Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 4
Radical Orchiectomy Performed
See page A-46

Code	Description
000	Radical orchiectomy not performed
010	Radical orchiectomy performed
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)
999	Unknown if radical orchiectomy performed

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 5
Size of Metastasis in Lymph Nodes
Note 1: If the only information on the size of the metastatic lymph node mass is the physician's assignment of the N category, assign code 010 for N1, 020 for N2, or 030 for N3.
Note 2: If extranodal extension is not described on the pathology report or pathologic assessment of regional lymph nodes is not performed, assume extranodal extension is not present.
Note 3: Do not code the size of any node coded in CS Mets at DX.
See page A-46

Code	Description
000	No lymph node metastasis
010	Lymph node metastasis mass 2 centimeter (cm) or less in greatest dimension **WITHOUT** pathologic extranodal extension of tumor (See Note 2) Stated as N1 with no other information on regional lymph nodes
020	Lymph node metastasis mass more than 2 cm but not more than 5 cm in greatest dimension **OR** pathologic extranodal extension of tumor Stated as N2 with no other information on regional lymph nodes
030	Lymph node metastasis mass more than 5 cm in greatest dimension Stated as N3 with no other information on regional lymph nodes
988	Not applicable: Information not collected for this case; (If this item is required by your standard setter, use of code 988 will result in an edit error.)

Code	Description
999	Regional lymph nodes involved, size of lymph node mass not stated Unknown if regional nodes involved Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 7
Pre-Orchiectomy Alpha Fetoprotein (AFP) Range
Note 1: Record the range of the alpha fetoprotein (AFP) test as documented in the patient record prior to orchiectomy and other treatment.
Note 2: Use the same laboratory test to record values for CS Site-Specific Factors 6 and 7.
Note 3: A lab value expressed in micrograms/liter (ug/L) is equivalent to the same value expressed in nanograms/milliliter (ng/ml).
Note 4: If the pre-orchiectomy AFP test is unavailable but a physician's statement of the result is documented, use codes 991-993.
Note 5: For rare cases that are treated prior to orchiectomy, use code 995 in this field and record the initial AFP range in CS Site-Specific Factor 13.
Note 6: For rare cases that an orchiectomy is not performed, use code 996 in this field and record the initial AFP range in CS Site-Specific Factor 13.
See page A-50

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 1,000 nanograms/milliliter (ng/ml)
020	Range 2 (S2) 1,000 -10,000 ng/ml
030	Range 3 (S3) greater than 10,000 ng/ml
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
991	Pre-orchiectomy alpha fetoprotein (AFP) stated to be elevated
992	Pre-orchiectomy AFP unknown but preorchiectomy serum tumor markers NOS stated to be normal
993	Pre-orchiectomy AFP unknown but preorchiectomy serum tumor markers NOS stated to be elevated

Code	Description
995	Pretreated case, initial AFP range recorded in CS Site-Specific Factor 13
996	No orchiectomy performed, initial AFP range recorded in CS Site-Specific Factor 13
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 9
Pre-Orchiectomy Human Chorionic Gonadotropin (hCG) Range
Note 1: Record the range of the human chorionic gonadotropin (hCG) test as documented in the patient record prior to orchiectomy and other treatment.
Note 2: Use the same laboratory test to record values in CS Site-Specific Factors 8 and 9.
Note 3: A lab value expressed in International Units/liter (IU/L) is equivalent to the same value expressed in milli-International Units/milliliter (mIU/ml).
Note 4: If the pre-orchiectomy hCG test is unavailable but a physician's statement of the result is documented, use codes 991-993.
Note 5: For rare cases that are treated prior to orchiectomy, use code 995 in this field and record the initial hCG range in CS Site-Specific Factor 15.
Note 6: For rare cases that an orchiectomy is not performed, use code 996 in this field and record the initial hCG range in CS Site-Specific Factor 15.
See page A-52

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 5,000 milli-International Units/milliliter (mIU/ml)
020	Range 2 (S2) 5,000 - 50,000 mIU/ml
030	Range 3 (S3) greater than 50,000 mIU/ml
988	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 988 may result in an edit error.)

Code	Description
991	Pre-orchiectomy human chorionic gonadotropin (hCG) stated to be elevated
992	Pre-orchiectomy hCG unknown but preorchiectomy serum tumor markers NOS stated to be normal
993	Pre-orchiectomy hCG unknown but preorchiectomy serum tumor markers NOS stated to be elevated
995	Pretreated case, initial hCG range recorded in CS Site-Specific Factor 15
996	No orchiectomy performed, initial hCG range recorded in CS Site-Specific Factor 15
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed
999	Unknown or no information; Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 10
Pre-Orchiectomy Lactate Dehydrogenase (LDH) Range
Note 1: Of the three tumor markers, lactate dehydrogenase (LDH) is the least specific for testicular cancer and is more of a determinant of bulky or disseminated disease. Although recommended to be tested, LDH may not be routinely performed, especially if the primary is localized.
Note 2: Record the range of the LDH test as documented in the patient record prior to orchiectomy and other treatment.
Note 3: If the pre-orchiectomy LDH test is unavailable but a physician's statement of the result is documented, use codes 991-993.
Note 4: For rare cases that are treated prior to orchiectomy, use code 995 in this field and record the initial LDH range in CS Site-Specific Factor 16.
Note 5: For rare cases that an orchiectomy is not performed, use code 996 in this field and record the initial LDH range in CS Site-Specific Factor 16.
See page A-54

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)

Code	Description
020	Range 2 (S2) 1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
030	Range 3 (S3) greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
991	Pre-orchiectomy LDH stated to be elevated
992	Pre-orchiectomy LDH unknown but preorchiectomy serum tumor markers NOS stated to be normal
993	Pre-orchiectomy LDH unknown but preorchiectomy serum tumor markers NOS stated to be elevated
995	Pretreated case, initial LDH range recorded in CS Site-Specific Factor 16
996	No orchiectomy performed, initial LDH range recorded in CS Site-Specific Factor 16
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 13
Post-Orchiectomy Alpha Fetoprotein (AFP) Range
Note 1: Record the range of the alpha fetoprotein (AFP) test as documented in the patient record after orchiectomy and prior to further treatment.
Note 2: Use the same laboratory test to record values for CS Site-Specific Factors 12 and 13.
Note 3: A lab value expressed in micrograms/liter (ug/L) is equivalent to the same value expressed in nanograms/milliliter (ng/ml).
Note 4: If the initial post-orchiectomy AFP test remains elevated, review the subsequent tests until normalization or plateau occurs and use that test to code this field. See Part I for further explanation of serum tumor marker half life.
Note 5: If the post-orchiectomy AFP test is unknown but the preorchiectomy AFP test was normal, use code 990.

Note 6: If the post-orchiectomy AFP test is unavailable but a physician's statement of the result is documented, use codes 991-993.
Note 7: For rare cases that are treated prior to orchiectomy or an orchiectomy is not performed, code the initial AFP range in this field and not in CS Site-Specific Factor 7.
See page A-51

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 1,000 nanograms/milliliter (ng/ml)
020	Range 2 (S2) 1,000 -10,000 ng/ml
030	Range 3 (S3) greater than 10,000 ng/ml
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
990	Post-orchiectomy alpha fetoprotein (AFP) unknown but preorchiectomy AFP was normal
991	Post-orchiectomy AFP stated to be still elevated
992	Post-orchiectomy AFP unknown but post-orchiectomy serum tumor markers NOS stated to be normal
993	Post-orchiectomy AFP unknown but post-orchiectomy serum tumor markers NOS stated to be still elevated Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 15
Post-Orchiectomy Human Chorionic Gonadotropin (hCG) Range
Note 1: Record the range of the human chorionic gonadotropin (hCG) test as documented in the patient record after orchiectomy and prior to further treatment.
Note 2: Use the same laboratory test to record values in CS Site-Specific Factors 14 and 15.
Note 3: A lab value expressed in International Units/liter (IU/L) is equivalent to the same value

expressed in milli-International Units/milliliter (mIU/ml).

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

Note 5: If the post-orchiectomy hCG test is unknown but the preorchiectomy hCG test was normal, use code 990.

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

Note 7: For rare cases that are treated prior to orchiectomy or an orchiectomy is not performed, code the initial hCG range in this field and not in CS Site-Specific Factor 9.

See page A-53

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) above normal and less than 5,000 milli-International Units/milliliter (mIU/ml)
020	Range 2 (S2) 5,000 - 50,000 mIU/ml
030	Range 3 (S3) greater than 50,000 mIU/ml
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
990	Post-orchiectomy human chorionic gonadotropic (hCG) unknown but preorchiectomy hCG was normal
991	Post-orchiectomy hCG stated to be still elevated
992	Post-orchiectomy hCG unknown but post-orchiectomy serum tumor markers NOS stated to be normal
993	Post-orchiectomy hCG unknown but post-orchiectomy serum tumor markers NOS stated to be still elevated Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information; Not documented in patient record

Testis C62.0-C62.1, C62.9
CS Site-Specific Factor 16
Post-Orchiectomy Lactate Dehydrogenase (LDH) Range

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

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

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

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

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

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

See page A-54

Code	Description
000	Within normal limits (S0)
010	Range 1 (S1) less than 1.5 x N (Less than 1.5 times the upper limit of normal for LDH)
020	Range 2 (S2) 1.5 to 10 x N (Between 1.5 and 10 times the upper limit of normal for LDH)
030	Range 3 (S3) greater than 10 x N (Greater than 10 times the upper limit of normal for LDH)
988	Not applicable: Information not collected for this case; (If this information is required by your standard setter, use of code 988 may result in an edit error.)
990	Postorchiectomy LDH unknown but preorchiectomy LDH was normal
991	Postorchiectomy LDH stated to be still elevated
992	Postorchiectomy LDH unknown but post-orchiectomy serum tumor markers NOS stated to be normal
993	Postorchiectomy LDH unknown but postorchiectomy serum tumor markers NOS

Code	Description
	stated to be still elevated Stated as Stage IS
997	Test ordered, results not in chart
998	Test not done (test not ordered and not performed)
999	Unknown or no information Not documented in patient record

Scrotum C63.2
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 category.

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 millimeters (mm) thickness
Clark level IV or V
Perineural invasion

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

Note 4: The definition of high risk features was changed with the release of CSv2:V0203: Lymph-vascular invasion was removed as a high-risk feature, and tumor depth was changed from greater than or equal to 4mm to greater than 2mm. All cases with codes 000-004 coded in or updated to CSv2:V0202 should be reviewed and the correct number of high-risk features determined and coded.

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
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
998	No histologic examination of primary site
999	Unknown or no information Not documented in patient record

Scrotum C63.2
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"

Code	Description
999	Regional lymph node(s) involved, size not stated Unknown if regional lymph node(s) involved Not documented in patient record

Merkel Cell Scrotum 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 needle biopsy or therapeutic lymphadenectomy.
Note 2: Use codes 005 or 010 if nodes are described as clinically negative. Use code 020 if nodes are described as clinically positive.
Note 3: Use code 999 if no information is available about clinical nodal involvement.
See page A-21

Code	Description
005	Clinically negative lymph node metastases AND No pathologic examination performed Or unknown if pathologic examination performed or nodes negative on pathologic examination
010	Clinically occult lymph node metastases only (micrometastases) Isolated tumor cells (ITCs) only
020	Clinically apparent lymph node metastases (macrometastases)
100	Clinically apparent in transit metastasis only
150	Clinically apparent in transit metastasis and clinically apparent nodal metastasis
999	Unknown clinically if regional lymph nodes involved Unknown or no information about clinical nodal involvement Clinical nodal involvement not documented in patient record