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.

Esophagus
C150-C155, C158-C159

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Esophagus
CS Tumor Size (Revised: 07/28/2006)

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 (Revised: 03/17/2004)

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 Stomach, cardia (via serosa)	T4	RE	RE

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Esophagus
CS Lymph Nodes (Revised: 08/19/2006)
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

Code	Description	TNM	SS77	SS2000
10	Regional lymph nodes (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

Code	Description	TNM	SS77	SS2000
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
CS Reg Nodes Eval
SEE STANDARD TABLE

Esophagus
Reg LN Pos
SEE STANDARD TABLE

Esophagus
Reg LN Exam
SEE STANDARD TABLE

Esophagus
CS Mets at DX (Revised: 02/05/2007)

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 nodes Lower thoracic (abdominal) esophagus only: Celiac lymph nodes	M1a	D	D

Code	Description	TNM	SS77	SS2000
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 to 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

Esophagus
CS Mets Eval
SEE STANDARD TABLE

Esophagus
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Esophagus
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Esophagus
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Esophagus
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Esophagus
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Esophagus
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Esophagus
C150–C159
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 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

Stomach
C160-C169

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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

CS Tumor Size CS Extension CS TS/Ext-Eval CS Lymph Nodes CS Reg Nodes Eval Reg LN Pos Reg LN Exam CS Mets at DX CS Mets Eval	**CS Site-Specific Factor 1 -** Clinical Assessment of Regional Lymph Nodes CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6	**The following tables are available at the collaborative staging website:** Histology Exclusion Table AJCC Stage Lymph Nodes Clinical Evaluation Table Lymph Nodes Pathologic Evaluation Table Also Used When CS Reg Nodes Eval is Not Coded

Stomach
CS Tumor Size (Revised: 07/28/2006)

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 (Revised: 02/05/2007)

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 Gastrosplenic Omentum, NOS Greater Lesser Perigastric fat	T2b	RE	RE
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

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Stomach
CS Lymph Nodes (Revised: 09/17/2007)
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 information about named regional lymph nodes is available, use codes 10, 40, 42, or 50, rather than codes 60, 65, or 70.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE

Code	Description	TNM	SS77	SS2000
10	Regional lymph nodes: 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 NOS 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 nodes, NOS	*	RN	RN
60	Stated as N1	N1	RN	RN
65	Stated as N2	N2	RN	RN
70	Stated as N3	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 10-50 and 80 ONLY:** when CS Regional Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation Table, using Reg LN Pos and CS Site-Specific Factor 1; when CS Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation Table using Reg LN Pos.

Stomach
CS Reg Nodes Eval
SEE STANDARD TABLE

Stomach
Reg LN Pos
SEE STANDARD TABLE

Stomach
Reg LN Exam
SEE STANDARD TABLE

Stomach
CS Mets at DX (Revised: 02/05/2007)

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

Stomach
CS Mets Eval
SEE STANDARD TABLE

Stomach
CS Site-Specific Factor 1 Clinical Assessment of Regional Lymph Nodes (Revised: 10/22/2007)

Note: In the rare instance that the number of clinically positive nodes is stated but a clinical N category is not stated, code 1-6 nodes as 100 (N1), 7-15 nodes as 200 (N2), and more than 15 nodes as 300 (N3).

Code	Description
000	Nodes not clinically evident
100	Clinically N1
200	Clinically N2
300	Clinically N3
400	Clinically positive regional nodes, NOS
888	OBSOLETE - Not Applicable
999	Unknown if nodes are clinically evident

Stomach
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Stomach
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Stomach
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Stomach
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Stomach

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Stomach
C160–C169
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 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

Surgery Codes

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 Note:*** 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

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*** Incidental splenectomy NOT included

Small Intestine
C170-C179

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Small Intestine
CS Tumor Size
SEE STANDARD TABLE

Small Intestine
CS Extension (Revised: 08/21/2006)

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

Code	Description	TNM	SS77	SS2000
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 Liver, quadrate lobe Liver, right lobe Omentum, NOS Transverse colon Ureter, right For jejunum or ileum primary only: Colon, including appendix	T4	RE	RE
66	For duodenum primary only: Stomach	T4	RE	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Small Intestine
CS Lymph Nodes (Revised: 05/06/2004)
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 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	N1	RN	RN

Code	Description	TNM	SS77	SS2000
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 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 nodes cannot be assessed Not documented in patient record	NX	U	U

Small Intestine
CS Reg Nodes Eval
SEE STANDARD TABLE

Small Intestine
Reg LN Pos
SEE STANDARD TABLE

Small Intestine
Reg LN Exam
SEE STANDARD TABLE

Small Intestine
CS Mets at DX (Revised: 05/06/2004)

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 (For duodenal primary, see Lymph Nodes field)	M1	D	RN
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

Small Intestine
CS Mets Eval
SEE STANDARD TABLE

Small Intestine
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Small Intestine
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Small Intestine
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Small Intestine
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Small Intestine
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Small Intestine
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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 M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 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

Coding Guidelines
COLON
C180–C189

The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

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
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

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

***Note 1*:** Rectum and rectosigmoid are covered by The Other Sites rules.
Note 2: For the purpose of these rules, the words "exophytic" and "polypoid" are not synonymous with a polyp.

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

***Note*:** For the purpose of these rules, the words “exophytic” and “polypoid” are not synonymous with a polyp

- 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).

Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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.

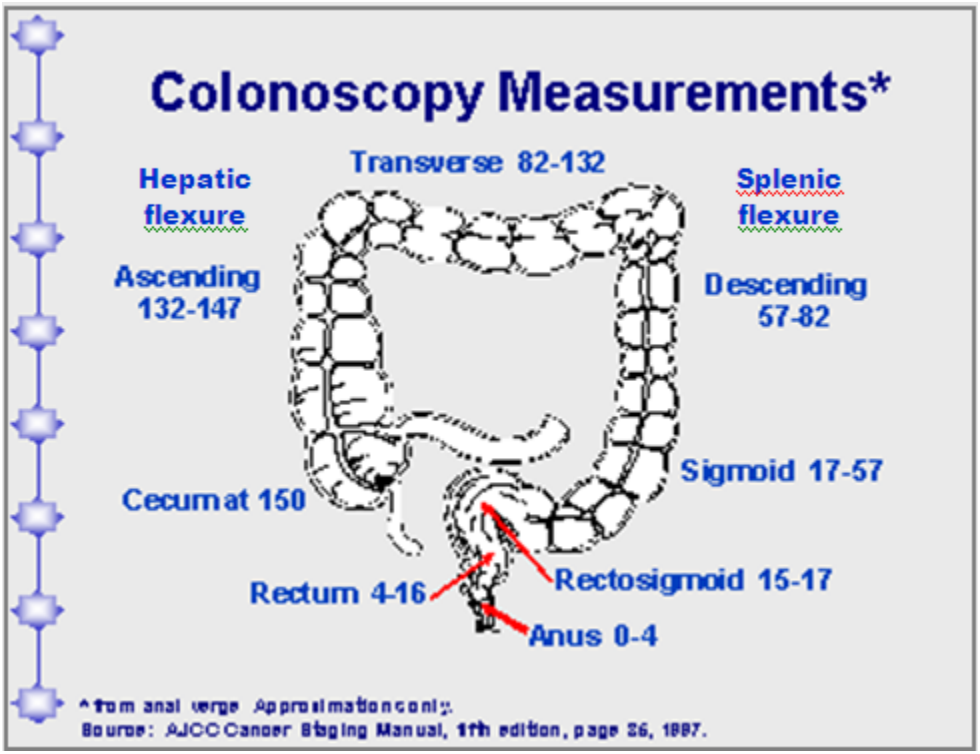
Signet ring cell carcinoma (8490): An adenocarcinoma containing **intra**-cellular mucin comprising more than 50% of the tumor.

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 Terms and Definitions

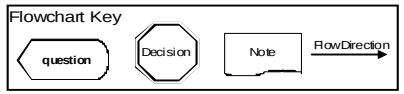
Colon Equivalent Terms, Definitions and Illustrations
C180-C189
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Colon Multiple Primary Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



* 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.

UNKNOWN IF SINGLE OR MULTIPLE TUMORS	DECISION	NOTES
		Tumor(s) not described as metastasis
M1 Is it impossible to determine if there is a single tumor or multiple tumors?	YES → SINGLE Primary*	Use this rule only after all information sources have been exhausted.
NO → Go to Single Tumor or Multiple Tumors	End of instructions for Unknown Number of Tumors.	

SINGLE TUMOR	DECISION	NOTES
		1. Tumor not described as metastasis 2. Includes combinations of in situ and invasive.
M2 Is there a single tumor?	YES → SINGLE Primary*	The tumor may overlap onto or extend into adjacent/contiguous site or subsite.
NO → Go to Multiple Tumors.	End of instructions for Single Tumor.	

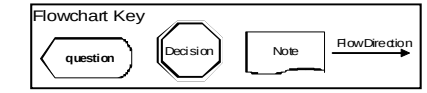
Colon Multiple Primary Rules - Flowchart

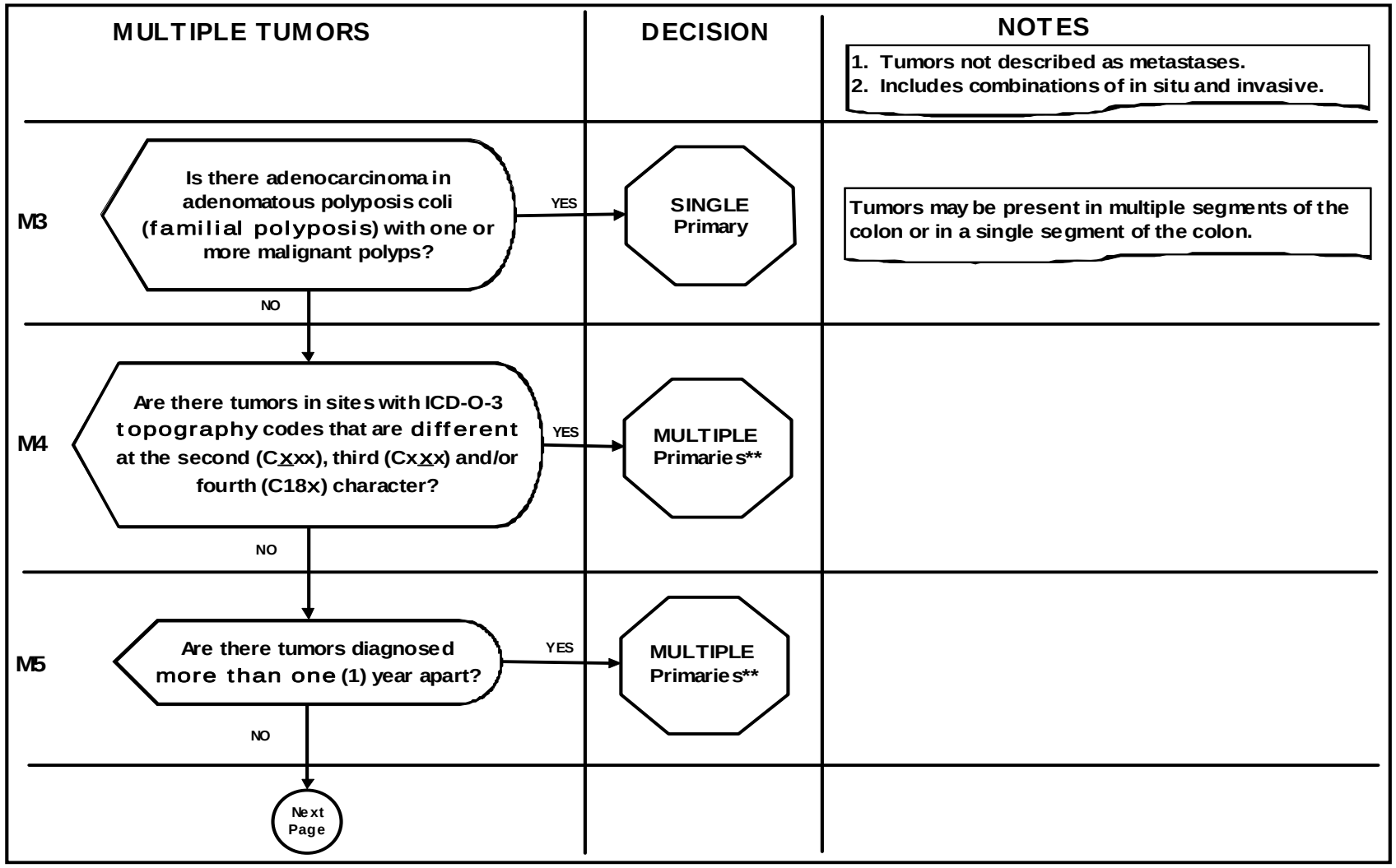
(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* 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.





Colon Multiple Primary Rules -Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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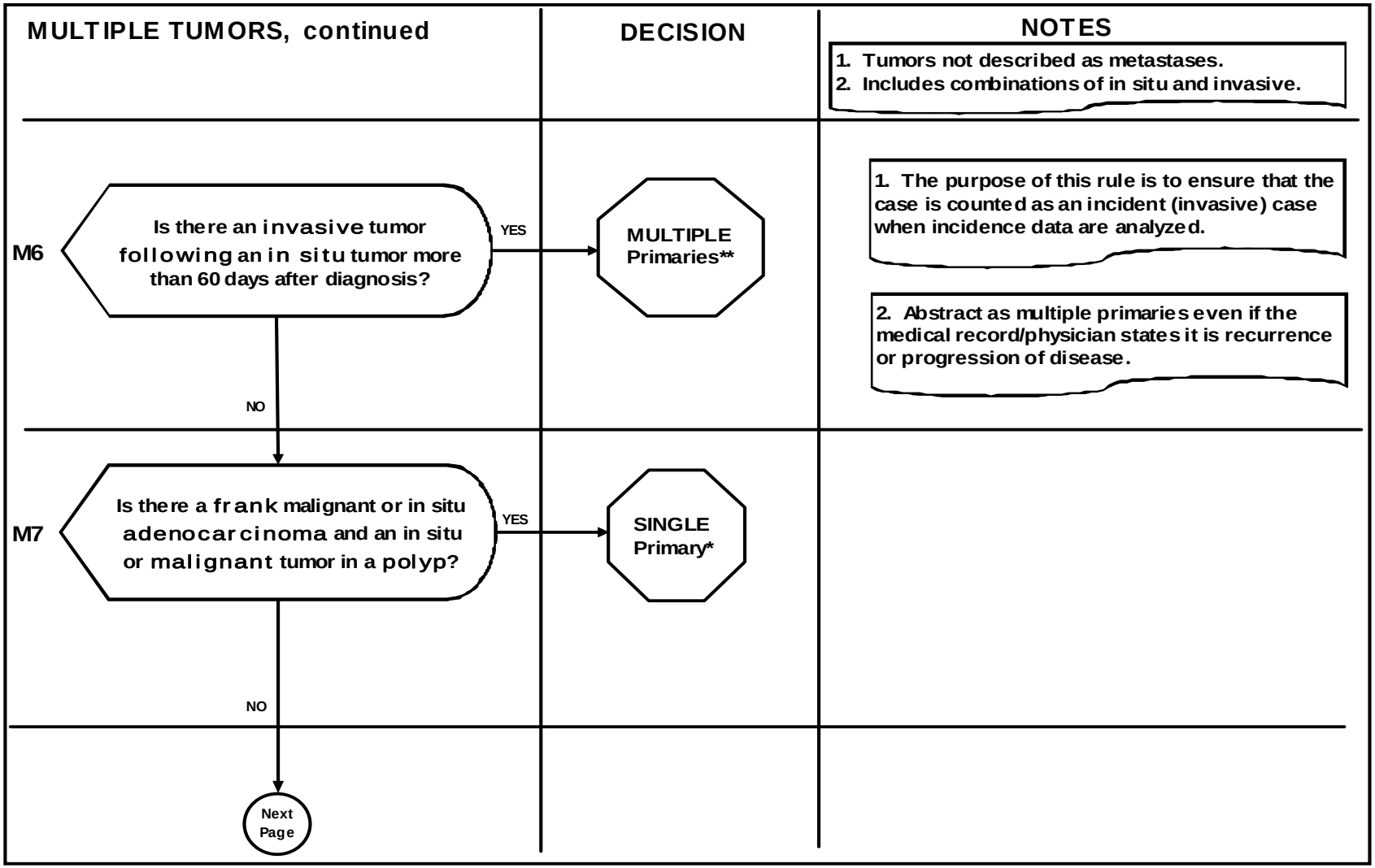


Colon MP

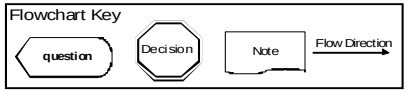
Colon Multiple Primary Rules - Flowchart

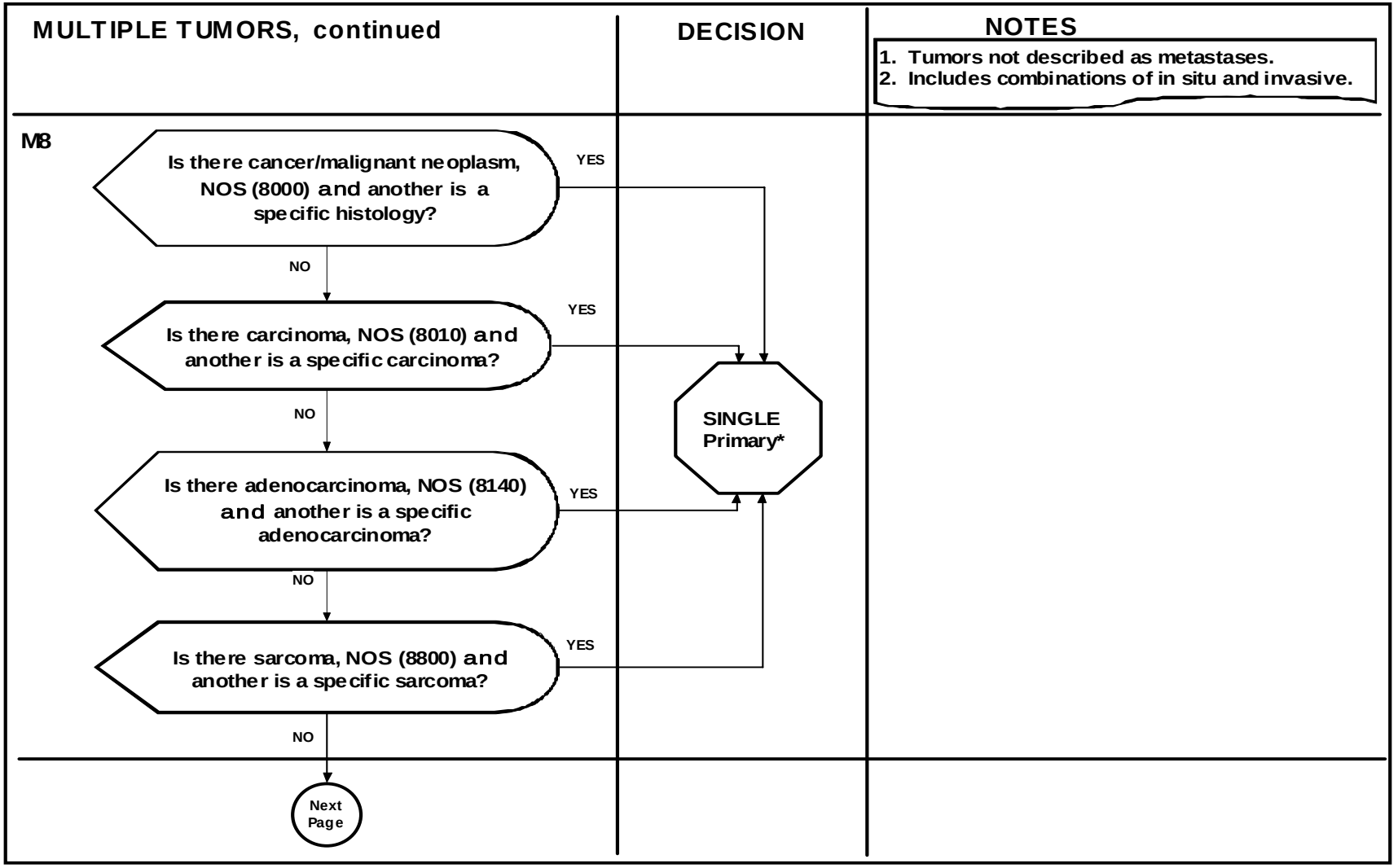
(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

* 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.





Colon Multiple Primary Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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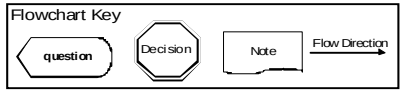
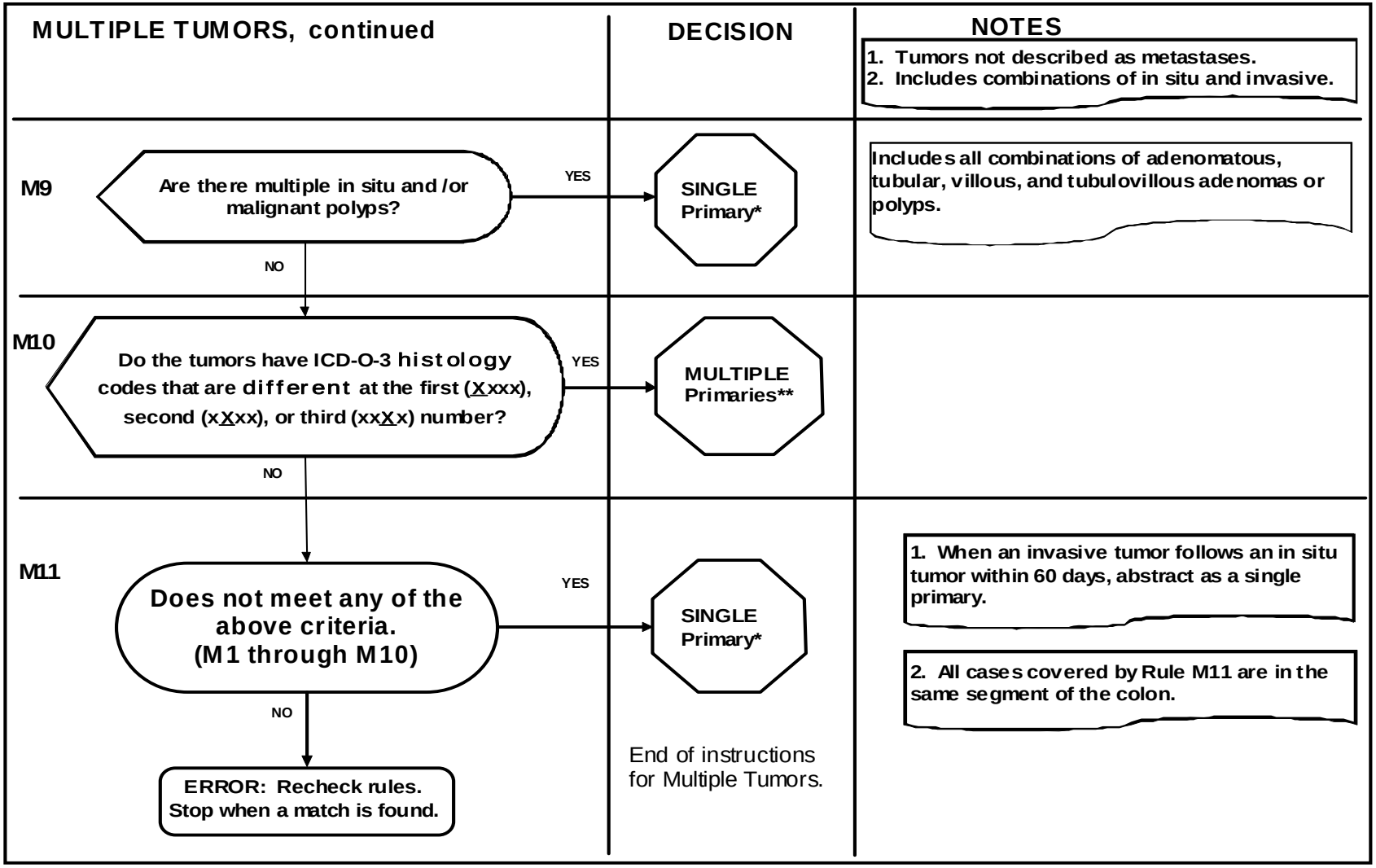




Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

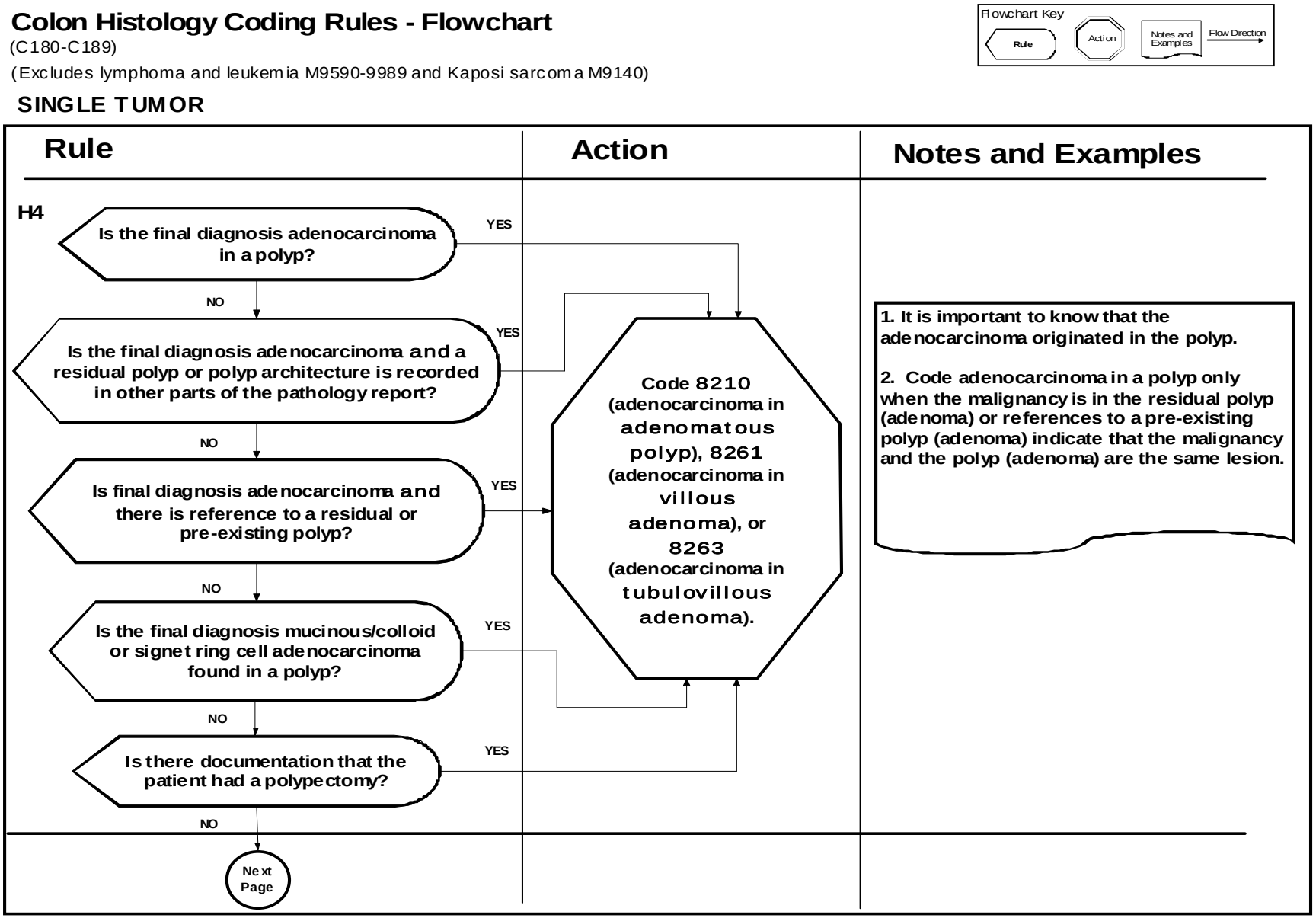
Rule	Action	Notes and Examples
H1 Is there no pathology/cytology specimen or is the pathology/cytology report unavailable? YES	Code the histology documented by the physician.	1. Priority for using documents to code the histology o Documentation in the medical record that refers to pathologic or cytologic findings o Physician's reference to type of cancer (histology) in the medical record o CT, PET or MRI scans 2. Code the specific histology when documented. 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.
NO		
H2 Is the specimen from a metastatic site? (There is no pathology/cytology specimen from the primary site) YES	Code the histology from a metastatic site.	Code the behavior /3.
NO		
H3 Does the pathology report describe only intestinal type adenocarcinoma or adenocarcinoma, intestinal type? YES	Code 8140 (adeno-carcinoma, NOS).	1. Intestinal type adenocarcinoma usually occurs in the stomach. 2. When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.
NO		
Next Page		

Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR



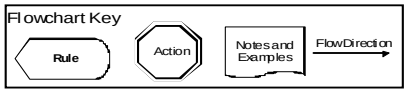
Colon Histo

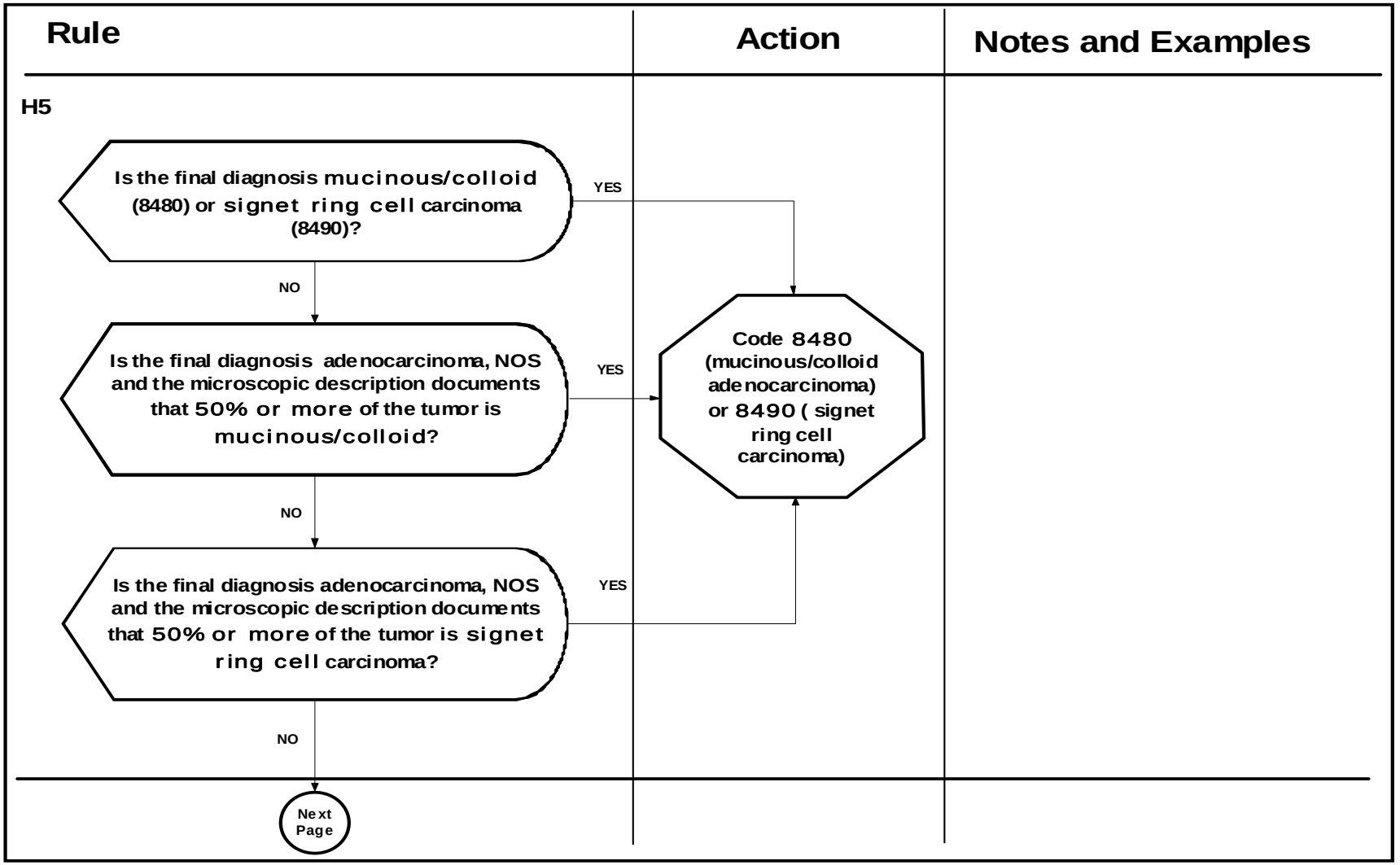
Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR



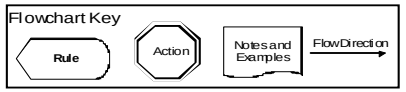


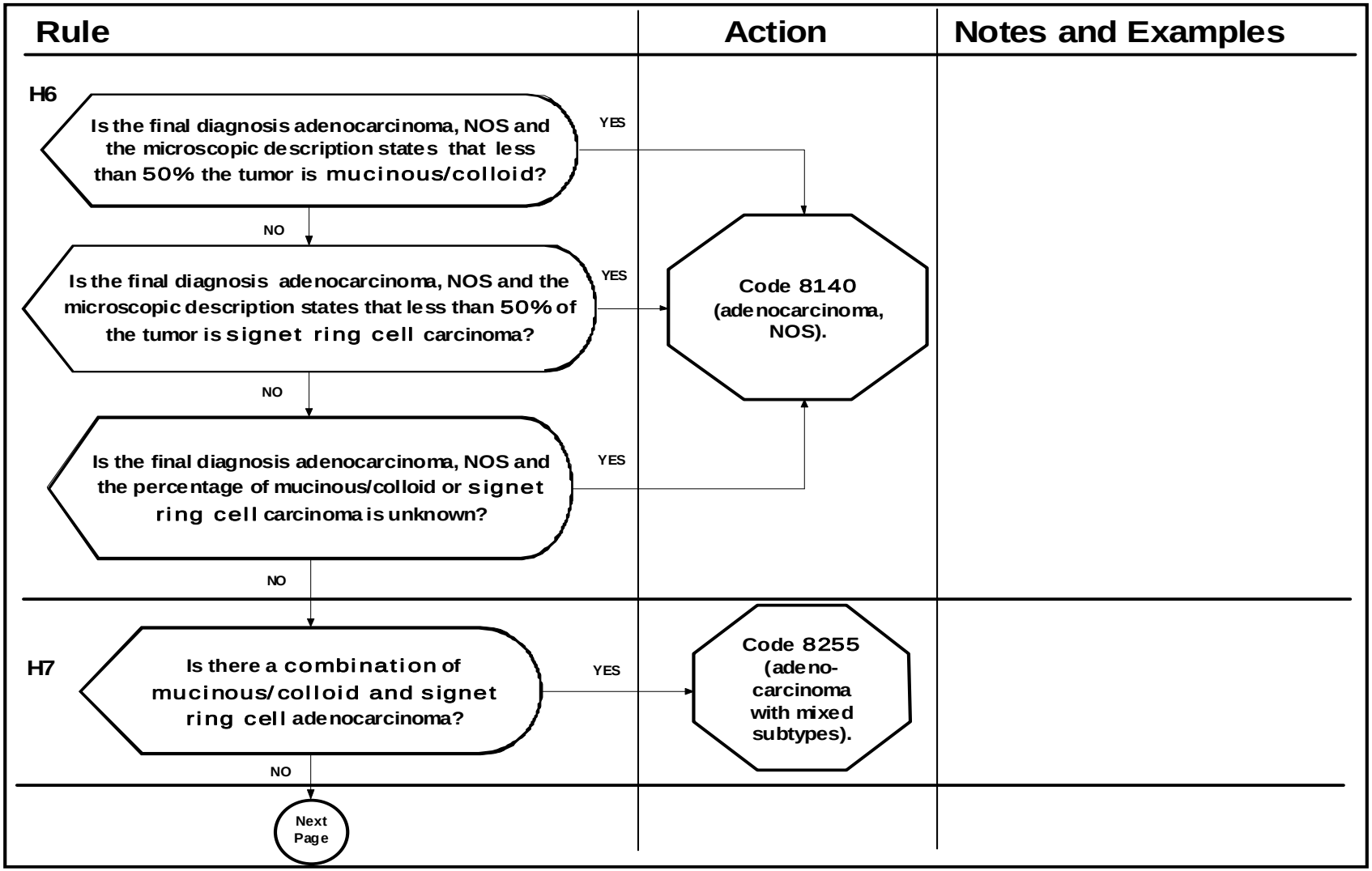
Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR



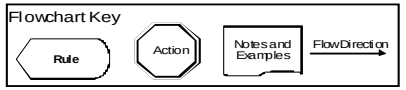


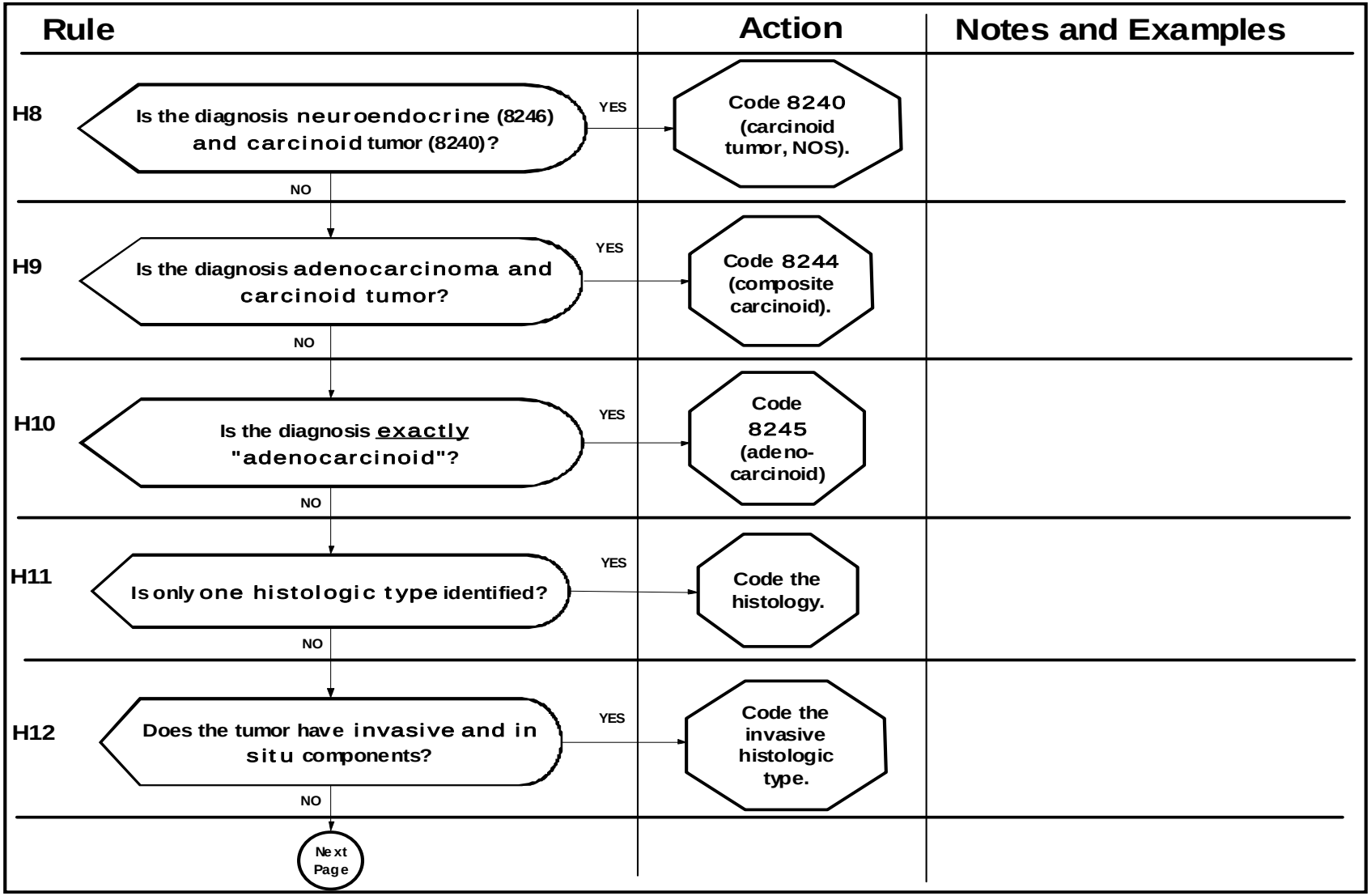
Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

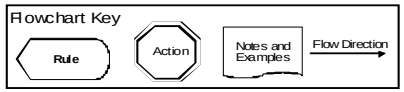


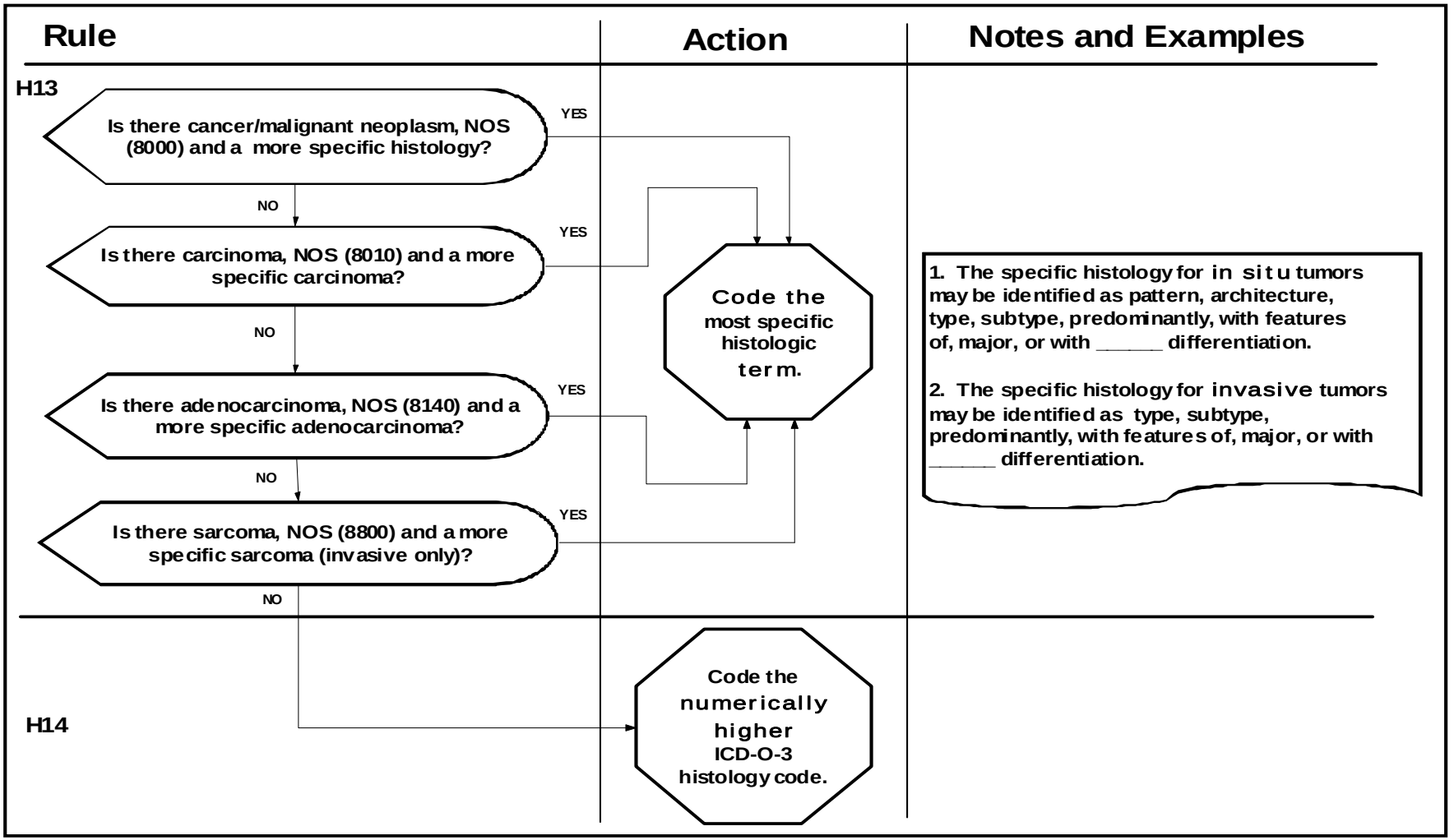


Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR





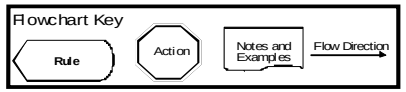
This is the end of instructions for Single Tumor.
Code the histology according to the rule that fits the case.

Colon Histo

Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



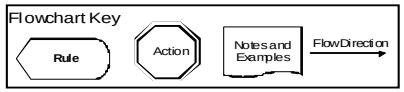
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H15 Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?		1. Priority for using documents to code the histology o Documentation in the medical record that refers to pathologic or cytologic findings o Physician's reference to type of cancer (histology) in the medical record o CT, PET or MRI scans 2. Code the specific histology when documented. 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.
YES	Code the histology documented by the physician.	
NO		
H16 Is the specimen from a metastatic site? (There is no pathology/cytology specimen from the primary site)		Code the behavior /3.
YES	Code the histology from a metastatic site.	
NO		
Next Page		

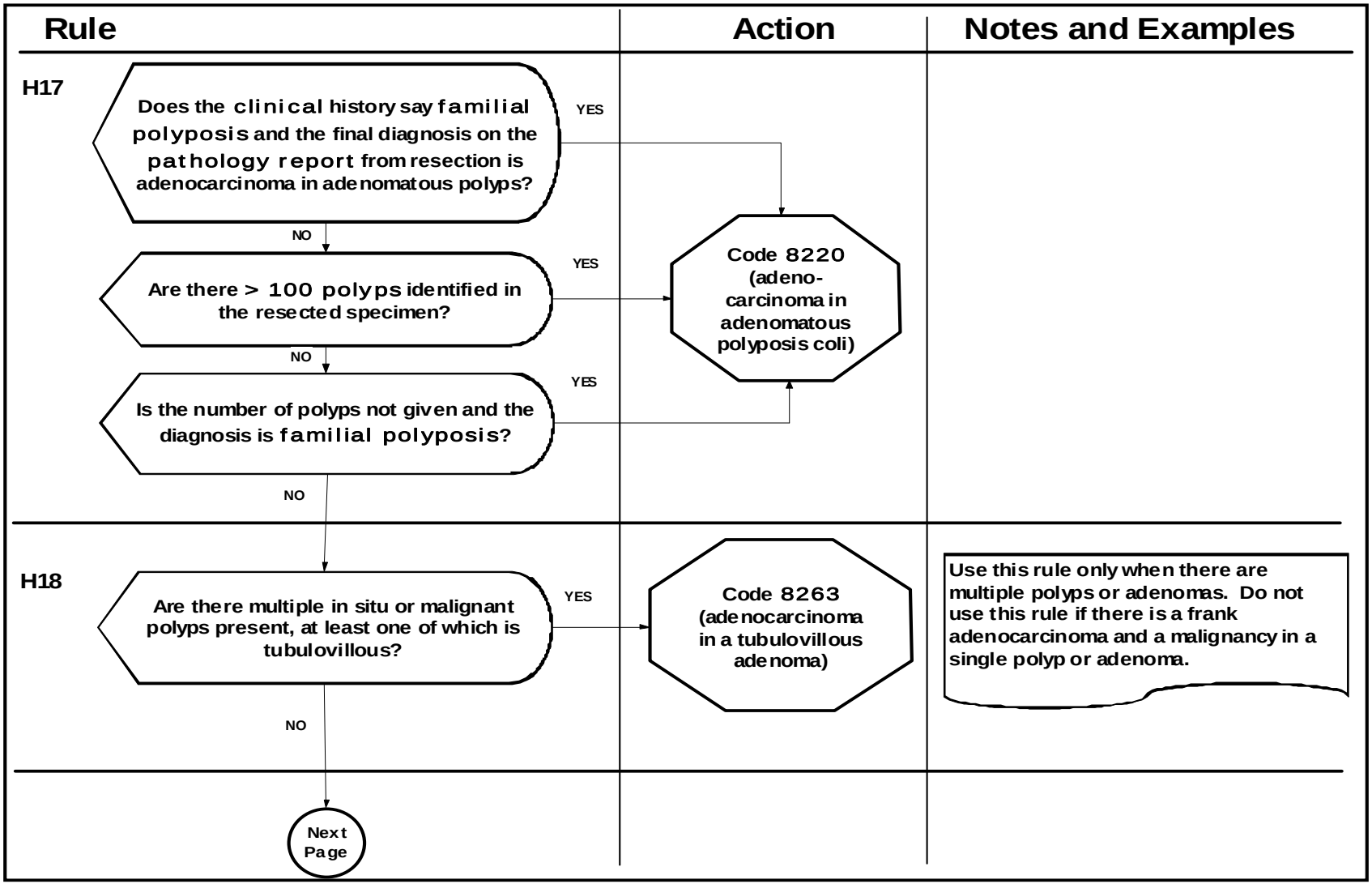
Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



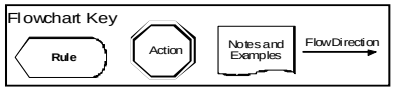
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY



Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

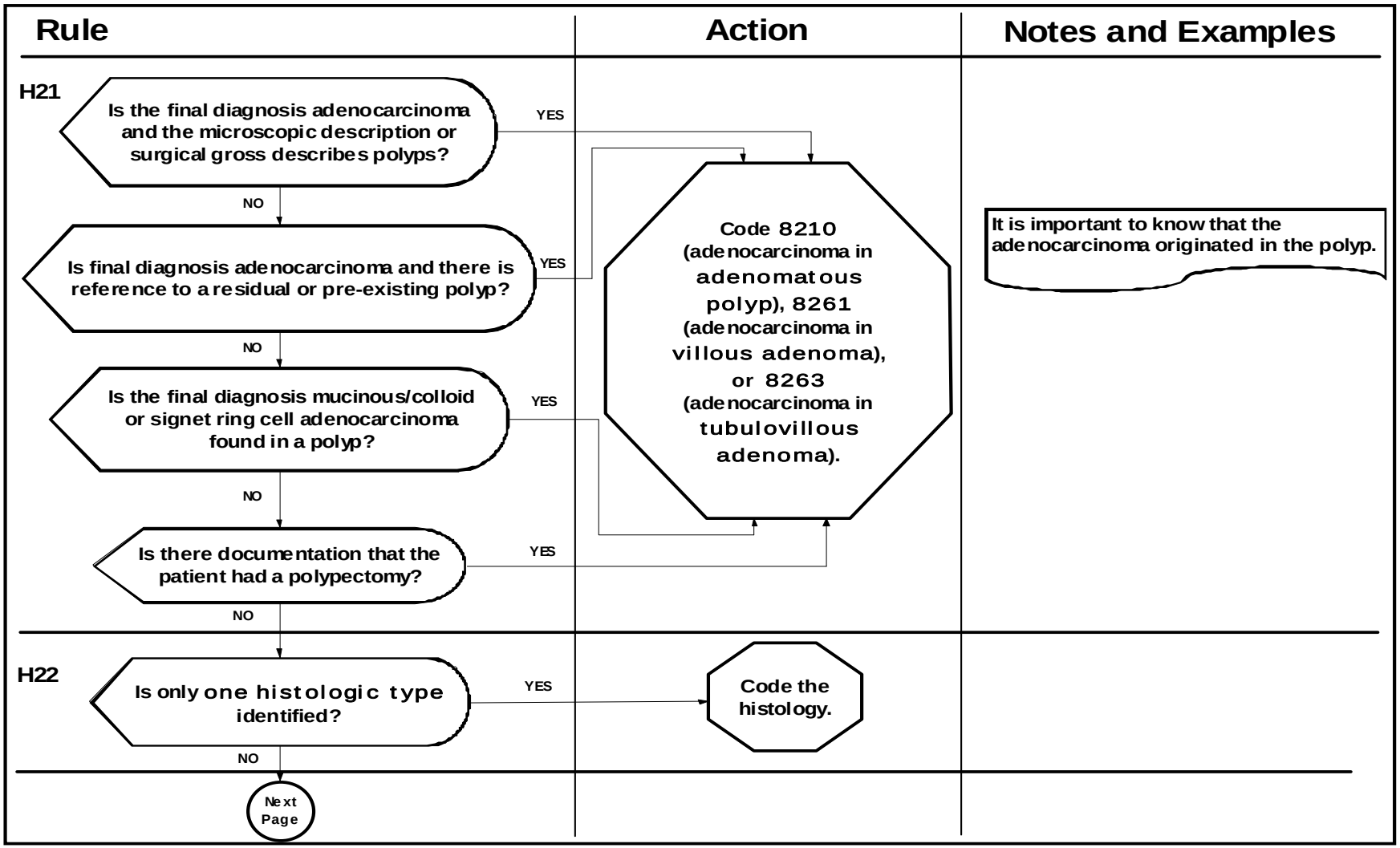
Rule	Action	Notes and Examples
H19 Are there >1 and < = 100 polyps identified in the resected specimen? YES → Code 8221 (adeno-carcinoma in adenomatous polyps) NO Are there multiple polyps and the number is not given and familial polyposis is not mentioned? YES → Code 8221 (adeno-carcinoma in adenomatous polyps) NO	Code 8221 (adeno-carcinoma in adenomatous polyps)	1. Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).
H20 Is there a frank adenocarcinoma and a carcinoma in a polyp? YES → Code the histology of the most invasive tumor. NO Are there in situ and invasive tumors? YES → Code the histology of the most invasive tumor. NO Are there multiple invasive tumors? YES → Code the histology of the most invasive tumor. NO Next Page	Code the histology of the most invasive tumor.	1. See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive. o If one tumor is in situ and one is invasive, code the histology from the invasive tumor. o If both/all histologies are invasive, code the histology of the most invasive tumor. 2. If tumors are equally invasive, go to the next rule.

Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

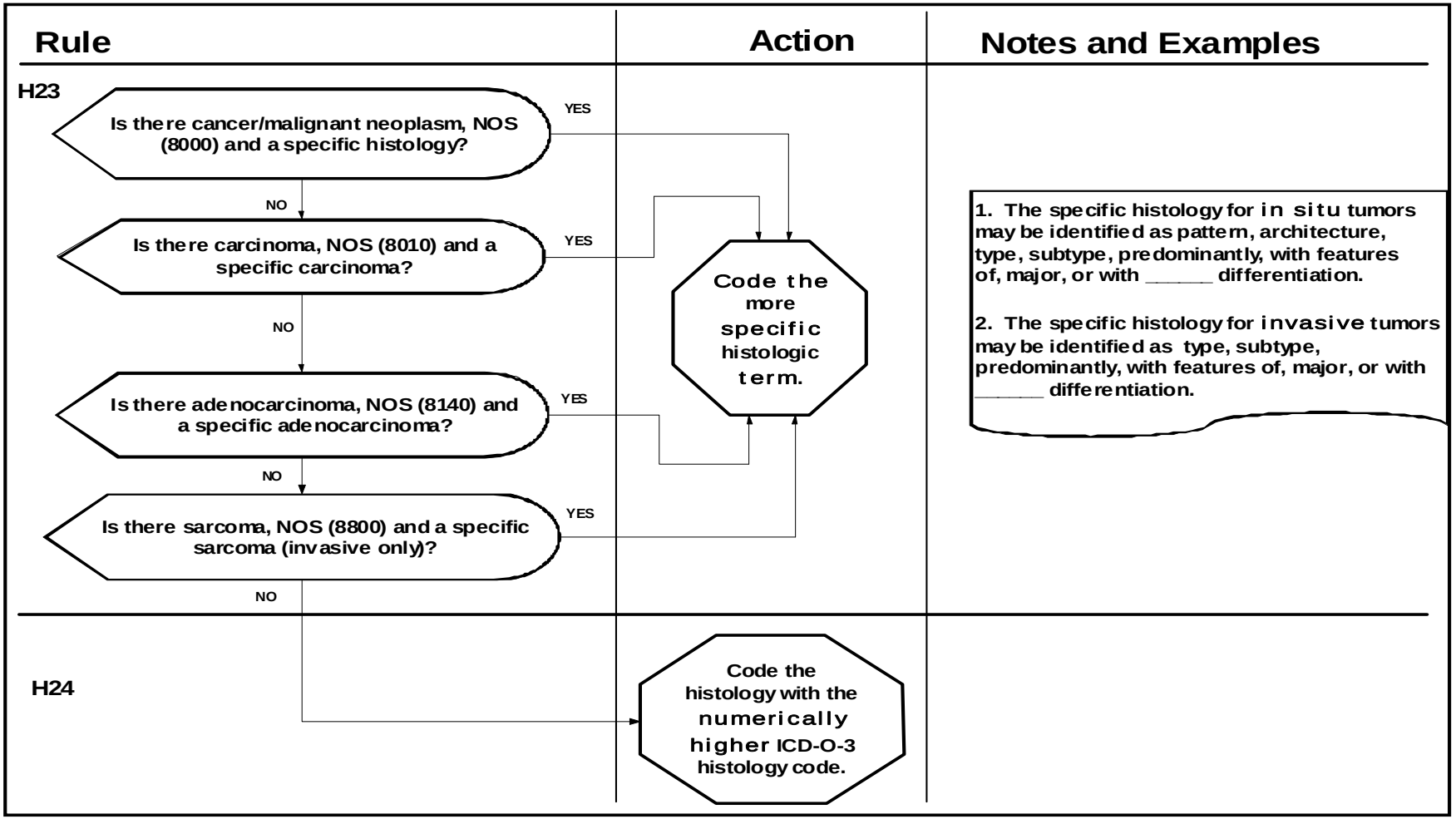


Colon Histology Coding Rules - Flowchart

(C180-C189)

(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY



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.

Colon Multiple Primary Rules – Matrix
C180-C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

* 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.

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
UNKNOWN IF SINGLE OR MULTIPLE TUMORS					Tumor(s) not described as metastasis	
M1					Use this rule only after all information sources have been exhausted.	Single*
SINGLE TUMOR					***1.*** Tumor not described as metastasis ***2.*** Includes combinations of in situ and invasive	
M2	Single				Tumor may overlap onto or extend into adjacent/contiguous site or subsite	Single*
MULTIPLE TUMORS **Multiple tumors may be a single primary or multiple primaries**					***1.*** Tumors not described as metastases ***2.*** Includes combinations of in situ and invasive	
M3		Adenocarcinoma in adenomatous polyposis (familial polyposis) with one or more malignant polyps			Tumors may be present in multiple segments of the colon or in a single segment of the colon.	Single*
M4	Sites with topography codes that are different at the second (C**x**xx), third (Cx**x**x) or fourth (C18**x**) character					Multiple**
M5			Diagnosed more than one (1) year apart			Multiple**
M6			More than 60 days after diagnosis	An invasive tumor following an in situ tumor	***1:*** The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. ***2:*** Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.	Multiple**

Colon MP

Colon Multiple Primary Rules – Matrix
C180-C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
M7		A frank in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp				Single*
M8		• 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				Single*
M9		Multiple in situ and/or malignant polyps			Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.	Single*
M10		Histology codes are different at the first (**x**xxx), second (x**x**xx), or third (xx**x**x) number				Multiple**
M11	Does not meet any of the above criteria				***1:*** When an invasive lesion follows an in situ within 60 days, abstract as a single primary. ***2:*** All cases covered by Rule M11 are in the same segment of the colon	Single*

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR					
H1	No pathology/cytology specimen or the pathology/cytology report is not available			***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 ***2:*** Code the specific histology when documented. ***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	The histology documented by the physician
H2	None from primary site			Code the behavior /3	The histology from metastatic site

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H3		Intestinal type adenocarcinoma or adenocarcinoma, intestinal type		***1:*** Intestinal type adenocarcinoma usually occurs in the stomach. ***2:*** When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.	8140 (Adenocarcinoma, NOS)
H4		Final diagnosis: • Adenocarcinoma in a polyp or • Adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report or • Adenocarcinoma **and** there is reference to a residual or pre-existing polyp within the medical record or • Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy		***1:*** It is important to know that the adenocarcinoma originated in a polyp. ***2:*** Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.	8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenoma)
H5		Final diagnosis is: • Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or • Adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is mucinous/colloid or • Adenocarcinoma, NOS **and** microscopic description documents 50% or more of the tumor is signet ring cell carcinoma			8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma)

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H6		Final diagnosis is adenocarcinoma and: • Microscopic description states less than 50% of the tumor is mucinous/colloid, or • Microscopic description states less than 50% of the tumor is signet ring cell carcinoma, or • Percentage of Mucinous/colloid or signet ring cell carcinoma is unknown			8140 (Adenocarcinoma, NOS)
H7		Combination of mucinous/colloid and signet ring cell carcinoma			8255 (Adenocarcinoma with mixed subtypes)
H8		Neuroendocrine carcinoma (8246) and carcinoid tumor (8240)			8240 (Carcinoid tumor, NOS)
H9		Adenocarcinoma and carcinoid tumor			8244 (Composite carcinoid)
H10		Exactly "adenocarcinoid"			8245 (Adenocarcinoid)
H11		One type			The histology
H12			Invasive and in situ		The invasive histologic type

Colon Histo

Colon Histo

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H13		• 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)		***1.*** The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation. ***2.*** The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.	The most specific histologic term
H14	None of the above conditions are met				The histology with the numerically higher ICD-O-3 code

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY These rules only apply to multiple tumors that are reported as a **single primary**					
H15	No pathology/cytology specimen or the pathology/cytology report is not available			***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 ***2:*** Code the specific histology when documented ***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	The histology documented by the physician
H16	None from primary site			Code the behavior /3	The histology from a metastatic site

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H17		• Clinical history says familial polyposis and final diagnosis on pathology report from resection is adenocarcinoma in adenomatous polyps, or • > 100 polyps in resected specimen or • Number of polyps is not given but the diagnosis is familial polyposis			8220 (Adenocarcinoma in adenomatous polyposis coli)
H18		Multiple in situ or malignant polyps are present, at least one of which is tubulovillous		Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.	8263 (Adenocarcinoma in a tubulovillous adenoma)
H19		• **>1 and** <= 100 polyps identified in resected specimen, or • Multiple polyps (adenomas) and the number is not given and familial polyposis is not mentioned		Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).	8221 (adenocarcinoma in multiple adenomatous polyps)

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H20		• Frank adenocarcinoma and a carcinoma in a polyp, or • In situ and invasive tumors or • Multiple invasive tumors		***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. ***2*:** If tumors are equally invasive, go to the next rule	The histology of the most invasive tumor
H21		Final diagnosis: • Adenocarcinoma **and** the microscopic description or surgical gross describes polyps or • Adenocarcinoma **and** there is reference to residual or pre-existing polyps or • Mucinous/colloid or signet ring cell adenocarcinoma in polyps or There is documentation that the patient had a polypectomy		It is important to know that the adenocarcinoma originated in a polyp.	8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenocarcinoma)
H22		One type			The histology

Colon Histo

Colon Histo

Colon Histology Coding Rules – Matrix
C180 – C189
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H23		• 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)		***1:*** The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation ***2:*** The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.	The more specific histologic term
H24	None of the above conditions are met				The histology with the numerically higher ICD-O-3 code

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**x**xx), third, (Cx**x**x) or fourth (C18**x**) 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 (**x**xxx), second (x**x**xx) or third (xx**x**x) 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

Note1: It is important to know that the adenocarcinoma originated in a polyp.

Note 2: Code adenocarcinoma in a polyp only when the malignancy is in the residual polyp (adenoma) or references to a pre-existing polyp (adenoma) indicate that the malignancy and the polyp (adenoma) are the same lesion.

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

***Note*:** Use this rule only when there are multiple polyps or adenomas. Do not use this rule if there is a frank adenocarcinoma and a malignancy in a single polyp or adenoma.

Rule H19 Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:

- There are **>1 and** <=100 polyps identified in the resected specimen or
- There are multiple polyps (adenomas) and the number is not given and **familial polyposis** is **not mentioned**

***Note*:** Use this rule only when there are multiple polyps. Do not use for a single polyp (adenoma) or for a frank malignancy and a malignancy in a single polyp (adenoma).

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.

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

CS Tumor Size	**CS Site-Specific Factor 1 -** Carcinoembryonic Antigen (CEA)	**The following tables are available at the collaborative staging website:**
CS Extension	**CS Site-Specific Factor 2 -** Clinical Assessment of Regional Lymph Nodes	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	Lymph Nodes Clinical Evaluation Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	Lymph Nodes Pathologic Evaluation Table Also Used When CS Reg Nodes Eval is Not Coded
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Colon
CS Tumor Size (Revised: 07/28/2006)

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 (Revised: 08/14/2006)

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

Code	Description	TNM	SS77	SS2000
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 Transverse 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

Code	Description	TNM	SS77	SS2000
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

Colon
CS TS/Ext-Eval
SEE STANDARD TABLE

Colon
CS Lymph Nodes (Revised: 09/17/2007)

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.
Note 4: The number of positive regional nodes is required to calculate the correct N category for this site. Codes 40 and 45 are for use when this number is not available, but the pathology report assigns an N1 or N2 category. If information about the number of positive nodes is available, use codes 10, 20, or 30 rather than codes 40 or 45. The actual number of involved nodes will be coded in Reg LN Pos.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
10	Regional lymph nodes 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 nodes, 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 Superior rectal	*	RN	RN
30	Regional lymph nodes for all colon sites: Mesenteric, NOS Regional lymph node(s), NOS	*	RN	RN
40	Stated as N1 pathologic	N1	RN	RN
45	Stated as N2 pathologic	N2	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 10-30 and 80 ONLY:** when CS Regional Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation Table, using Reg LN Pos and CS Site-Specific Factor 2; when CS Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation Table using Reg LN Pos.

Colon
CS Reg Nodes Eval
SEE STANDARD TABLE

Colon
Reg LN Pos
SEE STANDARD TABLE

Colon
Reg LN Exam
SEE STANDARD TABLE

Colon
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
08	Cecum, appendix, ascending, hepatic flexure and transverse colon: Superior mesenteric lymph nodes	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: Inferior mesenteric For splenic flexure, descending colon, and sigmoid colon: Superior mesenteric	M1	D	D
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

Colon
CS Mets Eval
SEE STANDARD TABLE

Colon
CS Site-Specific Factor 1 Carcinoembryonic Antigen (CEA) (Revised: 07/31/2002)

Code	Description
000	Test not done

Code	Description
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Colon
CS Site-Specific Factor 2 Clinical Assessment of Regional Lymph Nodes (Revised: 10/22/2007)

Note: In the rare instance that the number of clinically positive nodes is stated but a clinical N category is not stated, code 1-3 nodes as 100 (N1), and 4 or more nodes as 200 (N2).

Code	Description
000	Nodes not clinically evident
100	Clinically N1
200	Clinically N2
400	Clinically positive regional nodes, NOS
888	OBSOLETE - Not Applicable
999	Unknown if nodes are clinically evident

Colon
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Colon
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Colon
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Colon

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Colon
C180–C189
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 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, or 24 Laser ablation]

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

[***SEER Note:*** 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 thedistal 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]

Surgery Codes

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)
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

Rectosigmoid, Rectum
C199, C209

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Rectosigmoid, Rectum
C19.9, C20.9

C19.9 Rectosigmoid junction
C20.9 Rectum, NOS

CS Tumor Size	**CS Site-Specific Factor 1 -** Carcinoembryonic Antigen (CEA)	**The following tables are available at the collaborative staging website:**
CS Extension	**CS Site-Specific Factor 2 -** Clinical Assessment of Regional Lymph Nodes	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	Lymph Nodes Clinical Evaluation Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	Lymph Nodes Pathologic Evaluation Table Also Used When CS Reg Nodes Eval is Not Coded
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Rectosigmoid, Rectum
CS Tumor Size (Revised: 07/28/2006)

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," 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

Rectosigmoid, Rectum
CS Extension (Revised: 08/21/2006)

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.

CS Staging Schemas

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	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	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	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	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

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Rectosigmoid, Rectum
CS Lymph Nodes (Revised: 09/17/2007)
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.

Note 3: The number of positive regional nodes is required to calculate the correct N category for this site. Codes 40 and 45 are for use when this number is not available, but the pathology report assigns an N1 or N2 category. If information about the number of positive nodes is available, use codes 10, 20, or 30 rather than codes 40 or 45. The actual number of involved nodes will be coded in Reg LN Pos.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes: 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 promontory Sigmoidal (sigmoid mesenteric)	*	RN	RN
30	Mesenteric, NOS Regional lymph node(s), NOS	*	RN	RN
40	Stated as N1 pathologic	N1	RN	RN
45	Stated as N2 pathologic	N2	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 10-30 and 80 ONLY:** when CS Regional Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation Table, using Reg LN Pos and CS Site-Specific Factor 2; when CS Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation Table using Reg LN Pos.

Rectosigmoid, Rectum
CS Reg Nodes Eval
SEE STANDARD TABLE

Rectosigmoid, Rectum
Reg LN Pos
SEE STANDARD TABLE

Rectosigmoid, Rectum
Reg LN Exam
SEE STANDARD TABLE

Rectosigmoid, Rectum
CS Mets at DX (Revised: 05/06/2004)

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 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

Rectosigmoid, Rectum
CS Mets Eval
SEE STANDARD TABLE

Rectosigmoid, Rectum
CS Site-Specific Factor 1 Carcinoembryonic Antigen (CEA) (Revised: 11/18/2003)

Note: The Site-Specific Factors section includes factors that are needed to derive TNM or AJCC stage and also includes items that are considered important but are not needed for AJCC. This includes prognostic and predictive factors and tumor markers. There are many sites for which there are no Site-Specific Factors required at this time.

Code	Description
000	Test none done
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Rectosigmoid, Rectum
CS Site-Specific Factor 2 Clinical Assessment of Regional Lymph Nodes (Revised: 10/22/2007)

Note: In the rare instance that the number of clinically positive nodes is stated but a clinical N category is not stated, code 1-3 nodes as 100 (N1), and 4 or more nodes as 200 (N2).

Code	Description
000	Nodes not clinically evident
100	Clinically N1
200	Clinically N2
400	Clinically positive regional nodes, NOS
888	OBSOLETE - Not Applicable
999	Unknown if nodes are clinically evident

Rectosigmoid, Rectum
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Rectosigmoid, Rectum
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Rectosigmoid, Rectum
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Rectosigmoid, Rectum
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Rectosigmoid
C199
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

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 operation]

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]

Surgery Codes

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 Note***: 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

Surgery Codes

Rectum
C209
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 25 Laser excision
- 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

Surgery Codes

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

Anus
C210-C218

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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).

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	Extension Size Table
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Anus
CS Tumor Size
SEE STANDARD TABLE

Anus
CS Extension (Revised: 12/08/2003)

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

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Anus
CS Lymph Nodes (Revised: 05/06/2004)
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

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
30	Unilateral: For anal canal: Superficial inguinal (femoral)	N2	RN	RN
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
CS Reg Nodes Eval
SEE STANDARD TABLE

Anus
Reg LN Pos
SEE STANDARD TABLE

Anus
Reg LN Exam
SEE STANDARD TABLE

Anus
CS Mets at DX
SEE STANDARD TABLE

Anus
CS Mets Eval
SEE STANDARD TABLE

Anus
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Anus
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Anus
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Anus
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Anus
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Anus
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Anus
C210–C218
(Except for M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 Local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 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

Liver, Intrahepatic Bile Ducts
C220-C221

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Liver and Intrahepatic Bile Ducts
C22.0-C22.1

C22.0 Liver
C22.1 Intrahepatic bile duct

CS Tumor Size	**CS Site-Specific Factor 1 -**	**The following tables are available at the collaborative staging website:**
CS Extension	Alpha Fetoprotein (AFP)	Histology Exclusion Table
CS TS/Ext-Eval	**CS Site-Specific Factor 2 -**	AJCC Stage
CS Lymph Nodes	Fibrosis Score	Extension Size Table
CS Reg Nodes Eval	CS Site-Specific Factor 3	
Reg LN Pos	CS Site-Specific Factor 4	
Reg LN Exam	CS Site-Specific Factor 5	
CS Mets at DX	CS Site-Specific Factor 6	
CS Mets Eval		

Liver and Intrahepatic Bile Ducts
CS Tumor Size
SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts
CS Extension (Revised: 08/18/2006)

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

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
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 Hepatoduodenal Hepatogastric Round [of liver] 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 TS/Ext-Eval (Revised: 08/21/2006)

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c

CS Staging Schemas

Code	Description	Staging Basis
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques including surgical observation without biopsy. No autopsy evidence used.	p
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on clinical evidence.	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy).	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Liver and Intrahepatic Bile Ducts

CS Lymph Nodes (Revised: 05/06/2004)

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: 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
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 05/31/2006)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph nodes: Cardiac Lateral (aortic) (lumbar) Pericardial (pericardiac) Posterior mediastinal (tracheoesophageal) including juxtaphrenic nodes Retroperitoneal, NOS	M1	RN	D
12	Distant lymph nodes: 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

Liver and Intrahepatic Bile Ducts
CS Mets Eval
SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts
CS Site-Specific Factor 1 Alpha Fetoprotein (AFP) (Revised: 03/17/2004)

Code	Description
000	Test not done
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Liver and Intrahepatic Bile Ducts
CS Site-Specific Factor 2 Fibrosis Score (Revised: 11/18/2002)
Note: AJCC classifies fibrosis scores 0-4 (none to moderate fibrosis) as F0, and fibrosis scores 5-6 (severe fibrosis or cirrhosis) as F1. Fibrosis score is also called Ishak score.

Code	Description
000	F0: Fibrosis score 0-4 (none to moderate fibrosis)
001	F1: Fibrosis score 5-6 (severe fibrosis or cirrhosis)
999	Fibrosis score not recorded Insufficient information Not documented in patient record

Liver and Intrahepatic Bile Ducts
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Liver and Intrahepatic Bile Ducts
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Liver and Intrahepatic Bile Ducts

CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Liver and Intrahepatic Bile Ducts

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Liver and Intrahepatic Bile Ducts
C220–C221
(Except for M9750, 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)

[***SEER Note:*** Code 15 Alcohol (Percutaneous Ethanol Injection-PEI) can also be described as an "intratumoral injection of alcohol" or "alcohol ablation"]
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17

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

Gallbladder, Extrahepatic Bile Ducts, Ampulla of Vater
C239, C240-249

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Gallbladder
C23.9

C23.9 Gallbladder

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Gallbladder
CS Tumor Size
SEE STANDARD TABLE

Gallbladder
CS Extension (Revised: 03/17/2004)

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

Code	Description	TNM	SS77	SS2000
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 [(62) to (66)]	T3	D	D
72	Extension into liver greater than 2 cm PLUS extension to ONE structure in [(62) to (66)]	T3	D	D
73	Extension to two or more structures in [(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 TS/Ext-Eval
SEE STANDARD TABLE

Gallbladder
CS Lymph Nodes (Revised: 01/10/2005)
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

Code	Description	TNM	SS77	SS2000
10	Regional lymph nodes: Cystic duct (Calot's node) Node of foramen of Winslow (omental) (epiploic) Pericholedochal (common bile duct)	N1	RN	RN
11	Regional lymph nodes: 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	RN
60	Superior mesenteric lymph node(s)	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

Gallbladder
CS Reg Nodes Eval
SEE STANDARD TABLE

Gallbladder
Reg LN Pos
SEE STANDARD TABLE

Gallbladder
Reg LN Exam
SEE STANDARD TABLE

Gallbladder
CS Mets at DX (Revised: 05/06/2004)

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

Code	Description	TNM	SS77	SS2000
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

Gallbladder
CS Mets Eval
SEE STANDARD TABLE

Gallbladder
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Gallbladder
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Gallbladder
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Gallbladder
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Gallbladder
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Gallbladder

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)
C24.0

C24.0 Extrahepatic bile duct

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Extrahepatic Bile Duct(s)
CS Tumor Size
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
CS Extension (Revised: 08/02/2004)

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 portal vein (right or left) Unilateral branches of hepatic artery (right or left)	T3	RE	RE
65	Colon, NOS Transverse including flexure Duodenum, NOS Omentum, NOS Lesser Stomach, distal	T4	RE	RE
66	Main portal vein or its branches bilaterally Common hepatic artery Hepatic artery, NOS Portal vein, NOS	T4	RE	RE

Code	Description	TNM	SS77	SS2000
70	Other parts of colon Greater omentum Stomach, proximal	T4	D	RE
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 TS/Ext-Eval
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
CS Lymph Nodes (Revised: 12/08/2003)
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 nodes: 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 nodes, NOS	N1	RN	RN
35	Regional lymph nodes: Celiac Superior mesenteric	N1	D	D
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

Extrahepatic Bile Duct(s)
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 08/21/2006)

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 nodes, NOS	M1	D	D
40	Distant metastases except distant lymph nodes (code 10) Distant metastases, 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

Extrahepatic Bile Duct(s)
CS Mets Eval
SEE STANDARD TABLE

Extrahepatic Bile Duct(s)
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)

CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Extrahepatic Bile Duct(s)
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ampulla of Vater
C24.1

C24.1 Ampulla of Vater

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Ampulla of Vater
CS Tumor Size
SEE STANDARD TABLE

Ampulla of Vater
CS Extension (Revised: 08/18/2006)

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

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Ampulla of Vater
CS Lymph Nodes (Revised: 12/08/2003)
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 nodes: 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 nodes: 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 nodes: 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 nodes cannot be assessed Not documented in patient record	NX	U	U

Ampulla of Vater
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 08/21/2006)

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 nodes, 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 patient record	MX	U	U

Ampulla of Vater
CS Mets Eval
SEE STANDARD TABLE

Ampulla of Vater
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Ampulla of Vater
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ampulla of Vater
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ampulla of Vater
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ampulla of Vater
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ampulla of Vater
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Other Biliary and Biliary, NOS
CS Tumor Size
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
CS Extension (Revised: 04/12/2004)

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

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
63	Gallbladder Unilateral branches of the right or left hepatic artery Unilateral branches of the right or left portal vein	T3	RE	RE
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)-(63)]	T3	D	D
71	Extension to two or more adjacent organs any of which are in codes [(65)-(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 TS/Ext-Eval
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
CS Lymph Nodes (Revised: 01/10/2005)
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): Porta hepatis (portal) (hilar) [in hilus of liver]	N1	D	RN
20	Regional lymph node(s): Pancreaticoduodenal Periportal	N1	RN	RN

Code	Description	TNM	SS77	SS2000
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	RN
60	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

Other Biliary and Biliary, NOS
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 12/08/2003)

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 nodes (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

Other Biliary and Biliary, NOS

CS Mets Eval
SEE STANDARD TABLE

Other Biliary and Biliary, NOS
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Other Biliary and Biliary, NOS
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other Biliary and Biliary, NOS
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other Biliary and Biliary, NOS
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other Biliary and Biliary, NOS
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other Biliary and Biliary, NOS
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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 M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 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

Pancreas
C250-C259

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	Extension Size Table
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Pancreas: Head
CS Tumor Size

SEE STANDARD TABLE

Pancreas: Head
CS Extension (Revised: 11/19/2004)

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 vein Transverse colon, including hepatic flexure	T3	RE	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
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 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: Head
CS TS/Ext-Eval
SEE STANDARD TABLE

Pancreas: Head
CS Lymph Nodes (Revised: 11/19/2003)

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 nodes: 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 nodes cannot be assessed Not documented in patient record	NX	U	U

Pancreas: Head
CS Reg Nodes Eval
SEE STANDARD TABLE

Pancreas: Head
Reg LN Pos
SEE STANDARD TABLE

Pancreas: Head
Reg LN Exam
SEE STANDARD TABLE

Pancreas: Head
CS Mets at DX (Revised: 12/09/2003)

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

Pancreas: Head
CS Mets Eval
SEE STANDARD TABLE

Pancreas: Head
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Pancreas: Head
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Head
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Head
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Head
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Head
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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 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.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	Extension Size Table
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Pancreas: Body and Tail
CS Tumor Size
SEE STANDARD TABLE

Pancreas: Body and Tail
CS Extension (Revised: 08/21/2006)

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

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
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 TS/Ext-Eval
SEE STANDARD TABLE

Pancreas: Body and Tail

CS Lymph Nodes (Revised: 08/14/2006)

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
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 08/21/2006)

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

Pancreas: Body and Tail
CS Mets Eval
SEE STANDARD TABLE

Pancreas: Body and Tail
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Pancreas: Body and Tail
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Body and Tail
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Body and Tail
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Body and Tail
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Body and Tail
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	Extension Size Table
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Pancreas: Other and Unspecified
CS Tumor Size
SEE STANDARD TABLE

Pancreas: Other and Unspecified
CS Extension (Revised: 12/09/2003)

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

Code	Description	TNM	SS77	SS2000
60	Tumor is inseparable from the celiac axis or superior mesenteric artery Aorta Celiac artery Superior mesenteric artery	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

***** 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 TS/Ext-Eval
SEE STANDARD TABLE

Pancreas: Other and Unspecified
CS Lymph Nodes (Revised: 08/14/2006)
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

Code	Description	TNM	SS77	SS2000
99	Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record	NX	U	U

Pancreas: Other and Unspecified
CS Reg Nodes Eval
SEE STANDARD TABLE

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 (Revised: 08/21/2006)

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

Pancreas: Other and Unspecified
CS Mets Eval
SEE STANDARD TABLE

Pancreas: Other and Unspecified
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Pancreas: Other and Unspecified
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Other and Unspecified
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Other and Unspecified
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Other and Unspecified
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Pancreas: Other and Unspecified
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Pancreas
C250–C259
(Except for M9750, 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

Other Digestive
C260-C269

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

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.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histologies for Which AJCC Staging Is Not Generated
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	AJCC Stage
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Other and Ill-Defined Digestive Organs
CS Tumor Size

SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs
CS Extension (Revised: 03/17/2004)

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 TS/Ext-Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Ill-Defined Digestive Organs
CS Lymph Nodes (Revised: 03/17/2004)

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 Intra-abdominal Paracaval Pelvic Subdiaphragmatic Regional lymph nodes, 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

Other and Ill-Defined Digestive Organs
CS Reg Nodes Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

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 (Revised: 12/09/2003)

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D

Code	Description	TNM	SS77	SS2000
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

Other and Ill-Defined Digestive Organs
CS Mets Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Ill-Defined Digestive Organs
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

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 M9750, 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

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

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

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