

Testis**C62.0-C62.1, C62.9****C62.0 Undescended testis****C62.1 Descended testis****C62.9 Testis, NOS**

Note 1: Instructions for coding pre- or post-orchietomy tumor marker values were ambiguous for CS version 1 and there was variation in data collection by registrars. Furthermore, AJCC 7th Edition clarified that S value stage group IS is to be calculated based on the persistence of elevated serum tumor markers after surgery. As a consequence, there is uncertainty about the reliability of the data for the S parameter in data collected with CS version 1. The data elements and codes have been modified in CS version 2 to calculate the S value correctly. Any analysis of testis staging over time relying on the tumor marker data collected in CS version 1 might require review of medical records to verify the appropriate preoperative tumor marker values and the presence of persistent tumor markers post-orchietomy.

Note 2: CS version 2 corrects some version 1 errors in the calculation of the N category. For this reason, analysis of data originally collected in version 1 may show a different distribution of N categories and stage groups once the version 2 algorithm is run to re-derive AJCC 6th edition staging.

Note 3: For cases collected in CSv1, the T category is derived using the Extension Orchietomy Table CSv1, the S value is derived using the Serum Marker S Value Table CSv1, and the AJCC 6th Edition stage is derived using the AJCC TNM 6 Stage CSv1 table.

Note 4: For cases collected in CSv2, the T category is derived using the Extension Orchietomy LVI Table CSv2, the S value is derived using the Preorchietomy Serum Marker S Value Table CSv2, and the AJCC 6th and 7th Edition stages are derived using the AJCC TNM 6 Stage table and AJCC TNM 7 Stage table.

Note 5: Laterality must be coded for this site.

Testis**CS Tumor Size****See Standard Table****Testis****CS Extension**

Note 1: According to AJCC, "Except for pTis and pT4, extent of primary tumor for TNM is classified by radical orchietomy. TX is used for other categories in the absence of radical orchietomy." For Collaborative Stage, this means that the categories of T1, T2, and T3 are derived only when CS Site Specific Factor 4 indicates that a radical orchietomy is performed.

Note 2: Involvement of para-testicular (hilar/mediastinal) soft tissues does not alter the extension code. Code the extension based on other criteria documented in the patient record.

Note 3: Use code 300 (Localized, NOS) only when no further information is available to assign code 160, 200, 310, 320, or 330.

Note 4: Use codes 320, 330, 550, or 810 if the only information regarding tumor extension is the physician's statement of the T category.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ, intraepithelial, noninvasive; Intratubular germ cell neoplasia	Tis	Tis	IS	IS
100	OBSOLETE DATA RETAINED V0200 ; See code 160 Invasive tumor WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion not stated Body of testis Rete testis Tunica albuginea	ERROR	*	L	L
150	OBSOLETE DATA RETAINED V0200 ; See code 160 Invasive tumor WITH vascular/lymphatic invasion Body of testis Rete testis Tunica albuginea	ERROR	*	L	L
160	Body of testis Rete testis Tunica albuginea	^	*	L	L
200	Tunica vaginalis involved Surface implants (surface of tunica vaginalis)	^	*	L	L
300	Localized, NOS	^	*	L	L
310	Tunica, NOS	TX	TX	L	L
320	Stated as T1 with no other information on extension	^	*	L	L
330	Stated as T2 with no other information on extension	^	*	L	L

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
400	OBSOLETE DATA RETAINED V0200 ; See code 460 Epididymis involved WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion not stated	ERROR	*	RE	RE
450	OBSOLETE DATA RETAINED V0200 ; See code 460 Epididymis involved WITH vascular/lymphatic invasion	ERROR	*	RE	RE
460	Epididymis	^	*	RE	RE
470	460 + 200 Epididymis plus tunica vaginalis or surface implants	^	*	RE	RE
500	Spermatic cord, ipsilateral Vas deferens	^	*	RE	RE
550	Stated as T3 with no other information on extension	^	*	RE	RE
600	Dartos muscle, ipsilateral Scrotum, ipsilateral	T4	T4	RE	RE
700	Extension to scrotum, contralateral Ulceration of scrotum	T4	T4	D	D
750	Penis	T4	T4	D	D
800	Further contiguous extension	T4	T4	D	D
810	Stated as T4 with no other information on extension	T4	T4	RE	RE
950	No evidence of primary tumor	T0	T0	U	U

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
999	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	TX	U	U

^ For CS Extension codes 160-300, 320, 330, and 460-550 ONLY, the T category for AJCC 7 staging is assigned based on the values of CS Extension, CS Site-Specific Factor 4, Radical Orchiectomy Performed, and Lymph-vascular Invasion, as shown in the Extension Orchiectomy LVI AJCC 7 Table.

* For cases coded under CSv1 (CS Version Input Original less than 020000) and Year of Diagnosis less than 2010 with CS Extension codes 100-300 and 320-550, the T category for AJCC 6 staging is assigned based on the values of CS Extension, Lymph-vascular Invasion, and CS Site-Specific Factor 4, Radical Orchiectomy Performed, as shown in the Extension Orchiectomy LVI AJCC 6 Table CSv1. For cases coded under CSv2 (CS Version Input Original greater than 020000) or Year of Diagnosis greater than 2009 with CS Extension codes 100-300 and 320-550, the T category for AJCC 6 staging is assigned based on the values of CS Extension, CS Site-Specific Factor 4, Radical Orchiectomy Performed, and Lymph-vascular Invasion, as shown in the Extension Orchiectomy LVI AJCC 6 Table CSv2.

Testis

CS Tumor Size/Ext Eval

See Standard Table

Testis

CS Lymph Nodes

Note 1: Regional nodes in codes 100-300 include contralateral and bilateral nodes.

Note 2: Involvement of inguinal, pelvic, or external iliac lymph nodes (codes 300 and 400)

WITHOUT previous scrotal or inguinal surgery prior to presentation of the testis tumor is coded in CS Mets at DX, as distant lymph node involvement.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	No regional lymph node involvement	N0	N0	NONE	NONE
100	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Preaortic Retroaortic Retroperitoneal, NOS	^	*	RN	RN

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
100 cont'd	Spermatic vein	^	*	RN	RN
200	Regional lymph node(s): Pericaval, NOS: Interaortocaval Paracaval Precaval Retrocaval	^	*	D	RN
300	Regional lymph node(s): Pelvic, NOS External iliac WITH previous scrotal or inguinal surgery	^	*	RN	RN
350	300 + 200 Pelvic/external iliac nodes WITH previous scrotal or inguinal surgery plus pericaval nodes	^	*	D	RN
400	Inguinal nodes, NOS: Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITH previous scrotal or inguinal surgery	^	*	D	D
500	Regional lymph node(s), NOS	^	*	RN	RN
510	Stated as N1 with no other information on regional lymph nodes	N1	N1	RN	RN
520	Stated as N2 with no other information on regional lymph nodes	N2	N2	RN	RN
530	Stated as N3 with no other information on regional lymph nodes	N3	N3	RN	RN
800	Lymph nodes, NOS	N1	N1	RN	RN

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

^ For CS Lymph Nodes codes 100-500 ONLY, the N category for AJCC 7 staging is assigned based on the values of CS Site-Specific Factor 5, Size of Metastasis in Lymph Nodes, Regional Nodes Positive, and CS Lymph Nodes Eval. If the CS Lymph Nodes Eval code is 2 (p), 3 (p), 6 (y), or 8 (a), the N category is determined by using the Lymph Nodes Pathologic Evaluation Table. If the CS Lymph Nodes Eval code is 0 (c), 1 (c), 5 (c), or 9 (c), the N category is determined by using the Lymph Nodes Clinical Evaluation Table. If the CS Lymph Nodes Eval field is not coded, the N category is determined by using the Lymph Nodes Positive Eval Blank Table.

* For CS Lymph Nodes codes 100-500 ONLY, the N category for AJCC 6 staging is assigned based on the values of CS Site Specific Factor 5, Size of Metastasis in Lymph Nodes, Regional Nodes Positive and CS Lymph Nodes Eval. If the CS Lymph Nodes Eval code is 2 (p), 3 (p), 6 (y), or 8 (a), the N category is determined by using the Lymph Nodes Pathologic Evaluation Table. If the CS Lymph Nodes Eval code is 0 (c), 1 (c), 5 (c), or 9 (c), the N category is determined by using the Lymph Nodes Clinical Evaluation Table. If the CS Lymph Nodes Eval field is not coded, the N category is determined by using the Lymph Nodes Positive Eval Blank Table.

Testis

CS Lymph Nodes Eval

See Standard Table

Testis

Regional Nodes Positive

See Standard Table

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

Testis

Regional Nodes Examined

See Standard Table

Testis

CS Mets at DX

Note: Involvement of inguinal, pelvic, or external iliac lymph nodes (codes 11 and 12) with previous scrotal or inguinal surgery prior to presentation of the testis tumor is coded in CS Lymph Nodes as regional node involvement and not in CS Mets at DX.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
00	No distant metastasis	M0	M0	NONE	NONE

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
11	Distant lymph node(s): Pelvic, NOS External iliac WITHOUT previous scrotal or inguinal surgery Or unknown if previous scrotal or inguinal surgery	M1a	M1a	RN	RN
12	Distant lymph node(s): Inguinal nodes, NOS: Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITHOUT previous scrotal or inguinal surgery Or unknown if previous scrotal or inguinal surgery	M1a	M1a	D	D
13	Specified distant lymph nodes, other than code 11 or 12 Distant lymph node(s), NOS	M1a	M1a	D	D
20	Distant metastasis to lung	M1a	M1a	D	D
25	20 + (11, 12, or 13) Distant metastasis to lung and lymph nodes as described in code 11, 12, or 13	M1a	M1a	D	D
30	Stated as M1a with no other information on metastasis	M1a	M1a	D	D
40	Metastasis to other distant sites With or without metastasis to lung and/or distant lymph node(s) Carcinomatosis Stated as M1b with no other information on metastases	M1b	M1b	D	D

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
45	OBSOLETE DATA CONVERTED V0200 ; See code 60 Distant metastasis, NOS	ERROR	ERROR	ERROR	ERROR
60	Distant metastasis, NOS Stated as M1 [NOS] with no other information on metastases	M1NOS	M1NOS	D	D
99	Unknown; distant metastasis not stated Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

Testis**CS Mets Eval****See Standard Table**

Note 1: This item reflects the validity of the classification of the item CS Mets at DX only according to the diagnostic methods employed.

Note 2: If a specific subcategory of M1 will be derived from CS Mets at DX, then determine if there was any pathological evidence for the highest subcategory. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the highest subcategory, select an Eval code that will derive a "c" staging basis. See also CS Mets Eval in Part 1.

Testis**CS Site-Specific Factor 4****Radical Orchiectomy Performed**

Note: See page A-140

Code	Description
000	Radical orchiectomy not performed
001	OBSOLETE DATA CONVERTED V0203 ; See code 010 Radical orchiectomy performed
010	Radical orchiectomy performed
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)

Code	Description
999	Unknown if radical orchiectomy performed

Testis**CS Site-Specific Factor 5****Size of Metastasis in Lymph Nodes****Note:** See page A-141

Note 1: If the only information on the size of the metastatic lymph node mass is the physician's assignment of the N category, assign code 010 for N1, 020 for N2, or 030 for N3.

Note 2: If extranodal extension is not described on the pathology report or pathologic assessment of regional lymph nodes is not performed, assume extranodal extension is not present.

Note 3: Do not code the size of any node coded in CS Mets at DX.

Code	Description
000	No lymph node metastasis
001	OBSOLETE DATA CONVERTED V0200; See code 010 Lymph node metastasis mass 2 cm or less in greatest dimension AND no extranodal extension of tumor
002	OBSOLETE DATA CONVERTED V0200; See code 020 Lymph node metastasis mass more than 2 cm but not more than 5 cm in greatest dimension Extranodal extension of tumor
003	OBSOLETE DATA CONVERTED V0200; See code 030 Lymph node metastasis mass more than 5 cm in greatest dimension
010	Lymph node metastasis mass 2 centimeter (cm) or less in greatest dimension WITHOUT pathologic extranodal extension of tumor (See Note 2) Stated as N1 with no other information on regional lymph nodes
020	Lymph node metastasis mass more than 2 cm but not more than 5 cm in greatest dimension OR pathologic extranodal extension of tumor Stated as N2 with no other information on regional lymph nodes
030	Lymph node metastasis mass more than 5 cm in greatest dimension Stated as N3 with no other information on regional lymph nodes
988	Not applicable: Information not collected for this case; (If this item is required by

Code	Description
988 cont'd	your standard setter, use of code 988 will result in an edit error.)
998	OBSOLETE DATA CONVERTED V0203 ; See code 999 Regional lymph nodes involved, size of lymph node mass not stated
999	Regional lymph nodes involved, size of lymph node mass not stated Unknown if regional nodes involved Not documented in patient record

Testis**CS Site-Specific Factor 7****Pre-Orchiectomy Alpha Fetoprotein (AFP) Range****Note:** See page A-144**Note 1:** Record the range of the alpha fetoprotein (AFP) test as documented in the patient record prior to orchiectomy and other treatment.**Note 2:** Use the same laboratory test to record values for CS Site-Specific Factors 6 and 7.**Note 3:** A lab value expressed in micrograms/liter (ug/L) is equivalent to the same value expressed in nanograms/milliliter (ng/ml).**Note 4:** If the pre-orchiectomy AFP test is unavailable but a physician's statement of the result is documented, use codes 991-993.**Note 5:** For rare cases that are treated prior to orchiectomy, use code 995 in this field and record the initial AFP range in CS Site-Specific Factor 13.**Note 6:** For rare cases that an orchiectomy is not performed, use code 996 in this field and record the initial AFP range in CS Site-Specific Factor 13.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 1,000 nanograms/milliliter (ng/ml)
020	Range 2 (S2) 1,000 -10,000 ng/ml
030	Range 3 (S3) greater than 10,000 ng/ml
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.)
991	Pre-orchiectomy alpha fetoprotein (AFP) stated to be elevated

Code	Description
992	Pre-orchietomy AFP unknown but preorchietomy serum tumor markers NOS stated to be normal
993	Pre-orchietomy AFP unknown but preorchietomy serum tumor markers NOS stated to be elevated
995	Pretreated case, initial AFP range recorded in CS Site-Specific Factor 13
996	No orchietomy performed, initial AFP range recorded in CS Site-Specific Factor 13
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information Not documented in patient record

Testis**CS Site-Specific Factor 9****Pre-Orchietomy Human Chorionic Gonadotropin (hCG) Range****See page A-146**

Note 1: Record the range of the human chorionic gonadotropin (hCG) test as documented in the patient record prior to orchietomy and other treatment.

Note 2: Use the same laboratory test to record values in CS Site-Specific Factors 8 and 9.

Note 3: A lab value expressed in International Units/liter (IU/L) is equivalent to the same value expressed in milli-International Units/milliliter (mIU/ml).

Note 4: If the pre-orchietomy hCG test is unavailable but a physician's statement of the result is documented, use codes 991-993.

Note 5: For rare cases that are treated prior to orchietomy, use code 995 in this field and record the initial hCG range in CS Site-Specific Factor 15.

Note 6: For rare cases that an orchietomy is not performed, use code 996 in this field and record the initial hCG range in CS Site-Specific Factor 15.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 5,000 milli-International Units/milliliter (mIU/ml)
020	Range 2 (S2) 5,000 - 50,000 mIU/ml

Code	Description
030	Range 3 (S3) greater than 50,000 mIU/ml
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.)
991	Pre-orchietomy human chorionic gonadotropin (hCG) stated to be elevated
992	Pre-orchietomy hCG unknown but preorchietomy serum tumor markers NOS stated to be normal
993	Pre-orchietomy hCG unknown but preorchietomy serum tumor markers NOS stated to be elevated
995	Pretreated case, initial hCG range recorded in CS Site-Specific Factor 15
996	No orchietomy performed, initial hCG range recorded in CS Site-Specific Factor 15
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis

CS Site-Specific Factor 10

Pre-Orchietomy Lactate Dehydrogenase (LDH) Range

Note: See page A-148

Note 1: Of the three tumor markers, lactate dehydrogenase (LDH) is the least specific for testicular cancer and is more of a determinant of bulky or disseminated disease. Although recommended to be tested, LDH may not be routinely performed, especially if the primary is localized.

Note 2: Record the range of the LDH test as documented in the patient record prior to orchietomy and other treatment.

Note 3: If the pre-orchietomy LDH test is unavailable but a physician's statement of the result is documented, use codes 991-993.

Note 4: For rare cases that are treated prior to orchietomy, use code 995 in this field and record the initial LDH range in CS Site-Specific Factor 16.

Note 5: For rare cases that an orchietomy is not performed, use code 996 in this field and record the initial LDH range in CS Site-Specific Factor 16.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)
020	Range 2 (S2) 1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
030	Range 3 (S3) greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)
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.)
991	Pre-orchietomy LDH stated to be elevated
992	Pre-orchietomy LDH unknown but preorchietomy serum tumor markers NOS stated to be normal
993	Pre-orchietomy LDH unknown but preorchietomy serum tumor markers NOS stated to be elevated
995	Pretreated case, initial LDH range recorded in CS Site-Specific Factor 16
996	No orchietomy performed, initial LDH range recorded in CS Site-Specific Factor 16
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis**CS Site-Specific Factor 13****Post-Orchietomy Alpha Fetoprotein (AFP) Range****Note:** See page A-146**Note 1:** Record the range of the alpha fetoprotein (AFP) test as documented in the patient record after orchietomy and prior to further treatment.

Note 2: Use the same laboratory test to record values for CS Site-Specific Factors 12 and 13.

Note 3: A lab value expressed in micrograms/liter (ug/L) is equivalent to the same value expressed in nanograms/milliliter (ng/ml).

Note 4: If the initial post-orchietomy AFP test remains elevated, review the subsequent tests until normalization or plateau occurs and use that test to code this field. See Part I for further explanation of serum tumor marker half life.

Note 5: If the post-orchietomy AFP test is unknown but the preorchietomy AFP test was normal, use code 990.

Note 6: If the post-orchietomy AFP test is unavailable but a physician's statement of the result is documented, use codes 991-993.

Note 7: For rare cases that are treated prior to orchietomy or an orchietomy is not performed, code the initial AFP range in this field and not in CS Site-Specific Factor 7.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 1,000 nanograms/milliliter (ng/ml)
020	Range 2 (S2) 1,000 -10,000 ng/ml
030	Range 3 (S3) greater than 10,000 ng/ml
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	Post-orchietomy alpha fetoprotein (AFP) unknown but preorchietomy AFP was normal
991	Post-orchietomy AFP stated to be still elevated
992	Post-orchietomy AFP unknown but post-orchietomy serum tumor markers NOS stated to be normal
993	Post-orchietomy AFP unknown but post-orchietomy serum tumor markers NOS stated to be still elevated Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis**CS Site-Specific Factor 15****Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Range****Note:** See page A-148**Note 1:** Record the range of the human chorionic gonadotropin (hCG) test as documented in the patient record after orchiectomy and prior to further treatment.**Note 2:** Use the same laboratory test to record values in CS Site-Specific Factors 14 and 15.**Note 3:** A lab value expressed in International Units/liter (IU/L) is equivalent to the same value expressed in milli-International Units/milliliter (mIU/ml).**Note 4:** If the initial post-orchiectomy hCG test remains elevated, review the subsequent tests until normalization or plateau occurs and use that test to code this field. See Part I for further explanation of serum tumor marker half life.**Note 5:** If the post-orchiectomy hCG test is unknown but the preorchiectomy hCG test was normal, use code 990.**Note 6:** If the post-orchiectomy hCG test is unavailable but a physician's statement of the result is documented, use codes 991-993.**Note 7:** For rare cases that are treated prior to orchiectomy or an orchiectomy is not performed, code the initial hCG range in this field and not in CS Site-Specific Factor 9.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 5,000 milli-International Units/milliliter (mIU/ml)
020	Range 2 (S2) 5,000 - 50,000 mIU/ml
030	Range 3 (S3) greater than 50,000 mIU/ml
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	Post-orchiectomy human chorionic gonadotropic (hCG) unknown but preorchiectomy hCG was normal
991	Post-orchiectomy hCG stated to be still elevated
992	Post-orchiectomy hCG unknown but post-orchiectomy serum tumor markers NOS stated to be normal
993	Post-orchiectomy hCG unknown but post-orchiectomy serum tumor markers NOS stated to be still elevated

Code	Description
993 cont'd	Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis**CS Site-Specific Factor 16****Post-Orchiectomy Lactate Dehydrogenase (LDH) Range****Note:** See page A-149

Note 1: Of the three tumor markers, lactate dehydrogenase (LDH) is the least specific for testicular cancer and is more of a determinant of bulky or disseminated disease. Although recommended to be tested, LDH may not be routinely performed, especially if the primary is localized.

Note 2: Record the range of the LDH test as documented in the patient record after orchiectomy and prior to further treatment.

Note 3: If the initial post-orchiectomy LDH test remains elevated, review the subsequent tests until normalization or plateau occurs and use that test to code this field. See Part I for further explanation of serum tumor marker half life.

Note 4: If the post-orchiectomy LDH test is unknown but the preorchiectomy LDH test was normal, use code 990.

Note 5: If the post-orchiectomy LDH test is unavailable but a physician's statement of the result is documented, use codes 991-993.

Note 6: For rare cases that are treated prior to orchiectomy or an orchiectomy is not performed, code the initial LDH range in this field and not in CS Site-Specific Factor 10.

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)
020	Range 2 (S2) 1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
030	Range 3 (S3) greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)

Code	Description
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	Postorchiectomy LDH unknown but preorchiectomy LDH was normal
991	Postorchiectomy LDH stated to be still elevated
992	Postorchiectomy LDH unknown but post-orchiectomy serum tumor markers NOS stated to be normal
993	Postorchiectomy LDH unknown but postorchiectomy serum tumor markers NOS stated to be still elevated Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information Not documented in patient record