COLLABORATIVE STAGE STANDARD TABLES

CS TUMOR SIZE: Instructions for Coding

1. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.

2. **Schema-specific instructions.** Refer to site/histology-specific instructions (notes before the table) for additional information. Schema-specific instructions take priority over general instructions. Where there are no site/histology-specific instructions, the general instructions apply.

3. **Record the largest tumor diameter from reports in the following order**:

a. Record tumor size **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the final diagnosis, synoptic report, (also known as CAP protocol or pathology report checklist), microscopic, then gross examination, in that order.

Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. *Record tumor size as 032.*

Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. *Record tumor size as 028.*

b. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, **code the largest size of tumor prior to neoadjuvant treatment unless the size of tumor is larger at surgery (see 3.e below)**.

Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. *Record tumor size as 022*.

c. **Priority of imaging/radiographic techniques.** Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

d. **Tumor size discrepancies among reports.** If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record, regardless of which imaging technique reports it.

e. **If no response to neoadjuvant treatment.** In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, larger after preoperative treatment as determined by the operative or pathology report, code the greatest tumor size and code CS Tumor Size/Ext

Eval as 6, based on pathology/operative report after treatment.
i. If clinical tumor size is unknown but a pathologic tumor size is given after treatment and clinician states there was a response to neoadjuvant, code TS as 999 and TS/Ext Eval as 5.
ii. If clinical tumor size is unknown but a pathologic tumor size is given and clinician states no response to treatment, code TS from path report and TS Ext eval as 6.

4. **Record the exact size of the primary tumor** for all sites/histologies except those for which it is stated to be not applicable. Code the exact size in preference to a statement of a T category or a size range (see special codes below). If there is no reference at all about tumor size in the record, code as 999.

a. Always **code the size of the primary tumor**, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

b. **Record the largest dimension** or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

Example: A 3.3 cm tumor would be 33 millimeters and would be coded as 033.

Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. *Record tumor size as 051*.

c. **Record the size of the invasive component**, if given.

d. **If both an in situ and an invasive component** are present and the invasive component is measured, **record the size of the invasive component** even if it is smaller.

Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. *Record tumor size as 014.*

e. ***Additional rule for breast primaries:*** If the size of the invasive component is ***not*** given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

Example: Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. *Record tumor size as 023.*

Example: Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. *Record tumor size as 019.*

Note: For breast cancer, document how the size of the tumor was determined in Site Specific Factor 6. Information from the pathology report can be used to identify in situ versus invasive tumor even if exact size is not given. If tumor size is a clinical measurement only in the range 001-989, Site Specific Factor 6 must be coded as 987.

f. For purely ***in situ*** **lesions, code the size as stated**.

g. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.

h. **Do not add pieces or chips together to create a whole; they may not be from the same location,** or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the clinician gives a size not in agreement with the pathologist or pathology report, the clinician statement must be confirmed with pathology prior to reporting/coding.

i. **When residual tumor is larger than excisional biopsy.** If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

j. **No clinical size but incisional needle biopsy.** Code the size from an incisional needle biopsy only when no residual tumor is found on further resection **or** on the rare occasion when the size of the tumor on incisional needle biopsy is larger than the size of the tumor on resection. If there is no further resection, do not code the size from the incisional needle biopsy; code 999 in the absence of a clinical size.

k. **Malignant melanoma of skin, mucosal membrane, mucosa of head and neck sites, or eye.** Record tumor size (diameter or lateral dimension) for malignant melanoma. Depth of invasion (tumor thickness) is coded in a site-specific factor.

l. **Multifocal/multicentric tumors.** If the tumor is multi-focal or there are multiple tumors being reported as a single primary, code the size of the largest tumor.

m. **Size stated as T_.** If both a T category and exact tumor size are given, code the exact size. If the only information about tumor size given in the medical record is a physician statement of a T category, determine whether the T category is based on tumor size or extension.
i. If the T category is based solely on tumor size, use the appropriate "Stated as T_, NOS" code in CS Tumor Size **or** select the appropriate code from the 99_ series (see below for special codes).
ii. If the T category is based on extension, use the appropriate "Stated as T_" code in CS Extension.
iii. If the T category is based on both tumor size and extension, use the appropriate "Stated as T_, NOS" code in CS Extension. Code a specific tumor size as stated in the medical record. If an explicit tumor size is not given but there is a "Stated as T __ value based on size, code the tumor size in the 99__ series in CS Tumor Size. Otherwise, use code 999.

5. Special codes

a. **Use field for tumor dimension only.** Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to Site-Specific Factors for those sites/histologies.

b. **No size reported.** If size is not reported, code as 999, which means unknown size or not documented in the patient record.

c. **Use of Code 000**. Code 000 indicates no mass or no tumor was found at the primary site; for example, when a tumor has metastasized but no tumor can be found at the primary site.

d. **Use of code 990.** Code 990, Microscopic focus or foci only and no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

Note: The terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded to 990. If the tumor is described as both a microscopic focus and a specific size, code the specific size.

Example: Ovary specimen: extensive cystic disease with focal areas of tumor seeding. *Disregard "focal" and code tumor size to 999 unknown.*

Example: Cervix conization: severe dysplasia with focal areas of microinvasion. *Code tumor size as 990 microscopic focus, no size given.*

Example: Multicentric microscopic foci in breast, largest is 0.5 millimeters. *Code tumor size as 001*.

e. **Non-specific size descriptions.** Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, code the more precise size in the range 001-989. If the tumor is described as "greater than 5 cm" and there is not an applicable code in the site-specific schema, record as 051.

f. **Site-specific special codes.** Other special codes in the range 996 to 997 are used on a site specific basis. See the individual site/histology schemas for further information and definitions.

g. **Use of code 998.** The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following schemas sites:

Esophagus (C15.0-C15.5, C15.8-C15.9): Circumferential
EsophagusGEJunction (C16.0-C16.2): Diffuse; widespread: 3/4s or more; linitis plastica
Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse; widespread; 3/4s or more; linitis plastica

Appendix (C18.1): Familial/multiple polyposis
Carcinoid of appendix (C18.1): Familial/multiple polyposis
Colon (C18.0, C18.2-C18.9): Familial/multiple polyposis
Rectosigmoid and rectum (C19.9, C20.9): Familial/multiple polyposis
Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lung or NOS
Breast (C50.0-C50.6, C50.8-C50.9): Diffuse

h. **Size not applicable.** For the following diagnoses and/or primary sites, size is not applicable. *Code as 988:*

Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Kaposi sarcoma
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma) other than ocular adnexal lymphoma
Mast cell tumors
Multiple myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases
Polycythemia vera
Polymorphic Post-Transplant Lymphoproliferative Disorder (PTLD)
Refractory anemias
Other Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (*see HemeRetic schema for a complete list of codes and diagnoses)*
MelanomaChoroid
MelanomaCiliaryBody
MelanomaIris

i. **Use of CS Tumor Size/Ext Eval field with CS Tumor Size.** The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field when tumor size is the determining factor for the T category.

Document tumor size code in text.

Note: Remember to check individual schemas 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: Instructions for Coding

1. **Code the farthest documented extension of the primary tumor.** Do not include discontinuous metastases to distant sites (these are coded in CS Mets at Dx) except for corpus uteri, ovary, fallopian tube, and female peritoneum (see 2f below).

Example: In the CS Extension table for colon, Note 2 states that codes 600-800 are used for contiguous extension from the site of origin, and discontinuous involvement is coded in CS Mets at Dx. Thus direct tumor extension from the transverse colon onto the surface of the liver would be coded as CS Extension 600, while hematogenous metastases within the liver would be coded as CS Mets at Dx 26.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure involved by direct extension is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

2. **Record extension information in the following priority order**:

a. **No neoadjuvant treatment planned or administered.** Record extension **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

b. **Neoadjuvant treatment planned and administered.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, **code the farthest extension identified prior to treatment (clinically).**

Example: Patient has rectal mass firmly fixed to pelvic wall (clinically T4, extension code 610). Patient undergoes preoperative radiation therapy. The pathology report from the low

anterior resection shows residual tumor outside the rectum in perimuscular tissue (pathologically T3, extension code 400). *Code extension as 610, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.*

c. **Partial or no response to neoadjuvant treatment.** In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment. If response to treatment is unknown, code the farthest clinical extension and code CS Tumor Size/Ext Eval as 5.

Example: Patient found to have an obstructing central lung tumor very close to the main stem bronchus (clinically T2, extension code 200). Patient undergoes six weeks of intensive chemotherapy. At resection, tumor was observed directly extending into trachea (pathologically T4, extension code 700). *Code extension as 700, because the tumor was noted to be more extensive after the preoperative treatment.*

Example: Patient has a 5.5 cm hard, moveable mass in the right breast (clinically T3, extension code 100) and receives preoperative chemotherapy. The pathology report from the modified radical mastectomy shows residual 2.8 cm mass with infiltration of the deep subcutaneous tissues over the mass (pathologically T2, extension code 200). *Code extension as 200, because although the chemotherapy "shrank" the tumor, the residual tumor was found to be more extensive than the clinical presentation. (Code Tumor Size as 055 because the derived T3 pre-neoadjuvant treatment is greater than the post-treatment T2. Code TS/Ext Eval as 5 {clinical information prior to neoadjuvant treatment} because the tumor size determines the T classification for Extension codes 100, 200, and 300 for breast.)*

i. If clinical extension is unknown but a pathologic extension is given after treatment and clinician states there was a response to neoadjuvant, code CS Extension as 999 and TS/Ext Eval as 5.
ii. If clinical extension is unknown but a pathologic extension is given and clinician states no response to treatment, code CS Extension from path report and TS/Ext Eval as 6.

d. **Priority of imaging/radiographic techniques.** Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

e. **Involved organ not listed in schema.** If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area.

f. **Contiguous (direct) extension only.** With the exception of mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

Example: Carcinoma of the prostate with extension to pubic bone is coded 600. Carcinoma of the prostate with metastases to thoracic spine is coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine are coded in the CS Mets at Dx field.

3. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.

4. **Ambiguous terminology.** Refer to the ambiguous terminology section for terms that constitute tumor involvement or extension.

5. **Code the highest applicable specific number.** Codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or "Stated as T1, NOS" do not take priority over more specific codes with lower numbers.

Example: The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.

6. **Inferring extension code from stated T category or site-specific staging.** If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category or alternative staging system stated by the physician.

a. If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as T_, NOS" category or record the numerically lowest equivalent extension code for the site-specific staging system.

7. **Use of NOS categories.** Some schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

8. **Discontinuous or distant metastases.** Distant metastases must be coded in the CS Mets at Dx field. The only exceptions are mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in the CS Extension field.

9. **In situ pathology with nodal or metastatic tumor.** Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement; use the code for Localized, NOS, if there is no

better information.

Example: Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. *Code CS Extension as 100, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.*

10. **Microscopic residual or positive tumor margins.** The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

11. **Document choice of codes in text.** It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.

CS Extension Standard Table
Note: Remember to check individual schemas 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/EXT EVAL: Instructions for Coding

1. **Document the staging basis for the farthest extension and/or greatest tumor size.** The underlying purpose of this field is to capture the staging basis for the highest T category assigned to the case. In most circumstances, this will be the staging basis for the highest Tumor Size code or Extension code as appropriate to the site. See also instructions 2, 3, and 4.

a. Select the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension or largest size of the primary tumor (where applicable) was obtained; this may not be the numerically highest Eval code.

Example 1: Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy.*

Example 2: Patient has elevated PSA, negative digital rectal exam, and clinically inapparent prostate tumor. Needle biopsy identifies adenocarcinoma in right lobe only. *Code CS Tumor Size/Ext Eval as 1 because the needle biopsy, not the clinical examination, established the extent of disease.*

Example 3: Patient has bronchoscopic biopsy (Eval code 1) confirming squamous cell carcinoma

of the right upper lobe bronchus. CT scan of chest (Eval code 0) shows that RUL mass extends into mediastinum (Lung Extension code 700). *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed the farthest extension of tumor.*

Example 4: Imaging shows 3.0 cm mass in right upper lobe of lung. Fine needle aspiration biopsy shows adenocarcinoma. *Code CS Tumor Size/Ext Eval as 0 because the imaging documents what is known about the tumor and drives the classification of T, and the FNA simply confirms that the mass is cancer.*

Example 5: Patient has 6 cm mass in left breast with overlying erythema and edema. Core needle biopsy confirms duct carcinoma and the patient receives neoadjuvant chemotherapy followed by a modified radical mastectomy. The pathology report from the surgery shows a 2.5 cm residual carcinoma. *Code the Tumor Size/Ext Eval as 5 (surgical resection after neoadjuvant therapy – size/extension based on clinical information prior to treatment), which maps to clinical staging. (Tumor size would be coded 060.)*

b. In the infrequent situation where there is both clinical and pathologic documentation of the same T category, **pathologic information takes priority.**

Example: Lung cancer patient has biopsy-proven extension to adjacent trachea (Extension code 700) and radiographic evidence of extension to neural foramina (Extension code 750). *Code CS Extension as 750 and TS/Ext Eval as 3. When both codes map to T4,pathologic staging basis takes priority.*

c. **Mapping of T subcategories.** Select the CS TS/Ext Eval code that describes how the most advanced subcategory of the derived T was determined.
i. If a specific subcategory of T will be derived (such as T2a, etc.), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Tumor Size/Ext Eval code that will derive a “p” staging basis.
ii. If there was only clinical evidence of the subcategory disease, select a CS Tumor Size/Ext Eval code that will derive a “c” staging basis. In the latter case there may have been pathological evidence of a lower T subcategory, but this is not considered in assigning the Eval code.

Example: Cervical carcinoma with bullous edema of bladder (CS Extension code 605, maps to T3a) demonstrated on cystoscopy (CS Tumor Size/Eval code 1). KUB radiography (CS Tumor Size/Eval code 0) shows non-functioning kidney (CS Extension code 635, maps to T3b). *Code CS Tumor Size/Ext Eval as 0 because the imaging documented a higher subcategory of T3 than the cystoscopy.*

d. **When the only procedure is a polypectomy.** In some situations, an endoscopic procedure may remove the entire tumor, and the TS/Ext Eval must be coded to reflect the correct staging basis for tumor extension.
i. If there is no tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 3 (pathologic).
ii. If there is tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 1 (endoscopic/diagnostic biopsy).

When the patient has further surgery

iii. If there is no primary tumor in resection, use extension information from polypectomy and code TS/Ext Eval as 3 (pathologic).
iv. If more tumor is found at resection, code farthest extension from polypectomy or resection and code Eval as 3 (pathologic).

2. **When tumor size is the primary factor.** For primary sites where tumor size is the primary factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of how the tumor size was determined.

Note: In the CS Extension field, an asterisk (*) in the TNM 6 Map column or a caret (^) in the TNM 7 Map column usually indicates that tumor size is the determining factor in the mapping.

a. If the tumor size is taken from physical exam or imaging and there was also a needle biopsy or incisional biopsy, code CS Tumor Size/Ext Eval according to which gave the better information about tumor size.

Example: On physical examination, patient has a 1.5 cm (T1) lesion in the floor of mouth with mucosal extension onto the gingiva. A biopsy confirms the malignancy and the patient is treated with radiation therapy. *Code the CS Tumor Size/Ext Eval as 0 since the tumor size was determined on physical exam and the biopsy simply confirmed the malignant diagnosis. (Mucosal extension to another structure does not alter the T classification).*

Example: Bronchoscopy (Eval code 1) shows blockage in right middle bronchus with no parenchymal extension (Extension code 100). CT scan (Eval code 0) shows tumor size as 2.5 cm (maps to T1b). *Code CS Tumor Size/Ext Eval as 0 because the tumor size determines the difference between T1a, T1b and T2.*

3. **When tumor size is not a factor.** For primary sites/histologies where tumor size is not a factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of the CS extension field only.

Note: For most primary sites, if the tumor is classified as T4 or sometimes even T3, tumor size is no longer a factor.

Example: CT scan of head and neck (Eval code 0) shows tumor confined to supraglottic larynx (Extension code 100). Panendoscopy (Eval code 1) demonstrates that there is impaired vocal cord mobility (Extension code 250). *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documented a higher Extension code than the CT scan.*

Example: Sigmoidoscopy and biopsy (Eval code 1) show a 4 cm adenocarcinoma in the upper rectum. Ultrasound (Eval code 0) shows that the carcinoma invades into the perirectal fat. Patient opts for radiation therapy. *Code the CS Tumor Size/Ext Eval field as 0 because the ultrasound showed the depth of invasion, which is the primary factor in classifying the T category for colorectal cancers.*

Note: For colon, rectosigmoid and rectum carcinomas, always assign the Tumor Size/Ext Eval code based on extension (depth of invasion). Tumor size is not a factor in classifying colorectal cancers.

4. **When both tumor size and extension determine T category.** For primary sites where both tumor size and extension determine the T category in TNM, select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

Example: Tumor size for a breast cancer biopsy is 020 (maps to T1). On physical exam, there is ulceration of the skin (extension code 512, maps to T4). *Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from thephysical examination results in a higher T category.*

Note: For breast, unless there is skin or chest wall involvement, always assign the Tumor Size/Ext Eval code based on size. If there is skin or chest wall involvement or a statement of inflammatory carcinoma (T4 disease), assign Eval code based on extension.

Example: Panendoscopy and biopsy (Eval code 1) confirm a 3.5 cm lesion on the lateral border of the anterior tongue involving the intrinsic musculature (Extension code 200 with tumor size 035, equivalent to a T2). CT scan of the head and neck (Eval code 0) indicates that the lesion actually involves the extrinsic or deep muscles of the tongue (Extension code 750, equivalent to T4a). *Code CS Tumor Size/Ext Eval as 0 because the CT scan documented a higher stage than the tumor size.*

b. If the patient had no surgery, use code 0, 1, or 9.

Example: Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. *Code this field as 0. Staging algorithm will identify information as clinical (c).*

Example: Colon cancer with colonoscopy and biopsy confirming adenocarcinoma in the submucosa. *Code this field as 1. Staging algorithm will identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.*

Example: Information obtained from endoscopies for cervix or bladder showing size or extent of the tumor is coded as 1 in this field and the staging algorithm will identify the information as clinical (c).

Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. *Code this field as 1. The staging algorithm will identify information as pathologic (p) in the sixth edition mapping and clinical (c) in the seventh edition mapping.*

c. If the patient had surgery followed by other treatment(s), use code 3.

d. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5. Cases coded to Tumor Size/Ext Eval code 5 can be analyzed or compared with other cases with a clinical staging basis.

e. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis. Cases coded to Tumor Size/Ext Eval code 6 cannot be analyzed with or compared to any other cases that did not receive neoadjuvant treatment and surgery.

f. If the patient had an autopsy and the autopsy information meets the timing rules for determining extension, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

5. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Appendix 3.) For any sites and histologies not listed in Table 6, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

6. **Examples of imaging studies included in Code 0.** Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

7. **Explanation of Code 1.** Codes 0 – 3 are oriented to the AJCC staging basis. In general, Code 1 includes microscopic analysis of tissue that does not meet the requirements for pathologic staging in the TNM system. Code 1 also includes observations at surgery, such as an exploratory laparotomy in which unresectable pancreatic cancer is identified and further tumor extension is not biopsied. However, pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, seventh edition*.

Example: A total cystectomy is required to pathologically stage a bladder cancer. Any tissue removed during another procedure, such as a transurethral resection of a bladder tumor, does not meet the requirements for pathologic staging and should be coded to 1 in this field. This also applies to transurethral resection of the prostate.

a. If there is a choice between Eval code 0 (physical exam and imaging) and Eval code 1 (needle biopsy), use the Eval code that provides the best information about the tumor size and/or extent of disease. In most situations, the needle biopsy simply confirms the malignancy and the physical exam or imaging provides more information about tumor extension.

Example: Colposcopic examination and biopsy (Eval code 1) of the cervix shows extensive involvement of the endocervix. Bimanual examination of the pelvis (Eval code 0) indicates that the tumor is fixed to the pelvic sidewall ("frozen pelvis"). *Code CS Tumor Size/Ext Eval as 0 (clinical) because the bimanual examination indicates farther extension than the endoscopy.*

Example: Patient has nonspecific abdominal symptoms. An Upper GI exam (Eval code 0) shows localized thickening of the stomach wall. Esophagogastroscopy and biopsy (Eval code 1) confirm diffuse involvement of the upper part of the stomach with extension into the lower esophagus. *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documents more involvement than the imaging.*

8. **Explanation of Code 3.** For most schemas, Code 3 meets the criteria for pathologic staging. For most schemas, use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. In CSv2, the definition of code 3 has been reworded to include not only surgical resection but also a positive biopsy that confirms the highest T classification. In other words, according to TNM rules, if the highest T category can be confirmed microscopically (positive cytology or tissue), this meets the requirements for pathologic staging basis and the CS Tumor Size/Ext Eval field should be coded to 3.

Example: Patient visits doctor complaining of urinary frequency and pain. Pelvic examination shows extensive cervical carcinoma (Eval code 0). Cystoscopic biopsy of bladder shows squamous carcinoma compatible with cervical origin (cervix extension code 700, equivalent to T4). *Code CS Tumor Size/Ext Eval as 3 (pathologic) because biopsy documents highest T category.*

9. **Neoadjuvant therapy and 2nd primaries.** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

10. **Different code structure for prostate.** The CS Tumor Size/Ext Eval field for prostate is unique. An extra category was inserted between codes 1 and 2 in the common (standard table used for other sites) Tumor Size/Ext Eval table to provide a code for situations where no prostatectomy was performed, but there was a positive biopsy of extraprostatic tissue. This allows assignment of codes in the T3-T4 range (Extension 410-700). Common table code 2 (autopsy of suspected/known cancer) becomes code 3 for prostate, and common table code 3 (pathologic) becomes code 4.

Example: A prostate cancer patient has a biopsy of the rectum that shows microscopic involvement of the rectal wall (Extension code 500, equivalent to T4). Code Tumor Size/Ext Eval as 2 (positive biopsy of extraprostatic tissue, which maps to pathologic) because according to the *AJCC Cancer Staging Manual, seventh edition*, the case meets the requirements for pathologic staging in the T category.

Example: Patient presents with urinary symptoms and undergoes transurethral resection to improve urinary flow. Adenocarcinoma is found in the chips of tissue removed from the prostate. *Code Tumor Size/Ext Eval as 1 because there was no clinical evidence of cancer and the transurethral resection is an endoscopic procedure that does not meet the criteria for pathologic staging of prostate.*

Example: Needle biopsies of the prostate confirm adenocarcinoma. The patient undergoes a radical prostatectomy that shows extensive involvement of the prostate. *Code Tumor Size/Ext Eval as 4 because the prostatectomy meets the criteria for pathologic staging.*

Note: Cryoprostatectomy does not meet pathologic staging criteria because there is no tissue available for the pathologist to examine.

11. **Coding Eval field when tumor size or extension is unknown.** The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or CS Mets at Dx) is unknown. For example, even if it is not possible to determine the tumor size or extension and the Extension field is coded as 999, the registrar still knows what procedures were used to try to determine those fields. In other words, just because the tumor size or extension is coded 999, the Eval field does not have to be coded 9.

12. **Schemas always coded 9.**
AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
RespiratoryOther
SinusOther
Trachea
UrinaryOther

CS Tumor Size/Extent Eval Standard Table

Note: Remember to check individual schemas 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. No autopsy 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. *See Notes 1 and 2 below*	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). *See Note 3 below.*	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. *See Note 3 below.*	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. *See Note 4 below.*	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 *For sites with no TNM schema:* Not applicable	c

Note 1: For lung, code 1 was pathologic staging basis in CS version 1 and clinical in CS version 2. For liver, code 1 was clinical in CS version 1 and pathologic 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.
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: Instructions for Coding

1. **Record the specific involved regional lymph node chain(s) farthest from the primary site.** The lymph nodes may be involved by tumor either clinically or pathologically. Regional lymph nodes are listed for each schema. In general, the regional lymph nodes in the chain(s) closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. If a lymph node chain is not listed, check an anatomy book or medical dictionary for a synonym. If the lymph node chain and its synonym are not listed in CS Lymph Nodes, code the involved node in CS Mets at DX. **Record the highest applicable code in the following order: pathology report, imaging, physical exam.**

Exception: The higher codes for "Regional lymph nodes, NOS;" "Lymph nodes, NOS;" "Stated as N1, no other information;" "Stated as N2a, no other information;" and so forth, should be used only when there is no available information regarding the specific regional nodes involved.

Example: Patient has a right upper lobe lung cancer, and right hilar lymph nodes are positive on fine needle aspiration biopsy. CT scan shows matted left paratracheal (contralateral mediastinal) nodes, but they are not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

a. **If there is no neoadjuvant therapy.** Record involved regional lymph nodes **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

b. **Pathologic information takes precedence.** If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, pathologic information takes precedence if no preoperative treatment was administered. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement.

Example: Axillary lymphadenopathy stated as "suspicious for involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. *Code CS Lymph Nodes as 000, no regional lymph node involvement.*

c. **Inaccessible lymph nodes rule for regional lymph nodes.** For inaccessible lymph nodes, record CS Lymph Nodes as Code 000 (None) rather than Code 999 (Unknown) when the following three conditions are met:

1. There is no mention of regional lymph node involvement in the physical examination, pretreatment diagnostic testing or surgical exploration.

2. The patient has clinically low stage (T1, T2, or localized) disease.

3. The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) or is offered usual treatment but refuses it, since this presumes that there are no involved regional lymph nodes that would otherwise alter the treatment approach.

Note: Code 999 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of involved regional lymph nodes. Code 999 should also be used when there is no documentation in the medical record about the status of accessible regional lymph nodes.

Note: If the inaccessible nodes rule applies and the case is coded 000, use code 0 in CS Reg Nodes Eval, as this code documents that criteria were met for a clinical N0.

d. **Direct tumor extension into lymph node.** If there is direct extension of the primary tumor into a regional lymph node, code the involved node in this field.

e. **Multiple nodes involved for head and neck primary.** The code structure for CS Lymph Nodes for head and neck cancers varies by primary site, but in general, the following code ranges apply:

000 None
100-190 Single positive ipsilateral node involved
200-290 Multiple positive ipsilateral nodes
300-320 Positive ipsilateral nodes, unknown if 1 or > 1
400-490 Bilateral or contralateral positive nodes
500-520 Regional nodes, NOS, unk. number and laterality
800 Lymph nodes, NOS

If even one involved node is in a higher category, use the appropriate code in the higher category.

Example: Patient with hypopharyngeal cancer has two positive ipsilateral level IV nodes and one positive ipsilateral level V node. Level IV nodes are listed in CS Lymph Nodes code 100; level V nodes are listed in CS Lymph Nodes code 120. Because more than one node is involved, the correct code range is 200-290. *Code as 220 because there are multiple lymph nodes involved and at least one of them is in code 120.*

Example: Patient with base of tongue cancer has regional lymph nodes involved on both sides of neck. “Regional nodes, NOS” is in code 100, but bilateral nodes are involved. *Code as 400, bilateral lymph nodes listed in 100.*

f. **Neoadjuvant treatment planned or administered.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes based on information prior to surgery.

Example: Patient has a hard matted mass in the axilla (code 510) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 000). *Code CS Lymph Nodes as 510 because prior to treatment they appeared to be clinically involved and the chemotherapy apparently "sterilized" the lymph nodes.*

g. **Partial or no response to neoadjuvant treatment.** In the infrequent event that clinically involved regional lymph nodes do not respond to neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Reg Nodes Eval as 6, based on pathology/ operative report after treatment. If response to treatment is not documented, code the clinical status of the lymph nodes and code CS Reg Nodes Eval as 5.

Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on CT scan (Negative, code 000). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 100) to lymph nodes and the prostatectomy is canceled. *Code CS Lymph Nodes as 100 because the preoperative treatment (Lupron) had no effect on the lymph nodes.*

i. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated after treatment and clinician states there was a response to neoadjuvant, code CS Lymph Nodes as 999 and CS Reg Nodes Eval as 5.
ii. If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated and clinician states no response to treatment, code CS Lymph Nodes from path report and CS Reg Nodes Eval as 6.

h. **Use of Code 800.** The CS Lymph Nodes table for nearly every schema contains a code 800, defined as Lymph nodes, NOS. This code is to be used only when it is not possible to determine whether the involved lymph nodes are regional or distant. Each schema also includes a separate code for "Regional lymph nodes, NOS". In general, lymph nodes removed during a resection of the primary site are regional and should be coded as such. Occasionally a distant lymph node will be removed separately from the primary site. In the infrequent situation where the involved lymph node is not identified as either regional or distant, use code 800, which will map to N1 category using the TNM downstaging rule applied in the CS computer algorithm.

2. **When CS Extension is coded as in situ/noninvasive.** Use code 000 for lymph node involvement when the CS Extension is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so involved lymph nodes can be coded as appropriate for the case. Code the CS Extension field and the behavior code to reflect that the tumor is invasive.

3. **Terms meaning lymph node involvement.** For solid tumors, the terms "fixed" or "matted" and

"mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes.

a. Any other terms, such as "palpable," "enlarged," "visible swelling," "shotty," or "lymphadenopathy" should be ignored, unless there is a statement of involvement by the clinician.

Exception: The terms *adenopathy, enlargement,* and *mass in the hilum or mediastinum* should be coded as involvement for lung primaries only.

Example: Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

b. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes. Keep in mind, however, that involved lymph nodes are coded in CS Extension for lymphomas.

c. Regional lymph nodes are not palpable for inaccessible lymph nodes sites such as bladder, colon, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be on imaging studies or in the surgeon's evaluation at the time of exploratory surgery or definitive surgery. If regional lymph nodes for these sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative (code 000) based on the inaccessible lymph nodes rule.

d. The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

e. Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS.

4. **Coding size of lymph node.** When size of involved regional lymph nodes is required, code from pathology report, if available.

a. Code the size of the metastasis, not the entire node, unless otherwise stated in the site-specific schema. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes; for example, a single involved node 1.5 cm in size can be coded to "single lymph node < 2 cm" because the metastasis cannot be larger than 1.5 cm.

Example: Patient has radical nephroureterectomy for urothelial carcinoma of the renal pelvis. Synoptic pathology list shows three involved nodes, the largest of which is 2 cm in greatest diameter. *Code CS Lymph Nodes as 200 because multiple lymph nodes are involved and no single lymph node or its metastasis is larger than 5 cm in size.*

b. If the size of the metastasis in the node is unknown, code the size of the involved node(s) if given.

c. Code the clinical size of the involved node(s) in the absence of a pathologic size.

d. If the size given is described as a mass, code the size of the mass.

Example: Patient presents with 6 cm hard upper jugular (Level II) neck mass. Needle biopsy of mass shows metastatic squamous carcinoma. Panendoscopy finds lesion on soft palate. *Code CS Lymph Nodes as 300 (regional lymph nodes listed in 100 {regional lymph node, NOS}, not stated if single or multiple). Code Lymph Nodes Eval as 0 (physical exam). Code Site-specific Factor 1 (size of lymph node) as 060.Code Site-specific Factor 2 as 988 (not applicable in CSv2). Code Site-specific Factor 3 as 010 (level II node involved).Code Site-specific Factors 4-6 as 000 (no nodes involved). Code Site-specific Factor 7 as 010 (upper level nodes involved).Code Site-specific Factor 8 as 010 (nodes involved clinically, no extracapsular extension clinically).Code Site-specific Factor 9 as 050 (lymph nodes involved pathologically, unknown if extracapsular extension).The computer algorithm will combine the codes from CS Lymph Nodes, SSF1, and Lymph Nodes Eval and derive a cN2a.*

e. Information about location, number and size of lymph nodes may be split among the CS Lymph Nodes field and one or more site-specific factors. Code the fields as completely as possible and the computer algorithm will derive the correct N category. Refer to the discussion of head and neck lymph nodes and breast lymph nodes in Section 2 of this manual for further information.

5. **Inferring lymph node involvement from stated N category or site-specific staging.** If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as N_, NOS" category or record the numerically lowest equivalent CS Lymph Nodes code for the site-specific staging system. CS Version 2 includes many code choices to accommodate physician statements of N1, N2 NOS, N2a, and so forth.

a. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

b. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

6. **Isolated Tumor Cells (ITCs) in lymph nodes.** Several chapters in the TNM seventh edition refer to isolated tumor cells or ITCs. ITCs are single cells or small clusters of epithelial cells in regional lymph nodes whose metastatic potential is unknown. ITCs are coded according to site-specific guidelines.

a. For breast, ITCs are coded as negative lymph nodes (CS Lymph Nodes code 000 or 050, which maps to pN0(i+) or pN0(mol+).

b. For cutaneous melanoma, ITCs are coded as positive lymph nodes.

c. For Merkel cell carcinoma, ITCs are coded as positive lymph nodes.

7. **Use of NOS categories.** Some schemas include designations such as N1, NOS; N2, NOS, and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

8. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum.** Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. These various aspects are handled in different ways in CS. Furthermore, there are different definitions in the sixth and seventh editions of the *AJCC Cancer Staging Manual* for discontinuous tumor nodules found near the primary site.

a. In the seventh edition and CSv2, if the primary tumor is localized or maps to T1 or T2, code CS Lymph Nodes as 050 if the only information available is the presence of tumor nodules in pericolic fat. In addition, code the total number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits. If there are tumor deposits and involved regional lymph nodes, code the information on regional lymph nodes in CS Lymph Nodes, the number of positive nodes in Lymph Nodes Positive, and the number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits.

b. In the sixth edition of TNM and CS Version 1, tumor nodule(s) present in pericolic or perirectal fat should be coded using the following guidelines:
i. Code as regional lymph node involvement if the nodule has a smooth contour.
ii. Code as tumor extension if the nodule has an irregular contour.

9. **Sentinel lymph nodes**. Involved nodes found during sentinel lymph node procedures are classified as positive nodes and coded in CS Lymph Nodes. However, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor. For further information, see the coding guidelines for CS Reg Nodes Eval.

10. For the following primary sites, CS Lymph Nodes is always coded 988, Not applicable.
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hodgkin and Non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Other and Ill-Defined Primary Sites
Unknown Primary Site

11. **Document choice of code in text.** It is strongly recommended that the choice of regional lymph node codes be documented in a related text field on the abstract.

CS Lymph Nodes Standard Table

Note: Remember to check individual schemas 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

Seventh Edition TNM and CSv2 Changes in Eval Code Definitions

A major change reflecting current medical practice occurred in the rules for clinical and pathologic classification of regional lymph nodes effective with the seventh edition of the *AJCC Cancer Staging Manual*. In CSv2, CS Lymph Nodes Eval is coded as clinical or pathologic based on the intent of the procedure and matching the assessment of the T classification (coded in CS TS/Ext Eval). The intent can be either clinical/diagnostic or therapeutic.

When the lymph node procedure is part of the workup, the staging basis is clinical (CS Lymph Nodes Eval codes 0, 1, 5, 9). If the microscopic assessment (workup) of lymph nodes, such as a regional node biopsy or sentinel lymph node procedure, is intended to help choose the treatment plan, the information obtained is part of clinical staging. In these circumstances, the tumor size and/or extension (T-category) information is also clinical and any resection of the primary site does not meet the criteria for pathologic T classification.

When the intent of the lymph node procedure is therapeutic (treatment), the staging basis is pathologic (CS Reg Nodes Eval codes 2, 3, 6). In these circumstances, there is also a resection of the primary site that meets the criteria for pathologic T classification (also part of the treatment) or there is microscopic confirmation of the highest T category without a surgical resection of the primary site.

Example 1: Breast cancer patient diagnosed by mammography and core needle biopsy; axilla clinically negative. Patient opts for lumpectomy and sentinel node biopsy, which is negative for lymph node metastases. *Code CS Lymph Nodes Eval as 3 because the sentinel node biopsy was part of the treatment.*

Example 2: Large breast mass found to be cancerous on core needle biopsy. Fullness in axilla on physical examination. Sentinel node biopsy shows micrometastasis in one of three nodes.

Patient received neoadjuvant chemotherapy followed by modified radical mastectomy. On the mastectomy pathology report, no positive lymph nodes were found. *Code CS Lymph Nodes Eval as 5 because the sentinel node biopsy was performed as part of the workup and the patient received surgical treatment to primary site following neoadjuvant treatment.*

Example 3: Patient has hard lump in low neck and an endoscopic paratracheal node biopsy confirms metastatic lung cancer. Patient treated with chemoradiation. *Code CS Lymph Nodes Eval as1 because the endoscopic biopsy was part of the workup and patient did not have resection of the primary site.*

Example 4: Sigmoid colon cancer diagnosed by colonoscopy. At the time of resection, 3/15 pericolic lymph nodes were found to contain metastatic cancer. *Code CS Lymph Nodes Eval as 3because positive nodes were found as part of surgical resection of primary site.*

Example 5: Patient diagnosed with medullary thyroid carcinoma, and undergoes total thyroidectomy and anterior compartment node dissection. Node dissection finds 2 of 12 lymph nodes contain metastatic carcinoma. *Code CS Lymph Nodes Eval as 3 because the lymph nodes were part of the therapeutic resection of the primary site.*

Example 6: Patient has malignant melanoma on the forearm confirmed by shave biopsy. Patient has an FNA of an enlarged axillary lymph node that shows no involvement of the axillary lymph node by melanoma. Patient's treatment consists of wide excision of primary site. *Code CS Lymph Nodes Eval as 1 because the sentinel node biopsy was done to determine what type of treatment the patient should have.*

CS LYMPH NODES EVAL: Instructions for Coding

1. **Document the farthest involved regional nodes.**

a. Select the CS Lymph Nodes Eval code that identifies the type of report or procedure from which the information about the farthest involved regional lymph nodes was obtained. This may not be the numerically highest eval code.

Example: Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (CS LN code 100, Eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (CS LN code 320, Eval code 0). *Code CS Lymph Nodes Eval as 0 because the scalene node involvement was determined clinically rather than by examination of tissue.*

b. If there is a discrepancy between clinical and pathologic information about the same lymph node chain(s), **pathologic information takes priority**. It is not necessary to biopsy every node in the chain to prove that they are negative.

Example Lung cancer patient has a CT scan showing a mass of lymph nodes in the ipsilateral mediastinum. Biopsies at mediastinoscopy report that two ipsilateral mediastinal lymph nodes are negative for tumor. *Code CS Lymph Nodes as 000 and CS Lymph Nodes Eval as 1 because the mediastinoscopy disproved the clinically suspicious mediastinal nodes.*

c. **Mapping of N subcategories.** Select the CS Lymph Node Eval code that describes how the most advanced subcategory of the derived N was determined.
i. If a specific subcategory of N will be derived (such as N2b), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Lymph Node Eval code that will derive a "p" staging basis if the patient also has surgical resection of the primary site.

ii. If there was only clinical evidence of the subcategory disease, select a CS Lymph Node Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower N subcategory, but this is not considered in assigning the Eval code.

Example: Breast cancer patient with 10 of 14 axillary nodes positive at time of modified radical mastectomy (CS Lymph Nodes code 600, Site-specific Factor 3 code 010, maps to pN3a). Patient also has palpable hard supraclavicular node presumed to be involved by the clinician (CS Lymph Nodes code 800, maps to N3c). *Code CS Lymph Node Eval as 0 because the physical examination documented a higher N subcategory than the axillary dissection.*

2. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. For any sites that have no TNM mapping, code to the value that best identifies the diagnostic methods used, whether or not a stage group is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, for a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

3. Select the code that best explains how the information in the CS Lymph Nodes field was determined.

a. **If no lymph nodes are removed.** If the patient had no removal of lymph node(s), use code 0, 1, or 9.

Example: Prostate cancer with laparoscopic lymph node biopsy showing microscopically involved nodes; radical prostatectomy canceled. *Code CS Lymph Node Eval as 3. Staging algorithm will identify information as pathologic (p). According to AJCC, a positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.*

Example: Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. *Code CS Lymph Node Eval as 0. Staging algorithm will identify information as clinical (c).*

b. **Lymph nodes removed followed by other treatment(s).** If the patient had removal of lymph node(s) surgery together with removal of the primary site that meets the criteria for a pathologic T and these procedures are followed by other treatment(s), use code 3.

c. **When there is pre-operative treatment.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of lymph nodes takes precedence (code 5). If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.

d. **When there is more extensive lymph node involvement after preoperative treatment.** Use only code 5 or 6 if the node assessment is performed after neoadjuvant therapy. If the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is found during lymph node examination after neoadjuvant therapy, use code 6.

e. **Use of autopsy codes 2 and 8.** If the patient had an autopsy and the autopsy information meets the timing rules for determining regional lymph node involvement, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. **Definition of code 0**. Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Lymph Nodes is coded 000 based on the clinician's impression that there are no involved regional nodes (inaccessible nodes rule), use code 0 to document that met the criteria for a clinical M0.

Examples of imaging studies included in Code 0. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues. According to the *AJCC Cancer Staging Manual* seventh edition, extensive imaging is not necessary to assign a clinical staging basis.

5. **Use of code 1.** Codes 0-3 are oriented to the AJCC staging basis. Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.

For example, a needle biopsy of an axillary lymph node will document that a lymph node contains metastases from a breast cancer, but does not meet the requirement for removal of a sufficient number of lymph nodes so that the highest N stage can be assessed. For specific classification rules, refer to the *AJCC Cancer Staging Manual, seventh edition*. Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied. Code 1 is used when the lymph node procedure is part of the patient's workup to determine the course of treatment and the patient does not undergo resection of the primary site sufficient to meet the criteria for a pathologic T category.

6. **Use of code 3.** Code 3 maps to pathologic staging across all sites. Use code 3 when the lymph node procedure meets the requirements for pathologic staging basis of regional lymph nodes. The requirements vary among sites as to the location and number of lymph nodes involved, the size of the involved nodes, and other characteristics. For example, for prostate cancer, a positive fine needle aspiration biopsy of a single lymph node is sufficient to code CS Lymph Nodes Eval as code 3, because only one positive node is needed to classify the case as pN1 and there is only one positive N category (N1). In contrast, a fine needle aspiration of a hilar mass (N1) associated with a lung cancer should be coded in CS Lymph Nodes Eval as 1 because by itself it is not sufficient to document the highest N since there are three positive N categories. However, microscopic assessment of the

highest N category, for example a supraclavicular node containing metastatic lung cancer, is always pathologic (code 3).

7. **Sentinel nodes.** The coding guidelines for positive sentinel lymph nodes in CS Lymph Nodes Eval are site-specific. In general, however, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor or if the resection of the primary tumor is not adequate for pathologic T.

a. When the tumor size and/or extension of the primary tumor meets the criteria for pathologic staging and lymph nodes are biopsied or removed for examination, information on lymph nodes is considered pathologic and it is not necessary to document the highest N category.

Example: Patient has a lumpectomy and sentinel lymph node procedure for breast cancer. The margins around the primary tumor are clear, and there is one of three sentinel nodes positive for metastatic duct carcinoma. *Code CS Lymph Nodes Eval as 3 because when the primary tumor procedure meets the criteria for pathologic T and sentinel nodes meet the criteria for pathologic N.*

b. When the tumor size and/or extension of the primary tumor does not meet the criteria for pathologic staging, examination of a single lymph node or sentinel nodes is considered clinical.

Example: Patient presents with large ulcerated mass in the breast and clinically positive axillary nodes. Core needle biopsies of the breast mass and the axillary node confirm carcinoma. Patient undergoes pre-operative chemotherapy followed by a modified radical mastectomy. *Code CS Lymph Nodes Eval as 5 because when the primary tumor procedure does not meet the criteria for pathologic T, and a core needle biopsy of level I lymph nodes performed prior to neoadjuvant treatment is clinical.*

c. If there is a positive biopsy of a lymph node in the highest N category, CS Lymph Nodes Eval should be coded as 3 regardless of whether the primary tumor is clinical or pathologic.

Example: Patient presents with a hard supraclavicular mass, which is excised and shows metastatic squamous carcinoma. Further diagnostic workup shows a mass in the left upper lobe of the lung with several satellite nodules. *Code CS Lymph Nodes Eval as 3 because supraclavicular nodes are in the highest N category (N3).*

8. **Neoadjuvant therapy and 2nd primaries.** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

9. **Coding CS Lymph Nodes Eval when lymph node status is unknown.** The Eval fields should be

coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or Mets at Dx) is unknown. For example, even if it is not possible to determine lymph node involvement and the CS Lymph Nodes field is coded as 999, the registrar still knows what procedures were used to try to determine that field. In other words, just because the lymph nodes are coded 999, the Eval field does not have to be coded 9.

10. **The following schemas are always coded 9 Not Applicable or Does Not Apply:**
AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
Placenta
RespiratoryOther
SinusOther
Trachea
UrinaryOther

CS Lymph Nodes Eval Standard Table
Note: Remember to check individual schemas 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**	c

Code	Description	Staging Basis
	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).	
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 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 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. *See Note 1*.	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 ***For sites that have no TNM staging:*** 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 NODES POSITIVE: Instructions for Coding

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the "CS Mets at Dx" field.

a. Although all lymph node involvement (regional and distant) is coded in CS Lymph Nodes for Kaposi sarcoma, retinoblastoma and lymphoma ocular adnexa, only count positive regional lymph nodes in this field. Do not include distant nodes coded in CS Lymph Nodes. If CS Lymph Nodes is coded 800, assume these are regional and count in this field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

4. **Cumulative nodes positive.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

a. The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Definition of Code 95 below.

Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

Example: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. *Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.*

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected. (Code Reg Nodes Eval as 5.)*

7. **Definition of code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection “several” of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. *Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.*

Note: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1and therefore should be avoided.

Note: If the aspirated node is the only one that is microscopically positive, use code 95.

Note: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

8. **Use of code 98.** Code 98 may be used in several situations.

a. When the assessment of lymph nodes is clinical only.

b. When no lymph nodes are removed and examined.

c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

9. **Isolated tumor cells (ITCs) in lymph nodes.** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

a. **For cutaneous melanoma and Merkel cell carcinoma**, count nodes with ITCs as positive lymph nodes.

10. **Use of code 99.** Use code 99 if it is unknown whether regional lymph nodes are positive.

11. **Primary sites always coded 99.** For the following primary sites and histologies, the Regional Nodes
Positive field is always coded as 99.
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hodgkin and non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Myeloma and PlasmaCell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

Regional Lymph Nodes Positive Standard Table
Note: Remember to check individual schemas 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: Instructions for Coding

1. **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the "CS Mets at Dx" field.

a. Although all lymph node involvement (regional and distant) is coded in CS Lymph Nodes for

Kaposi sarcoma, retinoblastoma and lymphoma ocular adnexa, only count regional lymph nodes in this field. Do not include distant nodes coded in CS Lymph Nodes. If CS Lymph Nodes is coded 800, assume these are regional and count in this field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. **Use of code 00.** Code 00 may be used in several situations.
i. When the assessment of lymph nodes is clinical.
ii. When no lymph nodes are removed and examined.
iii. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
iv. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.

4. **Cumulative nodes removed and examined.** Record the total number of regional lymph nodes removed and examined by the pathologist.

a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.

b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an

axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95**. Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery.
Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.

7. **Lymph node biopsy.** If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. **Definition of "sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. **Definition of "dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures.** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

11. **Use of code 99.** If it is unknown whether nodes were removed or examined, code as 99.

12. **Primary sites always coded 99.** For the following schemas, the Regional Nodes Examined field is always coded as 99.
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Hodgkin and non-Hodgkin Lymphoma
Myeloma and Plasma Cell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

Regional Nodes Examined Standard Table
Note: Remember to check individual schemas 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: Instructions for Coding
1. **Discontinuous or hematogenous metastases.** This field represents distant metastases (the TNM M component or distant stage in Summary Staging) that are known at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or to a site remote from the primary tumor.

Note: The structure of the CS Mets at Dx field is based on the M category of TNM. In some schemas, there may be additional items in CS Extension or CS Lymph Nodes that map to distant stage in Summary Staging (1977 and/or 2000) and there may be some items in CS Mets at Dx that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

2. **Use highest applicable code.** Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy. Code 40 includes statements of metastases to specific named structures or "carcinomatosis." Code 60 is nonspecific distant metastases or a statement of M1 with no further information about metastases; code 60 does not take priority over lower codes.

3. **Progression of disease.** Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in the CS Mets at Dx field.

4. **Coding 00 versus 99**

a. Record CS Mets at Dx as Code 00 (None) if there is no clinical or pathologic evidence of distant metastases and the patient is not treated as if metastases are present or suspected. This presumes that there are no distant metastasis that would otherwise alter the treatment approach.

b. Code 99 may be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases. Note that code 99 maps to MX in sixth edition and cM0 in seventh edition.

c. Based on the *AJCC Cancer Staging Manual*, seventh edition, determination of the clinical M classification (CS Mets at Dx code 00) only requires history and physical examination. Imaging of distant organ sites is not required to assign cM0 or CS Mets at Dx code 00. In other words, the data collector can infer that there are no distant metastases and code CS Mets at Dx as 00 (cM0) unless distant metastases are identified and classified as cM1 or pM1 (or its equivalents in CS Mets at Dx). Use code 0 in CS Mets Eval as this documents minimal physical examination to support the inference of clinical M0.

5. **No MX classification for AJCC seventh edition.** The category MX has been eliminated from the seventh edition of the TNM staging system. As noted above, if there are no symptoms or other indication of distant metastases, the mapping algorithm takes CS Mets at Dx codes 00 and 99 and maps both to cM0.

6. **Inferring distant metastases from stated M category or site-specific staging.** If the only indication of distant metastases in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes D, code the appropriate "Stated as M_, NOS" category or record the numerically lowest equivalent CS Mets at Dx code for the site-specific staging system. In most cases, this will be 60, Distant metastasis, NOS.

a. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the M category stated by the physician.

7. **Use of NOS categories.** Some schemas include a designation of M1, NOS. The NOS is added when there is further breakdown of the category into subsets (such as M1a, M1b, M1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as M1 NOS" when the appropriate subset (such as M1a or M1b) cannot be determined.

8. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs).** CTCs and DTCs are small clusters of tumor cells found in distant sites such as bone, circulating blood, or bone marrow having uncertain prognostic significance.

a. For breast, code CS Mets at Dx as 05 when a biopsy of a possible metastatic site shows isolated tumor cells or bone marrow micrometastases detected by IHC or molecular techniques. CS Mets at Dx code 05 maps to cM0(i+).

b. For other sites, CTCs and DTCs are coded in CS Mets at Dx as 00 and map to cM0.

9. **Primary sites always coded 98.** For the following primary sites and histologies, CS Mets at Dx is always coded as 98.
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Hodgkin and non-Hodgkin Lymphoma
Kaposi Sarcoma
Myeloma and Plasma Cell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

10. **Document choice of code in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis codes be documented as well as the choice of code in a related text field on the abstract.

CS Mets at Dx Standard Table
Note: Remember to check individual schemas 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: Instructions for Coding

1. **Document the highest code in CS Mets at Dx.** The primary use of the CS Mets Eval field is to assign a "c" or "p" to the M category derived from the CS Mets at Dx field. Since both clinical and pathologic evidence might be available for assessing distant metastasis, the coding of the Eval field can be confusing. The goal is to assign the Eval code that indicates the best evidence used to determine the M category. In other words, the concept of the Mets Eval field is slightly different from the other Eval fields in that results of the procedure are coded, rather than the type of procedure that provided the information about distant metastasis. Coding of the Eval field therefore requires that the abstractor take note of the M category that will be derived from the code in the CS Mets at Dx field and then use the following guidelines to determine the best Eval code to assign.

a. **Deriving M0.** If M0 will be derived (i.e., no distant metastasis are present), select an Eval code that will derive a "c" staging basis. There is no category of pM0, because it is impossible to disprove all possible sites of metastasis pathologically. Therefore, do not assign CS Mets Eval code 2, 3, or 6 when CS Mets at DX is coded 00.

Example: Pancreatic carcinoma with negative chest X-ray and negative liver biopsy. Code CS Mets at Dx as 00 (None), which maps to M0. *Code CS Mets Eval as 1 to document the liver biopsy, which maps to the "c" staging basis.*

Example: Chest x-ray negative and surgical observation during hemicolectomy shows no liver metastasis. *Code CS Mets Eval as 1, because there was an invasive technique (surgery observation) that yielded a negative result.*

Example: CT scan indicates thickened stomach wall with normal liver, spleen, lung bases and impression states presumed gastric malignancy. Patient dies 2 days later from chronic renal failure. Autopsy confirms primary gastric adenocarcinoma with all other body systems normal. Code CS Mets Eval as 0 (imaging prior to death) as there is no category of pM0.

b. **Mapping of CS Mets at Dx code 99.** If the status of distant metastases is unknown (CS Mets at Dx code 99), choose an Eval code that will derive a "c" staging basis, because code 99 maps to M0 in TNM7, and this category can only be clinical. The appropriate code might be 9 (Unknown) in rare situations or might be another code if workup was done but the results were not definitively positive or negative.

Example: Cecum carcinoma abstracted from a pathology report of biopsy only, no clinical data

or surgical observations available. *Code CS Mets at Dx as 99 (Unknown), which will map to M0 in the seventh edition. Code CS Mets Eval as 9 (Unknown), which maps to the "c" staging basis.*

Example: Lung cancer diagnosed by imaging. Patient has behavior changes, and brain imaging cannot rule out metastases. Patient is not a surgical candidate. *Code CS Mets at Dx as 99 (Unknown), which maps to M0 in the seventh edition. Code CS Mets Eval as 0(imaging), which maps to the "c" staging basis.*

c. **Pathologic M1 takes priority.** If M1 will be derived (i.e., there is metastatic disease present and coded in the CS Mets at Dx field) and there are no subcategories of M1, such as M1a and M1b, then determine if there was any pathological evidence for the M1 category.
i. If there is microscopic confirmation of distant metastases, select an Eval code that will derive a "p" staging basis. In other words, any microscopic confirmation of a distant metastasis meets the criteria for pathologic M1.

Example: Patient with perforated stomach cancer. At surgery, peritoneal cytology is positive. CT scan shows multiple liver metastases. *Code CS Mets at Dx as 40for both the liver and peritoneal metastases, which maps to M1. (There are no subcategories of M1 for stomach). Code CS Mets Eval as 3 because any positive microscopic confirmation of distant metastases meets the criteria for pathologic staging of distant metastases.*

ii. If there was only clinical evidence of the M1 disease, select an Eval code that will derive a "c" staging basis.

Example: Patient diagnosed with kidney cancer and discharged to nursing home where she expired within two weeks of diagnosis. Discharge summary states bone metastases from kidney cancer as final diagnosis. There is no supporting documentation for the bone metastases in either the original hospital record or the nursing home record. *Code CS Mets Eval as 0 because the physicians' statement of bone metastases is part of "other non-invasive clinical evidence" in code 0 and maps to a clinical staging basis. Do not use code 9, because the presence of distant metastases was assessed by the clinician.*

d. **Mapping of M1 subcategories.** If a specific subcategory of M1 will be derived (such as M1a), determine if there was any pathological evidence for the specific subcategory. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the subcategory disease, select an Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower M subcategory, but this is not considered in assigning the Eval code.

Example 1 Prostate carcinoma with one or more of the following:

Involvement	CS Mets at Dx Code	TNM Map
Positive biopsy of aortic lymph node (distant node)	Code 12	pM1a
Positive bone imaging	Code 30	cM1b
Positive brain imaging	Code 40	cM1c
All of the above	Code 55 (=codes 12+30+40)	cM1c

To code CS Mets at Dx, follow the general rule to code the highest applicable code, even though there is pathological evidence of metastases. *Code CS Mets at Dx as 55, which combines the codes for the lymph node, bone, and brain involvement. Code 55 maps to M1c. There is no pathologic evidence for the subcategory M1c (the only pathological evidence is for subcategory M1a). Code CS Mets Eval as 0 (imaging), which maps to the "c" staging basis.* The positive lymph node would map to M1a, a lower M subcategory. Do not base the Eval code on positive microscopic findings for a lower subcategory.

Example 2: Prostate carcinoma with positive biopsy of aortic lymph node (distant node), negative bone scan, and negative brain scan. *Code CS Mets at Dx as 12 (distant lymph node), which maps to M1a. Code CS Mets Eval as 3, which maps to the "p" staging basis.*

Example 3: Testicular carcinoma patient has a positive pelvic lymph nodes on FNA (CS Mets at Dx code 11, maps to M1a). Patient has CT of brain showing distant metastases (CS Mets at Dx code 40, maps to M1b). *Code CS Mets Eval as 0 because the higher M subcategory was established by imaging.*

Example 4: Cecum carcinoma with lung metastases on chest X-ray and positive liver biopsy. CS Mets at Dx is coded 36 (Metastases to more than one distant organ), which maps to M1b. *Code CS Mets Eval as 0, which maps to the "c" staging basis because only one organ/site was microscopically proven.*

Example 5: Sigmoid adenocarcinoma with liver metastases on ultrasound and positive peritoneal nodule biopsy. CS Mets at Dx is coded 36 (Metastasis to peritoneum). *Code CS Mets Eval as 3, which maps to the "p" staging basis because although only one organ/site is microscopically confirmed, that one organ/site is the peritoneum (M1b).*

2. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Rule 9.) For any sites and histologies not listed there, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

3. **When there is neoadjuvant treatment.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of metastases at diagnosis takes precedence (code 5), unless the pathologic evidence is more extensive (code 6).

4. **Definition of code 0**. Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Mets at Dx is coded 00 based on the clinician's impression that there are no distant metastases, use code 0 to document that met the criteria for a clinical M0.

Examples of imaging studies included in Code 0. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET), spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

5. **Definition of Code 1.** Code 1 includes endoscopy and observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied as well as biopsies of distant sites that are negative.

6. **Definition of Code 3.** In general, any positive microscopic confirmation of a metastasis meets the criteria for pathologic staging. Therefore, a positive needle biopsy of a metastatic site is Eval Code 3.

Complete removal of a metastatic site is not required for pathologic staging.

7. **No pathologic M0.** AJCC does not recognize a pM0 category since it is not possible to microscopically rule out all possible metastatic sites. According to the *AJCC Cancer Staging Manual*, seventh edition, "A case where there are no symptoms or signs of metastases is classified as clinically M0. The only evaluation necessary to classify a case as clinically M0 is history and physical examination. It is not necessary to do extensive imaging studies to classify a case as clinically M0."

a. If there is no mention in the medical record of distant metastases, code CS Mets at Dx as 00 and CS Mets Eval as 0, which maps to cM0.

b. If there is evidence of metastases on physical examination, imaging, or exploratory surgery and there is no biopsy of the suspected metastatic site, code CS Mets at Dx appropriately (not 00 or 99) and CS Mets Eval with a code that maps to "c" staging basis. In general, such cases will map to cM1_.

c. If the patient has a biopsy or removal of a distant site and the pathology report is negative, generally use Eval code 1, because this does not meet the criteria for pathologic staging.

8. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs) in metastatic sites.** CTCs and DTCs, including bone marrow micrometastases, are clinical findings if detected by immunohistochemistry or molecular methods. The significance of these small clusters of tumor cells in distant sites is indeterminate. When identified, CTCs and DTCs are coded in CS Mets at Dx as 00 and CS Mets Eval should be assigned a code that maps to "c" staging basis. In general, such cases will map to cM0 or cM0(i+).

9. **Neoadjuvant therapy and 2nd primaries.** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully

treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

10. **Schemas always coded 9 Not Applicable.**
AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
RespiratoryOther
SinusOther
Trachea
UrinaryOther

CS Mets Eval Table
Note: Remember to check individual schemas for site-specific codes.

Code	Description	Staging Basis
0	**Does not meet criteria for AJCC pathologic staging of distant metastasis:** 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.	c
1	**Does not meet criteria for AJCC pathologic staging of distant metastasis:** 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.	**c**
2	**Meets criteria for AJCC pathologic staging of distant metastasis:**	p

Code	Description	Staging Basis
	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).	
3	**Meets criteria for AJCC pathologic staging of distant metastasis:** 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
5	**Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis:** Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.	c
6	**Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis:** Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence. *See Note 1*.	yp
8	**Meets criteria for AJCC autopsy (a) staging of distant metastasis:** Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.	a
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.