

**Mycosis Fungoides and Sezary Disease of Skin, Vulva, Penis, Scrotum
(M-9700-9701)****C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2**

C44.0 Skin of lip, NOS

C44.1 Eyelid

C44.2 External ear

C44.3 Skin of other and unspecified parts of face

C44.4 Skin of scalp and neck

C44.5 Skin of trunk

C44.6 Skin of upper limb and shoulder

C44.7 Skin of lower limb and hip

C44.8 Overlapping lesion of skin

C44.9 Skin, NOS

C51.0 Labium majus

C51.1 Labium minus

C51.2 Clitoris

C51.8 Overlapping lesion of vulva

C51.9 Vulva, NOS

C60.0 Prepuce

C60.1 Glans penis

C60.2 Body of penis

C60.8 Overlapping lesion of penis

C60.9 Penis

C63.2 Scrotum, NOS

Note 1: Laterality must be coded for C44.1-C44.3 and C44.5-C44.7. For codes C44.3 and C44.5, if the tumor is midline (e.g., chin), code as 9 (midline) in the laterality field.

Note 2: Source: Developed by the Mycosis Fungoides Cooperative Group (MFCG)

MycosisFungoides**CS Tumor Size****See Standard Table**

MycosisFungoides**CS Extension**

Note 1: Physicians use more than one method to estimate percentage of skin involvement by MF. Code percent of skin involvement as stated by the physician. If no percentage is stated and no word such as localized or generalized is used and no stage is given by the physician, code as percent not stated.

Note 2: For skin, patch indicates any size skin lesion without significant elevation or induration.

Note 3: For skin, plaque indicates any size skin lesion that is elevated or indurated.

Note 4: According to AJCC, for skin tumor indicates at least one 1-cm diameter solid or nodular lesion with evidence of depth and/or vertical growth. If a physician describes a skin lesion of less than 1 cm as a tumor, use code 550.

Note 5: Use code 250 when skin involvement is present but only a general location/site is mentioned (i.e., face, legs, torso, arms). Use code 300 when there is skin involvement but there is no mention of location/site.

Note 6: Ignore erythroderma if stated to involve less than 50% of the skin. Use codes 110-650.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
100	OBSOLETE DATA RETAINED V0200 Plaques, papules, or erythematous patches ("plaque stage"): Less than 10 % of skin surface, no tumors Limited plaques/patches MFCG Stage I	ERROR	T1	L	L
110	Patches only with less than 10% of skin surface involved	T1a	T1	L	L
120	Plaques or papules, with or without patches, with less than 10% of skin surface involved, no tumors	T1b	T1	L	L
130	Skin involvement less than 10%, not stated whether plaques, papules or patches, no tumors Limited plaques/patches MFCG Stage I	T1NOS	T1	L	L
200	OBSOLETE DATA RETAINED V0200 Plaques, papules, or erythematous	ERROR	T2	L	L

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
200 cont'd	patches ("plaque stage"): Greater than or equal to 10% of skin surface, no tumors Generalized plaques/patches MFCG Stage II	ERROR	T2	L	L
210	Patches only with 10% or more of skin surface involved	T2a	T2	L	L
220	Plaques or papules, with or without patches, with 10% or more of skin surface involved, no tumors	T2b	T2	L	L
230	Skin involvement 10% or more, not stated whether plaques, papules or patches, no tumors Generalized plaques/patches MFCG Stage II Stated as T2, NOS	T2NOS	T2	L	L
250	Plaques, papules, or erythematous patches: % body surface not stated, no tumors	T1NOS	T1	L	L
300	Skin involvement, NOS: Extent not stated, no tumors Localized, NOS	T1NOS	T1	L	L
500	OBSOLETE DATA RETAINED V0200 One or more tumors (tumor stage) Cutaneous tumors	ERROR	T3	RE	RE
550	Skin lesion described as tumor less than 1 cm	T2NOS	T3	RE	RE
600	One or more tumors equal to 1 cm or greater Cutaneous tumor size not stated	T3	T3	RE	RE

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
650	Stated as T3 with no other information on extension	T3	T3	RE	RE
700	OBSOLETE DATA RETAINED V0200 Generalized erythroderma (greater than 50% body involved with diffuse redness) Sezary syndrome/Sezary disease MFCG Stage III	ERROR	T4	RE	RE
730	Generalized erythroderma (greater than 50% less than 80% body involved with diffuse redness)	T3	T4	RE	RE
750	Generalized erythroderma (greater than or equal to 80% body involved with diffuse redness)	T4	T4	RE	RE
800	Stated as T4 with no other information on extension	T4	T4	RE	RE
950	No evidence of primary tumor	T0	T0	U	U
999	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	TX	U	U

MycosisFungoides
CS Tumor Size/Ext Eval
See Standard Table

MycosisFungoides**CS Lymph Nodes**

Note 1: For this site, code ALL lymph node (regional and distant) involvement in this field.

Note 2: Only peripheral lymph nodes are to be assessed which include the cervical, supraclavicular, epitrochlear, axillary, and inguinal nodal groups. Clinically abnormal peripheral lymph node(s) is defined as any palpable peripheral node that on physical examination is firm, irregular, clustered, fixed or 1.5 cm or larger in diameter. Central nodes, which are not generally amenable to pathologic assessment, are not currently considered in the nodal classification unless used to establish N3 histopathologically.

Note 3: Clinically abnormal nodes must be histopathologically confirmed positive to assign codes 110-800.

Note 4: Dutch grade System includes:

Grade 1 - dermatopathic lymphadenopathy (DL)

Grade 2 - early involvement by MF (presence of cerebriform nuclei > 7.5 um)

Grade 3 - partial effacement of LN architecture; many atypical cerebriform mononuclear cells (CMCs)

Grade 4 - complete effacement

Note 5: NCI LN grade system includes:

LN 0 - no atypical lymphocytes

LN 1 - occasional and isolated atypical lymphocytes not arranged in clusters

LN 2 - many atypical lymphocytes or in 3-6 cell clusters

LN 3 - aggregates of atypical lymphocytes; nodal architecture preserved

LN 4 - partial/complete effacement of nodal architecture by atypical lymphocytes or frankly neoplastic cells

Note 6: A T-cell clone (clone negative or clone positive) is defined by polymerase chain reaction (PCR) or Southern blot analysis of the T-cell receptor gene.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	None; no regional lymph node involvement No clinically abnormal peripheral lymph nodes	N0	N0	NONE	NONE
100	Clinically enlarged palpable lymph node(s) (adenopathy), and either pathologically negative nodes or no pathological statement	N0	N1	RN	RN
110	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone negative	N1a	N2	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
115	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone negative Stated as N1a with no other information on regional lymph nodes	N1a	N3	RN	RN
120	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone positive	N1b	N2	RN	RN
125	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone positive Stated as N1b with no other information on regional lymph nodes	N1b	N3	RN	RN
130	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone unknown	N1NOS	N2	RN	RN
135	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 1 or NCI LN 0-2: Clone unknown	N1NOS	N3	RN	RN
140	Stated as N1 [NOS] with no other information on regional lymph nodes	N1NOS	N1	RN	RN
200	OBSOLETE DATA RETAINED V0200 No clinically enlarged palpable lymph node(s) (adenopathy); pathologically positive lymph node(s)	ERROR	N2	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
210	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone negative	N2a	N2	RN	RN
215	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone negative Stated as N2a with no other information on regional lymph nodes	N2a	N3	RN	RN
220	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone positive	N2b	N2	RN	RN
225	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone positive Stated as N2b with no other information on regional lymph nodes	N2b	N3	RN	RN
230	Clinically normal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone unknown	N2NOS	N2	RN	RN
235	Clinically abnormal peripheral lymph node(s) AND histopathology Dutch grade 2 or NCI LN 3: Clone unknown	N2NOS	N3	RN	RN
240	Stated as N2 [NOS] with no other information on regional lymph nodes	N2NOS	N2	RN	RN
300	OBSOLETE DATA RETAINED	ERROR	N3	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
300 cont'd	V0200 Both clinically enlarged palpable lymph node(s) (adenopathy) and pathologically positive lymph nodes	ERROR	N3	RN	RN
310	Clinically normal peripheral lymph nodes AND histopathology Dutch grades 3-4 or NCI LN 4: Clone positive or negative or unknown	N3	N2	RN	RN
315	Clinically abnormal peripheral lymph nodes AND histopathology Dutch grades 3-4 or NCI LN 4: Clone positive or negative or unknown Stated as N3 with no other information on regional lymph nodes	N3	N3	RN	RN
400	Clinically normal peripheral lymph node(s), histopathologically confirmed BUT Dutch grade and NCI LN grade unknown: Clone positive, negative or unknown	N1NOS	N2	RN	RN
405	Clinically abnormal peripheral lymph node(s), histopathologically confirmed BUT Dutch grade and NCI LN grade unknown: Clone positive, negative or unknown	N1NOS	N3	RN	RN
800	Lymph nodes, NOS	N1NOS	N1	RN	RN
850	Clinically abnormal peripheral lymph nodes AND no histopathologic confirmation	NX	NX	U	U

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
999	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	NX	U	U

MycosisFungoides**Reg LN Pos**

Note: Record this field even if there has been preoperative treatment.

See Standard Table

MycosisFungoides**Reg LN Exam**

See Standard Table

MycosisFungoides**CS Mets at DX**

Note 1: For this site, code ALL lymph node (regional and distant) involvement in the CS Lymph Nodes field. Only Visceral involvement is coded here. Bone marrow and?? is coded in SSF 1.

Note 2: Visceral involvement is considered metastatic and should be questioned in the absence of node or blood involvement.

Note 3: To be considered as having visceral disease (stage IVb), documentation of involvement by only one organ outside the skin, nodes, or blood is needed.

Note 4: Visceral involvement must be pathologically confirmed, except for the Liver and Spleen, which may be documented with imaging (code 60).

Note 5: For pathological confirmation of bone, brain, liver and lungs mets (or combination), use the new data items (insert name of new field) field to specify organ and then code 50.

Note 6: If Liver or Spleen is involved clinically without imaging, use code 05.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
00	No; none No visceral organ involvement	M0	M0	NONE	NONE
05	Clinical confirmation only of Visceral (non-cutaneous, extra nodal) involvement, (except for Liver and Spleen imaging, see code 10)	M0	M1	NONE	NONE
10	Imaging confirmation of Spleen or	M1	M1	D	D

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
10 cont'd	Liver metastases	M1	M1	D	D
40	OBSOLETE DATA RETAINED V0200 Visceral (non-cutaneous, extra nodal) involvement Carcinomatosis Distant metastasis, NOS MFCG Stage IV	ERROR	M1	D	D
45	Visceral (non-cutaneous, extra nodal) involvement, pathologically confirmed, involvement by at least one organ outside the skin nodes or blood or bone marrow,	M1	M1	D	D
60	Carcinomatosis MFCG Stage IV Unknown if clinical or pathological confirmation	M0	M1	D	D
70	Stated as M1 Distant metastasis, NOS	M1	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U