

## COLLABORATIVE STAGE STANDARD TABLES

### CS Tumor Size Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes

Code	Description
000	No mass/tumor found
001-988	Exact size in millimeters
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
996-998	<b>SITE-SPECIFIC CODES WHERE NEEDED</b>
999	Unknown; size not stated Not documented in patient record

For schemas that do not use tumor size:

Code	Description
988	Not applicable

### CS Extension Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes

Code	Description	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
000	In situ; non-invasive	Tis	Tis	IS	IS
	<b>SITE/HISTOLOGY-SPECIFIC CODES</b>				
800	Further contiguous extension				
950	No evidence of primary tumor	T0	T0	U	U
999	Unknown extension; primary tumor cannot be assessed; not stated in patient record	TX	TX	U	U

**CS Tumor Size/Extent Eval Standard Table**

**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

<b>Code</b>	<b>Description</b>	<b>Staging Basis</b>
0	<b>Does not meet criteria for AJCC pathologic staging:</b> No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence.	c
1	<b>Does not meet criteria for AJCC pathologic staging:</b> 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. <i>See Notes 1 and 2 below.</i>	c
2	<b>Meets criteria for AJCC pathologic staging:</b> No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy). <i>See Note 3 below.</i>	p
3	<b>Either meets criteria for AJCC pathologic staging:</b> Surgical resection performed WITHOUT pre-surgical treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed <b>AND</b> Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. No surgical resection done. Evaluation based on positive biopsy of highest T classification. <i>See Note 3 below.</i>	p
5	<b>Does not meet criteria for AJCC y-pathologic (yp) staging:</b> Surgical resection performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6)	c
6	<b>Meets criteria for AJCC y-pathologic (yp) staging:</b> Surgical resection performed AFTER neoadjuvant therapy AND tumor size/extension based on pathologic evidence, because pathologic evidence at surgery is more extensive than clinical evidence before treatment. <i>See Note 4 below.</i>	yp
8	<b>Meets criteria for autopsy (a) staging:</b> 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 <i>For sites with no TNM schema: Not applicable.</i>	c

**Note 1:** For lung, code 1 was pathologic staging basis in CS version 1 and clinical in CS version 2.

**Note 2:** Where sixth and seventh editions differ, there will be separate Staging Basis columns for TNM6 and TNM7.

**Note 3:** The codes in this common table do not apply to prostate. See Instruction 8 above.

**Note 4:** This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.

**Note 5:** For primary sites with no TNM schema, code 9 is defined as not applicable and the staging basis is blank.

### CS Lymph Nodes Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
000	None; no regional lymph node involvement	N0	N0	None	None
	<b>Site/Histology-Specific Codes</b>				
999	Unknown; regional lymph nodes cannot be assessed; not stated in patient record	NX	NX	U	U

For schemas that do not use the CS Lymph Nodes field:

Code	Description
988	Not applicable; Information not collected for this schema

### Regional Lymph Nodes Positive Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes

Code	Description
00	All nodes examined are negative
01 - 89	1 to 89 nodes are positive (Code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration or core biopsy of lymph node(s) was performed. <i>See Rule 6</i>
97	Positive nodes are documented, but the number is unspecified. <i>See Rule 7</i>
98	No nodes were examined. <i>See Rule 8.</i>
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

### Regional Nodes Examined Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description
00	No nodes were examined
01 - 89	1 to 89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined.
95	No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed. <i>See Rule 5.</i>
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated. <i>See Rule 7.</i>
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown. <i>See Rule 10.</i>
99	It is unknown whether nodes were examined; not applicable or negative; not stated in

Code	Description
99 cont'd	patient record.

### CS Mets at Dx Standard Table

**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description	TNM7 Map	TNM6 Map	SS77 Map	SS2000 Map
00	No; none	M0	M0	None	None
10	Distant lymph node(s)	M1	M1	D	D
	<b>Site/Histology-Specific Codes Where Needed</b>				
40	Distant metastases except code 10 Carcinomatosis	M1	M1	D	D
50	40 + 10	M1	M1	D	D
60	Distant metastasis, NOS Stated as M1, NOS	M1	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

For Schemas that do not use the CS Mets at Dx field

Code	Description
98	Not applicable for this site