Skin C44.0, C44.2-C44.9
CS Site-Specific Factor 12
High Risk Features

Note 1: For AJCC 7 staging, the T category is not only dependent on tumor size but also on several high risk features that can upgrade the T assignment.

Note 2: Based on the information in the medical record, the registrar is required to count and code the number of high risk features (each feature equals 1 risk factor). If specific information is available about some but not all of the high risk features, count the number of features documented in the record.

Poorly differentiated/Undifferentiated (grade 3 or 4)
Depth greater than 2 millimeter (mm) thickness
Clark level IV or V
Perineural invasion
Primary site: skin of external ear (C44.2) OR skin of lip (hair-bearing, also called non-glabrous lip) (C44.0)

Note 3: Use codes 990, 991, and 992 only if no specific information is available about the high risk features (other than primary site), but the record contains a general statement about the presence of high risk features.

See page A-22

Code	Description
000	No high risk features
001	1 high risk feature
002	2 high risk features
003	3 high risk features
004	4 high risk features
005	5 high risk features
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
991	Stated as less than 2 high risk features
992	Stated as 2 or more high risk features
993	Stated as high risk features, NOS

Code	Description
999	Unknown or no information Not documented in patient record

Skin C44.0, C44.2-C44.9
CS Site-Specific Factor 16
Size of Lymph Nodes
Note: Code the largest diameter, whether measured clinically or pathologically, of any involved regional lymph node(s). Do not code the size of any nodes coded in CS Mets at DX.
See page A-23

Code	Description
000	No involved regional lymph nodes
001-979	001 - 979 millimeters (mm) (Exact size to nearest mm)
980	980 mm or larger
988	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 988 may result in an edit error.)
990	Microscopic focus or foci only and no size of focus given
991	Described as "less than 1 centimeter (cm)"
992	Described as "less than 2 cm" or "greater than 1 cm" or between 1 cm and 2 cm"
993	Described as "less than 3 cm" or "greater than 2 cm" or "between 2 cm and 3 cm"
994	Described as "less than 4 cm" or "greater than 3 cm" or "between 3 cm and 4 cm"
995	Described as "less than 5 cm" or "greater than 4 cm" or "between 4 cm and 5 cm"
996	Described as "less than 6 cm" or "greater than 5 cm" or "between 5 cm and 6 cm"
997	Described as "more than 6 cm"
999	Regional lymph node(s) involved, size not stated Unknown if regional lymph node(s) involved; Not documented in patient record

Skin Eyelid C44.1
CS Site-Specific Factor 6
Perineural Invasion

Note: Code the presence or absence of perineural invasion as documented in the pathology report. Use code 000 if histologic examination of primary site was performed, the pathology report is available for review, and perineural invasion is not mentioned.

Code	Description
000	Perineural invasion not present/not identified
010	Perineural invasion present/identified
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
997	Histologic examination of primary site performed, unknown results
998	No histologic examination of primary site
999	Unknown or no information Not documented in patient record

Merkel Cell Skin C44.0, C44.2-C44.9
CS Site-Specific Factor 3
Clinical Status of Lymph Node Mets

Note 1: AJCC defines microscopic lymph node metastases or "micrometastases" as those which are clinically inapparent by palpation and/or imaging but are pathologically positive. Micrometastases are diagnosed after sentinel or elective lymphadenectomy. "Macrometastases" are clinically detectable nodal metastases confirmed by therapeutic lymphadenectomy or needle biopsy.
Note 2: Assign code 000 if either there is no lymph node involvement (CS Lymph Nodes is coded 000), or there are in-transit metastases but no regional lymph node involvement (CS Lymph Nodes is coded 400).
Note 3: Assign code 000 if there are clinically apparent lymph node metastases but they are pathologically negative.
Note 4: Assign code 010 if lymph nodes are negative on palpation and/or imaging but are positive, including positive for isolated tumor cells (ITCs), on pathology.
Note 5: Assign code 010 if there is microscopic confirmation of lymph node metastases, including ITCs, but there is no documentation of the clinical status.
Note 6: Assign code 020 if there are clinically apparent lymph node metastases, whether they are confirmed by pathology or pathology is not performed.
See page A-21

Code	Description
000	No lymph node metastases; In-transit metastases **WITHOUT** regional lymph node involvement
010	Clinically occult lymph node metastases only (micrometastases) Isolated tumor cells (ITCs) only
020	Clinically apparent lymph node metastases (macrometastases)
988	Not applicable: Information not collected for this case; (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
999	Unknown if regional lymph nodes involved; Not documented in patient record

Note: See site-specific coding instructions for melanoma on page 95.

Melanoma Skin C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
Malignant Melanoma of Skin, Vulva, Penis, Scrotum
C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
CS Site-Specific Factor 1
Measured Thickness (Depth), Breslow's Measurement
Note: Code MEASURED THICKNESS (Depth) of tumor (Breslow's measurement), not size. Record actual measurement in hundredths of millimeters from the pathology report.
See page A-19

Code	Description
000	No mass/tumor found
001-979	0.01 - 9.79 millimeters Code exact measurement in HUNDREDTHS of millimeters. Examples: 001 0.01 millimeter 002 0.02 millimeters 010 0.1 millimeter 074 0.74 millimeters 100 1 millimeter 105 1.05 millimeters 979 9.79 millimeters
980	9.80 millimeters or larger
999	Microinvasion; microscopic focus or foci only and no depth given Not documented in patient record Unknown; depth not stated

Melanoma Skin C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
CS Site-Specific Factor 2
Ulceration
Note 1: Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon histopathological examination.
Note 2: If there is no documentation or no mention of ulceration in the pathology report, assume ulceration is not present and code 000.
See page A-21

Code	Description
000	No ulceration present

Code	Description
010	Ulceration present
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)
999	Unknown or no information Not documented in patient record

Melanoma Skin C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
CS Site-Specific Factor 3
Clinical Status of Lymph Node Mets

Note 1: AJCC defines microscopic lymph node metastases or "micrometastases" as those which are clinically inapparent by palpation and/or imaging but are pathologically positive. Micrometastases are diagnosed after sentinel or other node biopsy or elective lymphadenectomy. "Macrometastases" are clinically detectable nodal metastases confirmed by therapeutic lymphadenectomy or when nodal metastasis exhibits gross extracapsular extension.
Note 2: Use code 005 if nodes are described as clinically negative and are also negative on pathologic examination, or no pathologic examination is performed. Use code 010 if nodes are described as clinically negative but are positive on pathologic examination.
Note 3: Use codes 043-050 if nodes are described as clinically positive.
Note 4: Use code 150 to code information about nodal involvement with in transit satellite metastases. In transit metastasis without nodal involvement is coded to 100.
Note 5: Use code 999 if no information is available about the clinical evaluation of lymph nodes.
Note 6: Codes 043-050 and 150 are appropriate for cases with neoadjuvant treatment, where nodes are described as clinically positive before treatment but are shown to be either negative or positive on pathologic examination after treatment.
See page A-21

Code	Description
005	Clinically negative lymph node metastasis AND No pathologic examination performed Or unknown if pathologic examination performed Or nodes negative on pathologic examination
010	Clinically occult (microscopic) lymph node metastasis only (Nodes negative on clinical examination, positive on pathologic examination)
043	Clinically apparent nodal metastasis in 1 regional node

Code	Description
045	Clinically apparent nodal metastasis in 2-3 regional lymph nodes
048	Clinically apparent nodal metastasis in 4+ regional nodes
050	Clinically apparent nodal metastasis in regional node(s) but number not specified
100	Clinically apparent in transit metastasis only
150	Clinically apparent in transit metastasis and clinically apparent nodal metastasis (at least one node)
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)
999	Unknown if nodes are involved Unknown or no information Not documented in patient record

Melanoma Skin C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
CS Site-Specific Factor 4
Serum Lactate Dehydrogenase (LDH)

Note 1: Per AJCC, p. 334: "To confirm the elevated serum [lactate dehydrogenase] LDH for staging purposes, it is recommended to obtain two or more determinations obtained more than 24 [hours] h apart, since an elevated serum LDH on a single determination can be falsely positive as a result of hemolysis or other factors unrelated to melanoma metastases."

Note 2: Positive results from two laboratory tests are required to code a positive value in this field. If the first test is positive and the second test is negative, code the results as negative or within normal limits, unless an additional test with positive results is performed. If the first test is positive and there is no second test, record 998 if it is known that a second test was not performed; code 999 if there is no information about a second test. If the only test is negative or within normal limits, code the results from the single test.

Note 3: Record the range for the LDH value prior to treatment or within six weeks of diagnosis. Give priority to the first test performed. The information should be taken from the same test used to code CS Site-Specific Factors 5 and 6.

See page A-22

Code	Description
000	**CONVERTED AND CODE REUSED V0203** Prior to V0203 code defined as "Test not done, test was not ordered and was not performed". Cases converted to code 998 with V0203 and code 000 redefined as

Code	Description
	"Within normal limits". Within normal limits
010	Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay Stated as elevated, NOS
020	Range 2: 1.5 - 10 x upper limit of normal for LDH assay
030	Range 3: More than 10 x upper limit of normal for LDH assay
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Melanoma Skin C44.0-C44.9, C51.0-C51.2, C51.8-C51.9, C60.0-C60.2, C60.8-C60.9, C63.2
CS Site-Specific Factor 7
Primary Tumor Mitotic Count/Rate
Note 1: According to AJCC, p. 329, "Data from the AJCC Melanoma Staging Database demonstrated a highly significant correlation with increasing mitotic rate and declining survival rates, especially within thin melanoma subgroups."
Note 2: Mitotic rate/count is assessed on primary melanomas, based on the number of mitotic figures in one square millimeter (mm) surrounding either a "hot spot" with the most mitotic figures or a field with a representative mitosis.
Note 3: Record the mitotic rate/count as documented in the pathology report. Use code 999 if there is no documentation or no mention of mitotic rate in the pathology report.
See page A-22

Code	Description
000	0 mitoses per square millimeter (mm) Mitoses absent No mitoses present
001-010	1 - 10 mitoses/square mm; (Exact measurement in mitoses/square mm) Examples: 001 1 mitosis per square mm 002 2 mitoses per square mm

Code	Description
	010 10 mitoses per square mm
011	11 or more mitoses per square mm
990	Stated as "less than 1 mitosis/square mm" Stated as "nonmitogenic"
991	Stated as "at least 1 mitosis/square mm" Stated as "mitogenic"
996	Mitotic rate described with denominator other than square millimeter (mm)
997	Test performed, result not in chart Test performed, quantitative results not stated
998	No histologic examination of primary site.
999	Unknown or no information Not documented in patient record

This page left blank