GISTColon
Gastrointestinal Stromal Tumors of Colon (excluding Appendix)
C18.0, C18.2-C18.9
M-8935-8936
C18.0 Cecum
C18.2 Ascending colon
C18.3 Hepatic flexure of colon
C18.4 Transverse colon
C18.5 Splenic flexure of colon
C18.6 Descending colon
C18.7 Sigmoid colon
C18.8 Overlapping lesion of colon
C18.9 Colon, NOS
Note: The histologies included in this schema were not staged with AJCC 6th Edition. Therefore, the algorithm will not derive an AJCC 6th TNM or stage group.

GISTColon
CS Tumor Size
Note 1: Code exact tumor measurements when available. Use codes 990-997 only if a specific measurement is not available.
Note 2: The assignment of T categories for gastrointestinal stromal tumors (GIST) is based on tumor size. A physician's statement of the T category may be used to code CS Tumor Size and/or CS Extension if this is the only information in the medical record regarding one or both of these fields. However the two fields are coded independently: for example the record may document size but not extension, other than the physician's statement of the T category. Use codes 992, 993, 996, and 997 as appropriate to code CS Tumor Size based on a statement of T when no other size information is available.
Note 3: Codes 992-995 were obsolete in CS Version 2, V0201 and V0202. They are made active in V0203. Codes 996-997 are new for V0203. Tumors that now fall into one of these categories would have been coded as 011, 021, 051, 101, or 999 in V0201/V0202. Therefore cases with codes 011, 021, 051, 101, and 999 should be reviewed to determine if the cases should be recoded using codes 992-997.

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (mm); (Exact size to nearest mm)
989	989 mm or larger
990	Microscopic focus or foci only and no size of focus given
991	Described as "less than 1 centimeter (cm)"

Code	Description
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm" Stated as T1 with no other information on tumor size
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm" Stated as T2 with no other information on tumor size
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	Described as "less than 10 cm," or "greater than 5 cm" or "between 5 cm and 10 cm" Stated as T3 with no other information on tumor size
997	Described as "greater than 10 cm" Stated as T4 with no other information on tumor size
998	**OBSOLETE DATA RETAINED V0200** Familial/multiple polyposis (M-8220-8221)
999	Unknown; size not stated Size of tumor cannot be assessed Not documented in patient record

GISTColon
CS Extension

Note 1: AJCC does not include a Tis category for gastrointestinal stromal tumors (GIST). Any case with a CS Extension code of 000 is mapped to TX for AJCC 7 stage and in situ Summary Stage.

Note 2: Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extracolonic spread as indicated.

Note 3: The assignment of T categories for GISTs is based on tumor size. A physician's statement of the T category may be used to code CS Tumor Size and/or CS Extension if this is the only information in the medical record regarding one or both of these fields. However the two fields are coded independently: for example the record may document size but not extension, other than the physician's statement of the T category. Use codes 170, 210, 250, and 270 as appropriate to code CS Extension based on a statement of T when no other extension information is available.

Note 4: Use code 150 only if GIST is described as arising in a polyp. Do not use this code for GIST described as arising in the wall of the colon and extending into the lumen with a polypoid appearance.

Note 5: Use code 300 for localized cases only if no information is available to assign a more specific code.

Note 6: Use code 570 for tumor with macroscopic adhesions to other organs or structures and for

pathologically confirmed tumor in adhesions. However, if no tumor is present in adhesion(s) upon microscopic examination, use lower codes to describe the microscopically confirmed depth of tumor invasion for these cases (excluding adherence to liver, see Note 7).

Note 7: Adherence to the liver capsule is not considered distant metastasis. Use code 570 for any adherence to the liver capsule.

Note 8: Codes 600-800 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.Code

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ, intraepithelial, noninvasive	TX	NA	IS	IS
050	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See code 000 (Adeno)carcinoma in a polyp or adenoma noninvasive	TX	NA	IS	IS
100	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Invasive tumor confined to mucosa, NOS (includes intramucosal, NOS)	^	NA	L	L
110	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Lamina propria	^	NA	L	L
120	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Confined to and not through the muscularis mucosae	^	NA	L	L
130	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Confined to head of polyp, NOS	^	NA	L	L
140	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Confined to stalk of polyp, NOS	^	NA	L	L

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
150	Invasive tumor in polyp, NOS	^	NA	L	L
155	Tumor confined to muscular wall	^	NA	L	L
160	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 155 and 165 Invades submucosa (superficial invasion)	^	NA	L	L
165	Tumor invades through submucosa and muscularis mucosae to involve mucosa	^	NA	L	L
170	Stated as T1 with no other information on extension	^	NA	L	L
200	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See code 155 and 165 Muscularis propria invaded	^	NA	L	L
210	Stated as T2 with no other information on extension	^	NA	L	L
250	Stated as T3 with no other information on extension	^	NA	L	L
270	Stated as T4 with no other information on extension	^	NA	L	L
300	Confined to colon, NOS Localized, NOS	^	NA	L	L
400	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Non-peritonealized pericolic tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat	^	NA	L	L

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
400 cont'd	invaded Transmural, NOS Wall, NOS	^	NA	L	L
410	**OBSOLETE DATA CONVERTED V0203;** See code 250 Stated as T3, NOS	ERROR	ERROR	ERROR	ERROR
420	**OBSOLETE DATA CONVERTED V0203;** See code 458 Fat, NOS	ERROR	ERROR	ERROR	ERROR
450	For all colon sites: Adjacent tissue(s), NOS Connective tissue Mesenteric fat Mesentery Mesocolon Pericolic fat For ascending and descending colon : Retroperitoneal fat For transverse colon and flexures : Gastrocolic ligament Greater omentum	^	NA	RE	RE
458	Fat, NOS	^	NA	RE	RE
460	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See Note 6 and code 570 Adherent to other organs or structures, but no microscopic tumor found in adhesion(s)	^	NA	RE	RE
490	**OBSOLETE DATA CONVERTED V0203;** See code 270 Stated as T4, NOS	ERROR	ERROR	ERROR	ERROR
500	Invasion of/through serosa (mesothelium) (visceral peritoneum)	^	NA	RE	RE

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
550	500 + (420 or 450)	^	NA	RE	RE
560	Invasion of/through serosa with invasion of/through mucosa	^	NA	RE	RE
570	Adherent to liver capsule Adherent to other organs or structures, NOS	^	NA	RE	RE
600	For all colon sites: Small intestine For cecum: Greater omentum For ascending colon: Greater omentum Liver, right lobe For transverse colon and flexures: Bile ducts Gallbladder Kidney Liver Pancreas Spleen Stomach For descending colon: Greater omentum Pelvic wall Spleen For sigmoid colon: Greater omentum Pelvic wall	^	NA	RE	RE
650	Abdominal wall Retroperitoneum (excluding fat)	^	NA	RE	RE
660	For ascending colon: Kidney, right Ureter, right For descending colon: Kidney, left Ureter, left	^	NA	RE	RE

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
700	For cecum, ascending colon, descending colon , and sigmoid colon: Fallopian tube Ovary Uterus	^	NA	D	D
750	For all colon sites unless otherwise listed above: Adrenal (suprarenal) gland Bladder Diaphragm Fistula to skin Gallbladder Other segment(s) of colon via serosa	^	NA	D	D
800	Further contiguous extension including: For cecum: Kidney, right Liver Ureter, right For transverse colon and flexures: Ureter For sigmoid colon: Cul de sac (rectouterine pouch) Ureter	^	NA	D	D
950	No evidence of primary tumor	T0	NA	U	U
999	Unknown; extension not stated Primary tumor cannot be assessed Not documented in patient record	TX	NA	U	U

^ For CS Extension codes 100-800 ONLY, the T category for AJCC 7 staging is assigned based on the value of CS Tumor Size, as shown in the Extension Size AJCC 7 Table for this schema.

GISTColon
CS Tumor Size/Ext Eval
See Standard Table

GISTColon
CS Lymph Nodes
Note 1: Code only regional nodes and nodes, NOS in this field. Distant nodes are coded in CS Mets

at DX.

Note 2: Inferior mesenteric nodes are coded in CS Mets at DX for cecum, ascending colon, transverse colon, and hepatic flexure. Superior mesenteric nodes are coded in CS Mets at DX for all colon sites. Mesenteric node(s), NOS are coded in CS Lymph Nodes.

Note 3: Nodal metastasis is very rare in gastrointestinal stromal tumors (GISTs) and surgeons generally agree that nodal dissection is not indicated. In the absence of information on regional lymph node status, N0 is appropriate; code 999 is mapped to N0 accordingly.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	No regional lymph node involvement	N0	NA	NONE	NONE
050	Nodule(s) or foci in pericolic fat/adjacent mesentery/mesocolic fat	N1	NA	RN	RN
100	**OBSOLETE DATA RETAINED AND REVIEWED V0203;** Code 100 was defined as "Regional lymph nodes for all colon sites: Colic (NOS), Epicolic (adjacent to bowel wall), Mesocolic (NOS), Paracolic/pericolic, Nodule(s) or foci in pericolic fat/adjacent mesentery/mesocolic fat" in CSv1. Code 100 was defined as "Regional lymph nodes for all colon sites: Colic (NOS), Epicolic (adjacent to bowel wall), Mesocolic (NOS), Paracolic/pericolic" in CSv2:V0201, V0202. All cases should be reviewed and recoded to appropriate codes; see codes 050 and 110. Regional lymph nodes for all colon sites: Colic (NOS) Epicolic (adjacent to bowel wall) Mesocolic (NOS) Paracolic/pericolic	N1	NA	RN	RN
110	Regional lymph nodes for all colon sites: Colic, NOS Epicolic (adjacent to bowel wall) Mesocolic, NOS Paracolic/pericolic	N1	NA	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
200	**OBSOLETE DATA RETAINED AND REVIEWED V0203** See codes 210 and 220 Regional lymph nodes, for specific colon sites: Cecum: Cecal, NOS: Anterior (prececal) Posterior (retrocecal) Ileocolic Right colic Ascending colon: Ileocolic Middle colic Right colic Transverse colon and flexures: Inferior mesenteric for splenic flexure only Left colic for splenic flexure only Middle colic Right colic for hepatic flexure only Descending colon: Inferior mesenteric Left colic Sigmoid colon: Inferior mesenteric Sigmoidal (sigmoid mesenteric) Superior hemorrhoidal Superior rectal	N1 N1	NA NA	RN RN	RN RN
210	Transverse colon and flexures: Inferior mesenteric for splenic flexure only Left colic for splenic flexure only Middle colic Right colic for hepatic flexure only Descending colon: Inferior mesenteric Left colic Sigmoid colon: Inferior mesenteric Sigmoidal (sigmoid mesenteric) Superior hemorrhoidal	N1	NA	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
210 cont'd	Superior rectal	N1	NA	RN	RN
220	Regional lymph nodes for descending colon: Sigmoid	N1	NA	D	RN
300	Regional lymph nodes for all colon sites: Mesenteric, NOS Regional lymph node(s), NOS	N1	NA	RN	RN
400	Stated as N1 with no other information on regional lymph nodes	N1	NA	RN	RN
450	**OBSOLETE DATA RETAINED V0200** Stated as N2 pathologic	ERROR	NA	RN	RN
800	Lymph nodes, NOS	N1	NA	RN	RN
999	Unknown; regional lymph nodes not stated Regional lymph nodes cannot be assessed Not documented in patient record	N0	NA	U	U

GISTColon

CS Lymph Nodes Eval

Note 1: This field is used primarily to derive the staging basis for the N category in the TNM system. It records how the code for the item "CS Lymph Nodes" was determined based on the diagnostic methods employed and their intent.

Note 2: In the 7th edition of the AJCC manual, the clinical and pathologic classification rules for the N category were changed to reflect current medical practice. The N is designated as clinical or pathologic based on the intent (workup versus treatment) matching with the assessment of the T classification. When the intent is workup, the staging basis is clinical, and when the intent is treatment, the staging basis is pathologic.

A. Microscopic assessment including biopsy of regional nodes or sentinel nodes if being performed as part of the workup to choose the treatment plan, is therefore part of the clinical staging. When it is part of the workup, the T category is clinical, and there has not been a resection of the primary site adequate for pathologic T classification (which would be part of the treatment).

B. Microscopic assessment of regional nodes if being performed as part of the treatment is therefore part of the pathologic staging. When it is part of the treatment, the T category is pathologic, and there has been a resection of the primary site adequate for pathologic T classification (all part of the treatment).

Note 3: Microscopic assessment of the highest N category is always pathologic (code 3).

Note 4: If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.

Note 5: Only codes 5 and 6 are used if the node assessment is performed after neoadjuvant therapy.

Code	Description	Staging Basis 7	Staging Basis 6
0	**Does not meet criteria for AJCC pathologic staging:** No regional lymph nodes removed for examination. Evidence 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. Evidence based on endoscopic examination, or other invasive techniques including surgical observation, without biopsy. No autopsy evidence used. **OR** Fine needle aspiration, incisional 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:** Any microscopic assessment of regional nodes (including FNA, incisional core needle bx, excisional bx, sentinel node bx 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	

Code	Description	Staging Basis 7	Staging Basis 6
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) 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 the pathologic evidence at surgery is more extensive than clinical evidence before treatment.	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	c	

GISTColon
Regional Nodes Positive
See Standard Table
Note: Record this field even if there has been preoperative treatment.

GISTColon
Regional Nodes Examined
See Standard Table

GISTColon
CS Mets at DX
Note 1: Liver metastasis implies the presence of tumor inside the liver parenchyma as one or more nodules. Adherence to the liver capsule, even if extensive, should not be considered liver metastasis. Code direct adherence to the liver in CS Extension code 570.
Note 2: When a patient has more than one area of GIST, it is important to try to distinguish between intra-abdominal metastasis and tumor multiplicity. Distant metastases are relatively rare in GISTs, but they are increasingly detected with sophisticated radiological studies. Intra-abdominal metastasis will present as tumor involvement in the abdominal cavity outside the main tumor mass, in the

peritoneum, omentum, serosae of organs, and the cul-de-sac, among other areas. Code this form of metastasis in CS Mets at DX.

Tumor multiplicity, in contrast, will present with anatomically separate, multiple tumors of different sizes arising independently in the GI tract. This form of tumor multiplicity usually will be seen in patients with neurofibromatosis type 1 or familial GIST syndrome, but in rare instances may be seen in patients without these conditions. This form of multiplicity should not be coded as metastasis, but the presence of multiple tumors should be coded in CS Site-Specific Factor 15, Tumor Multiplicity.

When a solitary omental or mesenteric tumor mass is found with a primary GIST elsewhere, do not code this as a metastasis. Code it as multiple tumors in CS Site-Specific Factor 15, Tumor Multiplicity.

When multiple tumor areas are present and it is not stated whether these are metastases or independent tumors, consult with a physician if possible to determine how to code them. If a decision cannot be made, code as 99

Note 3: Involvement of superior mesenteric node(s) is coded 08. Inferior mesenteric node(s) are included in code 10. Mesenteric node(s), NOS are coded in CS Lymph Nodes.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
00	No distant metastasis	M0	NA	NONE	NONE
08	For cecum, ascending colon, hepatic flexure , and transverse colon: Superior mesenteric lymph node(s)	M1	NA	RN	D
10	Distant lymph node(s) other than those in code 08 , including: For all colon sites: Common iliac External iliac Para-aortic Retroperitoneal Distant lymph node(s), NOS For cecum, ascending colon, transverse colon, and hepatic flexure : Inferior mesenteric For splenic flexure, descending colon, and sigmoid colon: Superior mesenteric	M1	NA	D	D
40	Distant metastasis except distant lymph node(s including: Peritoneal nodules Liver parenchymal nodules	M1	NA	D	D

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
40 cont'd	Carcinomatosis	M1	NA	D	D
50	40 + (08 and/or 10) Distant metastasis plus distant lymph node(s)	M1	NA	D	D
60	Distant metastasis, NOS Stated as M1 with no other information on distant metastasis	M1	NA	D	D
99	Unknown; distant metastasis not stated Distant metastasis cannot be assessed Not documented in patient record	M0	NA	U	U

GISTColon
CS Mets Eval
See Standard Table
Note: This item reflects the validity of the classification of the item CS Mets at DX only according to the diagnostic methods employed.

GISTColon
CS Site-Specific Factor 11
Mitotic Count
Note: See page A-94
Note 1: The mitotic rate, the count of mitoses per 50 high-power fields (HPF), reflects the potential aggressiveness or prognosis of gastrointestinal stromal tumors (GIST) and is used alone to determine their histologic grade (low or high). The mitotic rate is also a factor in assigning the AJCC 7 anatomic stage/prognostic group. This site-specific factor presumes the denominator of 50 HPF or its equivalent, so just the numerator (the mitotic count) is coded here. For other schemas in which mitotic count is collected, the denominator may vary.
Note 2: A HPF usually has a magnification objective of 40 (a 40x field). As described in the AJCC chapter on GIST, 50 HPF are equivalent to viewing a total area of 5 square millimeters (mm) at 40x magnification.
Note 3: Record mitotic count, to the nearest tenth of a mitosis, as documented in the pathology report. For example, a mitotic count of 6/50 HPF, or 6 per 5 square mm, would be coded 060.
Note 4: Code the specific mitotic count only per 50 HPF or 5 square mm; assume the denominator is 50 HPF or 5 square mm if not specified. Use code 996 only if the mitotic count is expressed with a specific denominator other than 50 HPF or 5 square mm.

Code	Description
000	0.0 mitoses per 50 HPF (40x fields) 0.0 mitoses per 5 square mm Mitoses absent No mitoses present
001-008	0.1 - 0.8 mitoses per 50 HPF (40x fields) 0.1 - 0.8 mitoses per 5 square mm
009	0.9 mitoses per 50 HPF (40x fields) 0.9 mitoses per 5 square mm Stated as less than 1 mitosis per 50 HPF (40x fields) Stated as less than 1 mitosis per 5 square mm
010-100	1 - 10 mitoses per 50 HPF (40x fields) 1 - 10 mitoses per 5 square mm
110	11 or more mitoses per 50 HPF (40x fields) 11 or more mitoses per 5 square mm
988	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 988 may result in an edit error.)
990	Specific number not stated, described as less than or equal to 5 mitoses per 50 HPF (40x fields) Specific number not stated, described as less than or equal to 5 mitoses per 5 square mm Stated as low mitotic count or rate with no specific number
991	Specific number not stated, described as more than 5 mitoses per 50 HPF (40x fields) Specific number not stated, described as more than 5 mitoses per 5 square mm Stated as high mitotic count or rate with no specific number
995	**OBSOLETE DATA CONVERTED V0203;** See code 991 Specific number not stated, described as greater than 5 mitoses per 50 high power fields (40x field) Specific number not stated, described as greater than 5 mitoses per 5 square millimeters
996	Mitotic count described with denominator other than 50 HPF (40x field)/5 square mm

Code	Description
998	No histologic specimen from primary site
999	Unknown or no information; Not documented in patient record