

## INTRODUCTION TO COLLABORATIVE STAGING SYSTEM

The majority of instructions and examples for the Collaborative Staging (CS) System have been taken directly from the CS Manual version 01.04.00 to ensure consistency in cancer registration.

The Collaborative Staging (CS) Task Force was formed in 1998 to address the issue of discrepancies in staging guidelines among the three major staging systems (TNM, SEER EOD, and SS). The initial focus was to develop a conversion method between the systems. The CS System is a unified set of data items that describe how far the cancer has spread at the time of diagnosis. The data set also includes several items derived from the computer algorithms that classify each case in multiple staging systems. The TCR collects the CS data items required to derive the SEER Summary Stage (SSS). In addition, beginning with cases diagnosed January 1, 2008 and forward, TCR will collect CS Tumor Size/Ext Eval.

### CHANGES IN ABSTRACTING RULES

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

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

#### **Example:**

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

The CS System introduces a change in the collection of information documenting the extent of disease, particularly in the collection of information about regional lymph nodes or distant metastases for primary sites **not easily examined by palpation, observation, physical examination, or other clinical methods**. These inaccessible sites include (but are not limited to) bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, and ovary. The CS System allows the recording of regional lymph nodes and distant metastasis as negative (based on clinical evaluation) for these sites rather than unknown when there is no mention of regional lymph nodes and no mention of distant metastasis involvement in the physical examination, pre-treatment diagnostic testing or

surgical exploration and the patient receives what would be the usual treatment to the primary site.

*Note: The inaccessible sites guidelines apply primarily to localized disease.*

The primary sites that **can be observed, palpated, or examined without instruments** should have some description of the regional lymph nodes. Examples of these sites include (but are not limited to) breast, oral cavity, skin, salivary gland, and other organs. **A statement such as “remainder of examination negative” is sufficient to record regional lymph nodes as clinically negative.**

## HOW THE COLLABORATIVE STAGING SYSTEM WORKS

The information specific to that cancer site/histology is extracted from the medical record and coded in the CS System fields using the appropriate schema. When the data collection is complete, the registrar activates the computer algorithms to derive the values for the items in the TNM and SS systems. The output values are returned as a set of numeric codes designed for storage in the computerized abstract. The CS System schemas consist of the 15 data fields; however, the TCR requires only the CS data fields needed to derive the SSS. Beginning with cases diagnosed January 1, 2008 and forward an additional data item, CS Tumor Size/Ext Eval will be collected. The 2008 TCR CRH provides codes and instructions for the correct coding of these data items in Appendix A. To derive the desired SSS, the computer algorithms must be used.

From time to time, it is necessary to revise CS coding tables by reassigning concepts from one code to another to maintain the underlying structure and rules for code assignment. Codes affected by these changes will be marked as **OBSOLETE**. Codes marked as **OBSOLETE** may **NOT** be used.

*Do not* use the schemas for cases diagnosed prior to January 1, 2004. Cases diagnosed prior to this date should be coded to whatever coding system was in place at the time of diagnosis.

### Examples:

- a. Patient admitted March 17, 2008 for surgery for recurrent colon cancer. Chart states original colon cancer was diagnosed on September 7, 2003. Document date of diagnosis is 09/07/2003. This case should be staged according to 2003 guidelines (SSSM2K).
- b. Cases with unknown date of diagnosis should be staged according to the guideline in place for the Date of First Contact. All facility resources must be reviewed in order to obtain the date of diagnosis.

TCR will not collect all of the CS fields. Eight of the fields collected by TCR are needed to derive the SSS. In addition, CS Tumor Size/Ext Eval will be collected to record how the “CS Tumor Size” and “CS Extension” were determined, based on the diagnostic methods employed.

#### CS DATA FIELDS COLLECTED BY THE TCR

1. CS TUMOR SIZE (#2800)
2. CS EXTENSION (#2810)
3. CS TUMOR SIZE/EXT EVAL (#2820)
4. CS LYMPH NODES (#2830)
5. REGIONAL LYMPH NODES POSITIVE (#820)
6. REGIONAL LYMPH NODES EXAMINED (#830)
7. CS METS AT DX (#2850)
8. CS SITE-SPECIFIC FACTOR 1, FOR PLEURA (C38.4) PRIMARIES ONLY (#2880)
9. CS SITE SPECIFIC FACTOR 3, FOR PROSTATE (C61.9) PRIMARIES ONLY (#2900)

#### CODES AND GUIDELINES FOR USING THE COLLABORATIVE STAGING SYSTEM

CS is collected on all cases regardless of whether they are microscopically confirmed. A description of the type of diagnostic confirmation is collected in a separate data item. The diagnostic confirmation fields can be used to exclude non-microscopically confirmed cases during analysis as necessary, since the *AJCC Cancer Manual, 6<sup>th</sup> edition*, states: “all cases should be microscopically confirmed”. Cases not microscopically confirmed should be coded from the schema for the site/histology the clinician considers most likely to be the primary.

**All staging information available in the medical record should be documented. Include dates in chronological order. Both positive and negative findings should be recorded in the Summary Stage Documentation text field.** Pertinent staging information can be found in the following documents of the medical record. This list is not all-inclusive.

**Pathology Report:** Details on morphology, topography, tumor size, and stage of disease.

**Operative Report:** Details on stage of disease, tumor size, origin of tumor, and both positive and negative findings observed during the procedure.

**Imaging Exams, Lab Tests, Scopes, etc.:** Details on tumor size, stage of disease, and both positive and negative findings.

**History and Physical Report:** Details on other tumors, staging information, primary site, and any prior cancer directed treatment the patient may have had.

**Discharge Summary:** Supplemental details on diagnosis, morphology, topography, staging and treatment or treatment plan.