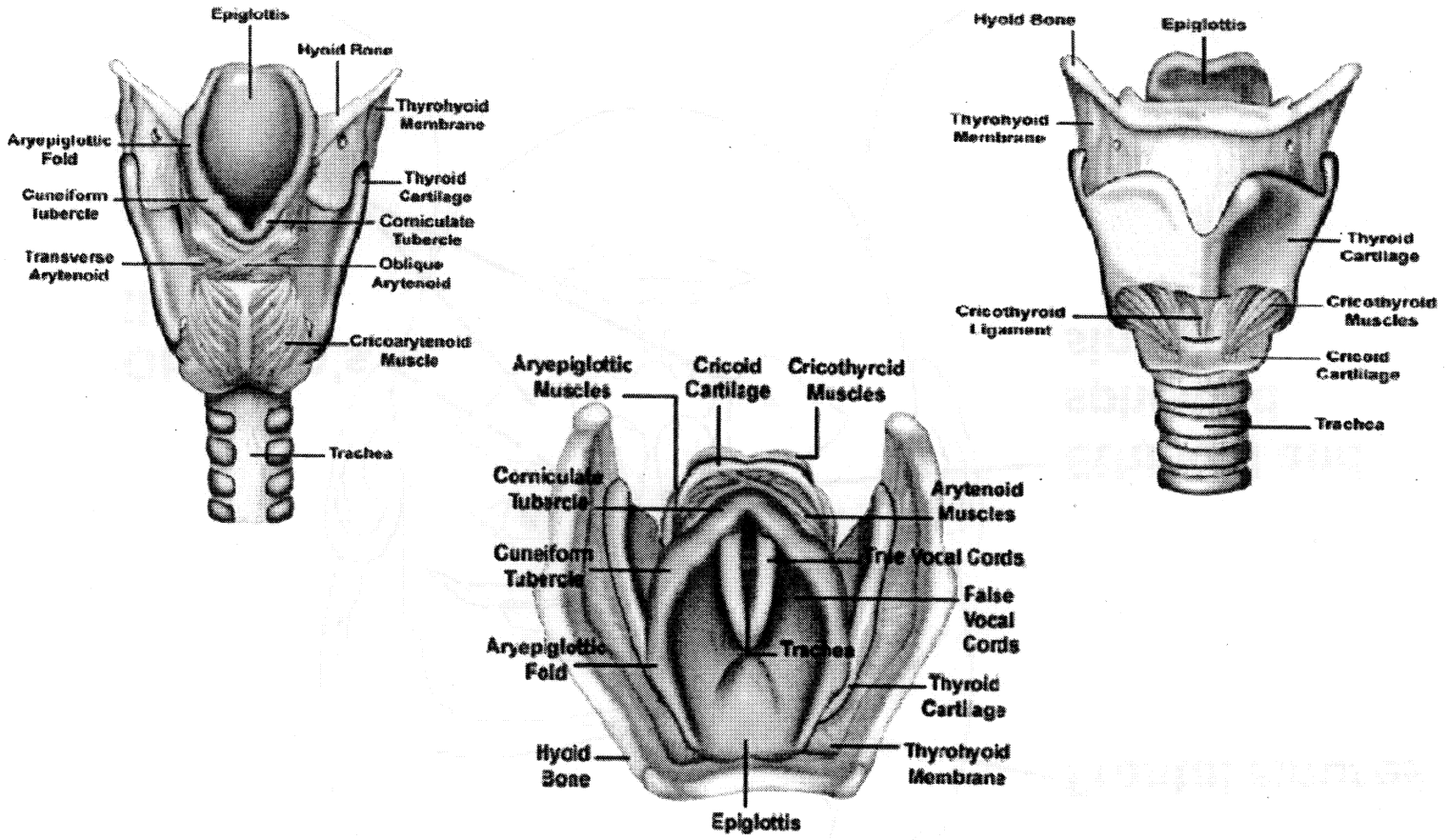
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)



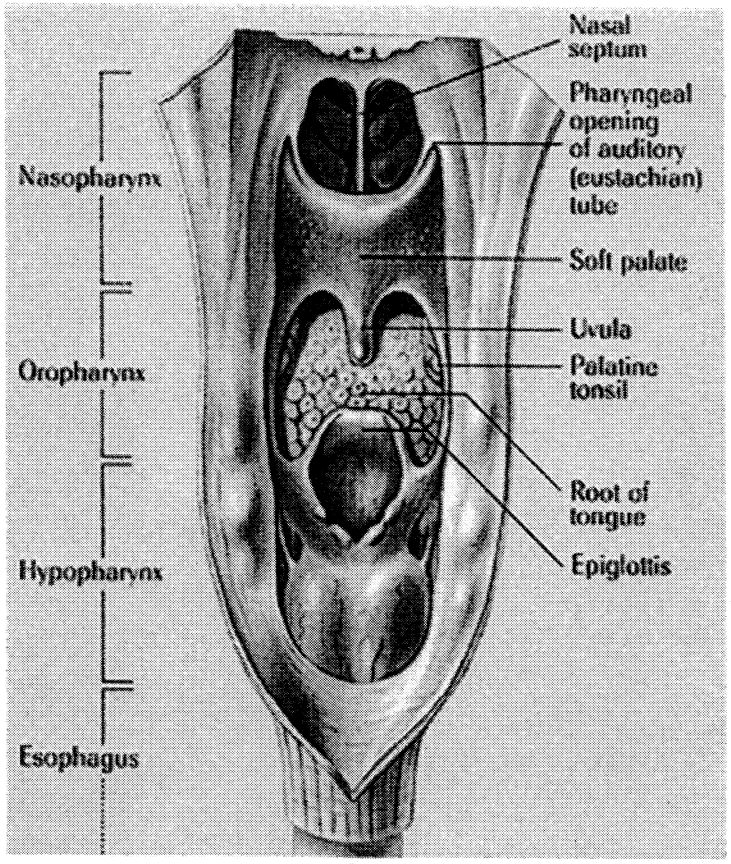


Nasal Sinuses

Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)



Larynx



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Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*

Note: Use this rule only after all information sources have been exhausted.

Example 1: History and physical exam states large tumor in nasopharynx. Biopsy base of tongue shows squamous cell carcinoma. No further information available. Abstract as a single primary.

Example 2: Pathology report states extensive squamous cell carcinoma involving nasopharynx and larynx. Fragments of epiglottis positive for squamous cell carcinoma. No other information available. Abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *

Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Tumors on the **right** side **and** the **left** side of a **paired site** are multiple primaries. **

Note: See Table 1 for list of paired sites.

Rule M4 Tumors on the **upper lip** (C000 or C003) **and** the **lower lip** (C001 or C004) are multiple primaries. **

Rule M5 Tumors on the **upper gum** (C030) **and** the **lower gum** (C031) are multiple primaries. **

Head and Neck Multiple Primary Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors in the **nasal cavity** (C300) **and** the **middle ear** (C301) are multiple primaries. **

Rule M7 Tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (Cxxx) and/or third (Cxxx) character are multiple primaries. **

Rule M8 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **

Rule M10 Abstract as a single primary* when one tumor is:
- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** another is a **specific carcinoma** or
- **Adenocarcinoma, NOS** (8140) **and** another is a **specific adenocarcinoma** or
- **Squamous cell carcinoma, NOS** (8070) and another is **specific squamous cell carcinoma** or
- **Melanoma**, NOS (8720) and another is a **specific** melanoma
- **Sarcoma, NOS** (8800) and another is a **specific sarcoma**

Rule M11 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M12 Tumors that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M12 have the same first 3 numbers in ICD-O-3 histology code.

This is the end of instructions for Multiple Tumors.
*** If a single primary, prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** If multiple primaries, prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Multifocal tumors in floor of mouth	**Example 2:** An in situ and invasive tumor diagnosed within60 days	**Example 3:** In situ following an invasive tumor more than 60 days apart

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Example: Squamous cell carcinoma. Code 8070.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis.

Rule H4 Code the **invasive** histologic type when a single tumor has invasive and in situ components.

Example: The final diagnosis is keratinizing squamous cell carcinoma (8073) with areas of squamous cell carcinoma in situ (8070). Code the invasive histologic type, keratinizing squamous cell carcinoma (8073).

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H5 Code the most **specific** histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H7 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H8 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Head and Neck Histology Coding Rules - Text
C000-C148, C300-C329
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule H9 Code the histology when only **one histologic type** is identified.
Example: Squamous cell carcinoma. Code 8070.
Note: Do not code terms that do not appear in the histology description.
Example: Do not code 8072 (squamous cell carcinoma non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis

Rule H10 Code the histology of the **most invasive** tumor.
Note 1: See the Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.
- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the more invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H11 Code the most **specific** histologic term using Chart 1 when there are multiple histologies within the same branch. Examples of histologies within the same branch are:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note 1: The specific histology for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 2: The specific histology for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation
Example: The final diagnosis is squamous cell carcinoma (8070), papillary (8050). Code the specific type, papillary (8050).

Rule H12 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case

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Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

Use these rules only for cases with primary colon cancer.

Ninety-eight percent of colon cancers are adenocarcinoma. Ten to fifteen percent of these cases produce enough mucin to be categorized as mucinous/colloid.* Mixed histologies and specific types other than mucinous/colloid or signet ring cell are rare.

**ACS Clinical Oncology*

Equivalent or Equal Terms

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.

Definitions

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Adenoma: A **benign** lesion composed of tubular or villous structures showing **intraepithelial neoplasia** (See definition of **intraepithelial neoplasia**).

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Composite carcinoid (8244): One tumor which contains both carcinoid and adenocarcinoma.

Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in: a condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

Frank adenocarcinoma: Adenocarcinoma arising from the colon wall (no evidence of a polyp)

In Situ: Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

Intraepithelial neoplasia, high grade may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

Intraepithelial neoplasia, low grade is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

Intramucosal tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria..

Invasive tumor: A tumor that penetrates the basement membrane and invades the lamina propria.

Most invasive: The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:

- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolic fat, subserosal fat)
- Retroperitoneal fat (pericolic fat)
- Mesenteric fat (pericolic fat)
- Serosa (visceral peritoneum).

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Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing **extra**-cellular mucin comprising more than 50% of the tumor. Note that "mucin-producing" and "mucin-secreting" are not synonymous with mucinous.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor (8240), atypical carcinoid tumor (8249).

Pericolic fat: A general term for the fat surrounding the colon. Subserosal fat, retroperitoneal fat and mesenteric fat are pericolic fat.

Signet ring cell carcinoma (8490): An adenocarcinoma containing **intra**-cellular mucin comprising more than 50% of the tumor.

Transmural: Through the wall of the colon (the tumor has extended through the colon wall and may invade a regional organ or regional tissue.

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is not a histologic type; it is a non-specific term.

Colon Equivalent Terms, Definitions and Illustrations
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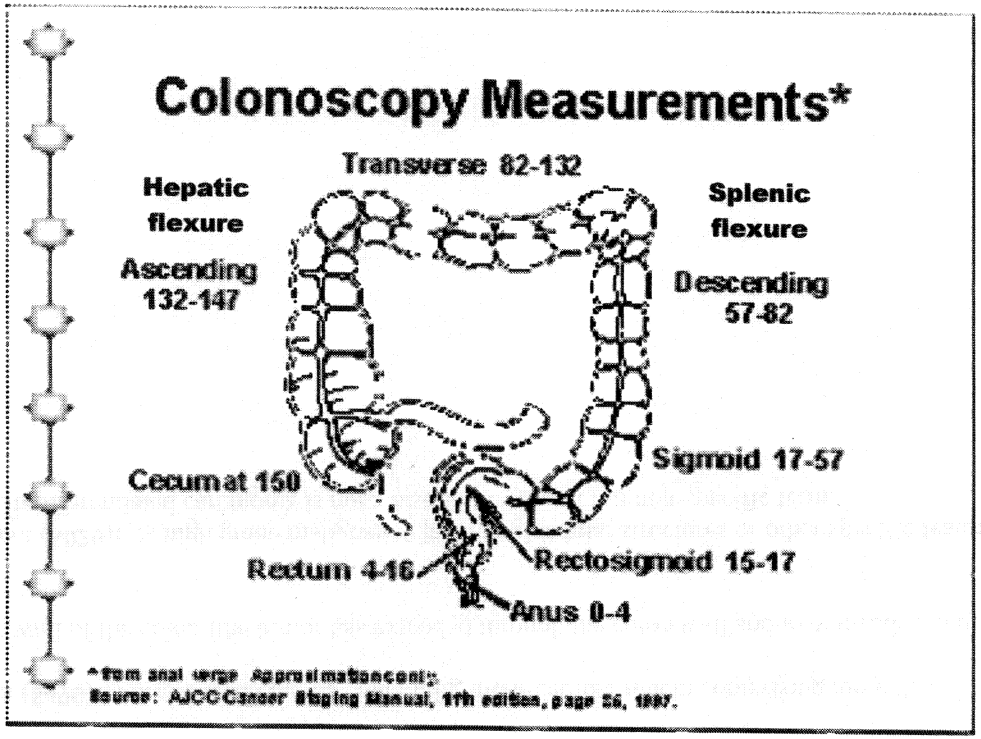
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Colon Multiple Primary Rules – Text
C180 - C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Adenocarcinoma in adenomatous polyposis coli (**familial polyposis**) with one or more malignant polyps is a single primary.*
Note: Tumors may be present in multiple segments of the colon or in a single segment of the colon.

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are different at the second (C<u>x</u>xx), third, (Cx<u>x</u>x) or fourth (C18<u>x</u>) character are multiple primaries. **

Rule M5 Tumors diagnosed **more than one (1) year** apart are multiple primaries. **

Colon Multiple Primary Rules – Text
C180 - C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M6 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7 A **frank** malignant or in situ **adenocarcinoma and** an in situ or **malignant** tumor in a **polyp** are a single primary.*

Rule M8 Abstract as a single primary* when one tumor is:

- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** another is a **specific carcinoma** or
- **Adenocarcinoma, NOS** (8140) **and** another is a **specific adenocarcinoma** or
- **Sarcoma, NOS** (8800) **and** another is a **specific sarcoma**

Rule M9 **Multiple** in situ and/or malignant **polyps** are a single primary.*
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M11 are in the same segment of the colon.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code **8140** (adenocarcinoma, NOS) when pathology describes only **intestinal type adenocarcinoma** or adenocarcinoma, intestinal type.

Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.

Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.

Rule H4 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:
- The final diagnosis is adenocarcinoma in a polyp
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H5 Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:
- **Mucinous/colloid** (8480) or **signet ring cell** carcinoma (8490) or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid** or
- Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell** carcinoma

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6 Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:
- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
- The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell** carcinoma or
- The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**

Rule H7 Code **8255** (adenocarcinoma with mixed subtypes) when there is a **combination** of **mucinous/colloid and signet ring cell** carcinoma.

Rule H8 Code **8240** (carcinoid tumor, NOS) when the diagnosis is **neuroendocrine** carcinoma (8246) **and carcinoid tumor** (8240).

Rule H9 Code **8244** (composite carcinoid) when the diagnosis is **adenocarcinoma and carcinoid tumor**.

Rule H10 Code **8245** (adenocarcinoid) when the diagnosis is **exactly "adenocarcinoid."**

Rule H11 Code the histology when only **one histologic type** is identified.

Rule H12 Code the invasive histology when both **invasive and in situ** histologies are present.

Rule H13 **Code the** most **specific** histologic **term when** the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H14 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Note: These rules only apply to multiple tumors that are reported as a **single primary.**

Rule H15 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- From CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H16 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H17 Code **8220** (adenocarcinoma in adenomatous polyposis coli) when:
- **Clinical** history says **familial polyposis** and final diagnosis on the **pathology report** from resection is **adenocarcinoma in adenomatous polyps** or
- There are **>100 polyps** identified in the resected specimen or
- The number of polyps is not given but the diagnosis is **familial polyposis**

Rule H18 Code **8263** (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous

Rule H19 Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:
- There are **<=100 polyps** identified in the resected specimen or
- There are multiple polyps and the number is not given and **familial polyposis** is **not mentioned**

Colon Histology Coding Rules – Text
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H20 Code the histology of the **most invasive** tumor when:

- There is a frank adenocarcinoma and a carcinoma in a polyp or
- There are in situ and invasive tumors or
- There are multiple invasive tumors

Note 1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Note 2: If tumors are equally invasive, go to the next rule

Rule H21 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma **and** the microscopic description or surgical gross describes polyps or
- The final diagnosis is adenocarcinoma **and** there is reference to residual or pre-existing polyps or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H22 Code the histology when only **one histologic type** is identified.

Rule H23 **Code the** more **specific** histologic **term** when the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
- Carcinoma, NOS (8010) and a specific carcinoma or
- Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
- Sarcoma, NOS (8800) and a specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H24 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

Use these rules only for cases with primary lung cancer.

Lung carcinomas may be broadly grouped into two categories, small cell and non-small cell carcinoma.
Frequently a patient may have two or more tumors in one lung and may have one or more tumors in the contralateral lung. The physician may biopsy only one of the tumors. Code the case as a single primary (See Rule M1, Note 2) unless one of the tumors is proven to be a different histology. It is irrelevant whether the other tumors are identified as cancer, primary tumors, or metastases.

Equivalent or Equal Terms

- Low grade neuroendocrine carcinoma, carcinoid
- Tumor, mass, lesion, neoplasm (for multiple primary and histology coding rules only)
- Type, subtype, predominantly, with features of, major, or with ___differentiation

Obsolete Terms for Small Cell Carcinoma (Terms that are no longer recognized)

- Intermediate cell carcinoma (8044)
- Mixed small cell/large cell carcinoma (8045) (Code is still used; however current accepted terminology is combined small cell carcinoma)
- Oat cell carcinoma (8042)
- Small cell anaplastic carcinoma (No ICD-O-3 code)
- Undifferentiated small cell carcinoma (No ICD-O-3 code)

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the subtypes of adenocarcinoma such as acinar, papillary, bronchoalveolar, or solid with mucin formation.

Adenosquamous carcinoma (8560): A single histology in a single tumor composed of both squamous cell carcinoma and adenocarcinoma.

Bilateral lung cancer: This phrase simply means that there is at least one malignancy in the right lung and at least one malignancy in the left lung. Do not base multiple primary decision on this phrase; bilateral does not mean this is a single primary. Use the multiple primary rules to decide whether to code bilateral lung cancers as a single or multiple primary.

Combined small cell carcinoma (8045): A small cell carcinoma that is combined with a non-small cell carcinoma. The combinations are small cell and adenocarcinoma, or squamous cell carcinoma, or large cell carcinoma.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
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Large cell carcinoma (8012): Large cell is a diagnosis that is used when the tumor is a non-small cell carcinoma that is undifferentiated. Because the tumor is undifferentiated, the pathologist cannot find glandular (adeno), or squamous differentiation.

Large cell neuroendocrine carcinoma (8013): A non-small cell carcinoma with neuroendocrine differentiation proven by immunohistochemical stain, currently classified as large cell carcinoma. These tumors require further study before being included as a separate category in a histologic classification.

Most invasive: The tumor with the greatest continuous extension.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor and small cell carcinoma. Code the specific histology when given. Code neuroendocrine carcinoma, NOS (8246) when no specific histology is documented.

Non-small cell carcinoma (8046): The term non-small cell is used two ways, as a group term describing all carcinomas that are not small cell; and as a default diagnosis when there isn't enough tissue to classify the tumor beyond the exclusion of small cell.

Pancoast tumor: An anatomic designation (not a specific histology) for a lung cancer that starts in the upper lobe of the lung and extends outward to destroy the ribs and vertebrae. The tumor may compress or directly invade the brachial plexus (nerve bundles) of the neck, causing pain. Pancoast tumor may also be called **superior sulcus tumor**.

Pleomorphic carcinoma (8022): A poorly differentiated non-small cell carcinoma (squamous cell carcinoma, adenocarcinoma, or large cell carcinoma) containing spindle cells and/or giant cells or, a carcinoma containing only spindle cells and giant cells. These fall under the general category of **sarcomatoid carcinoma**.

Sarcomatoid carcinoma: A group of tumors that are non-small cell in type and contain spindle cells and/or giant cells. Depending on the histologic features the tumor may be designated: pleomorphic carcinoma (8022); spindle cell carcinoma (8032); giant cell carcinoma (8031), carcinosarcoma (8980); or pulmonary blastoma (8972)

Small cell carcinoma: Malignant epithelial tumor consisting of small cells. There are many types of lung cancer, but most can be categorized into one of two basic types, "small cell carcinoma" or "non-small cell carcinoma"

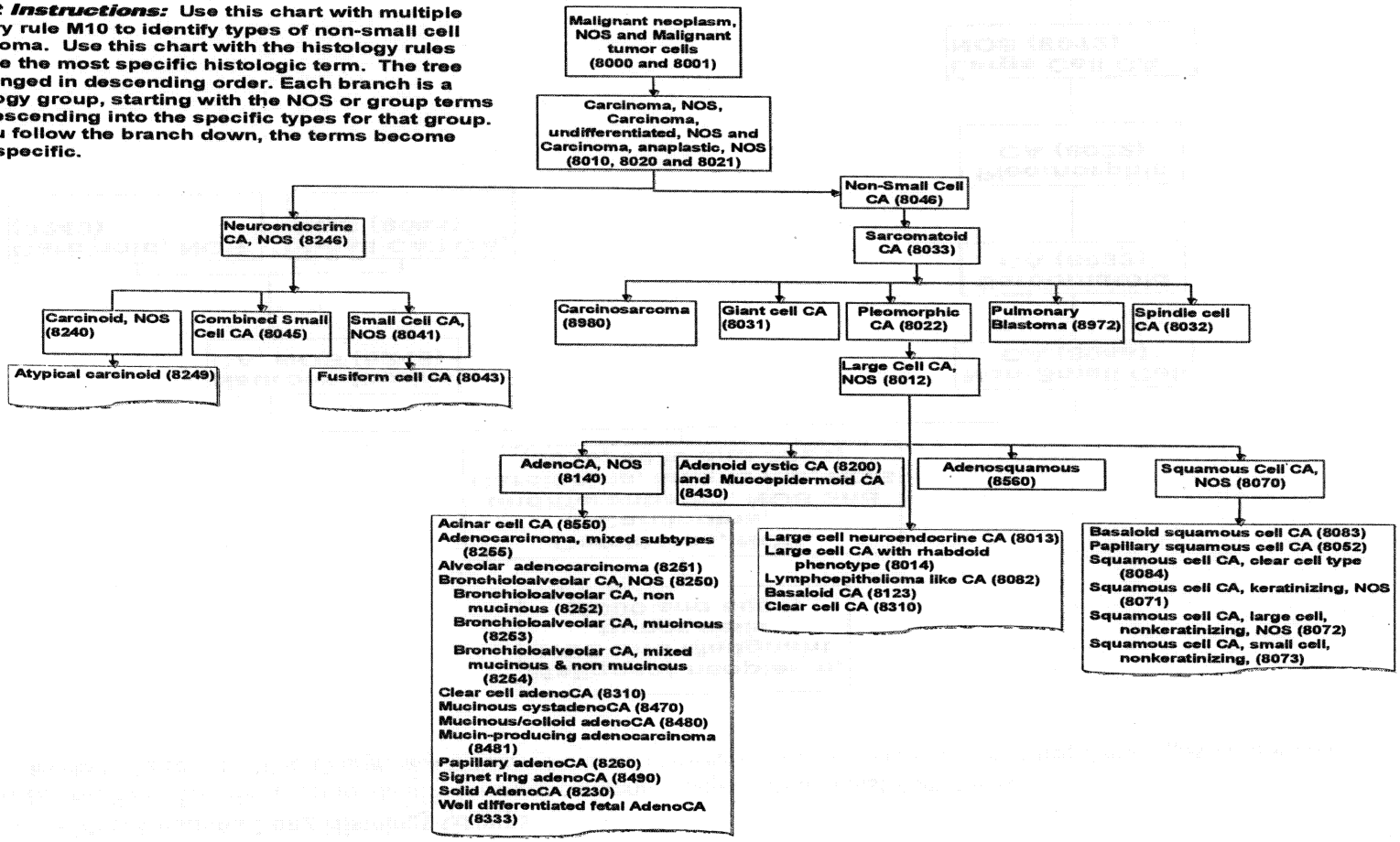
Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is used by pathologists when they believe the tumor is a carcinoma (not lymphoma, melanoma, or sarcoma) but they are not sure if the tumor is small cell or non-small cell.

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Chart 1 – Lung Histology Groups and Specific Types

Note: This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is **not** a complete listing of histologies that may occur in the lung.

Chart Instructions: **Use this chart with multiple primary rule M10 to identify types of non-small cell carcinoma. Use this chart with the histology rules to code the most specific histologic term. The tree is arranged in descending order. Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group. As you follow the branch down, the terms become more specific.**



Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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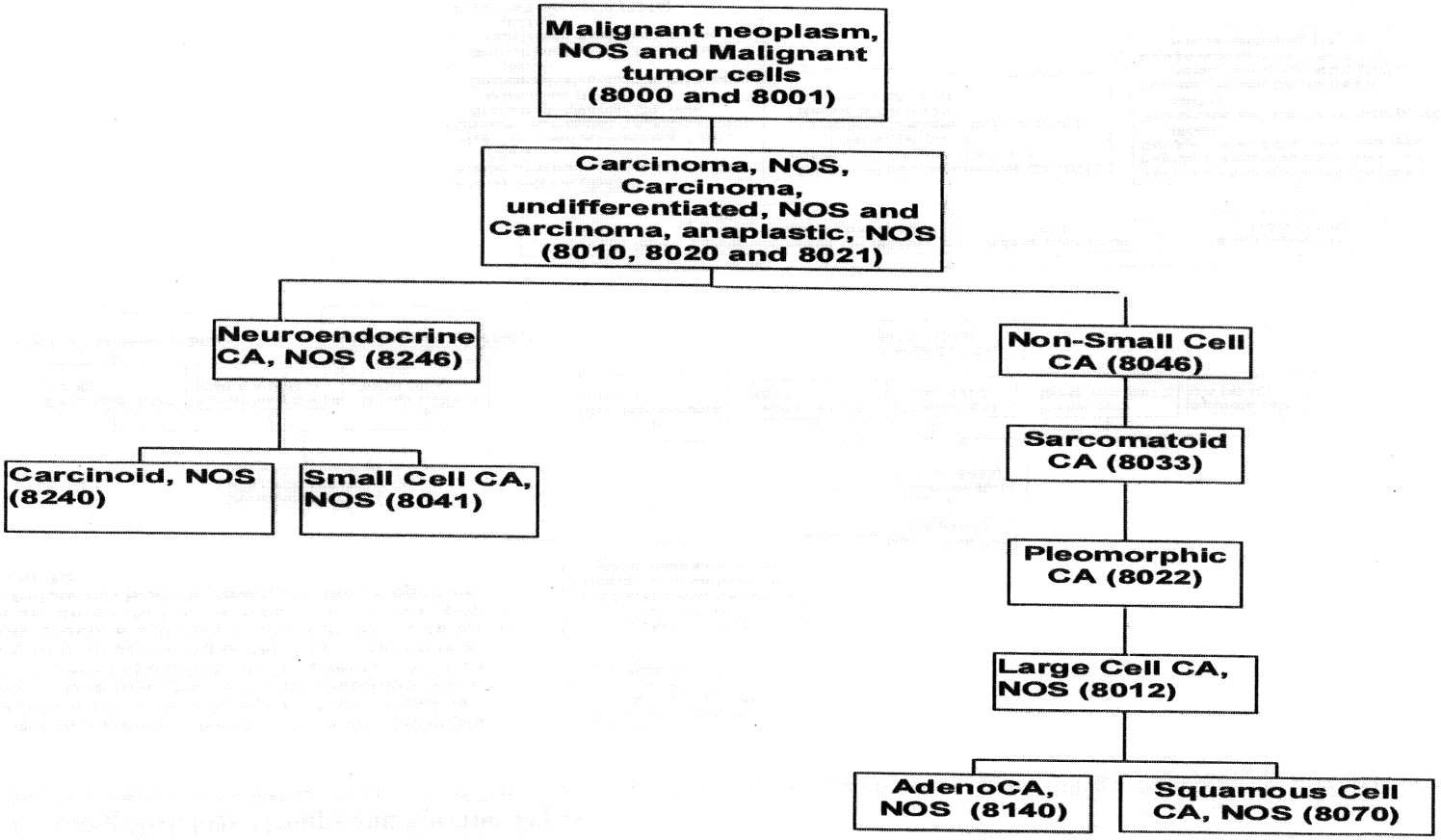
Chart 2 – Most Common Lung Histology Groups

Chart Instructions: Use this chart to identify the most common group terms and histology types.

Note: This chart is based on the *WHO Classification of Tumors* for tumors of the lung. The chart is **not** a complete listing of histologies that may occur in the lung.



Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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Table 1 –Combination/Mixed Codes for Lung Histologies

Table Instructions: Use this table to select combination/mixed histology codes. Compare the terms in the diagnosis to the terms in columns 1 and 2. If the terms match, abstract the case using the ICD-O-3 histology code in column 4. Use the combination/mixed codes listed in this table only when the histologies in the tumor match the histologies listed below. Use the combination/mixed codes for a **single tumor** when all histologies are present in a single tumor.

Note: This table is not a complete listing of histologies that may occur in the lung.

Column 1: Required Terms	**Column 2: Additional Required Terms**	**Column 3: ICD-O-3 Term**	**Column 4: ICD-O-3 Code**
Giant cell carcinoma AND spindle cell carcinoma		Giant cell and spindle cell carcinoma	8030
Small cell carcinoma AND one of the histologies in Column 2 *Note*: **Diagnosis must be small cell carcinoma (NOS), not a subtype of small cell**	Adenocarcinoma	Combined small cell carcinoma Mixed small cell carcinoma	8045
	Large cell carcinoma		
	Squamous cell carcinoma		
Squamous cell carcinoma* AND large cell nonkeratinizing		Squamous cell carcinoma, large cell, nonkeratinizing	8072
Squamous cell carcinoma AND small cell nonkeratinizing		Squamous cell caricinoma, small cell, nonkeratinizing	8073
Squamous cell carcinoma* AND one of the histologies in Column 2	Spindle cell carcinoma	Squamous cell carcinoma, spindle cell	8074
	Sarcomatoid	Squamous cell carcinoma, sarcomatoid	
A combination of at least two of the histologies in Column 2**	Acinar	Adenocarcinoma with mixed subtypes**	8255**
	Bronchioloalveolar carcinoma		
	Bronchioloalveolar carcinoma non mucinous (Clara cell/type II pneumocyte)		
	Bronchioloalveolar carcinoma mucinous (goblet cell)		
	Bronchioloalveolar carcinoma mixed mucinous and non-mucinous		
	Clear cell adenocarcinoma		
	Papillary adenocarcinoma		
	Solid adenocarcinoma		
	Well-differentiated fetal adenocarcinoma		

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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Column 1: Required Terms	Column 2: Additional Required Terms	Column 3: ICD-O-3 Term	Column 4: ICD-O-3 Code
Adenocarcinoma AND squamous cell carcinoma *Note:* **Diagnosis must be adenocarcinoma (NOS), not a subtype of adenocarcinoma**		Adenosquamous carcinoma	8560
Epithelial carcinoma AND myoepithelial carcinoma		Epithelial-myoepithelial carcinoma	8562

* Squamous cell carcinoma and epidermoid carcinoma are synonyms.

** **DO NOT USE** code **8255** for adenocarcinoma combined with mucinous subtypes such as mucinous "colloid" adenocarcinoma (8480) mucinous cystadenocarcinoma (8470) or signet ring adenocarcinoma (8490).

Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations
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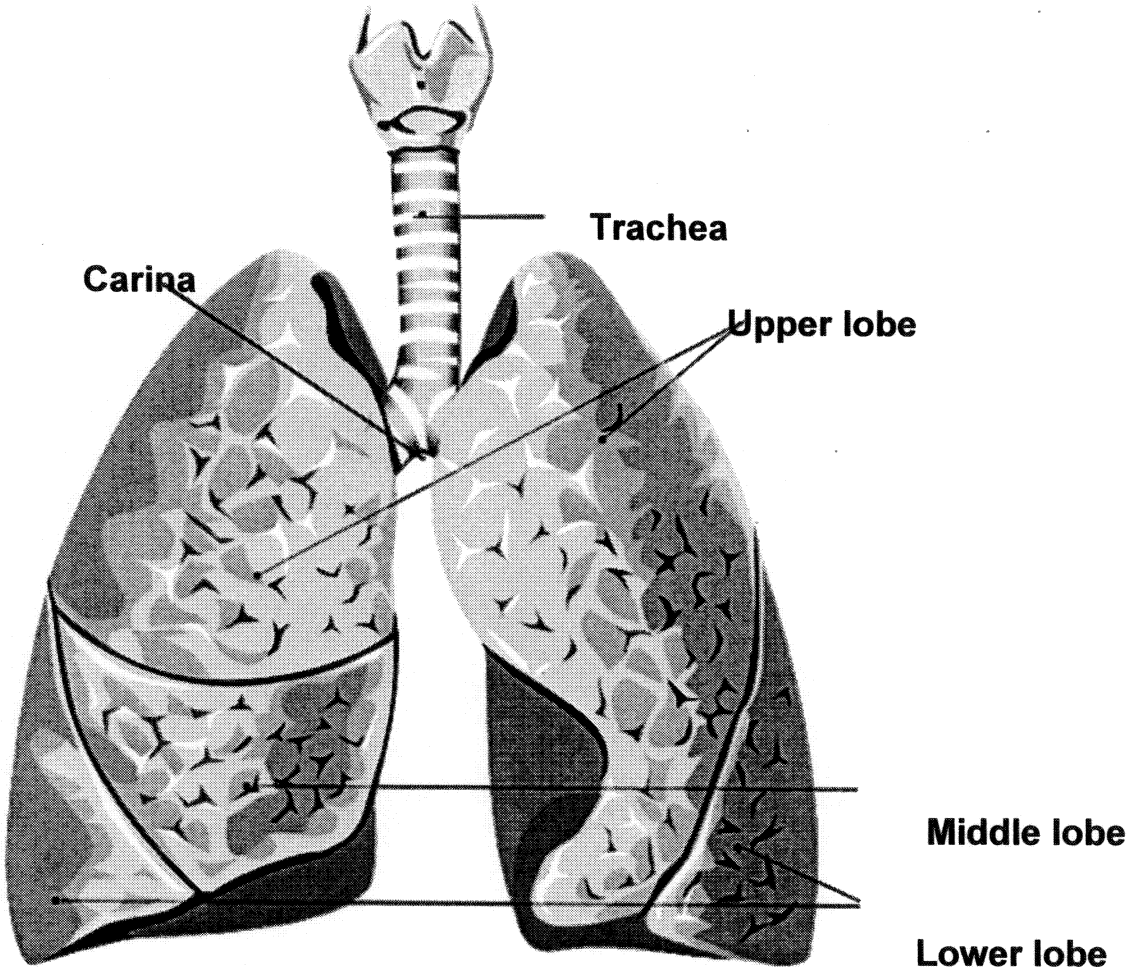

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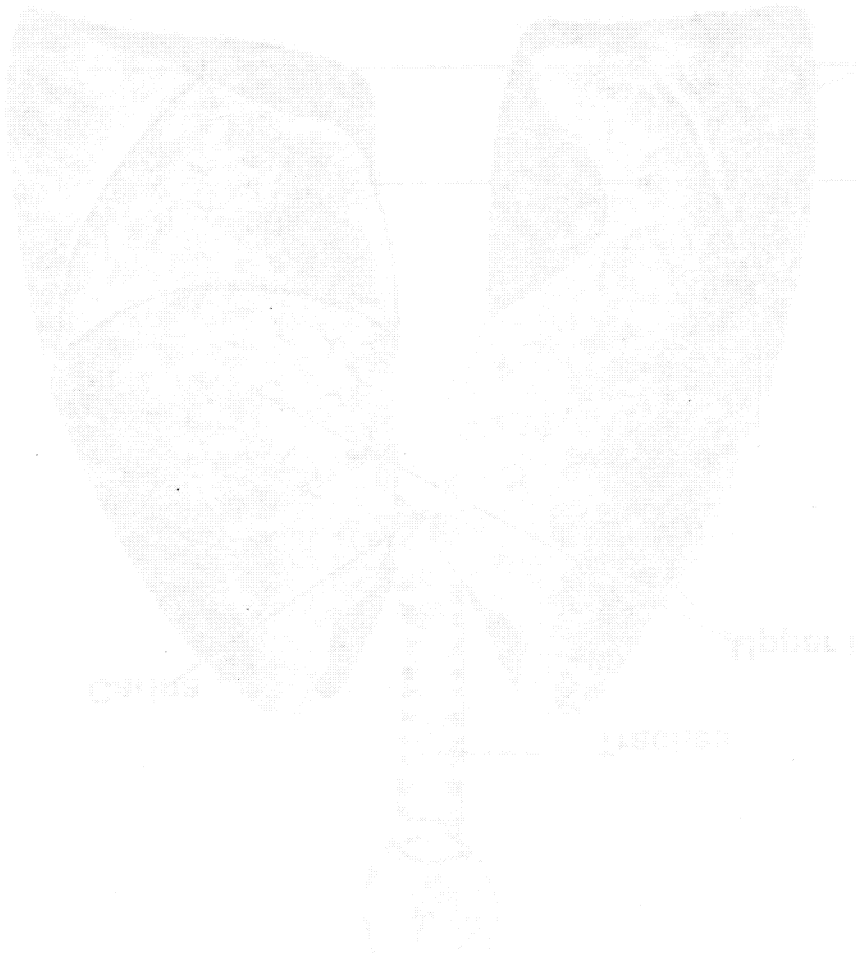

Lung Multiple Primary Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note 1: Use this rule only after all information sources have been exhausted.
Note 2: Use this rule when only one tumor is biopsied but the patient has two or more tumors in one lung and may have one or more tumors in the contralateral lung. (See detailed explanation in Lung Equivalent Terms and Definitions)

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note: Tumor not described as metastasis

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note: Tumors not described as metastases

Rule M3 Tumors in sites with ICD-O-3 **topography** codes that are **different** at the second (Cxxx) and/or third character (Cxxx) are multiple primaries. **
Note: This is a change in rules; tumors in the trachea (C33) and in the lung (C34) were a single lung primary in the previous rules.

Rule M4 At least one tumor that is **non-small cell** carcinoma (8046) **and** another tumor that is **small cell** carcinoma (8041-8045) are multiple primaries. **

Rule M5 A tumor that is **adenocarcinoma** with **mixed subtypes** (8255) **and** another that is **bronchioloalveolar** (8250-8254) are multiple primaries. **

Lung Multiple Primary Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M6 A **single** tumor in **each lung** is multiple primaries. **
Note: When there is a single tumor in each lung abstract as multiple primaries unless stated or proven to be metastatic.

Rule M7 **Multiple** tumors in **both lungs** with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M8 Tumors diagnosed **more than three (3) years** apart are multiple primaries. **

Rule M9 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M10 Tumors with **non-small cell** carcinoma, **NOS** (8046) **and** a more **specific** non-small cell carcinoma **type** (Chart 1) are a single primary.*

Rule M11 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **
Note: Adenocarcinoma in one tumor and squamous cell carcinoma in another tumor are multiple primaries.

Rule M12 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by this rule are the same histology.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M12 Examples: The following are examples of cases that use Rule M12. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Solitary tumor in one lung, multiple tumors in contralateral lung	**Example 2:** Diffuse bilateral nodules (This is the only condition when laterality = 4)	**Example 3:** An in situ and invasive tumor diagnosed within 60 days
Example 4: Multiple tumors in left lung metastatic from right lung	**Example 5:** Multiple tumors in one lung	**Example 6:** Multiple tumors in both lungs

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Note: Do not code terms that do not appear in the histology description.

Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Example 2: Do not code bronchioalveolar non-mucinous unless the words "non-mucinous" actually appear in the diagnosis.

Rule H4 Code the invasive histologic type when a single tumor has **invasive and in situ** components

Rule H5 Code the **most specific** term using Chart 1 **when** there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example 1: Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

Example 2: Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H6 Code the appropriate combination/mixed code (Table 1) when there are **multiple specific histologies** or when there is a non-specific **with multiple specific histologies**

Note: The specific histologies may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.
Example 1 (multiple specific histologies): Solid and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes).
Example 2 (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma).
Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes).

Rule H7 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans
- Chest x-rays

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm), or 8010 (carcinoma) as stated by the physician when nothing more specific is documented.

Rule H9 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.
Note: Do not code terms that do not appear in the histology description.
Example 1: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.
Example 2: Do not code bronchioalveolar non-mucinous unless the words "non-mucinous" actually appear in the diagnosis.

Lung Histology Coding Rules – Text
C340-C349
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology of the **most invasive** tumor.

Note 1: This rule should only be used when the first three numbers of the histology codes are identical (This is a single primary.)

Note 2: See the Lung Equivalent Terms, Definitions, Charts, Tables and Illustrations for the definition of most invasive.

- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
- Both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H12 Code the **most specific** term using Chart 1 **when** there are multiple histologies within the same branch. Examples of histologies within the same branch are:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation

Example 1: Adenocarcinoma, predominantly mucinous. Code 8480 (mucinous adenocarcinoma).

Example 2: Non-small cell carcinoma, papillary squamous cell. Code 8052 (papillary squamous cell carcinoma).

Rule H13 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Introduction

Cutaneous melanoma starts in the melanocyte cells of the skin. Melanocytes lie in the epidermis, the outermost layer of the skin. Melanocytes often cluster together and form moles (nevi). Most moles are benign, but some may go on to become malignant melanomas.

Melanomas are divided into 5 main types, depending on their location, shape and whether they grow outward or downward into the dermis:

- **Acral melanoma:** occurs on the palms of the hand, soles of the feet, or nail beds
- **Desmoplastic melanoma:** is a rare malignant melanoma marked by non-pigmented lesions on sun-exposed areas of the body
- **Lentigo maligna:** usually occur on the faces of elderly people
- **Superficial spreading or flat melanoma:** grows outwards at first to form an irregular pattern on the skin with an uneven color
- **Nodular melanomas:** are lumpy and often blue-black in color and may grow faster and spread downwards

These types account for the majority of melanomas occurring in the US population. For a more complete listing of histologic types of melanoma, see the *AJCC Cancer Staging Manual*, 6th Ed.

Melanoma can also start in the mucous membranes of the mouth, anus and vagina, in the eye or other places in the body where melanocytes are found. This scheme is used only for melanomas that occur on the skin.

Equivalent or Equal Terms

- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.
- Giant pigmented nevus, giant congenital nevus
- Mole, Nevus

Synonyms for In Situ

Behavior code 2
Clark level 1 (limited to the epithelium)
Hutchinson freckle (See synonyms for Hutchinson freckle)
Intraepidermal, NOS
Intraepithelial, NOS
Lentigo maligna
Noninvasive
Precancerous melanoma of Dubreuilh
Stage 0
Tis

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Synonyms for Hutchinson freckle

Circumscribed precancerous melanosis
Intraepidermal malignant melanoma
Lentigo maligna
Precancerous melanosis of Dubreuilh

Definitions

Amelanotic melanoma: A non-pigmented malignant melanoma.

Atypical melanocytic hyperplasia (dysplasia): Tumor-like lesion or condition may represent precursor stage or stage in development of melanoma. Not reportable.

Different lateralities: The right side of the body, the left side of the body and the midline are separate lateralities in the melanoma coding rules.

Evolving melanoma (borderline evolving melanoma): Evolving melanoma are tumors of uncertain biologic behavior. Histological changes of borderline evolving melanoma are too subtle for a definitive diagnosis of melanoma in situ. The tumors may be described as "proliferation of atypical melanocytes confined to epidermal and adnexal epithelium," "atypical intraepidermal melanocytic proliferation, "atypical intraepidermal melanocytic hyperplasia"; or "severe melanocytic dysplasia." Not reportable.

Familial Atypical Multiple Mole Melanoma Syndrome (FAMM, FAM-M): An inherited condition identified when:

- Melanoma has been diagnosed in a family member, including grandparents, aunts, uncles, and cousins
- Several family members have large numbers of moles (often more than 50) which may be abnormal or atypical moles.

Giant pigmented nevus: Diameter larger than 20 cm; frequently covers large areas of the body in a garment-like fashion. The trunk, head and neck are the most common sites.

Junctional nevus: Smooth, hairless, light to dark brown mole. Can be slightly elevated, usually multiple and can occur on any part of the body. Melanocytes are confined to the dermo-epidermal junction.

Hypodermis: A subcutaneous layer of loose connective tissue containing a varying number of fat cells.
Synonyms: subcutaneous fat; subcutis.

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

In-transit metastasis: Metastasis found in the lymphatic channels more than 2cm away from the primary melanoma, but not reaching the regional lymph nodes.

Invasive tumor: A tumor that penetrates the basement membrane and invades the dermis.

Laterality: For skin sites, laterality divides the body into a right and left half as though a line were drawn from mid forehead to mid pelvis and from mid skull to mid buttocks. A midline laterality describes a tumor that is in the center of the "line" drawn from the mid forehead to mid pelvis or from the mid skull to the mid buttocks; it is impossible to categorize the tumor as being on the right or left side of the body.

Lentigo maligna: Is a specific histologic type of in situ melanoma. It appears as a brown or black mottled, irregular, lesion with increased numbers of scattered atypical melanocytes in the epidermis. It usually occurs on the face.

Lentigo maligna melanoma: Is an invasive melanoma that begins as lentigo maligna, but usually after many years the dermis is invaded by the tumor. Once invasion has occurred, the lesion is called lentigo maligna **melanoma**.

Midline: the middle dividing line that separates the body into right and left sides.

Most invasive: the histology that has the greatest extension into the dermis or subcutaneous fat.

Non-invasive tumor: A tumor confined to epithelium (intraepithelial), in situ tumor, with no penetration below the basement membrane.

Precancerous melanosis: An obsolete term for lentigo maligna.

Proliferation of atypical melanocytes confined to epidermis: Number of (proliferation) pigmented cells (melanocytes) not showing the normal cell structure (atypical). Not reportable.

Regressing melanoma: The term "regressing melanoma" does not refer to a specific histology; it refers to the physical appearance and size of the lesion. A regressing melanoma is reacting to the body's immune system by shrinking in size. Partial spontaneous regression is not an uncommon finding in invasive primary melanoma; partial regression can be an indicator of poor prognosis. Proven complete regression is very rare; one website stated that only 33 cases of total regression have been reported. A regressive melanoma is usually thinner than it was originally. Although regression is a prognostic factor, the histologic type is more important for histology coding purposes. See Histology coding rules, Rule H5.

Satellite lesion or metastasis: Grossly evident metastatic skin lesion within the immediate vicinity (usually within 2 cm) of a primary malignant tumor; e.g., skin adjacent to primary malignant melanoma. This is a metastasis, not a separate primary.

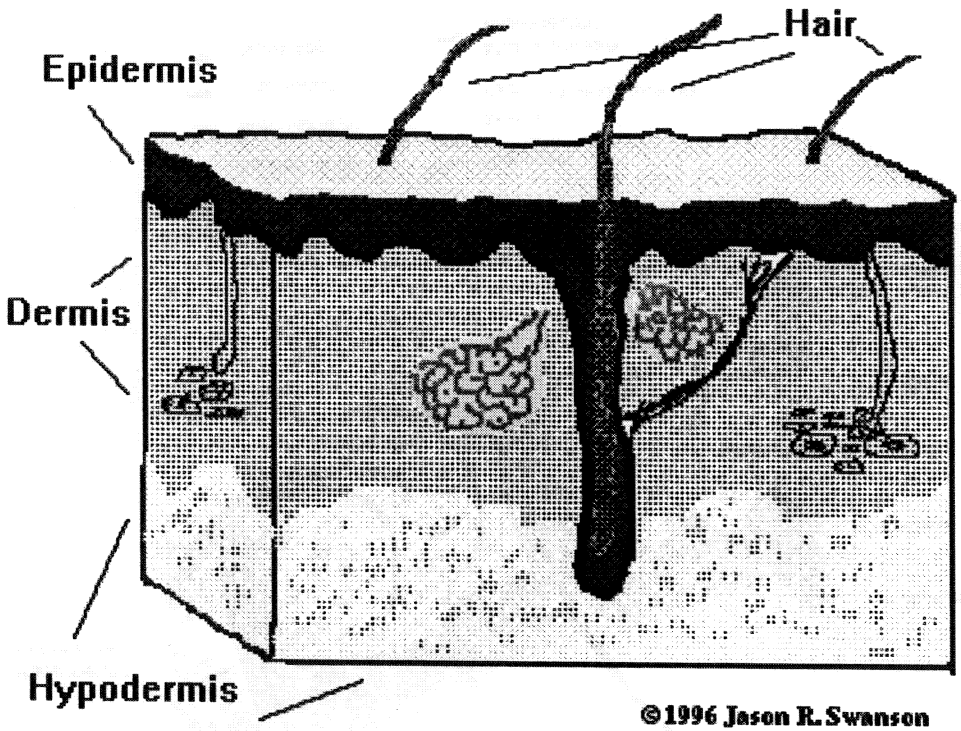
Severe melanotic dysplasia: Tumor-like lesion or condition. Not reportable.

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Skin Layers:

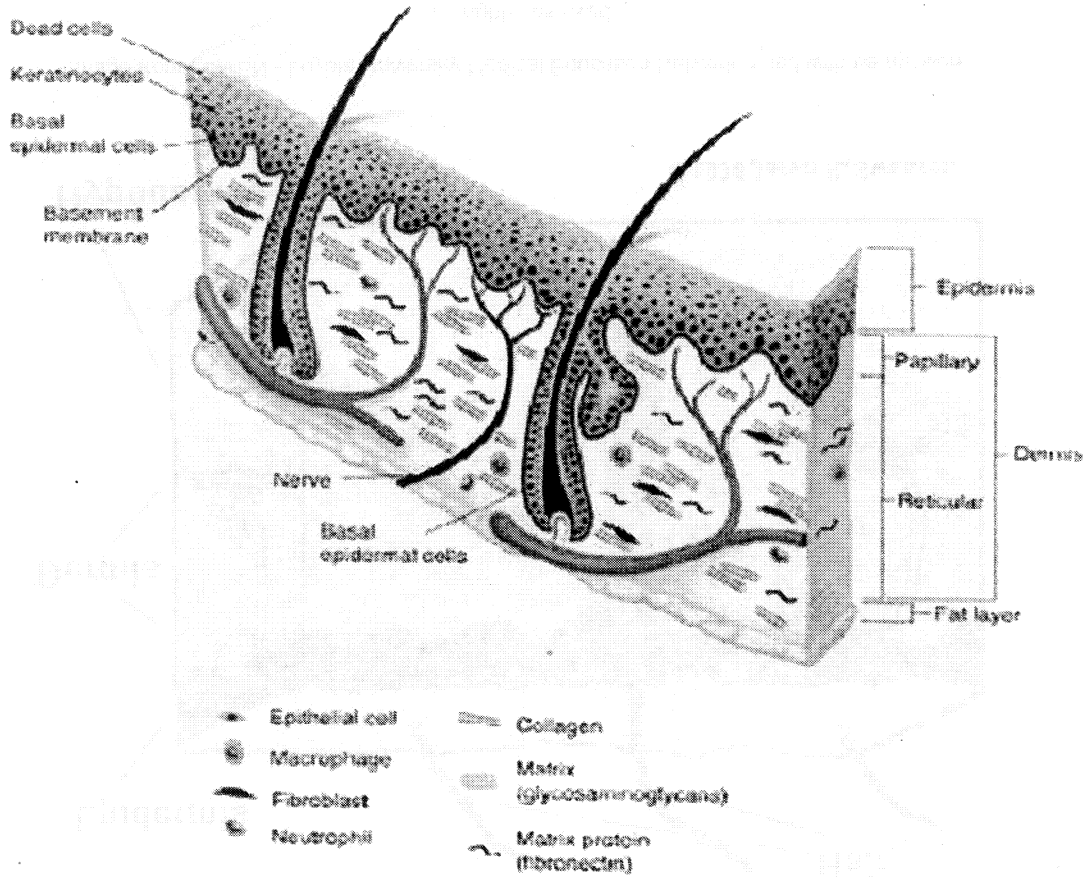
- Epidermis – upper surface, thin layer (outermost layer)
- Dermis – lower, intermediate thicker layer (intermediate layer)
- Hypodermis – also called subcutis or subcutaneous fat – lowest layer (innermost layer)

Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)



Cutaneous Melanoma Equivalent Terms, Definitions and Illustrations
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Anatomy of Normal Skin



Source: Burnsurgery.org

Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

UNKNOWN IF SINGLE OR MULTIPLE MELANOMAS

Note: Melanoma(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** melanoma **or multiple** melanomas, opt for a single melanoma and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Melanoma.

SINGLE MELANOMA

Note 1: Melanoma not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single melanoma** is always a single primary. *

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Melanoma.

MULTIPLE MELANOMAS

Multiple melanomas may be a single primary or multiple primaries
Note 1: Melanoma not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 Melanomas in sites with ICD-O-3 **topography** codes that are **different** at the second (C<u>x</u>xx), third (Cx<u>x</u>x) or fourth (C44<u>x</u>) character are multiple primaries. **

Melanoma MP

Cutaneous Melanoma Multiple Primary Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Rule M4 Melanomas with **different laterality** are multiple primaries. **
Note: A **midline** melanoma is a different laterality than right or left.
Example 1: Melanoma of the right side of the chest and a melanoma at midline of the chest are different laterality, multiple primaries
Example 2: A melanoma of the right side of the chest and a melanoma of the left side of the chest are multiple primaries

Rule M5 Melanomas with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third number (xxxx) are multiple primaries. **

Rule M6 An **invasive** melanoma that occurs **more than 60 days after** an **in situ** melanoma is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M7 Melanomas diagnosed **more than 60 days** apart are multiple primaries. **

Rule M8 Melanomas that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: Use the data item "Multiplicity Counter" to record the number of melanomas abstracted as a single primary.
Note 2: When an invasive melanoma follows an in situ melanoma within 60 days, abstract as a single primary.
Note 3: All cases covered by this rule are the same site and histology.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Melanomas.

Rule M8 Examples: The following are examples of cases that use Rule M8. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Solitary melanoma on the left back and another solitary melanoma on the left chest.	**Example 2:** Solitary melanoma on the right thigh and another solitary melanoma on the right ankle.

Cutaneous Melanoma Histology Coding Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

SINGLE MELANOMA OR MULTIPLE MELANOMAS ABSTRACTED AS A SINGLE PRIMARY

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available.**

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of melanoma in the medical record
- PET scan

Note 2: Code the specific histology when documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H3 Code the histology when only **one histologic type** is identified.

Rule H4 Code the invasive histologic type when there are **invasive and in situ** components.

Rule H5 Code the **histologic type** when the diagnosis is **regressing** melanoma **and** a **histologic** type.

Example: Nodular melanoma with features of regression. Code 8721 (Nodular melanoma).

Rule H6 Code 8723 (Malignant melanoma, regressing) when the diagnosis is **regressing melanoma.**

Example: Malignant melanoma with features of regression. Code 8723.

Rule H7 Code the **histologic type** when the diagnosis is **lentigo maligna** melanoma **and** a **histologic** type.

Rule H8 Code 8742 (Lentigo maligna melanoma) when the diagnosis is **lentigo maligna** melanoma.

Rule H9 **Code the** most **specific** histologic **term** when the diagnosis is melanoma, NOS (8720) with a single specific type.

Note 1: The specific type for **in situ** lesions may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific type for **invasive** lesions may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Cutaneous Melanoma Histology Coding Rules – Text
C440-C449 with Histology 8720-8780
(Excludes melanoma of any other site)

Rule H10 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Melanoma or Multiple Melanomas Abstracted as a Single Primary. Code the histology according to the rule that fits the case.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Equivalent or Equal Terms

- And, with (used in histology rules, i.e. duct and lobular is equivalent to duct with lobular)
- Duct, ductal
- Mammary, breast
- Mucinous, colloid
- NOS, NST
- Tumor, mass, lesion, neoplasm

Synonyms for "in situ"

- Behavior code '2'
- DCIS
- Intracystic
- Intraductal
- Noninfiltrating
- Noninvasive

Definitions

Carcinoma with osteoclast-like giant cells (8035): This is a specific type of **duct** carcinoma. The carcinomatous part of the lesion is most commonly an infiltrating duct carcinoma.

Ductular carcinoma (8521): A malignancy that is infrequently found in the breast and may be found with greater frequency in other organs such as pancreas or prostate. Code 8521 is seldom, if ever, applied to the breast. Although the ICD-O-3 suggests that 8521 is a site-associated code; the addition of (C50._) after this code may be misleading. The WHO Histological Classification of Tumours of the Breast does not list 8521, ductular carcinoma.

Duct carcinoma, NOS (8500): The largest group of breast cancers. Duct carcinoma, NOS is not a specific histologic type because it lacks specific features that can be used to better classify the tumor. See Table 1 and Table 2 for intraductal and duct types.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
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Inflammatory breast carcinoma (IBC): A breast cancer with a distinctive clinical presentation believed to be due to lymphatic obstruction from an underlying invasive adenocarcinoma. The vast majority of cases have a prominent dermal lymphatic infiltration by tumor. Dermal lymphatic infiltration without the characteristic clinical picture is insufficient to qualify as inflammatory carcinoma.

Intracystic carcinoma/Intracystic papillary carcinoma: Variant of intraductal carcinoma used to describe encysted forms of papillary carcinoma. Code intracystic carcinoma as in situ /2 unless the histology is described as invasive intracystic carcinoma.

In Situ: A tumor that is confined to the duct system (ductular or lobular) and does not invade surrounding stroma.

Invasive: A tumor that penetrates beyond the ductal basement membrane into the adjacent stroma of the breast parenchyma.

Lobular Carcinoma: Lobular carcinoma includes solid and alveolar patterns. About 5 to 10% of breast cancers are lobular. There is about a 20% chance that the opposite breast will also be involved, and many of them arise multicentrically in the same breast.

Paget Disease: Paget disease of the nipple is a condition where the epidermis of the nipple is infiltrated with neoplastic cells. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). Under the matrix system, only if the Paget disease is explicitly specified as in situ or non-invasive by the pathologist, code the behavior in situ (/2).

Phyllodes tumor (cystosarcoma phyllodes): A rare tumor with incidence ranging from 0.3% to 0.9% of all breast cancers. These tumors have a natural history and clinical behavior different from carcinoma of the breast. Criteria to classify benign, borderline and malignant cystosarcoma phyllodes utilize histologic parameters such as cellular atypia, mitotic activity and tumor margins. The reported incidence of malignant cystosarcoma phyllodes is approximately 25% of all phyllodes tumors.

Pleomorphic carcinoma (8022): This is a specific **duct** carcinoma type; A rare variant of high grade ductal carcinoma, NOS.

Sarcoma of breast: Primary sarcomas of the breast are rare accounting for less than 0.1% of all malignant tumors of the breast. Diagnoses may include fibrosarcoma, angiosarcoma, pleomorphic sarcoma, leiomyosarcoma, myxofibrosarcoma, hemangio-pericytoma, and osteosarcoma (extra-osseous osteosarcoma of breast).

Scirrhous Carcinoma: An adenocarcinoma with a firm-hard nodule associated with a dense connective tissue in the stroma. Scirrhous carcinoma is descriptive term, not a specific type of ductal carcinoma.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Intraductal(8500/2) and Specific Intraductal Carcinomas

Note: These are the most common specific intraductal carcinomas. This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).

Column 1: Code	Column 2: Type
8201	Cribriform
8230	Solid
8401	Apocrine
8500	Intraductal, NOS
8501	Comedo
8503	Papillary
8504	Intracystic carcinoma
8507	Micropapillary/Clinging

Table 2 – Duct (8500/3) and Specific Duct Carcinomas

Note: These are the most common specific duct carcinomas. This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

Column 1: Code	Column 2: Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like giant cells
8500	Duct, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma of breast
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecratory carcinoma

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 3 – Combination Codes for Breast Cancers

Use this **two-page** table with rules H5, H6, H7, H8, H16, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

Column 1: Required Histology	**Column 2: Combined with Histology**	**Column 3: Combination Term**	**Column 4: Code**
Any combination excluding lobular and duct histologies from Tables 1 and 2	Other than ductal and lobular	Adenocarcinoma with mixed subtypes*	8255/3*
Intraductal carcinoma and	Lobular carcinoma in situ	Intraductal carcinoma and lobular carcinoma in situ	8522/2
Infiltrating duct and	Infiltrating lobular carcinoma	Infiltrating duct and lobular carcinoma	8522/3
Intraductal and **one or more** of the histologies in Column 2	Cribriform	Intraductal mixed with other types of carcinoma	8523/2
	Solid		
	Apocrine		
	Papillary		
	Micropapillary		
	Clinging		
Infiltrating duct and **one or more** of the histologies in Column 2	Tubular	Infiltrating duct mixed with other types of carcinoma	8523/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		

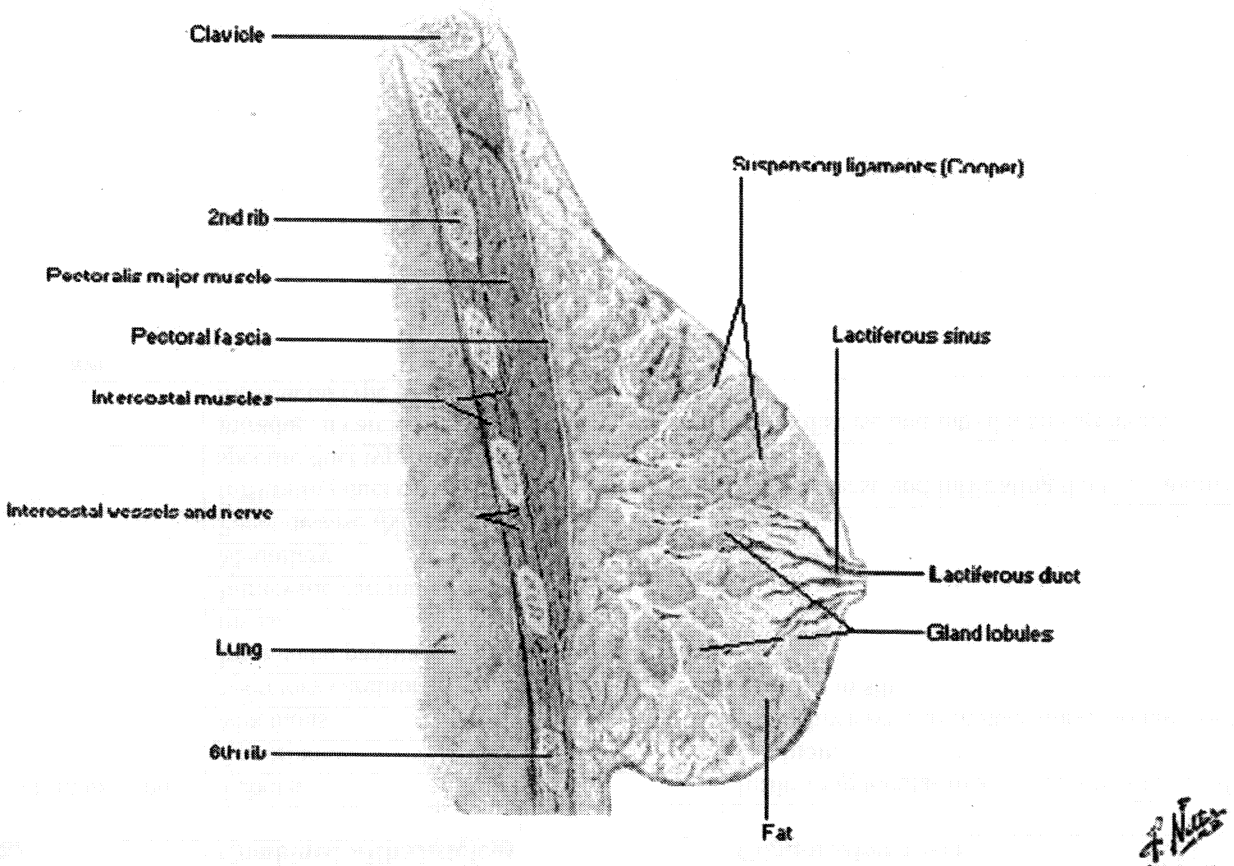
Table 3 continues on the next page

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Table 3 continued			
Infiltrating lobular carcinoma and	Tubular	Infiltrating lobular mixed with other types of carcinoma ***Note:*** Invasive carcinomas only. Do not use this code for in situ	8524/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		
	Paget disease (NOS and invasive)		
Paget disease and	Infiltrating duct carcinoma (includes any specific duct type listed in Table 2	Paget disease and infiltrating duct carcinoma	8541/3
Paget disease and	Intraductal carcinoma (includes any specific intraductal type in Table 1)	Paget disease and intraductal carcinoma	8543/3

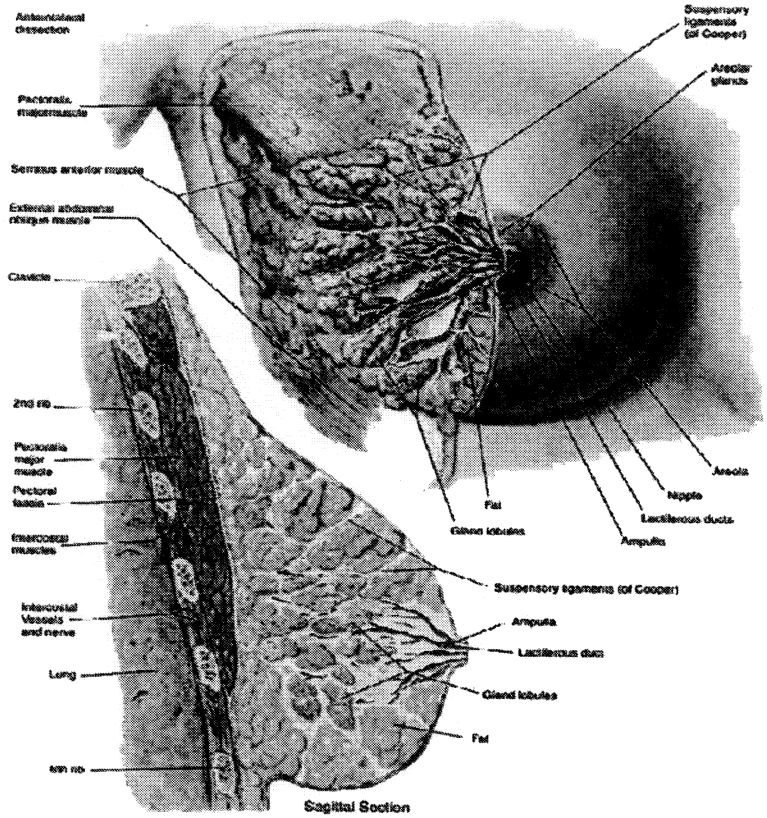
**Rarely used for breast cancer*

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Mammary Gland



Atlas of Human Anatomy -- Frank H. Netter

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Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary. *
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M3 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M4 Tumors in sites with ICD-O-3 **topography** codes (Cxxx) with **different** second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries. **

Rule M5 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **

Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M7 Tumors on both sides (**right and left breast**) are multiple primaries. **
Note: Lobular carcinoma in both breasts ("mirror image") is a multiple primary.

Rule M8 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors that are intraductal or **duct and Paget Disease** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M10 Tumors that are **lobular** (8520) **and** intraductal or **duct** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M11 **Multiple intraductal and/or duct carcinomas** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M12 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M13 Tumors that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M13 Examples: The following are examples of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Invasive duct and intraductal carcinoma in the same breast	**Example 2:** Multi-centric lobular carcinoma, left breast

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)

Rule H1 Code the histology documented by the physician when the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record

Note 2: Code the specific histology when documented.

Rule H2 Code the histology when only **one histologic type** is identified

Rule H3 **Code the** more **specific** histologic **term when** the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H4 Code **8501/2** (comedocarcinoma, non-infiltrating) when there is **non-infiltrating comedocarcinoma and any** other **intraductal** carcinoma (Table 1).
Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).

Rule H5 Code **8522/2** (intraductal carcinoma and lobular carcinoma in situ) when there is a combination of **in situ lobular** (8520) **and intraductal** carcinoma (Table 1).

Rule H6 Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) when there is a combination of intraductal carcinoma and one or more specific intraductal types OR there are **two or more specific intraductal** carcinomas.
Note 1: Use Table 1 to identify the histologies.
Note2: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H7 Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) when there is **in situ lobular** (8520) **and any in situ** carcinoma **other than intraductal** carcinoma (Table 1).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H8 Code **8255/2** (adenocarcinoma in situ with mixed subtypes) when there is a **combination** of in situ/non-invasive histologies that **does not include** either **intraductal** carcinoma (Table 1) **or in situ lobular** (8520).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA
(Single Tumor; in situ and invasive components)

Rule H9 **Code the invasive histology** when both invasive and in situ components are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE CARCINOMA ONLY
(Single Tumor; all parts are invasive)

Rule H10 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**
Note: Code the behavior /3.

Rule H12 **Code the** most **specific** histologic **term when** the diagnosis is:
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H13 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma.**
Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H14 Code the histology when only **one histologic type** is identified.

Rule H15 Code the histology with the numerically **higher ICD-O-3 code** when there are **two or more** specific **duct** carcinomas.
Note: Use Table 2 to identify duct carcinomas

Rule H16 Code **8522** (duct and lobular) when there is a combination of **lobular** (8520) **and duct** carcinoma.
Note: Use Table 2 to identify duct carcinomas

Rule H17 Code **8523** (duct mixed with other types of carcinoma) when there is a combination of **duct and** any **other** carcinoma.
Note 1: Use Table 2 to identify duct carcinomas
Note 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H18 Code **8524** (lobular mixed with other types of carcinoma) when the tumor is **lobular** (8520) **and** any **other carcinoma.**
Note: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H19 Code **8255** (adenocarcinoma with mixed subtypes) for multiple **histologies** that **do not include duct or lobular** (8520).
Note: Use Table 2 to identify duct carcinomas

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H20 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available.**

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H21 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H22 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma.**

Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H23 Code the histology when only **one histologic type** is identified.

Rule H24 Code **8543/2** (in situ Paget disease and intraductal carcinoma) when the **pathology** report **specifically states** that the **Paget disease** is **in situ and** the **underlying tumor** is **intraductal** carcinoma (Table 1).

Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H25 Code **8543/3** (Paget disease and intraductal carcinoma) for **Paget disease and intraductal** carcinoma

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 1 to identify intraductal carcinomas

Rule H26 Code **8541/3** (Paget disease and infiltrating duct carcinoma) for **Paget disease and** invasive **duct** carcinoma.

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 2 to identify duct carcinomas

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H27 Code the invasive histology when **both invasive and in situ** tumors are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).

Rule H28 Code **8522** (duct and lobular) when there is any combination of **lobular** (8520) **and duct** carcinoma.
Note: Use Table 2 to identify duct carcinomas

Rule H29 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

INTRODUCTION

Renal cell carcinoma (8312) is a group term for glandular (adeno) carcinomas of the kidney. Approximately 85% of all malignancies of the kidney are renal cell and specific renal cell types.

Transitional cell carcinoma rarely arises in the kidney parenchyma (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C659). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.

Equivalent or Equal Terms

- **Multifocal** and **multicentric**
- **Renal cell carcinoma (RCC)** and **hypernephroma (obsolete term)**
- **Tumor, mass, lesion,** and **neoplasm**

Definitions

Adenocarcinoma with mixed subtypes (8255): A mixture of two or more of the specific renal cell carcinoma types listed in Table 1.

Carcinoma of the collecting ducts of Bellini/collecting duct carcinoma (8319) is a malignant epithelial tumor. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Chromophobe RCC (8317) is a rare form of kidney cancer. Chromophobe is a renal carcinoma characterized by large pale cells with prominent membranes.

Clear cell RCC (8310) is the most common type of RCC. Clear cell is composed of clear or eosinophilic cytoplasm. Clear cell is architecturally diverse, with solid alveolar and acinar patterns the most common.

Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Cystic: Cystic may be used to describe the gross appearance or it may be used as a morphologic term. Cysts are common in clear cell renal cell carcinomas. Tumors composed completely of cysts are rare.

Medullary carcinoma of the kidney (8510) is a rare tumor almost exclusively associated with sickle cell trait. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to 8510 so we can differentiate between the medullary and the collecting duct carcinoma.

Most invasive: The tumor with the greatest continuous extension (see focal and foci/focus definitions).
In hierarchical order, the evaluation of least to greatest extension for **kidney** is based on:

- The largest tumor size
- Extension into major veins, adrenal gland, or perinephric tissue.
- Involvement of Gerota's fascia.

Papillary RCC (8260) form finger-like projections. Some doctors call these cancers chromophilic because the cells take up certain dyes making them appear pink. A malignant renal parenchymal tumor with papillary or tubular papillary architecture.

Renal cell carcinoma (RCC) (8312) is the most common type of kidney cancer. Renal cell is a group name that includes several specific types. See Table 1.

Renal sarcoma is a rare disease of the kidney's connective tissues.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Urinary tract: Structures lined by transitional epithelium also known as urothelium

Wilms Tumor/nephroblastoma, NOS (8960) can arise anywhere in the kidney tissue. Wilms tumor typically appears in children between 2-5 years of age.

Table 1 - Renal cell carcinoma and specific renal cell types

Table Instructions: Use this table to identify specific renal cell carcinoma types.
Note: Renal cell carcinoma, NOS (8312) is the non-specific term under which the specific renal cell carcinoma types are listed. This table **is a complete listing** of specific renal cell carcinoma types.

Column 1: Code	Column 2: Specific Renal Cell Carcinoma Types
8260	Papillary (Chromophil) *
8310	Clear Cell
8316	Cyst associated, cystic
8317	Chromophobe *
8318	Sarcomatoid (Spindle cell)
8319	Collecting duct type (Bellini duct)
8320	Granular cell
8510	Medullary carcinoma, NOS; medullary adenocarcinoma
8959	Malignant cystic nephroma; malignant multilocular cystic nephroma
* ***Note:*** Chromophil and chromophobe are different histologies	

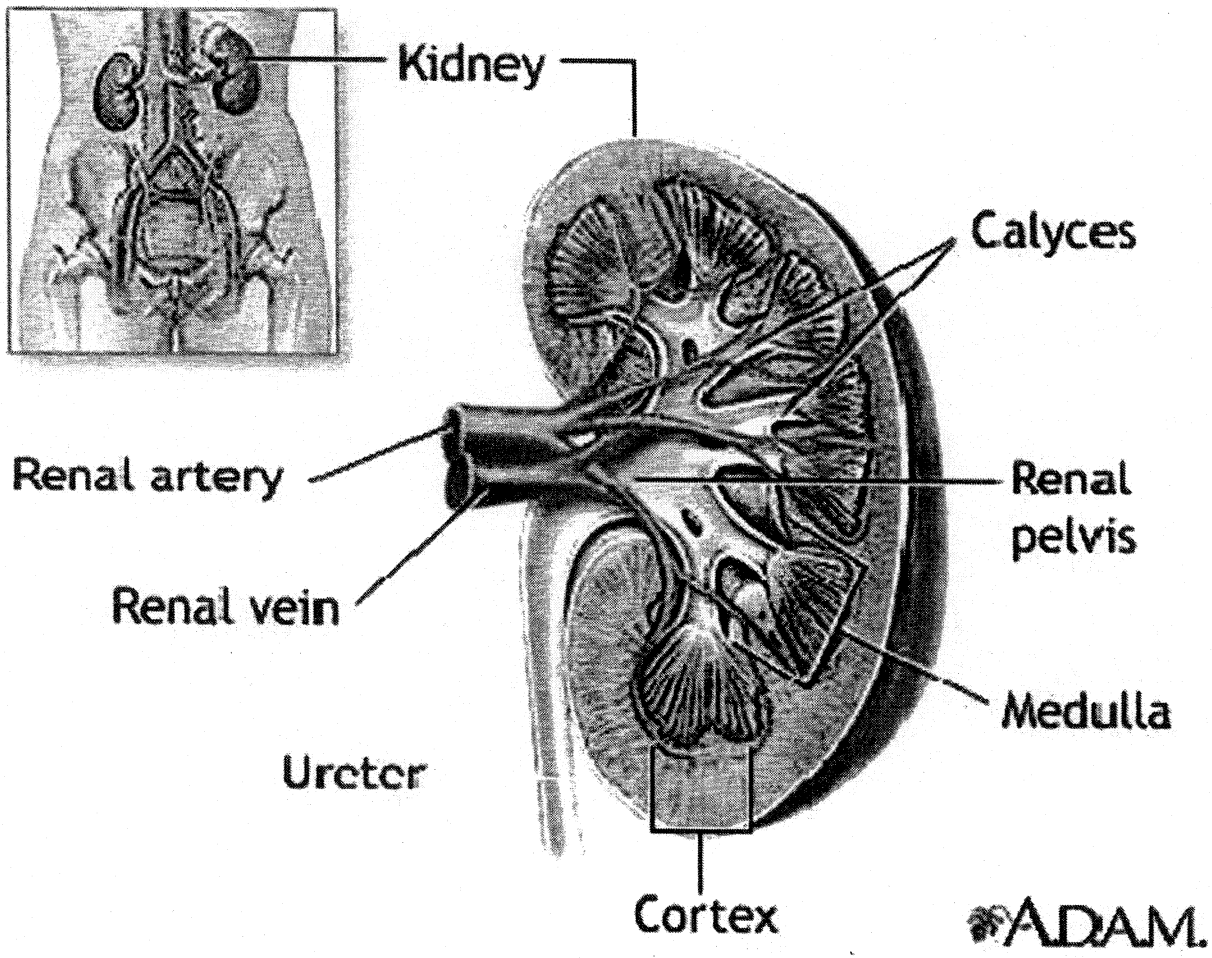
Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Table 2 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in the sites below were abstracted as a single primary.

Code	Site Grouping
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs

Kidney Equivalent Terms, Definitions, Tables and Illustrations
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)



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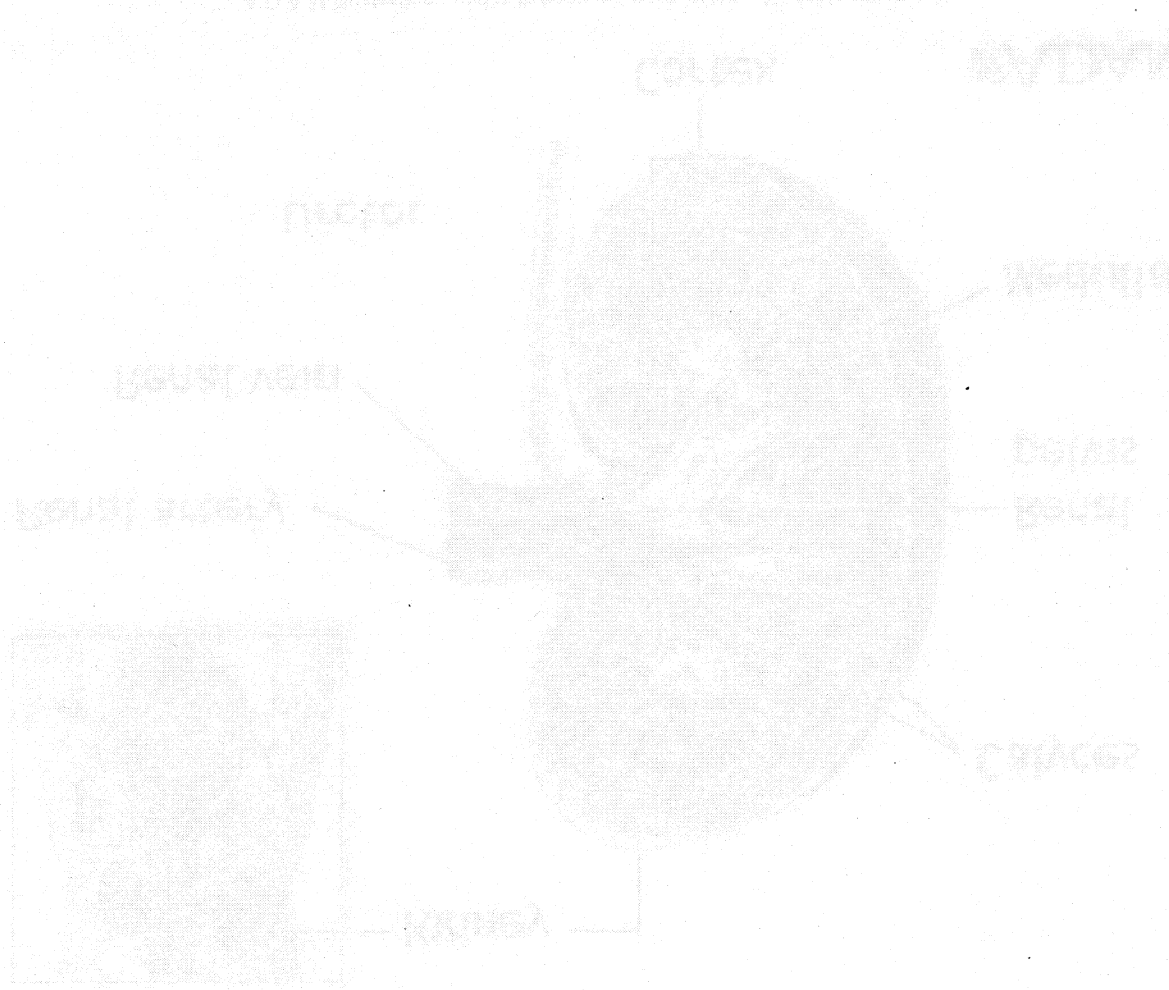

Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple tumors**, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

***Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for single tumors.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 **Wilms tumors** are a single primary. *

Rule M4 Tumors in sites with **ICD-O-3 topography** codes that are **different** at the second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries **

Rule M5 Tumors in **both** the **right kidney and** in the **left kidney** are multiple primaries. **
Note: Abstract as a single primary when the tumors in one kidney are documented to be metastatic from the other kidney.

Kidney Multiple Primary Rules - Text
C649
(Excludes lymphoma and leukemia – M9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 Tumors diagnosed more than **three (3) years apart** are multiple primaries. **

Rule M7 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M8 **One** tumor with a specific **renal** cell **type and** another tumor with a **different** specific renal cell **type** are multiple primaries (Table 1). **

Rule M9 Abstract as a single primary * when one tumor is

- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** the other is a **specific carcinoma** or
- **Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or**
- **Renal cell carcinoma, NOS** (8312) and the other is a **single renal cell type** (Table 1)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule M10 Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M11 Examples: The following are examples of cases that use Rule M11. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Multiple tumors in one kidney with same histology	**Example 2**: An in situ and invasive tumor diagnosed within 60 days

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology

- Documentation medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H3 Code the **histology** when only one histologic type is identified.

Rule H4 Code the **invasive** histologic type when there are invasive and in situ components.

Rule H5 Code the **specific type** when the diagnosis is

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.

Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H6 Code 8255 (adenocarcinoma with mixed subtypes) when there are **two or more specific** renal cell carcinoma types.

Note: Use Table 1 to identify specific renal cell types.

Example: Renal cell carcinoma, papillary and clear cell types. Assign code 8255.

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H7 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the pathology/cytology report is not available.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS), or 8010 (carcinoma, NOS) as stated by the physician when no specific histology is documented.

Rule H9 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H10 Code the histology when only **one histologic type** is identified.

Rule H11 Code the histology of the **most invasive** tumor.

Note 1: This rule should only be used when the first three digits of the histology codes are identical (This is a single primary).

Note 2: See the Kidney Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.
- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
- If both/all histologies are invasive, code the histology of the most invasive tumor.

Kidney Histology Coding Rules – Text
C649
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule H12 Code the **specific type** when the diagnosis is

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and one specific adenocarcinoma type or
- Renal cell carcinoma, NOS (8312) and one specific renal cell type

Note 1: Use Table 1 to identify specific renal cell types.
Note 2: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation
Note 3: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H13 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations C659, C669, C670-C679, C680-C689 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Renal Pelvis, Ureter, Bladder, and Other Urinary

The renal pelvis, ureters, bladder and proximal portion of the urethra are lined by transitional epithelium, also known as urothelium. Tumors of the urothelium are more often multifocal compared to other sites. Two mechanisms have been proposed to explain this phenomenon: 1). a "field effect" and 2) tumor cell implantation.

1. The **field effect** theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations. As a result, multiple tumors arise more easily.
2. The **implantation** theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site. Transitional cell tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter.

Molecular evidence has been found to support both of these theories, but neither has been proven to be the case for all tumors. Similarly, the widespread presence of flat carcinoma in situ may be a result of direct spread of neoplastic cells within the epithelium, direct extension, or due to implantation or field effect. The rules regarding histology and number of primaries are an attempt to reconcile these observations so that incidence data are consistent and reproducible.

Bladder

In the United States, transitional cell carcinomas account for more than 90% of all bladder cancers. Squamous cell carcinomas make up 3-8%, and adenocarcinomas make up about 1-2%. Pure squamous cell carcinoma of the bladder has a poor prognosis. See histology coding rules H5 and H13 for coding instructions.

Equivalent or Equal Terms

- **Flat transitional cell, flat urothelial, in situ transitional cell,** and **in situ urothelial**
- **Tumor, mass, lesion, neoplasm**
- **Urothelial** and **transitional**
- **Urothelium** and **transitional epithelium**
- **Intramucosal** and **in situ**

Definitions

Contiguous Sites:

- Renal pelvis
- Ureter
- Bladder
- Urethra/prostatic urethra

Field effect: Widespread changes in normal or relatively normal tissue that predispose a person to cancer

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations C659, C669, C670-C679, C680-C689 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Flat Tumor (bladder)/Noninvasive flat TCC: A flat tumor is a non-papillary bladder tumor that lies flat against the bladder tissue. Flat tumors usually have a poor prognosis. Noninvasive flat TCC (also called carcinoma in situ, or CIS) grows in the layer of cells closest to the inside of the bladder and appears as flat lesions on the inside surface of the bladder. Flat, invasive TCC may invade the deeper layers of the bladder, particularly the muscle layer.

In situ: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane

Intraluminal (Ureter): Within the lumen of a tubular or hollow structure. Urinary tumors may spread intraluminally to adjacent urinary organs.

Intramucosal: Within the mucosal surface.

Invasive: A tumor that penetrates beyond the basement membrane.

Most invasive: The tumor with the greatest continuous local/regional extension (see focal and foci/focus definitions).

Bladder

The walls of the **bladder** in order from least to greatest extension are:

- Mucosa
- Lamina propria (some pathologists equate this to submucosa)
- Muscularis mucosae (this layer not always present, may not be mentioned)
- Submucosa
- Muscular layer (muscularis propria, detrusor muscle)
- Serosa, adventitia

Renal pelvis and ureter

The walls of the **renal pelvis** and **ureter** from least to greatest extension are:

- Epithelium
- Subepithelial connective tissue, submucosa
- Periureteric fat, peripelvic fat.

Multicentric, multifocal, and polycentric are often used as synonyms. The tumor has multiple centers. The foci are not contiguous.

Non-invasive tumor: A tumor confined to epithelium (intraepithelial) with no penetration below the basement membrane.

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Papillary tumor: A papillary bladder, ureter, or renal pelvis tumor is a warty growth that is attached to the wall by a stalk.

Papillary and Flat Carcinomas: Urothelial carcinomas may be either flat or papillary. The terms papillary and flat describe the structure or architecture of the tumor, not a specific histologic type. Both are transitional cell/urothelial carcinoma, although there are behavioral differences between the two.

Prostatic Urethra: Adenocarcinoma of the prostatic urethra is usually an extension of adenocarcinoma of the prostate. Transitional cell/urothelial carcinoma in the prostatic urethra may be an extension from the bladder or may be primary in the prostatic urethra. .

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor.

Transitional cell carcinoma usually begins in the renal pelvis, not in the kidney. The cancer cells are different from renal cell carcinoma.

Transitional epithelium: A highly expandable epithelium that has a layered appearance with large cube-shaped cells in the relaxed state that transform and stretch into broad and flat cells in the expanded or distended state.

Urinary tract: Structures lined by transitional epithelium also known as urothelium.

Urothelium: The transitional epithelium lining the wall of the bladder, ureter, and renal pelvis, external to the basement membrane.

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations C659, C669, C670-C679, C680-C689 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Urothelial Tumors
Note: Excludes pure squamous carcinoma, glandular (adeno) carcinoma, or other bladder tumor histologies.

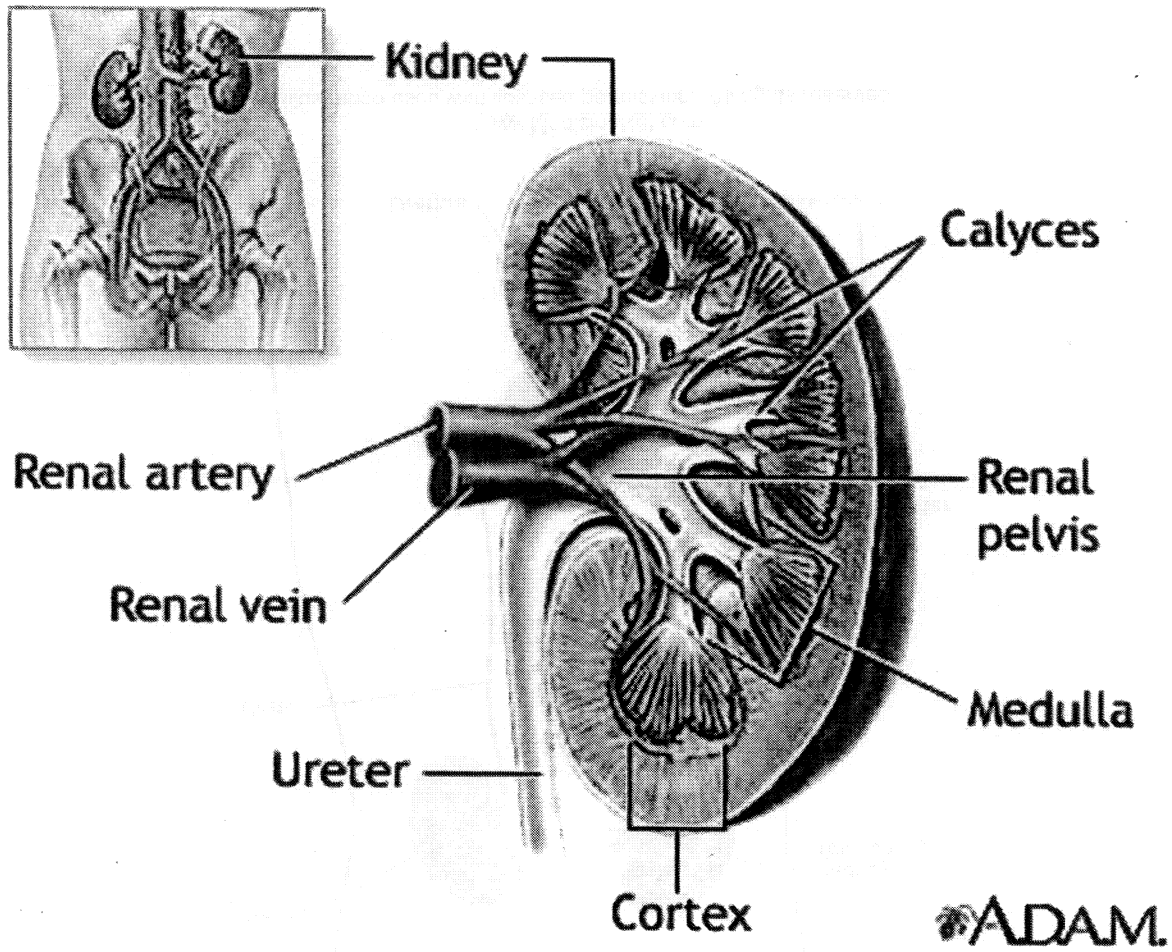
Urothelial/Transitional Cell Tumors	Code
With squamous differentiation	8120
With glandular differentiation	
With trophoblastic differentiation	
Nested	
Microcystic	
Transitional cell, NOS	
Papillary carcinoma	8130
Papillary transitional cell	
Micropapillary	8131
Lymphoepithelioma-like	8082
Plasmacytoid	
Sarcomatoid	8122
Giant cell	8031
Undifferentiated	8020

Table 2 – Changes to Previous SEER Site Grouping Table

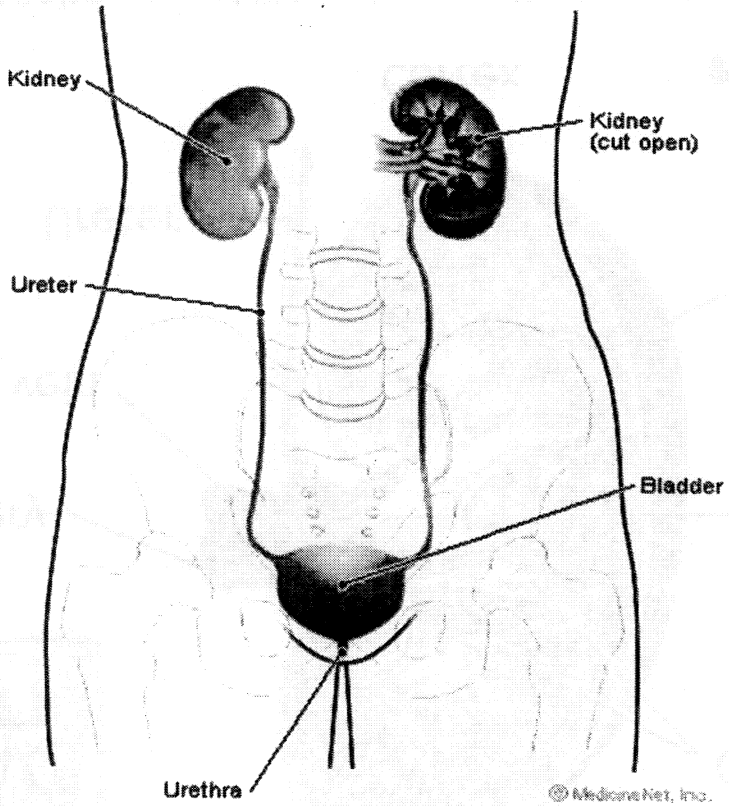
Previous to 2007, tumors in the sites below were abstracted as a single primary.

Code	Site Grouping
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs

Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



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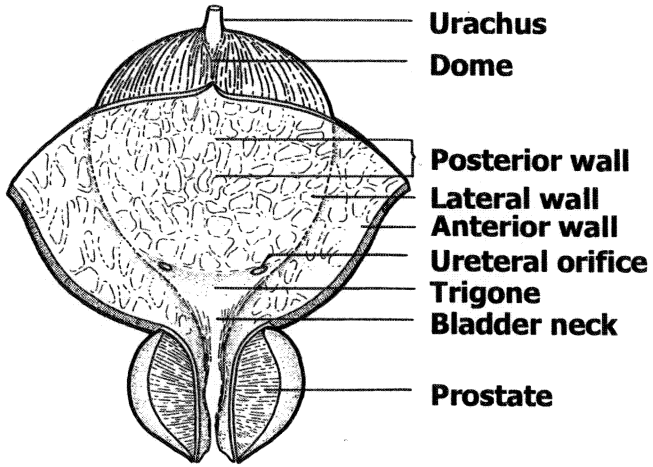
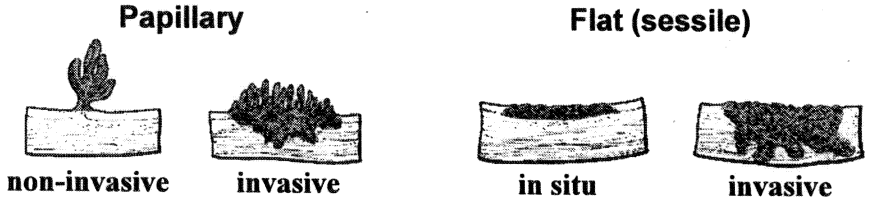
Renal Pelvis, Ureter, Bladder, and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Source: TNM Atlas, 3rd edition, 2nd revision



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Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 When no other urinary sites are involved, tumor(s) in the **right renal pelvis AND** tumor(s) in the **left renal pelvis** are multiple primaries. **
Note: Use this rule and abstract as a multiple primary unless documented to be metastatic

Rule M4 When no other urinary sites are involved, tumor(s) in both the **right ureter AND** tumor(s) in the **left ureter** are multiple primaries. **
Note: Use this rule and abstract as a multiple primary unless documented to be metastatic

Renal Pelvis, Ureter, Bladder, and Other Urinary Multiple Primary Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule M5 An **invasive** tumor **following** a **non-invasive or in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease

Rule M6 Bladder tumors with any **combination** of the following histologies: **papillary carcinoma** (8050), **transitional cell carcinoma** (8120-8124), **or papillary transitional cell carcinoma** (8130-8131), are a single primary. *

Rule M7 Tumors diagnosed **more than three (3) years** apart are multiple primaries. **

Rule M8 Urothelial tumors in two or more of the following sites are a single primary* (See Table 1)

- Renal pelvis (C659)
- Ureter(C669)
- Bladder (C670-C679)
- Urethra /prostatic urethra (C680)

Rule M9 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M10 Tumors in sites with ICD-O-3 **topography** codes with **different** second (Cxxx) and/or third characters (Cxxx) are multiple primaries*

Rule M11 Tumors that **do not meet any** of the above **criteria** are a single primary.*
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

This is the end of instructions for Multiple Tumors.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available.**

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H3 Code **8120** (transitional cell/urothelial carcinoma) (Table 1 - Code 8120) when there is:
- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

Rule H4 Code **8130** (papillary transitional cell carcinoma) (Table 1 - Code 8130) when there is:
- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

Rule H5 Code the histology when only **one histologic type** is identified

Note : Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Rule H6 Code the invasive histologic type when a single tumor has **invasive and in situ** components.

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H7 **Code the** most **specific** histologic **term**:

Examples

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H8 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H9 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H10 Code the histology from the metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Renal Pelvis, Ureter, Bladder, and Other Urinary Histology Coding Rules – Text
C659, C669, C670-C679, C680-C689
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code **8120** (transitional cell/urothelial carcinoma) (Table 1 – Code 8120) when there is:

- Pure transitional cell carcinoma or
- Flat (non-papillary) transitional cell carcinoma or
- Transitional cell carcinoma with squamous differentiation or
- Transitional cell carcinoma with glandular differentiation or
- Transitional cell carcinoma with trophoblastic differentiation or
- Nested transitional cell carcinoma or
- Microcystic transitional cell carcinoma

Note: Flat transitional cell carcinoma is a more important prognostic indicator than papillary, and is likely to be treated more aggressively.

Rule H12 Code **8130** (papillary transitional cell carcinoma) (Table 1 – Code 8130) when there is:

- Papillary carcinoma or
- Papillary transitional cell carcinoma or
- Papillary carcinoma and transitional cell carcinoma

Rule H13 Code the histology when only **one histologic type** is identified

Note: Only code squamous cell carcinoma (8070) when there are no other histologies present (pure squamous cell carcinoma).

Rule H14 Code the histology of the **most invasive** tumor.

Note: See the Renal Pelvis, Ureter, Bladder and Other Urinary Equivalent Terms, Definitions, Tables and Illustrations for the definition of most invasive.

- If one tumor is in situ and one is invasive, code the histology from the invasive tumor.
- If both/all histologies are invasive, code the histology of the most invasive tumor.

Rule H15 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Equivalent Terms, Definitions, Charts and Illustrations C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

There are two types of cells that make up the nervous system: *neurons* and *neuroglia* . Neurons send and receive nerve messages. Neuroglia, otherwise known as *glial cells* , often surround the neurons. Glial cells play a supportive role by nourishing, protecting and supporting neurons. There are six kinds of glial cells; oligodendrocytes, astrocytes, ependymal cells, Schwann cells, microglia, and satellite cells. http://www.braintumorfoundation.org/tumors/primer.htm.

It is important to know that any of the glial tumors (Chart 1) can recur as a glioblastoma or glioblastoma multiforme.

Equivalent or Equal Terms (Terms that can be used interchangeably)

- Tumor, mass, lesion, neoplasm
- Type, subtype, variant

Definitions

Astrocytoma: A tumor that begins in the brain or spinal cord in small, star-shaped cells called astrocytes. "Astrocytoma" is a term that applies to a group of neoplasms that can be divided into the following clinical-pathological components: Diffuse astrocytomas, anaplastic astrocytomas (grade III), and glioblastoma multiforme (grade IV).

Cerebellum: The part of the brain below the back of the cerebrum. It regulates balance, posture, movement, and muscle coordination.

Corpus Callosum: A large bundle of nerve fibers that connect the left and right cerebral hemispheres. In the lateral section, it looks a bit like a "C" on its side.

Ependymoma: A glioma derived from relatively undifferentiated ependymal cells, comprising approximately 1–3% of all intracranial neoplasms. Ependymomas occur in all age groups and may originate from the lining of any of the ventricles or, more commonly, from the central canal of the spinal cord. Histologically, the neoplastic cells tend to be arranged radially around blood vessels, to which they are attached by means of fibrillary processes.

Frontal Lobe of the Cerebrum: The top, front region of each of the cerebral hemispheres. Used for reasoning, emotions, judgment, and voluntary movement.

Glioblastoma: A malignant rapidly growing Astrocytoma of the central nervous system. These neoplasms grow rapidly, invade extensively, and occur most frequently in the cerebrum of adults. Any glial tumor can recur as a glioblastoma or a glioblastoma multiforme (see Chart 1)

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Equivalent Terms, Definitions, Charts and Illustrations C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Glioma: Any neoplasm derived from one of the various types of cells that form the interstitial tissue of the brain, spinal cord, pineal gland, posterior pituitary gland, and retina. About half of all primary brain tumors and one-fifth of all primary spinal cord tumors form from glial cells. Gliomas tend to grow in the cerebral hemispheres, but may also occur in the brain stem, optic nerves, spinal cord, and cerebellum.Gliomas are divided into subgroups depending on the origin of the glial cells. The most common type of glioma is an astrocytoma.

Infratentorial: Tumors located in the posterior fossa, cerebellum, or fourth ventricle.

Medulla Oblongata: The lowest section of the brainstem (at the top end of the spinal cord). It controls automatic functions including heartbeat, breathing, etc.

Medulloblastoma: A tumor consisting of neoplastic cells that resemble the undifferentiated cells of the primitive medullary tube; medulloblastomas are usually located in the vermis of the cerebellum, and may be implanted discretely or coalescently on the surfaces of the cerebellum, brainstem, and spinal cord. They comprise approximately 3% of all intracranial neoplasms, and occur most frequently in children. A type of primitive neuroectodermal tumor.

Mixed glioma: The presence of at least two of the following cells/differentiation in a single tumor: astrocytic; oligodendroglial; ependymal

Occipital Lobe of the Cerebrum - the region at the back of each cerebral hemisphere that contains the centers of vision and reading ability (located at the back of the head).

Oligodendroglioma: A relatively rare, relatively slowly growing glioma derived from oligodendrocytes that occurs most frequently in the cerebrum of adults

Parietal Lobe of the Cerebrum: The middle lobe of each cerebral hemisphere between the frontal and occipital lobes. It contains important sensory centers (located at the upper rear of the head).

Pituitary Gland: A gland attached to the base of the brain that secretes hormones. It is located between the Pons and the Corpus Callosum, above the Medulla Oblongata. Synonym: Hypophysis.

PNET (Primitive Neuroectodermal Tumor): A group of malignant central nervous system tumors that includes medulloblastoma, pineoblastoma, ependymoblastoma, retinoblastoma, neuroblastoma, esthesioneuroblastoma, medulloepithelioma and ganglioneuroblastoma. Tumors are composed of primitive, undifferentiated embryonal cell lines and frequently classified according to anatomic location. Also known as central PNET or supratentorial PNET, depending on location of the tumor.

pPNET (peripheral Primitive Neuroectodermal Tumor): These tumors usually occur in the soft tissues of the chest, pelvis, and retroperitoneum and are rarely intracranial. There is known clinical and histological association between pPNET and both extraosseous Ewing sarcoma and peripheral neuroblastoma. Peripheral PNET is clinically and pathologically distinct from central PNET.

Satellite lesion or metastasis: Metastatic lesion within the immediate vicinity of the primary tumor. This is a metastasis, not a separate primary.

Spinal Cord - a thick bundle of nerve fibers that runs from the base of the brain to the hip area, running through the spine (vertebrae).

Supratentorial: Tumors located in the sellar or suprasellar region or in other areas of the cerebrum.

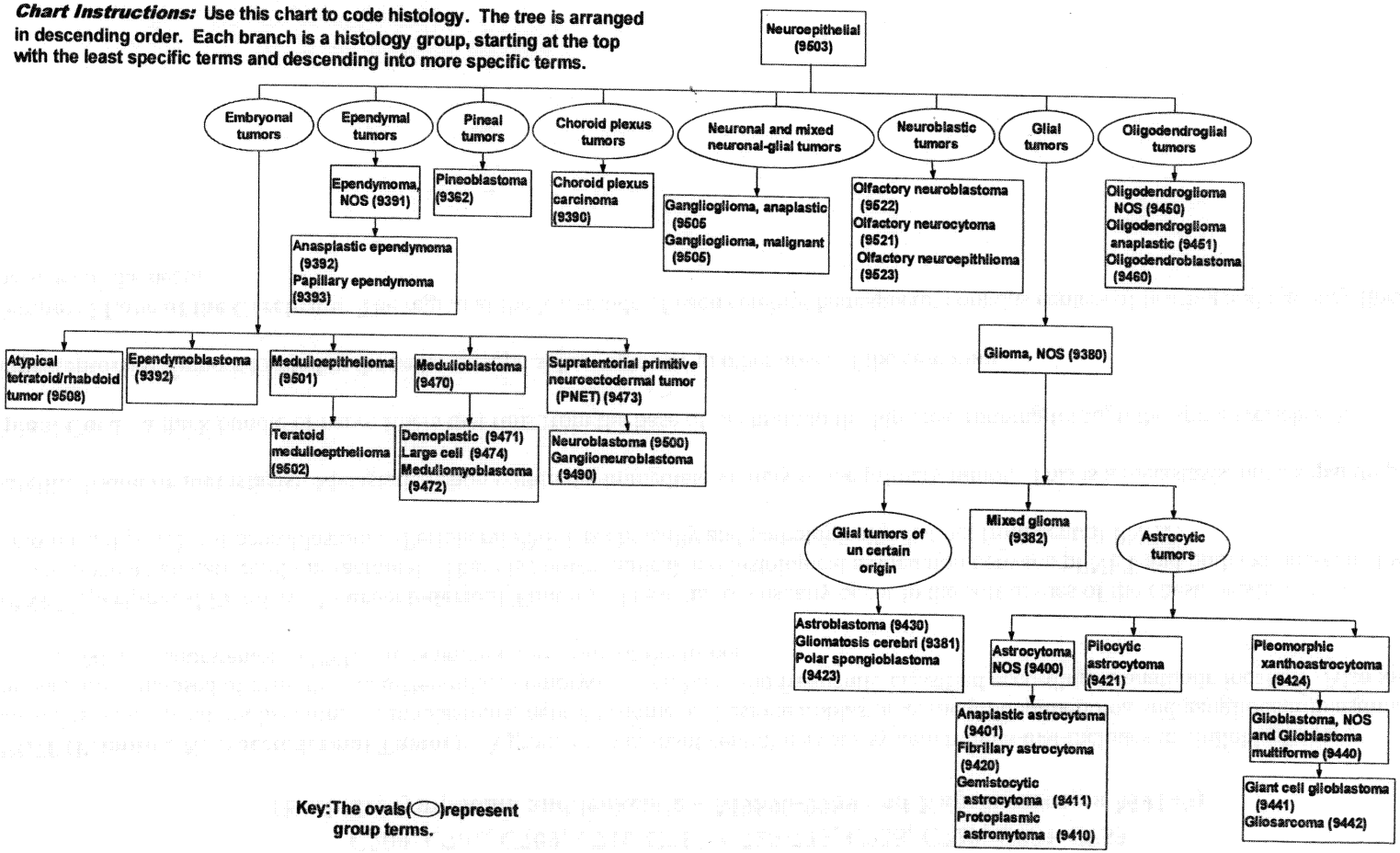
Temporal Lobe of the Cerebrum: The region at the lower side of each cerebral hemisphere; contains centers of hearing and memory (located at the sides of the head).

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Equivalent Terms, Definitions, Charts and Illustrations C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Chart 1 –Neuroepithelial Malignant Brain and Central Nervous System Tumors

Note: This chart is based on the *WHO Classification of Tumors* of the brain and central nervous system. The chart is **not** a complete listing of histologies that may occur in the brain or central nervous system.

Chart Instructions: **Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.**

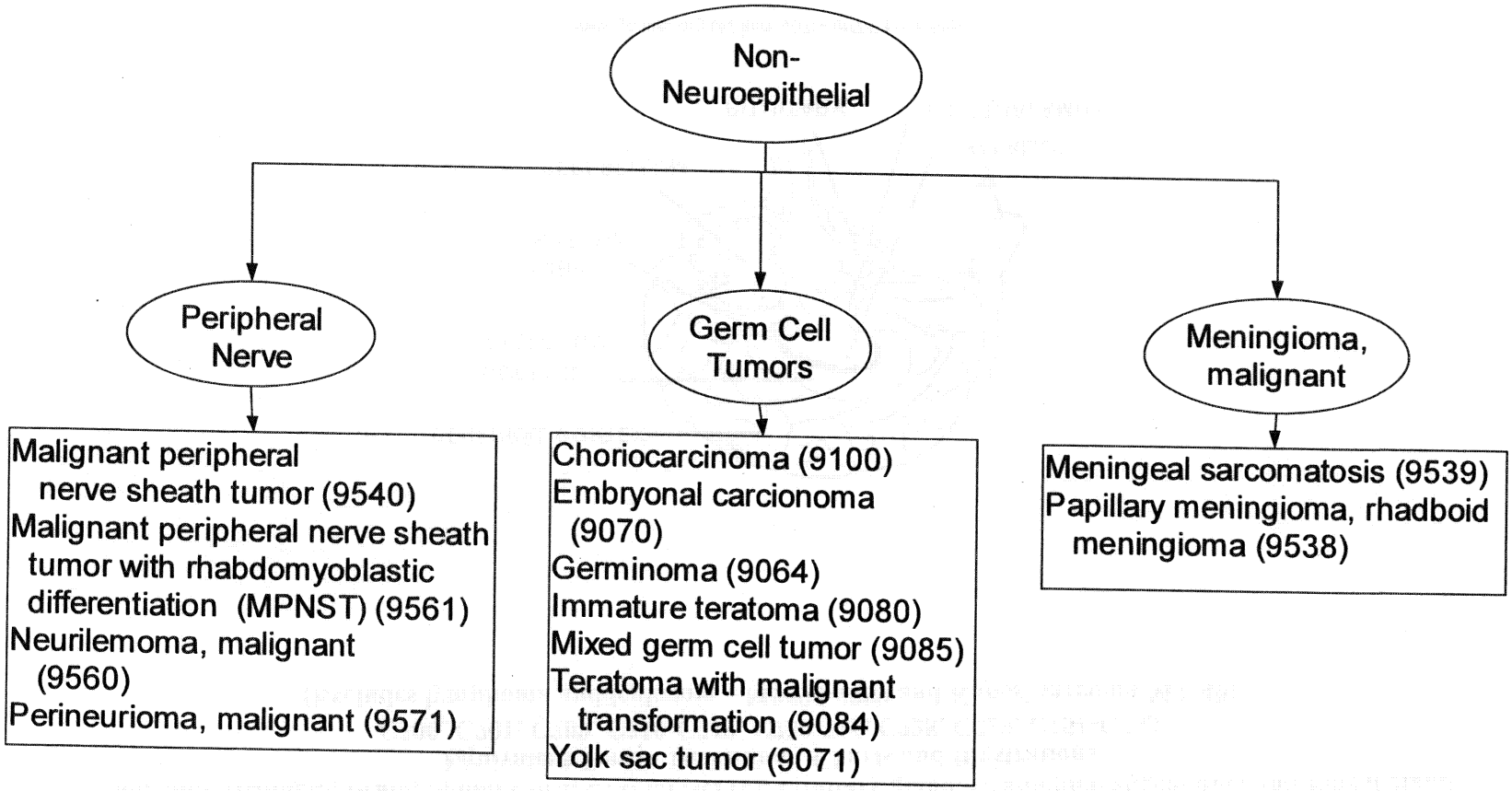


Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

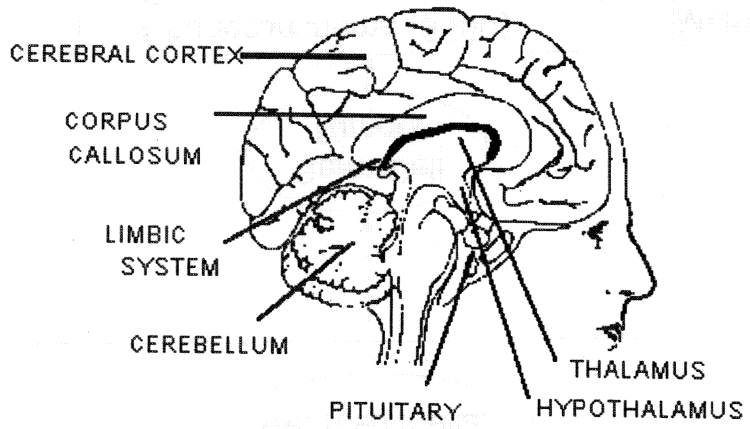
Chart 2 – Non-neuroepithelial Malignant Brain and Central Nervous System Tumors

Chart Instructions: Use this chart to code histology. The tree is arranged in descending order. Each branch is a histology group, starting at the top with the least specific terms and descending into more specific terms.

Note: Chart 2 is based on the *WHO Classification of Tumors* of the brain and central nervous system. This chart is **not** a complete listing of histologies that may occur in the brain or central nervous system.

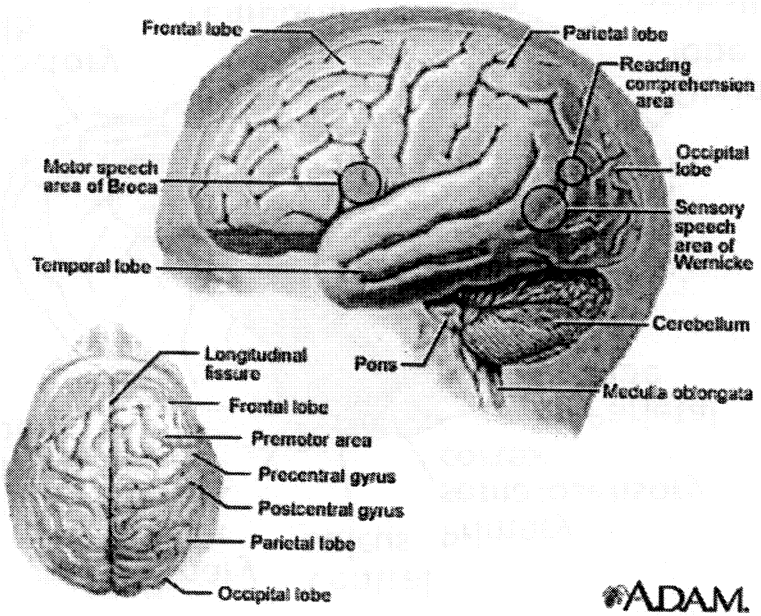


Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland Equivalent Terms, Definitions, Charts and Illustrations C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753 (Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

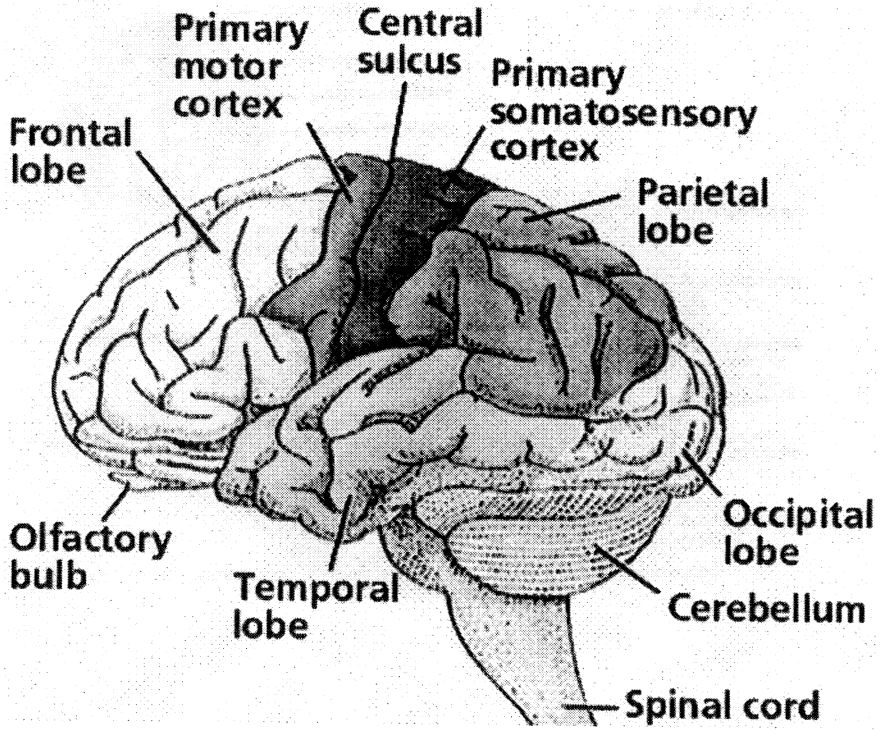


www.gender.org.uk/ about/07neur/74_brain.htm

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)



Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Equivalent Terms, Definitions, Charts and Illustrations
C700, C701, C709, C710-C719, C720-725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)



Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 An **invasive** brain tumor (/3) **and either** a **benign** brain tumor (/0) **or** an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **

Rule M2 When it is not possible to determine if there is a **single** tumor **or multiple tumors**, opt for a single tumor and abstract as a single primary.*
Note: Use this rule only after all information sources have been exhausted

This is the end of instructions for Unknown if Single or Multiple Tumors.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

SINGLE TUMOR

Note: Tumor not described as metastasis

Rule M3 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

This is the end of instructions for Single Tumor.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note: Tumors not described as metastases

Rule M4 An **invasive** brain tumor (/3) **and either** a **benign** brain tumor (/0) **or** an **uncertain/borderline** brain tumor (/1) are always multiple primaries. **

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Multiple Primary Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Rule M5 Tumors in sites with ICD-O-3 **topography** codes with **different** second (Cxxx) and/or third characters (Cxxx) are multiple primaries.**

Rule M6 A glioblastoma or glioblastoma multiforme (9440) following a glial tumor is a single primary* (See Chart 1)

Rule M7 Tumors with ICD-O-3 histology codes on the **same** branch in Chart 1 or Chart 2 are a single primary.*
Note: Recurrence, progression, or any reappearance of histologies on the same branch in Chart 1 or Chart 2 is always the same disease process.
Example: Patient has an astrocytoma. Ten years later the patient is diagnosed with glioblastoma multiforme. This is a progression or recurrence of the earlier astrocytoma.

Rule M8 Tumors with ICD-O-3 histology codes on **different** branches in Chart 1 or Chart 2 are multiple primaries. **

Rule M9 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M10 Tumors that **do not meet any** of the above **criteria** are a single primary. *
Note 1: Neither timing nor laterality is used to determine multiple primaries for malignant intracranial and CNS tumors.
Example: The patient is treated for an anaplastic astrocytoma (9401) in the right parietal lobe. Three months later the patient is diagnosed with a separate anaplastic astrocytoma in the left parietal lobe. This is one primary because laterality is not used to determine multiple primary status.
Note 2: Multicentric brain tumors which involve different lobes of the brain that do not meet any of the above criteria are the same disease process.

This is the end of instructions for Multiple Tumors.
*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

Note: Benign and borderline intracranial and CNS tumors have a separate set of rules.

SINGLE TUMOR

Rule H1 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology report** is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H3 Code **9382/3** (mixed glioma) when **at least two** of the following cells and/or differentiation are present:
- Astrocytic
- Oligodendroglial
- Ependymal

Rule H4 Code the histology when only **one histologic type** is identified.

Rule H5 Code the specific type when the diagnosis includes a **non-specific** term **and** a **specific** term or type **on** the **same branch** in Chart 1 or Chart 2.

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

Malignant Meninges, Brain, Spinal Cord, Cranial Nerves, Pituitary gland, Craniopharyngeal duct and Pineal gland
Histology Coding Rules – Text
C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
(Excludes lymphoma and leukemia – M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H7 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or as stated by the physician when nothing more specific is documented.

Rule H8 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site.**

Note: Code the behavior /3.

Rule H9 Code the histology when only **one histologic type** is identified.

Rule H10 Code the specific type when the diagnosis includes a **non-specific** term **and** a **specific** term or type **on** the **same branch** in Chart 1 or Chart 2.

Rule H11 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Other Sites Equivalent Terms, Definitions and Tables
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast,
Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

INTRODUCTION

The Other Sites rules cover rectosigmoid, rectum and all sites not included in the site-specific rules.

EQUIVALENT TERMS

Acinar adenocarcinoma, adenocarcinoma (For prostate primaries only)
Adenocarcinoma, glandular carcinoma

DEFINITIONS

Acinar adenocarcinoma of the prostate: The prostate gland is sponge-like consisting primarily of acini or very tiny sacs that produce the fluids for ejaculation. Acinar adenocarcinoma is not a specific histologic type. The term acinar refers to the fact that the adenocarcinoma originates in the prostatic acini. 95% of all prostate cancers are (acinar) adenocarcinoma.

Adenoacanthoma: Adenocarcinoma with squamous metaplasia.

Parametrium: The connective tissue of the pelvic floor extending from the fibrous subserous coat of the supracervical portion of the uterus laterally between the layers of the broad ligament.

Uterine adnexa: The appendages of the uterus, namely the ovaries, fallopian tubes, and ligaments that hold the uterus in place.

Other Sites Equivalent Terms, Definitions and Tables
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Table 1 – Paired Organs and Sites with Laterality

Note: This table only includes anatomic sites covered by the Other Sites Rules.

Site Code	Site or Subsite
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib, clavicle (excluding sternum)
C414	Pelvic bones (excluding sacrum, coccyx, symphysis pubis)
C441	Skin of the eyelid
C442	Skin of the external ear
C443	Skin of other and unspecific parts of the face (if midline, assign code 9)
C445	Skin of the trunk (if midline, assign code 9)
C446	Skin of upper limb and shoulder
C447	Skin of the lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of the lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of the lower limb and hip
C569	Ovary
C570	Fallopian tube
C620-C629	Testis
C630	Epididymis
C631	Spermatic cord
C690-C699	Eye and adnexa
C740-C749	Adrenal gland
C754	Carotid body

Table 2 – Mixed and Combination Codes

This table is used to determine mixed and combination codes ONLY

Apply the multiple primary rules FIRST. Combination codes are most often used when multiple histologies are present in a single tumor; they are rarely used for multiple tumors. Use a combination code for multiple tumors ONLY when the tumors meet the rules for a single primary.

Use this **two-page** table to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

Column 1: Required Histology	**Column 2: Combined with Histology**	**Column 3: Combination Term**	**Column 4: Code**
Small cell carcinoma	Large cell carcinoma	Combined small cell carcinoma	8045
	Adenocarcinoma		
	Squamous cell carcinoma		
Squamous carcinoma	Basal cell carcinoma	Basosquamous carcinoma	8094
Islet cell	Exocrine	Mixed islet cell and exocrine adenocarcinoma (pancreas)	8154
Acinar	Endocrine		
Hepatocellular carcinoma	Cholangiocarcinoma	Combined hepatocellular carcinoma and cholangiocarcinoma	8180
Adenocarcinoma	Carcinoid	Composite carcinoid	8244
Adenocarcinoma	Papillary	Adenocarcinoma with mixed subtypes Adenocarcinoma combined with other types of carcinoma	8255
	Clear cell		
	Mucinous (colloid)		
	Signet ring		
	Acinar		
Table 2 continues on the next page			

Other Sites Equivalent Terms, Definitions and Tables
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Table 2 continued			
Gyn malignancies with two or more of the histologies in column 2	Clear cell Endometroid Mucinous Papillary Serous Squamous Transitional (Brenner)	Mixed cell adenocarcinoma	8323
Papillary and Follicular		Papillary carcinoma, follicular variant	8340
Medullary	Follicular	Mixed medullary-follicular carcinoma	8346
Medullary	Papillary	Mixed medullary-papillary carcinoma	8347
Squamous carcinoma and Adenocarcinoma		Adenosquamous carcinoma	8560
Any combination of histologies in Column 2	Myxoid Round cell Pleomorphic	Mixed liposarcoma	8855
Embryonal rhabdomyosarcoma	Alveolar rhabdomyosarcoma	Mixed type rhabdomyosarcoma	8902
Teratoma	Embryonal carcinoma	Teratocarcinoma	9081
Teratoma and one or more of the histologies in Column 2	Seminoma Yolk sac tumor	Mixed germ cell tumor	9085
Choriocarcinoma	Teratoma Seminoma Embryonal	Choriocarcinoma combined with other germ cell elements	9101

Table 3 – Changes to Previous SEER Site Grouping Table

Previous to 2007, tumors in sites on the same row were abstracted as a single primary.

Code	Site Groupings
C23	Gallbladder
C24	Other and unspecified parts of the biliary tract
C37	Thymus
C380	Heart
C381-3	Mediastinum
C388	Overlapping lesion of heart, mediastinum, and pleura
C51	Vulva
C52	Vagina
C577	Other specified female genital organs
C578-9	Unspecified female genital organs
C569	Ovary
C570	Fallopian tube
C571	Broad ligament
C572	Round ligament
C573	Parametrium
C574	Uterine adnexa
C60	Penis
C63	Other and unspecified male genital organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

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Other Sites Multiple Primary Rules – Text
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary. *
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M3 **Adenocarcinoma** of the **prostate** is always a single primary. *
Note 1: Report only one adenocarcinoma of the prostate per patient per lifetime.
Note 2: 95% of prostate malignancies are the common (acinar) adenocarcinoma histology (8140). See Equivalent Terms, Definitions and Tables for more information.

Other Sites Multiple Primary Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemi

Rule M4 **Retinoblastoma** is always a single primary (**unilateral or bilateral**). *

Rule M5 **Kaposi sarcoma** (any site or sites) is always a single primary. *

Rule M6 **Follicular and papillary** tumors in the **thyroid** within 60 days of diagnosis are a single primary. *

Rule M7 **Bilateral epithelial** tumors (8000-8799) of the **ovary** within 60 days are a single primary. *

Rule M8 Tumors on **both sides** (right and left) of a site listed in Table 1 are multiple primaries. **
Note: Table 1 – Paired Organs and Sites with Laterality)

Rule M9 Adenocarcinoma in adenomatous polyposis coli (**familial polyposis**) with one or more in situ or malignant polyps is a single primary.*
Note: Tumors may be present in a single or multiple segments of the **colon, rectosigmoid, rectum**.

Rule M10 Tumors diagnosed **more than one (1) year** apart are multiple primaries. **

Rule M11 Tumors with ICD-O-3 **topography** codes that are **different** at the second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries. **
Example 1: A tumor in the penis C**6**09 and a tumor in the rectum C**2**09 have different second characters in their ICD-O-3 topography codes, so they are multiple primaries.
Example 2: A tumor in the cervix C5**3**9 and a tumor in the vulva C5**1**9 have different third characters in their ICD-O-3 topography codes, so they are multiple primaries.

Rule M12 Tumors with ICD-O-3 **topography** codes that **differ** only at the **fourth character** (Cxx**x**) and are **in** any one of the following primary sites are multiple primaries. **

- **Anus and anal canal** (C21_)
- **Bones, joints, and articular cartilage** (C40_- C41_)
- **Peripheral nerves and autonomic nervous system** (C47_)
- **Connective subcutaneous and other soft tissues** (C49_)
- **Skin** (C44_)

Other Sites Multiple Primary Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule M13 A **frank** in situ or malignant **adenocarcinoma and** an in situ or **malignant** tumor in a **polyp** are a single primary. *

Rule M14 **Multiple** in situ and/or **malignant polyps** are a single primary. *
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.

Rule M15 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M16 Abstract as a single primary* when one tumor is:

- **Cancer/malignant neoplasm, NOS** (8000) **and** another is a **specific histology** or
- **Carcinoma, NOS** (8010) **and** another is a **specific carcinoma** or
- **Squamous cell carcinoma, NOS** (8070) and another is **specific squamous cell carcinoma** or
- **Adenocarcinoma, NOS** (8140) **and** another is a **specific adenocarcinoma** or
- **Melanoma, NOS** (8720) and another is a **specific melanoma**
- **Sarcoma, NOS** (8800) and another is a **specific sarcoma**

Rule M17 Tumors with ICD-O-3 **histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **

Rule M18 Tumors that **do not meet any** of the above **criteria** are a single primary. *
Note: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

SINGLE TUMOR: IN SITU ONLY

(Single Tumor; all parts are in situ)

Rule H1 Code the histology documented by the physician when the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer in the medical record

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H2 Code the histology when only **one histologic type** is identified.

Note: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Rule H3 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H4 **Code the** most **specific** histologic **term** when the diagnosis is:

- Carcinoma in situ, NOS (8010) and a specific in situ carcinoma or
- Squamous cell carcinoma in situ, NOS (8070) and a specific in situ squamous cell carcinoma or
- Adenocarcinoma in situ, NOS (8140) and a specific in situ adenocarcinoma or
- Melanoma in situ, NOS (8720) and a specific in situ melanoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H5 Code the appropriate combination/mixed code (Table 2) when there are **multiple specific histologies** or when there is a non-specific histology **with multiple specific histologies**

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H6 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU

(Single Tumor; in situ and invasive components)

Rule H7 Code the single invasive histology. **Ignore the in situ** terms.

Note: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

SINGLE TUMOR: INVASIVE ONLY

(Single Tumor; all parts are invasive)

Rule H8 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- CT, PET, or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H9 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H10 Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H11 Code the histology when only **one histologic type** is identified

Note: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Rule H12 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma and there is reference to a residual or pre-existing polyp or
- The final diagnosis is adenocarcinoma mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H13 **Code the** most **specific** histologic **term.** Examples include:

- Cancer/malignant neoplasm, NOS (8000) **and** a more specific histology or
- Carcinoma, NOS (8010) **and** a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) **and** a more specific squamous cell carcinoma or
- Adenocarcinoma, NOS (8140) **and** a more specific adenocarcinoma or
- Melanoma, NOS (8720) **and** a more specific melanoma or
- Sarcoma, NOS (8800) **and** a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.
Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.
Example 2: Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma 8052.

Rule H14 Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Rule H15 Code follicular and papillary carcinoma of the thyroid to papillary carcinoma, follicular variant (8340).

Rule H16 Code the appropriate combination/mixed code (Table 2) when there are **multiple specific histologies** or when there is a non-specific histology **with multiple specific histologies**
Note: The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with ____ differentiation.
Example 1 (multiple specific histologies): Mucinous and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes)
Example 2 (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma)
Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)

Rule H17 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H18 Code the histology documented by the physician when there is **no** pathology/cytology specimen or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- From reports or notes in the medical record that document or reference pathologic or cytologic findings
- From clinician reference to type of cancer (histology) in the medical record
- CT, PET or MRI scans

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H19 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H20 Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma.

Rule H21 Code 8077/2 (Squamous intraepithelial neoplasia, grade III) for in situ squamous intraepithelial **neoplasia grade III** in sites such as the **vulva** (VIN III) **vagina** (VAIN III), or **anus** (AIN III).

Note 1: VIN, VAIN, and AIN are squamous cell carcinomas. Code 8077 cannot be used for glandular intraepithelial neoplasia such as prostatic intraepithelial neoplasia (PIN) or pancreatic intraepithelial neoplasia (PAIN).

Note 2: This code may be used for reportable-by-agreement cases

Rule H22 Code 8148/2 (Glandular intraepithelial neoplasia grade III) for in situ glandular **intraepithelial neoplasia grade III** in sites such as the **pancreas** (PAIN III).

Note: This code may be used for reportable-by-agreement cases such as intraepithelial neoplasia of the **prostate** (PIN III)

Rule H23 Code the histology when only **one histologic type** is identified

Note: Do not code terms that do not appear in the histology description.

Example: Do not code squamous cell carcinoma non-keratinizing unless the words "non-keratinizing" actually appear in the diagnosis.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H24 Code the histology of the underlying tumor when there is **extramammary Paget disease** and an underlying tumor of the **anus**, **perianal** region, or **vulva**.

Rule H25 Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:

- The final diagnosis is adenocarcinoma in a polyp or
- The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report or
- The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
- The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
- There is documentation that the patient had a polypectomy

Note: It is important to know that the adenocarcinoma originated in a polyp.

Rule H26 Code papillary carcinoma of the thyroid to papillary adenocarcinoma, NOS (8260).

Rule H27 Code **follicular** and **papillary** carcinoma of the **thyroid** to papillary carcinoma, follicular variant (8340).

Rule H28 Code the single invasive histology for **combinations** of **invasive** and **in situ.** Ignore the in situ terms.
Note: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category.

Rule H29 **Code the** most **specific** histologic **term.** Examples include:

- Cancer/malignant neoplasm, NOS (8000) **and** a more specific histology or
- Carcinoma, NOS (8010) **and** a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) **and** a more specific squamous cell carcinoma or
- Adenocarcinoma, NOS (8140) **and** a more specific adenocarcinoma or
- Melanoma, NOS (8720) **and** a more specific melanoma or
- Sarcoma, NOS (8800) **and** a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.
Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.
Example 2: Non-small cell carcinoma, papillary squamous cell. Code papillary squamous cell carcinoma 8052.

Other Sites Histology Coding Rules – Text

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia

Rule H30 Code the appropriate combination/mixed code (Table 2) when there are **multiple specific histologies** or when there is a non-specific histology **with multiple specific histologies**

Note: The specific histologies may be identified as a type, subtype, predominantly, with features of, major, or with ____ differentiation.

Example 1 (multiple specific histologies): Gyn malignancy with mucinous, serous and papillary adenocarcinoma. Code 8323 (mixed cell adenocarcinoma)

Example 2 (multiple specific histologies): Combined small cell and squamous cell carcinoma. Code 8045 (combined small cell carcinoma)

Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)

Rule H31 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

IX.
New Data Items

New Data Item
Effective with cases diagnosed 1/1/2007

Ambiguous Terminology

Item Length: 1
NAACCR Item #: 442
NAACCR Name: Ambiguous Terminology

This data item identifies all cases, including DCO and autopsy only, which are accessioned based only on ambiguous terminology. Registrars are required to collect cases with ambiguous terminology and it is advantageous to be able to identify those cases in the database.

Code	Label	Definition	Time Frame	Examples
0	Conclusive term	There was a conclusive diagnosis within 60 days of the original diagnosis. Case was accessioned based on conclusive terminology. Includes all diagnostic methods such as clinical diagnosis, cytology, pathology, etc.	Within 60 days of the date of initial diagnosis.	1. Adenocarcinoma in TURP chips. 2. Mammogram suspicious for DCIS. Excisional biopsy 1 week later positive for DCIS.
1	Ambiguous term only	The case was accessioned based only on ambiguous terminology. There was no conclusive terminology during the first 60 days following the initial diagnosis. Includes all diagnostic methods except cytology. *Note:* Cytology is excluded because registrars are not required to collect cases with ambiguous terms describing a cytology diagnosis.	N/A	1. Chest MRI shows a malignant appearing lesion in the right upper lobe. Patient refused further workup or treatment. 2. Pt with elevated PSA admitted for TRUS. Biopsy. Pathology: Prostatic chips: Consistent with adenocarcinoma. No further information is available
2	Ambiguous term followed by conclusive term	The case was originally assigned a code 1 (was accessioned based only on ambiguous terminology). More than 60 days after the initial diagnosis the information is being updated to show that a conclusive diagnosis was made by any diagnostic method including clinical diagnosis, cytology, pathology, autopsy, etc.	60 days or more after the date of diagnosis	The biopsy of the thyroid reads: most likely thyroid cancer. Three months later a biopsy is positive for papillary follicular cancer. The case would have been coded 1 Ambiguous term only. Change the code to 2 Ambiguous term followed by conclusive term.
9	Unknown term	There is no information about ambiguous terminology..	N/A	.

Definitions

Phrase	Definition	Examples
Ambiguous terminology	Terms that have been mandated as reportable when used in a diagnosis. See the reportable list below for a complete listing of those terms. See the 2007 SEER Coding and Staging Manual or the FORDS for detailed instructions on how to use the list.	**Clinical:** a physician's statement that the patient most likely has lung cancer. **Laboratory tests:** A CBC suspicious for leukemia. **Pathology:** A prostate biopsy compatible with adenocarcinoma
Conclusive terminology	A clear and definite statement of cancer. The statement may be from a physician (clinical diagnosis); or may be from a laboratory test, autopsy, cytologic findings, and/or pathology	**Clinical:** a physician's statement that the patient has lung cancer. **Laboratory tests:** A CBC diagnostic of acute leukemia. **Cytologic findings:** A FNA (fine needle aspiration) with findings of infiltrating duct carcinoma of the breast. **Pathology:** A colon biopsy showing adenocarcinoma

New Data Item
Effective with cases diagnosed 1/1/2007

Ambiguous terms that are reportable
Apparent(ly)
Appears (effective with cases diagnosed 1/1/1998 and later)
Comparable with (effective with cases diagnosed 1/1/1998 and later)
Compatible with (effective with cases diagnosed 1/1/1998 and later)
Consistent with
Favor(s)
Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
Most likely
Presumed
Probable
Suspect(ed)
Suspicious (for)
Typical (of)

Coding Instructions

1. Use **Code 0** when a case is accessioned based on conclusive terminology. The diagnosis includes clear and definite terminology describing the malignancy within 60 days of the original diagnosis.
   Note: Usually the patient undergoes a diagnostic work-up because there is a suspicion of cancer (ambiguous terminology). For example, a mammogram may show calcifications suspicious for intraductal carcinoma; the date of the mammogram is the date of initial diagnosis. When there is a clear and definite diagnosis within 60 days of that mammogram (date of initial diagnosis) such as the pathology from an excisional biopsy showing intraductal carcinoma, assign a code 0.
2. Use **Code 1** when a case is accessioned based on ambiguous terminology and there is no clear and definite terminology used to describe the malignancy within 60 days of the date of initial diagnosis.
   The diagnosis may be from a pathology report, a radiology report, an imaging report, or on the medical record.

3. Use **Code 2** when a case is accessioned based on ambiguous terminology followed by clear and definite terminology more than 60 days after the initial diagnosis.

4. Follow-back to a physician or subsequent readmission (following the initial 60 days period) may eventually confirm cancer (conclusive cancer term more than 60 days after ambiguous term). Assign **Code 2**.
5. Leave this data item blank for cases diagnosed prior to 01/01/2007.

Cases accessioned based on ambiguous terminology **(Code 1)** should be excluded from case selection in research studies. Direct patient contact is not recommended.

Date of Conclusive Terminology

Item Length: 8
NAACCR Item #: 443
NAACCR Name: Date of Conclusive Term

For those cases originally accessioned based on ambiguous terminology only, this data item documents the date of a definite statement of malignancy. The abstractor will change the code for the data item "Ambiguous Terminology" from a 1 to a 2 and enter the date that the malignancy was described clearly and definitely in Date of Conclusive Terminology.

Date

Date fields are recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Special Codes

00000000	Accessioned based on ambiguous terminology only (Code 1 in data item "Ambiguous Terminology")
88888888	Not applicable. The case was accessioned based on conclusive diagnosis (Code 0 in data item "Ambiguous Terminology")
99999999	Unknown date; unknown if diagnosis was based on ambiguous terminology or conclusive terminology (Code 9 in data item "Ambiguous Terminology"

Leave this field blank for cases diagnosed prior to 01/01/2007.

New Data Item
Effective with cases diagnosed 1/1/2007

Multiplicity Counter

Item Length: 2
NAACCR Item #: 446
NAACCR Name: Multiplicity Counter

This data item is used to count the number of tumors (multiplicity) reported as a single primary. Do not count metastatic tumors. Use the multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries.

Example 1: The patient has a 2 cm infiltrating duct carcinoma in the LIQ and a 1 cm infiltrating duct carcinoma in the UIQ of the left breast. Accession as a single primary and enter the number 02 in the data item Multiplicity Counter

Example 2: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. Record 99 (multiple tumors, unknown how many) in Multiplicity Counter.

Example 3: Pathology from colon resection shows a 3 cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with the colon primary. Record 01 in Multiplicity Counter (do not count the metastatic lesion).

Example 4: Patient has an excisional biopsy of the soft palate. The pathology shows clear margins. Record 01 in the Multiplicity Counter. Within six months another lesion is excised from the soft palate. Use the head and neck multiple primary rules to determine this tumor is not accessioned as a second primary. Change the Multiplicity Counter to code 02 to reflect the fact that there were two separate tumors abstracted as a single primary.

Example 5: CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesions shows adenocarcinoma. No other workup is done. Using the multiple primary rules for lung, the case is abstracted as a single primary. Enter the number 03 in the data item Multiplicity Counter.

Codes

01 One tumor only
02 Two tumors present
03 Three tumors present
..
..
88 Information on multiple tumors not collected/not applicable for this site
99 Multiple tumors present, unknown how many

Coding Instructions

1. Code the number of tumors being abstracted as a single primary.
2. Do not count metastasis.
3. When there is a tumor or tumors with separate single or multiple foci, ignore/do not count the foci
4. Use code 01 when
   a. There is a single tumor in the primary site being abstracted
   b. There is a single tumor with separate foci of tumor
   c. It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor
5. Use code 88 for:
   a. Leukemia
   b. Lymphoma
   c. I,mmunoproliferative disease
   d. Unknown primary
6. Use code 99 when
   a. The original pathology report is not available and the documentation does not specify whether there was a single or multiple tumors in the primary site.
   b. The tumor is described as multifocal or multicentric and the number of tumors is not mentioned.
   c. The tumor is described as diffuse.
   d. The operative or pathology report describes multiple tumors but does not give an exact number.
7. Leave this field blank for cases diagnosed prior to 01/01/2007.

New Data Item
Effective with cases diagnosed 1/1/2007

Date of Multiple Tumors

Item Length: 8
NAACCR Item #: 445
NAACCR Name: Date of Multiple Tumors

This data item is used to identify the month, day and year the patient is diagnosed with multiple tumors reported as a single primary. Use the multiple primary rules for that specific site to determine whether the tumors are a single primary or multiple primaries.

Date
Date fields are recorded in the month, day, century, year format (MMDDCCYY) with 99 for unknown month or day and 9999 for unknown year.

Special Codes

00000000	Single tumor
88888888	Information on multiple tumors not collected/not applicable for this site
99999999	Unknown date

Coding Instructions

When multiple tumors are present at diagnosis, record the date of diagnosis.

Example 1: The patient has multiple tumors; a 2 cm infiltrating duct in the LIQ and a 1 cm infiltrating duct carcinoma in the UIQ of the left breast. According to the breast multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date of Multiple Tumors.
Example 2: Operative report for TURB mentions multiple bladder tumors. Pathology report: Papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall. According to the Bladder, Renal Pelvis, and Ureter multiple primary rules these tumors are accessioned as a single primary. Enter the date of diagnosis in Date if Multiple Tumors.

When subsequent tumor(s) are counted as the same primary.

Example: Patient has an excisional biopsy of a single tumor in the soft palate on January 2, 2007. The pathology shows clear margins. Record 01 in Multiplicity Counter. On July 10, 2007 another tumor is excised from the soft palate. The multiple primary rules for head and neck state that this tumor is the same primary. Change the 01 in Multiplicity Counter to 02 and enter 07102007, the date the second tumor was diagnosed. in Date of Multiple Tumors.

Leave this field blank for cases diagnosed prior to 01/01/2007.

Type of Multiple Tumors Reported as One Primary

Item Length: 2
NAACCR Item #: 444
NAACCR Name: Mult Tum Rpt as One Prim

This data item is used to identify the type of multiple tumors that are abstracted as a single primary. Ignore metastatic tumors for this data item.

Code	Code Text	Description	Example(s)
00	Single tumor	All **single tumors.** Includes single tumors with both in situ and invasive components	Code 01 in the Multiplicity Counter
10	Multiple benign	At least two benign tumors in same organ/primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
11	Multiple borderline	At least two borderline tumors in the same organ/primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
12	Benign and borderline	At least one benign **AND** at least one borderline tumors in the same organ/ primary site Use this code for reportable tumors in **intracranial** and **CNS** sites only May be used for reportable by agreement cases	
20	Multiple in situ	At least two in situ tumors in the same organ/primary site	Cystoscopy report documents multiple bladder tumors. Pathology: Flat transitional cell carcinoma of bladder.
30	In situ and invasive	One or more in situ tumor(s) **AND** one or more invasive tumors in the same organ/primary site	

New Data Item
Effective with cases diagnosed 1/1/2007

Code	Code Text	Description	Example(s)
31	Polyp and adenocarcinoma)	One or more polyps with either • In situ carcinoma or • invasive carcinoma **AND** one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum	
32	FAP with carcinoma	Diagnosis of familial polyposis (FAP) **AND** carcinoma (in situ or invasive) is present in at least one of the polyps	
40	Multiple invasive	At least two invasive tumors in the same organ	
80	Unk in situ or invasive	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive	
88	NA	Information on multiple tumors not collected/not applicable for this site	Leukemia, lymphoma, immunoproliferative diseases, and unknown primaries. All codes 88 in Multiplicity Counter
99	Unk	Unknown	Code 99 in Multiplicity counter, and DCO cases.

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Multiple Primary and Histology Coding Rules Project

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Co-Chairs: Carol Johnson, BS, CTR
Steven Peace, BS, CTR

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	Last Name	First Name	Credential	Status
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CDC NPCR	Intlekofer	Ryan	RN, CTR	Active
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Kentucky	Pardee	Reita	CTR	Active
Los Angeles	Conant	Cynthia	CTR	Active
Registry Widgets	Scharber	Wendy	RHIT, CTR	Active
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NCCC	Douglas	Lynda	CTR	Active
NCI SEER	Hankey	Ben	ScD	Active
NCI SEER	Ries	Lynn	MS	Active
NCI SEER	Fritz	April	BA, RHIT, CTR	Active
NCI SEER	Adamo	Peggy	AAS, RHIT, CTR	Active
NCI SEER	Percy-Laurry	Antoinette	MSPH	Active
NCRA	Moats	Pam	RHIT, CTR	Active
New Jersey	Halama	Maria	MD, CTR	Active
New Jersey	Johnson	Linda	CTR	Active
Seattle	Tisdale	Tiffany		Active
Statistics Canada	Friesen	Ingrid	HRT	Active
Statistics Canada	Hamlyn	Elaine	CCHRA (A), CTR	Active
Utah	McFadden	SuAnn	CTR	Active
WHO / AFIP / ICD-O-3 Editor	Sobin	Leslie H	MD	Ad hoc
WHO / UICC / ICD-O-3 Editor	Shanmugaratnam	Kanagaratnam	MD, PhD	Ad hoc

Multiple Primary and Histology Coding Rules Project

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Brain	Johnson, Carol	All		All
Colon	Johnson, Carol	All		All
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		Intelkoffer, Ryan	RN, CTR	NPCR
		TBA		CoC
		TBA		AJCC
		Vann, Shannon	CTR	NAACCR
		TBA		NCRA
		Friesen, Ingrid	HRT	Statistics Canada
		Platz, Charles	MD	Iowa – specialty only
		Scharber, Wendy	RHIT, CTR	Minnesota

Multiple Primary and Histology Coding Rules Project
Roster

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CASEFINDING QUICK REFERENCE

DEPARTMENT OF STATE HEALTH SERVICES
TEXAS CANCER REGISTRY

CASEFINDING AND REPORTABLE LIST (*Detailed instructions on pages. 16–33*)

- Every **inpatient** and/or **outpatient** case with active disease and/or receiving cancer-directed therapy **MUST** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) **regardless of the state or country of residence**.

- Cases of cancer to be reported to the TCR include:

  1) All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and

  2) All benign and borderline neoplasms of the central nervous system (includes brain and other CNS neoplasms)

- Obtain a disease index including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).

- Check the index against a list of cases previously reported to the TCR to identify new cases.

- Complete an abstract for patients found on the disease index who have not been previously reported to the TCR. **Patients who have been previously reported to the TCR need to be checked for possible multiple primaries**. Refer to the *Criteria for Determining Multiple Primaries* in *Appendix D, Appendix E, and Appendix O* for assistance.

- To prevent reporting the same patient with the same primary twice compare the patient name and primary cancer site from your registry database (accession list or SCL facility data report) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

- Other department logs/records (radiation therapy logs, emergency room logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same manner as the disease index to insure all reportable cases are submitted to the TCR.

- Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR to avoid reporting duplicates. Check for **multiple primaries** if you find a patient was previously submitted to the TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-9-CM codes. The reporter should review all inpatient and outpatient admissions with the diagnosis codes listed in the tables.

Reportable Neoplasms:

- Malignant neoplasms *(exclusions noted on page 22)*
- Benign and borderline neoplasms of central nervous system
- Carcinoma in-situ *(exclusions noted on page 22)*
- Carcinoid, NOS *(excluding appendix, unless stated to be malignant)*
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3
- Squamous intraepithelial neoplasia grade III of vulva **[VIN]**, vagina **[VAIN]**, and anus **[AIN]** will be reportable **beginning with 2001 cases**.
- Malignant neoplasms of the skin of genital sites are reportable. These sites include: vagina, clitoris, vulva, prepuce, penis, and scrotum.
- Reportable skin tumors such as adnexal carcinomas, carcinomas of the sweat gland, ceruminous gland, and hair follicle, adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor must be reported regardless of site. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

ICD-9-CM CODES	DIAGNOSIS (IN PREFERRED ICD-O-3 TERMINOLOGY)
CODE RANGES	
140.0–208.9	Malignant neoplasms
225.0–225.9	Benign & Borderline Neoplasms of Central Nervous System
230.0–234.9	Carcinoma in-situ
235.0–238.9	Carcinoid, NOS (excluding appendix, unless stated to be malignant neoplasms of uncertain behavior)
239.0–239.9	Neoplasms of unspecified behavior
INDIVIDUAL CODES	
042	AIDS (review records for AIDS-related malignancies)
203.1	Plasma cell leukemia (9733/3)
205.1	Chronic neutrophilic leukemia (9963/3)
227.3	Pituitary (body, fossa, gland, lobe)
227.3	Craniopharyngeal (duct, pouch)
227.4	Pineal (body, gland)
238.4	Polycythemia vera (9950/3)
238.6	Solitary plasmacytoma (9731/3)
238.6	Extramedullary plasmacytoma (9734/3)
238.7	Chronic myeloproliferative disease (9960/3)
238.7	Myelosclerosis with myeloid metaplasia (9961/3)
238.7	Essential thrombocythemia (9962/3)
238.7	Refractory cytopenia with multilineage dysplasia (9985/3)
238.7	Myelodysplastic syndrome with 5q-syndrome (9986/3)

ICD-9-CM CODES	DIAGNOSIS (IN PREFERRED ICD-O-3 TERMINOLOGY)
238.7	Therapy-related myelodysplastic syndrome (9987/3)
273.2	Gamma heavy chain disease; Franklin's disease
273.3	Waldenstrom's macroglobulinemia
273.9	Unspecified disorder of plasma protein metabolism (screen for potential 273.3 miscodes)
238.72	Refractory anemia (9980/3)
238.72	Refractory anemia with ringed sideroblasts (9982/3)
238.73	Refractory anemia with excess blasts (9983/3)
238.73	Refractory anemia with excess blasts in transformation (9984/3)
288.3	Hypereosinophilic syndrome (9964/3)
289.8	Acute myelofibrosis (9931/3)

Admissions with the following codes **must** be screened for reportable neoplasms:

ICD-9-CM CODES	DESCRIPTION
V07.3	Other prophylactic chemotherapy (screen carefully for miscoded malignancies)
V07.4	Other specified prophylactic measure
V10.0–V10.9	Personal history of malignancy (review these for recurrences, subsequent primaries, subsequent treatment and diagnosis date)
V58.0	Admission for radiotherapy
V58.11	Admission for chemotherapy
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V67.1	Radiation therapy follow-up
V67.2	Chemotherapy follow-up
V71.1	Observation for suspected malignant neoplasm
V76.0–V76.9	Special screening for malignant neoplasm

The following are **exclusions** and **do not** need to be reported to the TCR:

MORPHOLOGY CODES	DESCRIPTION
8000–8004	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix **beginning with 1996 cases**
8010–8045	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia

Non-Reportable Neoplasms

Borderline cystadenomas (8442, 8451, 8462, 8472, 8473), of the ovaries changed from behavior code /3 to /1 and are **not** to be collected as of January 01, 2001.

Cases in which the disease is **no longer active** (i.e., leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.

Example:

A patient was diagnosed 6 months ago with acute myelocytic leukemia, now in remission, on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the last course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Guidelines for using Ambiguous Terms for Cases Diagnosed Prior to 2007

Note: Refer to Appendix O for cases diagnosed on or after 1/1/2007.

Diagnostic of Cancer: *apparently, appears to, comparable with, compatible with, consistent with, favor(s), malignant appearing, most likely, presumed, probable, suspect(ed), suspicious and typical (of/for), known.*

EXCEPTION: If cytology is reported as "suspicious" do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician's clinical impression of cancer supporting the cytology findings, or cancer directed therapy is administered.

Non-Diagnostic of Cancer: *approaching, cannot be ruled out, equivocal, maybe, possible, potentially malignant, questionable, rule out, suggests, very close to, and worrisome.*

Note: *Report these cases only if cancer-directed therapy is administered.*

Cases to Report Only if Cancer-Directed Therapy is Planned or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed.

  Note: *Stable disease indicates active disease.*

- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.

- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.

- Do not report non analytical cases diagnosed prior to 1995.
- Do not complete a report for each admission; submit one report per primary tumor.

Examples:

a. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

b. A patient is diagnosed with two separate PRIMARY tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

DEPARTMENT OF STATE HEALTH SERVICES
TEXAS CANCER REGISTRY

HANDBOOK QUICK REFERENCE SHEET

The Sample Abstract Form can be found in Appendix F in the 2006 CRH

Data Field 580 DATE OF FIRST CONTACT (MMDDCCYY (page 34): Enter month, day, century and year of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550 REGISTRY NUMBER (page 35)**:** To be completed only by SCL users or facilities with a cancer registry that maintains an accession register.

Data Field 540 REPORTING FACILITY NUMBER (page 36)**:** Enter 3 digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500 REPORTING SOURCE (page 36)**:** Enter code for the source documents and/or facility used to abstract the case.

1 - Facility Only (Inpatient, Outpatient, ER or Clinic)
2 – Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3 - Laboratory Only (Facility or Private)
4 - Physician's Office/Private Medical Practitioner
5 - Nursing/Convalescent Home/Hospice
6 - Autopsy Only
7 - Death Certificate Only
8 – Other hospital outpatient units/surgery centers

Data Field 2300 MEDICAL RECORD NUMBER (page37)**:** Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:

RT Radiation Therapy department patient without a medical record number
SU One-day surgery clinic patient without a medical record number
UNK Medical Record Number Unknown

Data Field 610 (page 38) **CLASS OF CASE:** Divides data into analytical and non-analytical categories.

Data Field 2230 LAST NAME (page 41)**:** Enter the name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. Do not leave blank.

Data Field 2240 FIRST NAME (page 42)**:** Enter first name of patient in capital letters. Hyphens, other special characters, and spaces are allowed.

Data Field 2250 MIDDLE NAME (page 43)**:** Enter the middle name of the patient in capital letters. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390 MAIDEN NAME (page 43)**:** Enter the maiden name of the female patients who are or have been married. Hyphens, other special characters and spaces are allowed. Leave blank if unknown.

Data Field 2280 NAME-ALIAS (page 43): Enter an alternative name or "AKA" used by the patient, if known.

Data Field 2330 STREET ADDRESS (page 44): Enter the number and street of the patient's residence at the time the cancer is diagnosed in 25 characters or less. If address is not known, enter "NO ADDRESS" or "UNKNOWN". DO NOT LEAVE BLANK. Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the web-site at http://www.usps.com/ncsc/lookups/abbrev.html

Data Field 2335 ADDRESS AT DX SUPPLEMENTAL (page 46): If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed leave blank.

Data Field 70 CITY (page 47): Enter the city of residence at the time the cancer is diagnosed. If no address is known, record "Unknown".

Data Field 80 STATE (page 47): Enter the two letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX or YY depending on the circumstance. If no address is known, enter "ZZ".

Data Field 100 ZIP CODE (page 50): Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS web site: http://zip4.usps.com/zip4/welcome.jsp
If resident of foreign country, code all "8's." If address is not available enter "99999".

Data Field 90 FIPS COUNTY CODE: (page 51) & APPENDIX C) Enter the three digit Federal Information Processing Standards code found in Appendix C. Code "998" for out-of-state or foreign residents. If address is not available enter "999".

Data Field 2320 SOCIAL SECURITY NUMBER (page 52): Every effort should be made to obtain social security number. If not available, code all "9's." Take caution to enter the patient's number and not the spouse's number. Dashes and /or slashes are not allowed in this field.

Data Field 240 DATE OF BIRTH (page 53): DOB must be coded. Enter month, day, century, and year of patient's birth. Unknown date of birth will not be accepted

Data Field 250 PLACE OF BIRTH (page 54 and Appendix G) Record Patient's place of birth (if available) using the SEER Geo-codes in Appendix G. If the place of birth is unknown, code 999.

Data Field 160 RACE 1 (page 54): Enter the 2 digit code to identify the primary race of the patient.

01 White (includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians)

02 Black (African Origin)	12 Hmong	30 Melanesian, NOS
03 American Indian, Aleutian, Eskimo	13 Kampuchean (Cambodian)	31 Fiji Islander
04 Chinese	14 Thai	32 New Guinean
05 Japanese	20 Micronesian, NOS	96 Other Asian including Asian/Oriental NOS
06 Filipino	21 Chamorran	97 Pacific Islander, NOS
07 Hawaiian	22 Guamanian, NOS	98 Other
08 Korean	25 Polynesian, NOS	99 Unknown
09 Asian Indian, Pakistani, Sri Lankan	26 Tahitian	
10 Vietnamese	27 Samoan	
11 Laotian	28 Tongan	

Data Field 161, 162, 163 & 164 RACE 2, RACE 3, RACE 4, & RACE 5 (page 57): If the patient is multi-racial, code all the races using new items (RACE 2) through (RACE 5) Use code "88" for no further race documented.

01 White	
88 No further race documented	98 Other
96 Other Asian and Oriental	99 Unknown
97 Pacific Islander, NOS	

Data Field 190 SPANISH/HISPANIC ORIGIN (page59): (The list of Spanish/Hispanic surnames is on the TCR website in Appendix M) this code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. **Persons of Spanish or Hispanic origin may be of any race.**

0 Non-Spanish; non Hispanic (includes Portuguese and Brazilian)
1 Mexican (includes Chicano, NOS)
2 Puerto Rican
3 Cuban
4 South Central American (Except Brazil)
5 Other specified Spanish/Hispanic
6 Spanish, NOS; Hispanic, NOS; Latino, NOS
7 Spanish surname only
9 Unknown whether Spanish or not

Data Field 220 SEX (page 60): Enter the code to identify the gender of the patient.

1 Male
2 Female
3 Other (Hermaphrodite)
4 Trans-sexual
9 Not stated/Unknown

Data Field 2680 OTHER PERTINENT INFORMATION (page 61) Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility thatthe patient was referred to in this field.

Data Field 2460 Physician Managing (page 61): Record the state license number of the physician responsible for the overall management of the patient's care during diagnosis and/or treatment for this cancer. Physician license numbers for Texas can be found at the following web-site: http://www.docboard.org/tx/df/txsearch.htm

Data Field 2470 Physician Follow Up (page 62): Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following website: http://www.docboard.org/tx/df/txsearch.htm

Data Field 2410 FACILITY REFERRED FROM (page 62): Enter the facility name or the following codes:

Patient not referred 0000000000
Patient referred unknown ID 0099999999
Document the name of the facility and city that referred the patient to your facility under OTHER PERTININT INFORMATION

Data Field 2420 FACILITY REFERRED TO (page 63): Enter the facility name or the following codes:

Patient not referred 0000000000
Patient referred unknown ID 0099999999
Document the name of the facility and the city that the patient wasreferred to for further care after discharge from your facility under OTHER PERTINENT INFORMATION.

Data Field 560 SEQUENCE NUMBER (page 64): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

00 One primary only
60 One benign tumor only
01 First of multiple
02 Second of multiple
03 Third of multiple
61 1st of two or more benign tumors
62 2nd of two or more benign tumors
63 3rd of three or more benign tumors
99 Unspecified number
88 Unspecified number of benign tumors

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (page 66): Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.

Data Field 630 PRIMARY PAYER AT DIAGNOSIS (page 66a) Record the type of insurance reported on the patient's admission page.

01 Not insured
62 Medicare-Administered through a managed care plan

02 Not insured, self pay
10 Insurance, NOS
20 Private Insurance: Managed Care, HMO, PPO
21 Private Insurance: Fee-for-Service
31 Medicaid
35 Medicaid-Administered through a managed care plan
60 Medicare without supplement, Medicare, NOS
61 Medicare with supplement
63 Medicare with private supplement
64 Medicare with Medicaid eligibility
65 TRICARE
66 Military
67 Veterans Affairs
68 Indian/Public Health Services
99 Insurance status unknown

Data Field 390 DATE OF INITIAL DIAGNOSIS (MMDDCCYY) (page 67)**:** Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (06992006) and document "Date of dx unknown" in Other Pertinent Information Text Field. Every effort must be made to obtain date of diagnosis.

Data Field 420, 430 MORPHOLOGY ICD-O-2: TYPE AND BEHAVIOR (page 70)**:** The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 01, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Data Field 522 & 523 MORPHOLOGY ICD-O-3: TYPE AND BEHAVIOR (page 70)**:** The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 01, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Histology Coding Rules in Hierarchical Order for Single Tumor

Rule 1: Code the histology if only one type is mentioned in the pathology report.
Rule 2: Code the **invasive histology** when both invasive and in situ tumor are present
Rule 3: Use a **mixed** or **combination** histology if one exists
Rule 4: Code the **more specific term** when one of the terms in "NOS" and the other is a more specific description of the same histology
Rule 5: Code the **majority** of the tumor
Rule 6: Code the **numerically higher** ICD-O-3 code.

Histology Coding Rules for Multiple tumors with Different Behaviors in the Same Organ Reported as a Single Primary

Note: Refer to Appendix O for cases diagnosed on or after 1/1/2007/

Rule 1: Code the histology of the invasive tumor when one lesion is in situ (/2) and the other is invasive (/3)

Histology Coding Rules in Hierarchical Order for Multiple Tumors in Same Organ Reported as a Single Primary

Rule 1: Code the histology when multiple tumors have the same histology
Rule 2: Code the histology to adenocarcinoma (8140/_; in situ or invasive) when there is an adenocarcinoma and an adenocarcinoma in a polyp (8210/_, 8261/_, and 8263/_) in the same segment of the colon or rectum.
Rule 3: Code the histology to carcinoma (8010/_; in situ or invasive) when there is a carcinoma and a carcinoma in a polyp (8210/_) in the same segment of the colon or rectum.
Rule 4: Use a **combination** code for the following:
- **a.** Bladder: Papillary and urothelial (transition cell) carcinoma (8130)
- **b.** Breast: Paget Disease and duct carcinoma (8541)
- **c.** Breast: Duct carcinoma and lobular carcinoma (8522)
- **d.** Thyroid: Follicular and papillary carcinoma (8340)

Rule 5: Code the **more specific** term when one of the terms is "NOS" and the other is a more specific description of

the same histology.

Rule 6: Code all other multiple tumors with different histologies as multiple primaries.

Data Field 400 PRIMARY SITE (page 77)**:** Record the specific topography code from ICD-O. **Adequate documentation must be provided** in the **FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Data Field 440 GRADE OF TUMOR (page 84)**:** The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastases and the more rapid the clinical course. Do not code the grade of a metastatic site. If the grade for the primary is unknown enter "9" in this field.

1 Grade I Well differentiated
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
9 Grade or differentiation not determined, not stated, or not applicable

Codes for T-cell and B-cell designation for lymphomas and leukemia:

5 T-cell, T-precursor
6 B-cell, pre B; B-precursor
7 Null cell; non T-non B (for leukemia only)
8 Natural Killer (NK) cell
9 Grade or differentiation not determined, not stated or not applicable

***For lymphomas, do not code the descriptions "high grade", "low grade", or "intermediate grade" in this field.**

Refer to pages 90-92 of 2006 CRH for specific coding guidelines on grade for Prostate, Breast, Kidney, Astrocytoma, Lymphoma, Leukemia, and Sarcoma primaries.

Coding Grade for Prostate Cases

1. If Gleason's score (2-10) is given:

Gleason's Score	Grading	Code
2, 3, 4	I Well differentiated	1
5, 6	II Moderately differentiated	2
7, 8,9,10	III Poorly differentiated	3

2. If Gleason's Pattern (1-5) is given:

Gleason's Pattern	Grading	Code
1, 2	I Well differentiated	1
3	II Moderately differentiated	2
4, 5	III Poorly Differentiated	3

Data Field 410 LATERALITY (page 93)**:** Enter the code to identify the laterality of a paired site.

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

Refer to page 97 for specific guidelines for CNS tumors.

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (page 98)**:** Record the morphology/behavior, grade, primary site, and

laterality descriptions.

Data Field 490 DIAGNOSTIC CONFIRMATION (page 99) The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer.

MICROSCOPICALLY CONFIRMED

1 Histology -- Microscopic diagnosis based upon tissue specimens from biopsy, frozen section, surgery, and autopsy, of D & C. Positive hematologic findings relative to leukemia are also included. Bone marow specimens (including aspiration biopsies) are coded as "1".

2 Cytology -- Cytologic diagnosis with no positive histology such as pap smears, bronchial brushings, FNA and peritoneal fluid.

4 Microscopic Confirmation, NOS -- Diagnosis stated to be microscopically confirmed but method not specified.

NOT MICROSCOPICALLY CONFIRMED

5 Laboratory test/marker study -- Clinical diagnosis of cancer based on certain laboratory tests or marker studies.

6 Direct Visualization -- Visualization without microscopic confirmation, i.e., exploratory laparotomy or endoscopy.

7 Radiology/Imaging -- Radiology and other imaging techniques without microscopic confirmation, i.e. CAT scans and MRI.

8 Other (other than 5, 6 or 7) -- Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings. Physician documented the tumor in the medical record. Refer to ambiguous Terminology List on page 23.

CONFIRMATION UNKNOWN

9 Unknown -- Cases for which it is unknown whether or not microscopically confirmed. Also includes "Death Certificate Only" cases.

Data Field 780 TUMOR SIZE (page 102): Largest dimension or diameter of the **primary** tumor. Always record the size in millimeters.

Data Field 760 SUMMARY STAGE 1977(page 6): To be used with cases diagnosed/admitted prior to 2001. Summary stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

0 In Situ
1 Localized
2 Regional direct extension
3 Regional to lymph nodes
4 Regional by both direct extension and regional LN involvement
5 Regional, NOS
7 Distant site(s)/node(s) involved; systemic disease
9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case

*Do not use Code "8" for Summary Stage.

Data Field 759 SUMMARY STAGE 2000(page 6): To be used with cases diagnosed/admitted January 1, 2001 and after. Summary stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

0 In Situ
1 Localized
2 Regional direct extension
3 Regional lymph nodes involved only
4 Regional by both direct extension and regional LN involvement
5 Regional, NOS
7 Distant site(s)/node(s) involved; systemic disease
9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case

*Do not use Code "8" for Summary Stage.

Data Field 2800 CS TUMOR SIZE (page A-8): Record for cases diagnosed on or after January 1, 2004. Record the largest dimension or diameter of the **primary tumor**. Use the size from the pathology report when there is no radiation or systemic therapy prior to surgery. If the patient receives neoadjuvant therapy record the largest size of the primary tumor prior to treatment. Always record the size in millimeters. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2810 CS EXTENSION (page A-13): Record for cases diagnosed on or after January 1, 2004. Code the farthest extension of the primary tumor. Do not code discontinuous metastases in thisfield. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2830 CS LYMPH NODES (page A-15): Record for cases diagnosed on or after January 1, 2004. Identifies the regional lymph nodes involved with the cancer at the timeof diagnoses. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically. Information can be obtained from; radiological reports, surgical reports, and pathology reports. If the patient receives preoperative

(neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery **Exception**: In the infrequent event that clinically involved lymph nodes do not respond to neoadjuvant treatment, and are, in fact, more extensively involved at surgery as determined by the pathology report, code the lymph node involvement based on pathology/operative report after surgery. **Documentation in the Summary Stage field is required to support coding.**

Data Field 820 Regional Nodes Positive (page 106): Enter the number of lymph nodes pathologically examined and found to be positive.

Use code 99 for sites for which information about the field is unknown or not applicable:

Examples:	Brain	Reticuloendotheliosis	Unknown Primaries
	Leukemia	Lymphoma	

Data Field 830 REGIONAL LYMPH NODES EXAMINED (page 108) Document and code the number of regional lymph nodes removed DURING THIS SURGICAL PROCEDURE ONLY. DO NOT add numbers of nodes removed at different surgical events. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites for which information about the field is unknown or not applicable:

Examples:	Brain	Reticuloendotheliosis	Unknown Primaries
	Leukemia	Lymphoma	

Data Field 2850 CS METS AT DIAGNOSIS (page A-17): Record for cases diagnosed on or after January 1, 2004. Identifies the distant site(s) of metastatic involvement at time of diagnosis. Assign the highest applicable code for metastasis at the time of diagnosis. This can be determined clinically or pathologically. Information can be obtained from radiological reports, surgical reports, pathology reports, or physician notes. Metastasis known to have developed after extent of disease was established should not be considered for this field **Documentation in the Summary Stage field is required to support coding.**

Data Field 2880 CS SITE-SPECIFIC FACTOR 1 (page A-18): Record for cases diagnosed on or after January 1, 2004. *The TCR collects this field for pleura primaries only.* Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival. Limit information to firstcourse of treatment in the absence of disease progression. Information can be obtained from; radiological reports, surgical reports, or pathology reports. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2900 CS SITE-SPECFIC FACTOR 3 (page A-19): Record for cases diagnosed on or after January 1, 2004. *The TCR collects this field for prostate primaries only.* Identifies additional information needed to generate stage, or prognostic factors that have an effect on stage or survival. Limit information to first course of treatment in the absence of disease progression. Information can be obtained from the prostatectomy pathology report. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2600 SUMMARY STAGE DOCUMENTATION (page 147): Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, and extension to adjacent organs. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. All combined clinical and surgical assessment within **FOUR MONTHS** of diagnosis in the absence of

disease progression, which ever is longer, should be documented. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Field 1292 SCOPE OF REGIONAL LYMPH NODE SURGERY (page 115): Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200 RX DATE-SURGERY (MMDDCCYY) (page 117): Document and enter the date of the first definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

Data Field 1290 SURGICAL PROCEDURE OF PRIMARY SITE (page 118 & APPENDIX A): Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed sdely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Data Field 1340 REASON FOR NO SURGERY (page 120): If no cancer directed surgery to the primary site was performed record the reason.

0 Surgery of the primary site was perfomed
1 Not part of the planned first course
2 Not recommended due to patient risk factors
5 Patient died prior to planned or recommended surgery
6 Surgery recommended and unknown why not performed
7 Patient or family refused surgery
8 Surgery recommended, unknown ifperformed
9 Unknown ifsurgery recommended or performed

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (page 122): Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Field 1210 DATE RADIATION STARTED (page 123): Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Data Field 1570 RADIATION-REGIONAL TREATMENT MODALITY (page 124): Document and code the type of radiation therapy the patient received at any facility as part of the first course of treatment.

Data Field 1380 RX SUMM-SURG/RAD SEQUENCE (page 126): This field will be collected for cases diagnosed on or after January 1, 2006. Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

Data Field 3230 DATE SYSTEMIC THERAPY STARTED (page 129): Document and enter the date systemic therapy began at any facility. Systemic therapy includes: chemotherapy, hormonal agents, immunotherapy, bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Record all zeros when no systemic therapy was delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown if any systemic therapy was delivered, the date is unknown, or the case was identified bydeath certificate only.

Data Field 1390 CHEMOTHERAPY (page 130): Code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code "00" if chemotherapy was not delivered

Data Field 1400 HORMONE THERAPY (HORMONE/STEROID THERAPY) (page 132): Code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapymay involve the delivery of one or a combination of agents. Code "00" if hormone therapy was not delivered

Data Field 1410 IMMUNOTHERAPY (page 134): Code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code "00" if Immunotherapy was not delivered.

Data Field 3250 RX SUMM-TRANSPLANT/ENDOCRINE (page 136): Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code "00" if a transplant or endocrine procedure was not done.

Data Field 1639 RX SUMM—SYSTEMIC SUR SEQ (page 139): This field will be collected for cases diagnosed on or after January 1, 2006. Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

Data Field 1250 DATE OTHER TREATMENT STARTED (page 141): Enter the date of other treatment that is delivered that is not included in surgery, radiation therapy, and systemic treatment. Record all zeros when no other treatment was delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown if other treatment was delivered, the date is unknown, or it is a death certificate only case.

Data Field 1420 OTHER TREATMENT (page 142): Code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Data Fields 2610, 2620, 2630, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION (page 144): Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1750 DATE OF LAST CONTACT OR DEATH (MMDDCCYY) (page 145): Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the "Other Pertinent Information" text area, document the patient is deceased and the date of death is not available.

Data Field 1760 VITAL STATUS (page 145): Patient's vital status as of the date recorded in the "Date of last contact/death" field.

0 Dead
1 Alive

Data Field 2090 DATE ABSTRACTED (MMDDCCYY) (page 146): Record month, day and full year reporting forms were completed.

Data Field 570 ABSTRACTOR INITIALS (page 146): Record the initials of the abstractor.

Data Field 50 NAACCR RECORD VERSION (page 146): TCR will automatically code this field.

HELPFUL HINTS:

- **REPORT ALL CASES OF *ACTIVE* CANCER REGARDLESS OF STATE OF RESIDENCE.**
- **REPORT ALL INPATIENTS AND OUTPATIENTS.**
- **DO NOT REPORT BASAL OR SQUAMOUS CELL CARCINOMAS OF THE SKIN (EXCEPT GENITAL SITES).**
- **TO ENSURE CASE ASCERTAINMENT - REVIEW DISEASE INDEX, PATHOLOGY REPORTS, CYTOLOGY, HEMATOLOGY, AND AUTOPSY REPORTS.**
- **REPORT ALL BENIGN AND BORDERLINE NEOPLASMS OF THE CENTRAL NERVOUS SYSTEM.**
- **DO NOT COMPLETE ABSTRACT FOR EACH ADMISSION; ONLY ONE PER PRIMARY TUMOR.**
- **CASES IN WHICH THE DISEASE IS NO LONGER ACTIVE (I.E., LEUKEMIA IN REMISSION) SHOULD ONLY BE REPORTED IF THE PATIENT IS STILL RECEIVING CANCER-DIRECTED THERAPY.**
- **DO NOT REPORT CARCINOMA IN SITU OF CERVIX (ANY HISTOLOGY).**

- **DO NOT REPORT INTRAEPITHELIAL NEOPLASIA OF THE PROSTATE (PIN III).**

For a diagnosis that uses ambiguous terms, the following should be used:

These ambiguous terms <u>are considered</u> to be diagnostic of cancer:

APPARENTLY, APPEARS TO, COMPARABLE WITH, COMPATIBLE WITH, CONSISTENT WITH, FAVOR (S), MALIGNANT APPEARING, MOST LIKELY, PRESUMED, PROBABLE, SUSPECT(ED), SUSPICIOUS, TYPICAL (OF/FOR), and KNOWN

These ambiguous terms <u>are not considered</u> to be diagnostic of cancer. Report these cases only if cancer-directed therapy is planned or given. ***Remember: Do not use the following ambiguous terminology for cases diagnosed on or after 1/1/2007. Refer to Appendix O.***

APPROACHING, CANNOT BE RULED OUT, EQUIVOCAL, MAYBE, POSSIBLE, POTENTIALLY MALIGNANT, QUESTIONABLE, RULE OUT, SUGGESTS, VERY CLOSE TO, AND WORRISOME

When phrases such as "highly suspicious" or "strongly suggests" are used, disregard the modifying phrase and refer to the guidelines above regarding the primary term.

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

SHADED ITEMS WILL BE COMPLETED BY CANCER REGISTRY STAFF	This form MUST be used for all cases diagnosed on or after 2007.
(580) DATE OF FIRST CONTACT: 34 (MMDDYYYY)	(2460) PHYSICIAN MANAGING: 61
(550) REGISTRY NUMBER: 35	(2470) PHYSICIAN FOLLOW UP: 62
(540) REPORTING FACILITY NUMBER: 36	(2410) FACILITY REFERRED FROM: 62
(500) REPORTING SOURCE: 36	(2420) FACILITY REFERRED TO: 63
(2300) MEDICAL RECORD #: 37	(560) SEQUENCE NUMBER: 64
(610) CLASS OF CASE: 38	(2200) OTHER PRIMARY TUMORS: 66 (SITE,MORPHOLOGY, and DATE)
(2230) LAST NAME: 41	
(2240) FIRST NAME: 42	
(2250) MIDDLE NAME: 43	
(2390) MAIDEN NAME: 43	(630) PRIMARY PAYER AT DX: 66a
(2280) ALIAS NAME: 43	(390) DATE OF INITIAL DX: 67 (MMDDYYYY)
(2330) STREET ADDRESS: 44	(420, 430) ICD-O-2 MORPH/BEHAVIOR BEFORE 2001:
(2335) ADDRESS AT DX SUPPLEMENTAL: 46	(522, 523) ICD-O-3 MORPH/BEHAVIOR DX ON OR AFTER 2001: 70
(70) CITY: 47	(400) PRIMARY SITE: 77
(80) STATE: 47	(440) GRADE OF TUMOR: 84
(100) ZIP CODE: 50	(410) LATERALITY: 93
(90) FIPS COUNTY CODE AT DX: 51	FINAL DIAGNOSIS (2580, 2590)
(2320) SSN: 52	(2590) MORPHOLOGY/BEHAVIOR AND GRADE: 98
(240) DATE OF BIRTH: 53	
(250) PLACE OF BIRTH: 54	
(160) RACE 1: 54	(2580) PRIMARY SITE AND LATERALITY: 98
(161) RACE 2: 57	
(162) RACE 3: 57	
(163) RACE 4: 57	
(164) RACE 5: 57	(490) DIAGNOSTIC CONFIRMATION: 99
(190) SPANISH/HISPANIC ORIGIN: 59	(780) TUMOR SIZE (MM): 102 DX PRIOR TO 2004
(220) SEX: 60	(760) SUMMARY STAGE 1977:
(2680) OTHER PERTINENT INFORMATION: 61	(759) SUMMARY STAGE 2000:

DEPARTMENT OF STATE HEALTH SERVICES
CONFIDENTIAL CANCER REPORTING FORM

(2800) (2004 and >) CS TUMOR SIZE: A-8	(2640) RX TEXT-CHEMO: 144
(2810) CS EXTENSION: A-13	
(2830) CS LYMPH NODES: A-15	
(820) REGIONAL LYMPH NODES POSITIVE: 106	(1400) HORMONE CODE: 132
(830) REGIONAL LYMPH NODES EXAMINED: 108	(2650) RX TEXT-HORMONE: 144
(2850) CS METS AT DX: A-17	
(2880) CS SITE-SPECIFIC FACTOR 1: A-18	
(2900) CS SITE-SPECIFIC FACTOR 3: A-19	(1410) IMMUNOTHERAPY CODE: 134
(2600) SUMMARY STAGE DOCUMENTATION: 147	(3250) RX SUMM-TRANSPLANT/ENDOCRINE: 136
	(2660) RX TEXT-IMMUNOTHERAPY: 144
FIRST COURSE TREATMENT	(1639) RX SUMM-SYSTEMIC/SURG SEQUENCE: 139
(1292) RX SUMM-SCOPE OF REG LN SURGERY: 115	(1250) DATE OTHER TREATMENT STARTED: 141 (MMDDYYYY)
(1200) RX DATE-SURGERY: 117 (MMDDYYYY)	(1420) OTHER TREATMENT CODE: 142
(1290) SURG RX CODE: 118	(2670) RX TEXT-OTHER: 144
(1340) REASON FOR NO SURGERY: 120	
(1294) RX SUMM-SURG OTHER/DIST RX CODE: 122	
(2610) RX TEXT-SURGERY: 144	(1750) DATE OF LAST CONTACT OR DEATH: 145 (MMDDYYYY)
	(1760) VITAL STATUS: 145
(1210) DATE RADIATION STARTED: 123 (MMDDYYYY)	(2090) DATE ABSTRACTED: 146 (MMDDYYYY)
(1570) RAD-REGIONAL RX MODALITY CODE: 124	(570) ABSTRACTOR INITIALS: 146
(2620, 2630) RX TEXT-RADIATION: 144	(50) NAACCR RECORD VERSION 11
(1380) RX SUMM-SURG/RAD SEQUENCE: 126	FOR CRD USE ONLY
(3230) RX DATE-SYSTEMIC: 129 (MMDDYYYY)	
(1390) CHEMOTHERAPY CODE: 130	

STANDARD TABLES FOR COLLABORATIVE STAGING SCHEMAS

CS TUMOR SIZE

Note: For specific instructions on coding this data field seeAppendix A, page 8 of this manual.

Code	Description
000	No mass or tumor found
001-988	001-988 millimeters (code 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," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
999	Unknown; size not stated; not stated in patient record.

REG LN POSITIVE

Note: Record this field even if there has been preoperative treatment.

Note: For specific instructions on codng this data field see page106 of this manual.

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

REG NODES EXAMINED

Note: For specific instructions on coding this data field see page 108 of this manual.

Code	Description
00	No nodes were examined.
01-89	1-89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration of regional 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 lymph 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 nodes were examined; not applicable or negative; not stated in patient record.

CS METS AT DX

Note: For specific instructions on coding this data field see Appendix A, page 17 of this manual.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastases, NOS Distant metastases except distant lymph node(s) code (10) Carcinomatosis	M1	D	D
50	(40) + (10) (Distant lymph node(s) plus other distant metastases)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in patient record	MX	U	U

TREATMENT STANDARD TABLES

SCOPE OF REGIONAL LYMPH NODE SURGERY

Note: For specific instructions on coding this data field see page 115of this manual.

CODE	DESCRIPTION	DEFINITION
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.
4	1-3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5. Or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedure by procedures coded as 3, 4, or 5.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

REASON FOR NO SURGERY PRIMARY SITE

Note: For specific instructions on coding this data field see page 120 of this manual.

Code	Definition
0	Surgery of the primary site was performed
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.
7	Surgery of the primary site was not performed: it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's record
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Diagnosed at autopsy or death certificate only.

RX SUMM – SURG OTH REG/DIST RX CODE

Note: For specific instructions on coding this data field see page 122 of this manual.

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site that is not included in combination surgery codes of the primary site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

RADIATION – REGIONAL TREATMENT MODALITY

Note: For specific instructions on coding this data field see page124 of this manual.

CODE	TYPE	DEFINITION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with a beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with a beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.

43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes.
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80.
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

RX SUMMARY-SURGERY/RADIATION SEQUENCE

Note: For specific instructions on coding this data field see page 126 of this manual.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given; and/or no surgery; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s) , or distant lymph node(s); or no reconstructive surgery. Diagnosed at autopsy
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s)
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s)
4	Radiation therapy both before and after surgery	Radiation therapy given before and after any surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph nodes(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site: scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s) or distant lymph node(s) were performed. Death certificate only.

CHEMOTHERAPY

Note: For specific instructions on coding this data field see page130 of this manual.

CODE	DEFINITION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

HORMONE THERAPY (HORMONE/STEROID THERAPY)

Note: For specific instructions on coding this data field see page132 of this manual.

CODE	DEFINITION
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

IMMUNOTHERAPY

Note: For specific instructions on coding this data field seepage 134 of this manual.

CODE	DESCRIPTION
00	None, Immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether Immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX SUMM – TRANSPLANT/ENDOCRINE

Note: For specific instructions on coding this data field see page136 of this manual.

CODE	DEFINITION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age.
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

SYSTEMIC /SURGERY SEQUENCE

Note: For specific instructions on coding this data field see page139 of this manual.

CODES	Label	DEFINITION
0	No systemic therapy and/or surgical procedures	No systemic therapy was given: and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	Systemic therapy was given before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed. Death certificate only.

OTHER TREATMENT

Note: For specific instructions on coding this data field see page 142 of this manual.

CODES	TYPE	DEFINITION
0	None	All Cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases.
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.