

COLLABORATIVE STAGE STANDARD TABLES**CS Tumor Size Standard Table page A-30****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	Describes 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	SITE-SPECIFIC CODES WHERE NEEDED
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 page A-38**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ; non-invasive	Tis	Tis	IS	IS
	SITE/HISTOLOGY-SPECIFIC CODES				
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 page A-50

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

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence.	c
1	Does not meet criteria for AJCC pathologic staging: 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	Meets criteria for AJCC pathologic staging: 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	Either meets criteria for AJCC pathologic staging: Surgical resection performed WITHOUT pre-surgical treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed AND 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	Does not meet criteria for AJCC y-pathologic (yp) staging: 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	Meets criteria for AJCC y-pathologic (yp) staging: 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	Meets criteria for autopsy (a) staging: 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 the Prostate Schema in Appendix A.

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 page A-52

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

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	None; no regional lymph node involvement	N0	N0	None	None
	Site/Histology-Specific Codes				
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

CS Lymph Nodes Eval Standard Table page A-60

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

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used	c
1	Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria No regional lymph nodes removed for examination. Evaluation based on endoscopic examination or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. OR Fine needle aspiration, incisional or core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup WITHOUT removal of the primary site adequate for pathologic T classification (treatment).	c
2	Meets criteria for AJCC pathologic staging: No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Meets criteria for AJCC pathologic staging based on at least one of the following criteria:	P

Code	Description	Staging Basis
3 cont'd	Any microscopic assessment of regional nodes (including FNA, incisional or core needle biopsy, excisional biopsy, sentinel node biopsy or node resection) WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category. OR Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy and lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant treatment) is more extensive (see code 6).	c
6	Meets criteria for AJCC y-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on pathologic evidence, because of the pathologic evidence at surgery is more extensive than clinical evidence before treatment. <i>See Note 1.</i>	yp
8	Meets criteria for AJCC autopsy (a) staging: Evidence from autopsy: tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record <i>For sites that have no TNM staging:</i> Not applicable; staging basis is displayed as a blank.	c

Note 1: This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.

Regional Lymph Nodes Positive Standard Table page A-67

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
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive, not applicable; not stated in patient record.

Regional Nodes Examined Standard Table page A-71**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.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
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.
99	It is unknown whether nodes were examined; not applicable or negative, not stated in record

CS Mets at Dx Standard Table page A-74**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description	TNM7 Map	TNM 6 Map	SS77 Map	SS2000 Map
00	No; none	M0	M0	None	None
10	Distant lymph node(s)	M1	M1	D	D
	Site/Histology-Specific Codes Where Needed				
40	Distant metastases except code 10 Carcinomatosis	M1	M1	D	D
50	40 + 10	M1	M1	D	D
60	Distant metastasis Stated 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

CS Mets Eval Table page A-78**Note:** Remember to check individual schemas in Appendix A for site-specific codes.

Code	Description	Staging Basis
0	<p>Does not meet criteria for AJCC pathologic staging of distant metastasis:</p> <p>Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastasis performed or pathologic examination was negative.</p>	c
1	<p>Does not meet criteria for AJCC pathologic staging of distant metastasis:</p> <p>Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastasis performed or pathologic examination was negative.</p>	c
2	<p>Meets criteria for AJCC pathologic staging of distant metastasis:</p> <p>No pathologic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).</p>	p
3	<p>Meets criteria for AJCC pathologic staging of distant metastasis:</p> <p>Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation OR specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed OR specimen from metastatic site microscopically positive prior to neoadjuvant treatment</p>	p
5	<p>Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis:</p> <p>Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.</p>	c
6	<p>Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis:</p> <p>Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence. <i>See Note 1.</i></p>	yp
8	<p>Meets criteria for AJCC autopsy (a) staging of distant metastasis:</p> <p>Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.</p>	a

Code	Description	Staging Basis
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites with no TNM staging: Not applicable	c

Note 1: This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.