

Collaborative Staging Codes**Cervix Uteri****C53.0-C53.1, C53.8-C53.9**

C53.0 Endocervix

C53.1 Exocervix

C53.8 Overlapping lesion of cervix

C53.9 Cervix uteri

Cervix Uteri**CS Tumor Size (Revised: 07/31/2007)**

Note: Code the largest measurement of horizontal spread or surface diameter in this field. Depth of invasion is coded in CS Extension.

Code	Description
000	No mass/tumor found
001 – 988	001 – 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus given
991	Described as “less than 1 cm”
992	Described as “less than 2 cm,” or “greater than 1 cm,” or “between 1 cm and 2 cm”
993	Described as “less than 3 cm,” or “greater than 2 cm,” or “between 2 cm and 3 cm”
994	Described as “less than 4 cm,” or “greater than 3 cm,” or “between 3 cm and 4 cm”
995	Described as “less than 5 cm,” or “greater than 4 cm,” or “between 4 cm and 5 cm”
999	Unknown: size not stated Not documented in patient record

Cervix Uteri**CS Extension (Revised: 07/20/2006)**

Note 1: Involvement of anterior and/or posterior septum is coded as involvement of the vaginal wall.

Note 2: Record positive pelvic or peritoneal washings as information only. Not to be coded as metastatic disease.

Code	Description	TNM	SS77	SS2000
00	In situ: Preinvasive; noninvasive; intraepithelial Cancer in situ WITH endocervical gland involvement FIGO Stage 0	Tis	IS	IS
01	CIN (Cervical intraepithelial neoplasia) Grade III	Tis	IS	IS

11	Minimal microscopic stromal invasion less than or equal to 3 mm in depth and less than or equal to 7 mm in horizontal spread FIGO Stage IA1	T1a1	L	L
12	"Microinvasion" Tumor WITH invasive component greater than 3 mm and less than or equal to 5 mm in depth, taken from the base of the epithelium, and less than or equal to 7 mm in horizontal spread FIGO Stage IA2	T1a2	L	L
20	Invasive cancer confined to cervix and tumor larger than that in code 12 FIGO Stage IB	*	L	L
25	Invasive cancer confined to cervix and clinically visible lesion	*	L	L
30	Localized, NOS Confined to cervix uteri or uterus, NOS, except corpus uteri, NOS (Not clinically visible or unknown if clinically visible.)	*	L	L
31	FIGO Stage I, not further specified	*	L	L
35	Corpus uteri, NOS	T1NOS	RE	RE
36	Code (35) + (11)	T1a1	RE	RE
37	Code (35) + (12)	T1a2	RE	RE
38	Code (35) + [(20) or (25)]	*	RE	RE
39	Code (35) + [(30) or (31)]	*	RE	RE
40	Extension to: Cul de sac (rectouterine pouch) Upper 2/3's of vagina including fornices Vagina, NOS Vaginal wall, NOS FIGO Stage IIA FIGO Stage II, NOS	T2a	RE	RE
50	Extension to: Ligament(s): Broad Cardinal Uterosacral Parametrium (paracervical soft tissue)	T2b	RE	RE

50 cont'd	FIGO Stage IIB	T2b	RE	RE
60	Extension to: Bladder wall Bladder, NOS excluding mucosa Bullous edema of bladder mucosa Lower 1/3 of vagina Rectal wall Rectum, NOS excluding mucosa FIGO Stage IIIA	T3a	RE	RE
62	Extension to: Ureter, intra- and extramural Vulva FIGO Stage IIIA	T3a	D	RE
63	Tumor causes hydronephrosis or nonfunctioning kidney FIGO Stage IIIB	T3b	RE	RE
65	Extension to pelvic wall(s) (Described clinically as "frozen pelvis", NOS) FIGO Stage IIIB	T3b	D	RE
68	Extension to: Fallopian tube Ovary(ies) Urethra FIGO Stage III, NOS	T3NOS	D	RE
70	Extension to rectal or bladder mucosa (Note: for bullous edema of bladder mucosa, see code 60.) FIGO Stage IVA	T4	D	D
80	Further contiguous extension beyond true pelvis Sigmoid colon Small intestine FIGO Stage IVA, not further specified	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Cervix Uteri**CS TS/Ext-Eval (Revised: 07/31/2007)**

Note: If a cone biopsy removes all of the tumor, (for example, negative margins) code CS TS/Ext eval as 3. If there is residual tumor after a cone biopsy, (for example, positive margins) code CS TS/Ext eval as 1.

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
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. Does not meet criteria for AJCC pathological T staging.	c
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. Meets criteria for AJCC pathologic T staging.	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

Cervix Uteri**CS Lymph Nodes (Revised: 05/06/2004)**

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.

Note 3: If either exploratory or definitive surgery is done with no mention of lymph nodes, assume nodes are negative, code 00.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Paracervical Parametrial Pelvic, NOS Sacral, NOS: Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Uterosacral 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

Cervix Uteri**Reg LN Pos****SEE STANDARD TABLE****Cervix Uteri****Reg LN Exam****SEE STANDARD TABLE**

Cervix Uteri**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: Aortic (para-, peri-, lateral) Inguinal (femoral) Mediastinal Distant lymph node(s), NOS FIGO Stage IV	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Site Specific Surgery Codes**Cervix Uteri****C530–C539**

(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

[SEER Note: Do not code dilation and curettage as Surgery of Primary Site for invasive cancers]

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 10 Local tumor destruction, NOS
 - 11 Photodynamic therapy (PDT)
 - 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
 - 13 Cryosurgery
 - 14 Laser
 - 15 Loop Electrocautery Excision Procedure (LEEP)
 - 16 Laser ablation
 - 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17

- 20 Local tumor excision, NOS
 - 26 Excisional biopsy, NOS
 - 27 Cone biopsy
 - 24 Cone biopsy WITH gross excision of lesion
 - 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH

- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

[SEER Note: Codes 21 to 23 above combine 20 Local tumor excision, 24 Cone biopsy WITH gross excision of lesion, 26 Excisional biopsy, NOS, 27 Cone biopsy or 29 Trachelectomy, removal of cervical stump; cervicectomy with 21 Electrocautery, 22 Cryosurgery, 23 Laser ablation or excision]

- 25 Dilatation and curettage; endocervical curettage (for insitu only)
- 28 Loop electrocautery excision procedure (LEEP)

[SEER Notes: Margins of resection may have microscopic involvement. Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, thermal ablation.]

Specimen sent to pathology from surgical events 20–29

- 30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff

- 40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff
- 50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
 - 52 Extended hysterectomy
 - 53 Radical hysterectomy; Wertheim procedure
 - 54 Extended radical hysterectomy
- 60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
 - 62 WITH removal of tubes and ovaries
- 70 Pelvic exenteration
- 71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
[SEER Note: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
 - 72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
[SEER Note: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site].
 - 73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
[SEER Note: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
 - 74 Extended exenteration
Includes pelvic blood vessels or bony pelvis
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY