Coding Guidelines
Breast
C500 -C509

Primary Site

C500 Nipple (areolar)
Paget disease without underlying tumor

C501 Central portion of breast (subareolar) area extending 1 cm around areolar complex
Retroareolar
Infraareolar
Next to areola, NOS
Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
Paget disease with underlying tumor

C502 Upper inner quadrant (UIQ) of breast
Superior medial
Upper medial
Superior inner

C503 Lower inner quadrant (LIQ) of breast
Inferior medial
Lower medial
Inferior inner

C504 Upper outer quadrant (UOQ) of breast
Superior lateral
Superior outer
Upper lateral

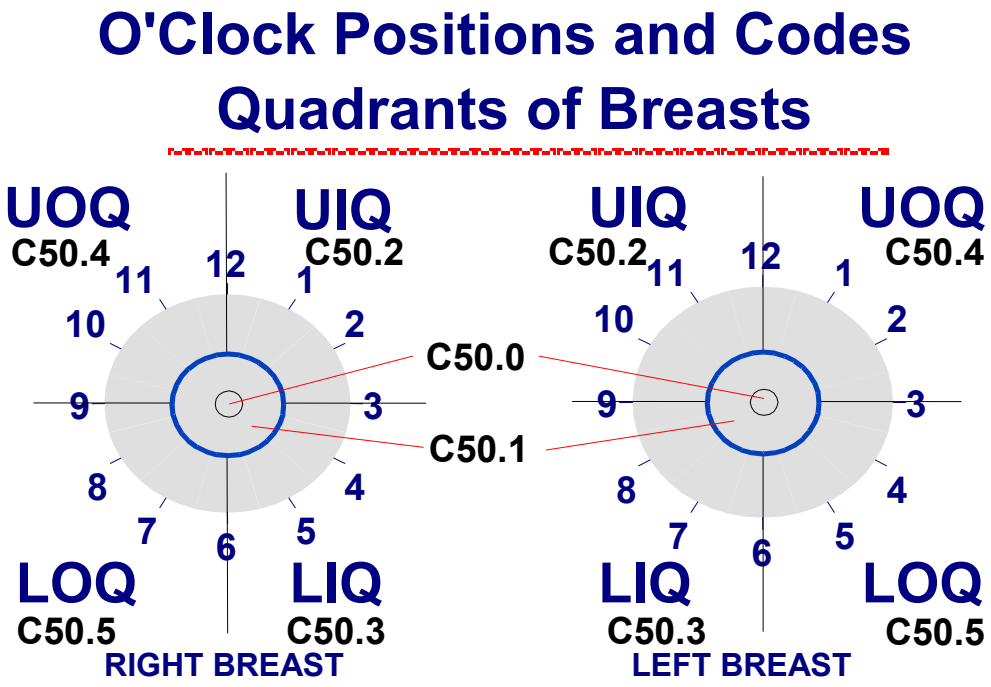
C505 Lower outer quadrant (LOQ) of breast
Inferior lateral
Inferior outer
Lower lateral

C506 Axillary tail of breast
Tail of breast, NOS
Tail of Spence

C508 Overlapping lesion of breast
Inferior breast, NOS
Inner breast, NOS
Lateral breast, NOS
Lower breast, NOS
Medial breast, NOS
Midline breast NOS
Outer breast NOS
Superior breast, NOS
Upper breast, NOS
3:00, 6:00, 9:00, 12:00 o'clock

C509 Breast, NOS
Entire breast
Multiple tumors in different subsites within breast
Inflammatory without palpable mass
¾ or more of breast involved with tumor
Diffuse (tumor size 998)

Additional Subsite Descriptors
The position of the tumor in the breast may be described as the positions on a clock



Priority Order for Coding Subsites
Use the information from reports in the following priority order to code a subsite contains conflicting information:

1. Pathology report
2. Operative report
3. Physical examination
4. Mammogram, ultrasound

If the pathology proves invasive tumor in one subsite and insitu tumor in all other involved subsites, code to the subsite involved with invasive tumor

When to Use Subsites 8 and 9

1. Code the primary site to C508 when there is a single tumor that overlaps two or more subsites, and the subsite in which the tumor originated is unknown
2. Code the primary site to C508 when there is a single tumor located at the 12, 3, 6, or 9 o'clock position on the breast
3. Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast

Grade

Convert BR Score/Grade to SEER Code

Use the table below to convert BR **score, grade or terminology** to SEER code.

BR Scores	BR Grade	Nuclear Grade	Terminology	Histologic Grade	SEER Code
3-5	Low	1/3; 1/2	Well differentiated	I, I/III, 1/3	1
6, 7	Intermediate	2/3	Moderately differentiated	II, II/III; 2/3	2
8, 9	High	2/2; 3/3	Poorly differentiated	III, III/III, 3/3	3
---	---	4/4	Undifferentiated/anaplastic	IV, IV/IV, 4/4	4

Priority Rules for Grading Breast Cancer

Code the tumor grade using the following priority order:

1. Bloom-Richardson (Nottingham) scores 3-9 converted to grade (see conversion table below)
2. Bloom Richardson grade (low, intermediate, high)
3. Nuclear grade only
4. Terminology
5. Differentiation (well differentiated, moderately differentiated, etc)
6. Histologic grade
7. Grade i, grade ii, grade iii, grade iv
8. Bloom-Richardson (BR)

BR may also be called: modified Bloom-Richardson, Scarff-Bloom-Richardson, SBR grading, BR grading, Elston-Ellis modification of Bloom Richardson score, the Nottingham modification of Bloom Richardson score, Nottingham-Tenovus, or Nottingham grade

BR may be expressed in scores (range 3-9)
The score is based on three morphologic features of "invasive no-special-type" breast cancers (degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism of tumor cells)
Use the following table to convert the score into SEER code

BR may be expressed as a grade (low, intermediate, high)
BR grade is derived from the BR score
For cases diagnosed 1996 and later, use the following table to convert the BR grade into SEER code (Note that the conversion of low, intermediate, and high is different from the conversion used for all other tumors).

Laterality

Laterality must be coded for all subsites.

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Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Equivalent or Equal Terms

- And, with (used in histology rules, i.e. duct and lobular is equivalent to duct with lobular)
- Duct, ductal
- Mammary, breast
- Mucinous, colloid
- NOS, NST
- Tumor, mass, lesion, neoplasm

Synonyms for "in situ"

- Behavior code '2'
- DCIS
- Intracystic
- Intraductal
- Noninfiltrating
- Noninvasive

Definitions

Carcinoma with osteoclast-like giant cells (8035): This is a specific type of **duct** carcinoma. The carcinomatous part of the lesion is most commonly an infiltrating duct carcinoma.

Ductular carcinoma (8521): A malignancy that is infrequently found in the breast and may be found with greater frequency in other organs such as pancreas or prostate. Code 8521 is seldom, if ever, applied to the breast. Although the ICD-O-3 suggests that 8521 is a site-associated code; the addition of (C50._) after this code may be misleading. The WHO Histological Classification of Tumours of the Breast does not list 8521, ductular carcinoma.

Duct carcinoma, NOS (8500): The largest group of breast cancers. Duct carcinoma, NOS is not a specific histologic type because it lacks specific features that can be used to better classify the tumor. See Table 1 and Table 2 for intraductal and duct types.

Breast Equivalent Terms, Definitions, Tables and Illustrations
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Inflammatory breast carcinoma (IBC): A breast cancer with a distinctive clinical presentation believed to be due to lymphatic obstruction from an underlying invasive adenocarcinoma. The vast majority of cases have a prominent dermal lymphatic infiltration by tumor. Dermal lymphatic infiltration without the characteristic clinical picture is insufficient to qualify as inflammatory carcinoma.

Intracystic carcinoma/Intracystic papillary carcinoma: Variant of intraductal carcinoma used to describe encysted forms of papillary carcinoma. Code intracystic carcinoma as in situ /2 unless the histology is described as invasive intracystic carcinoma.

In Situ: A tumor that is confined to the duct system (ductular or lobular) and does not invade surrounding stroma.

Invasive: A tumor that penetrates beyond the ductal basement membrane into the adjacent stroma of the breast parenchyma.

Lobular Carcinoma: Lobular carcinoma includes solid and alveolar patterns. About 5 to 10% of breast cancers are lobular. There is about a 20% chance that the opposite breast will also be involved, and many of them arise multicentrically in the same breast.

Paget Disease: Paget disease of the nipple is a condition where the epidermis of the nipple is infiltrated with neoplastic cells. ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). Under the matrix system, only if the Paget disease is explicitly specified as in situ or non-invasive by the pathologist, code the behavior in situ (/2).

Phyllodes tumor (cystosarcoma phyllodes): A rare tumor with incidence ranging from 0.3% to 0.9% of all breast cancers. These tumors have a natural history and clinical behavior different from carcinoma of the breast. Criteria to classify benign, borderline and malignant cystosarcoma phyllodes utilize histologic parameters such as cellular atypia, mitotic activity and tumor margins. The reported incidence of malignant cystosarcoma phyllodes is approximately 25% of all phyllodes tumors.

Pleomorphic carcinoma (8022): This is a specific **duct** carcinoma type; A rare variant of high grade ductal carcinoma, NOS.

Sarcoma of breast: Primary sarcomas of the breast are rare accounting for less than 0.1% of all malignant tumors of the breast. Diagnoses may include fibrosarcoma, angiosarcoma, pleomorphic sarcoma, leiomyosarcoma, myxofibrosarcoma, hemangio-pericytoma, and osteosarcoma (extra-osseous osteosarcoma of breast).

Scirrhous Carcinoma: An adenocarcinoma with a firm-hard nodule associated with a dense connective tissue in the stroma. Scirrhous carcinoma is descriptive term, not a specific type of ductal carcinoma.

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Table 1 – Intraductal(8500/2) and Specific Intraductal Carcinomas

***Note*:** These are the most common specific intraductal carcinomas**.** This is not intended to be a complete list of all possible intraductal types. If a histology appears only on table 1, it does not mean that it is impossible for that histology to occur with a malignant behavior (/3).

Column 1: Code	Column 2: Type
8201	Cribriform
8230	Solid
8401	Apocrine
8500	Intraductal, NOS
8501	Comedo
8503	Papillary
8504	Intracystic carcinoma
8507	Micropapillary/Clinging

Table 2 – Duct (8500/3) and Specific Duct Carcinomas

***Note*:** These are the most common specific duct carcinomas**.** This is not intended to be a complete list of all possible duct types. If a histology appears only on table 2, it does not mean that it is impossible for that histology to occur with an in situ behavior (/2).

Column 1: Code	Column 2: Type
8022	Pleomorphic carcinoma
8035	Carcinoma with osteoclast-like giant cells
8500	Duct, NOS
8501	Comedocarcinoma
8502	Secretory carcinoma of breast
8503	Intraductal papillary adenocarcinoma with invasion
8508	Cystic hypersecretory carcinoma

Breast Equivalent Terms, Definitions, Tables and Illustrations
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Table 3 – Combination Codes for Breast Cancers

Use this **two-page** table with rules H5, H6, H7, H8, H16, H17, H18, H19, H24, H25, H26 and H28 to select combination histology codes. Compare the terms in the diagnosis to the terms in Columns 1 and 2. If the terms match, code the case using the ICD-O-3 histology code in column 4. Use the combination codes listed in this table only when the histologies in the tumor match the histologies listed below.

Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Any combination excluding lobular and duct histologies from Tables 1 and 2	Other than ductal and lobular	Adenocarcinoma with mixed subtypes*	8255/3*
Intraductal carcinoma and	Lobular carcinoma in situ	Intraductal carcinoma and lobular carcinoma in situ	8522/2
Infiltrating duct and	Infiltrating lobular carcinoma	Infiltrating duct and lobular carcinoma	8522/3
Intraductal and **two or more** of the histologies in Column 2 OR **two or more** of the histologies in Column 2	Cribriform	Intraductal mixed with other types of carcinoma	8523/2
	Solid		
	Apocrine		
	Papillary		
	Micropapillary		
	Clinging		
Infiltrating duct and **one or more** of the histologies in Column 2	Tubular	Infiltrating duct mixed with other types of carcinoma	8523/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		

Table 3 continues on the next page

Breast Equivalent Terms, Definitions, Tables and Illustrations
C500-C509
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Column 1: Required Histology	Column 2: Combined with Histology	Column 3: Combination Term	Column 4: Code
Table 3 continued			
Infiltrating lobular carcinoma and	Tubular	Infiltrating lobular mixed with other types of carcinoma ***Note:*** Invasive carcinomas only. Do not use this code for in situ	8524/3
	Apocrine		
	Mucinous		
	Secretory carcinoma		
	Intraductal papillary adenocarcinoma with invasion		
	Intracystic carcinoma, NOS		
	Medullary		
	Paget disease (NOS and invasive)		
Paget disease and	Infiltrating duct carcinoma (includes any specific duct type listed in Table 2	Paget disease and infiltrating duct carcinoma	8541/3
Paget disease and	Intraductal carcinoma (includes any specific intraductal type in Table 1)	Paget disease and intraductal carcinoma	8543/3

**Rarely used for breast cancer*

Breast Equivalent Terms, Definitions, Tables and Illustrations
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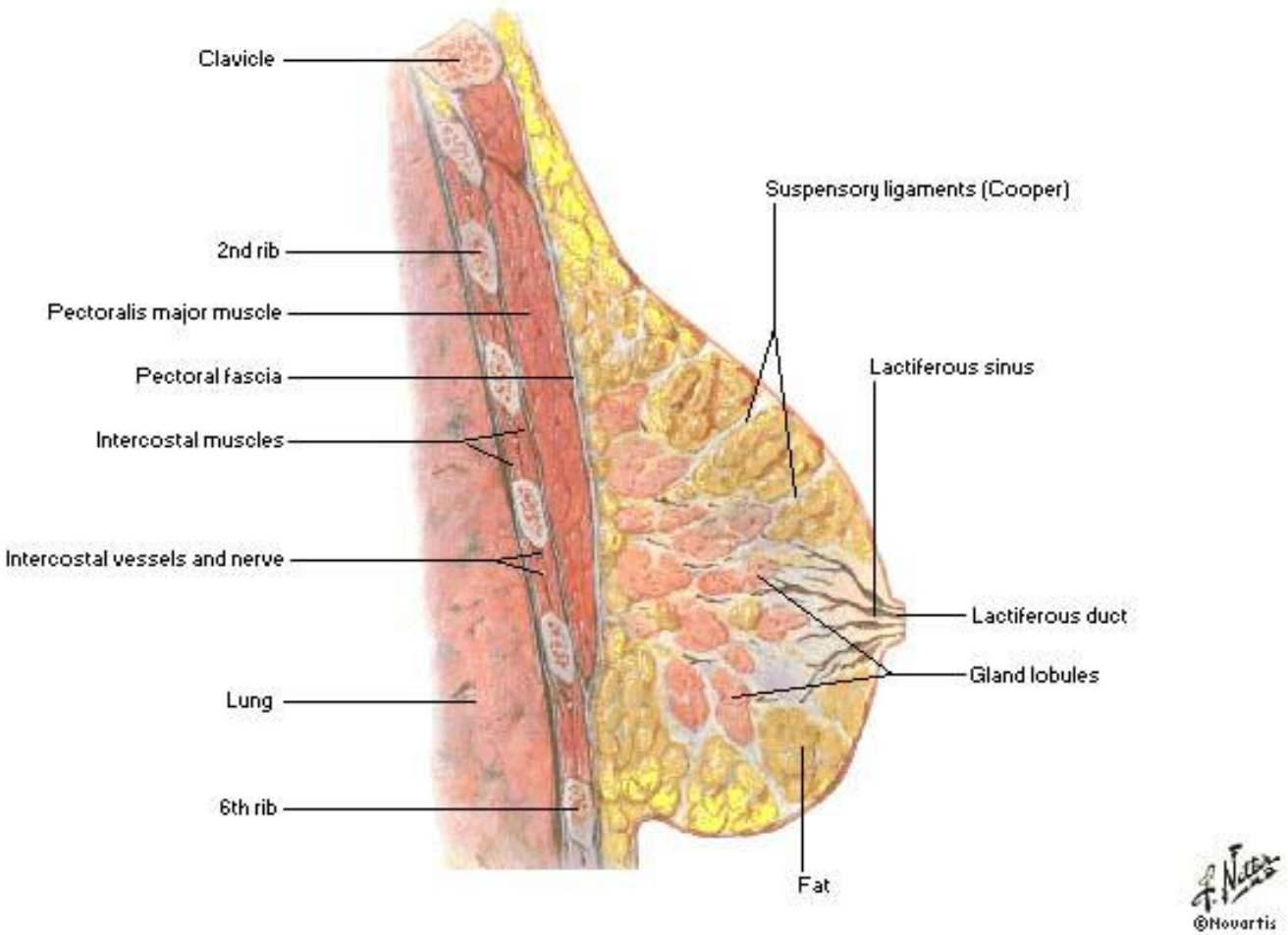

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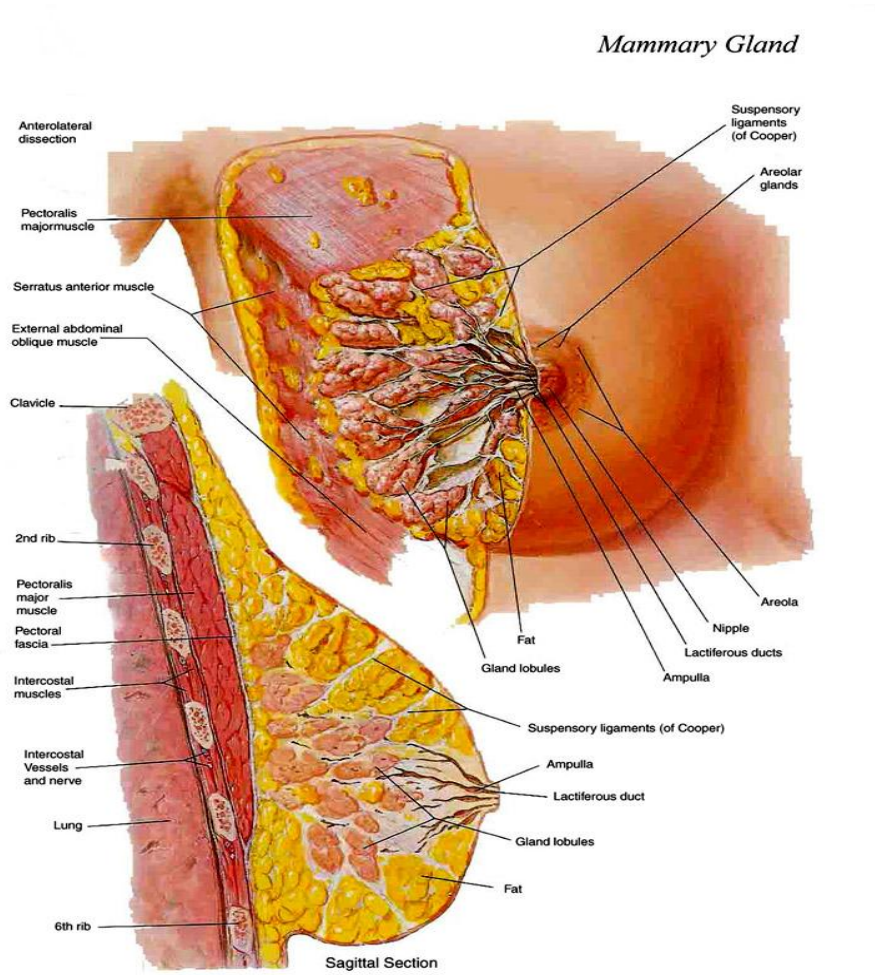

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Breast Terms and Definitions

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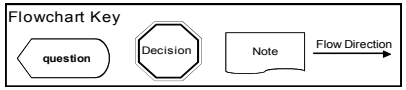
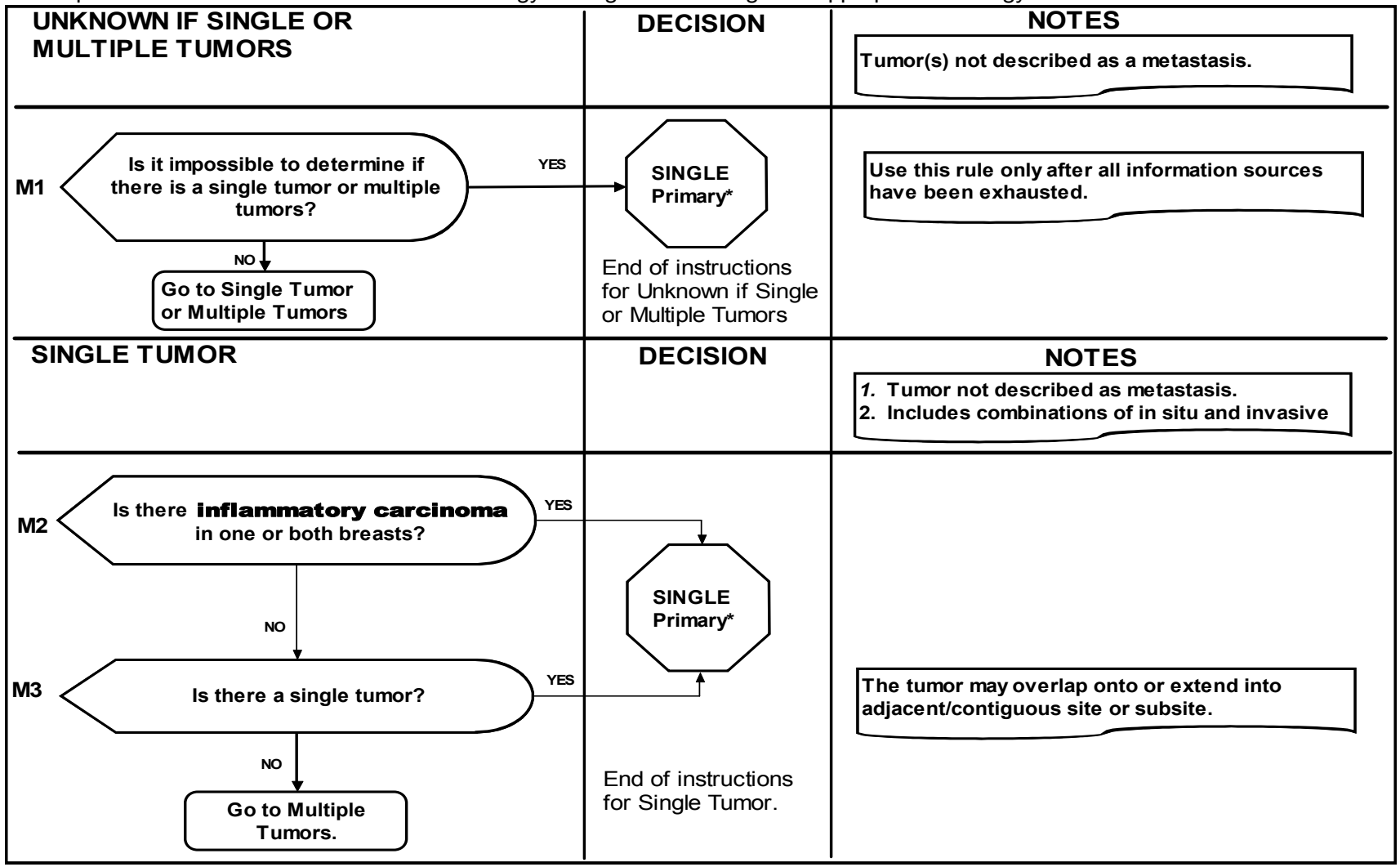
Breast Multiple Primary Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.



Breast Multiple Primary Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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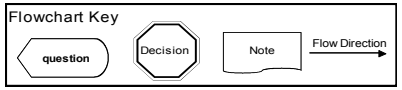

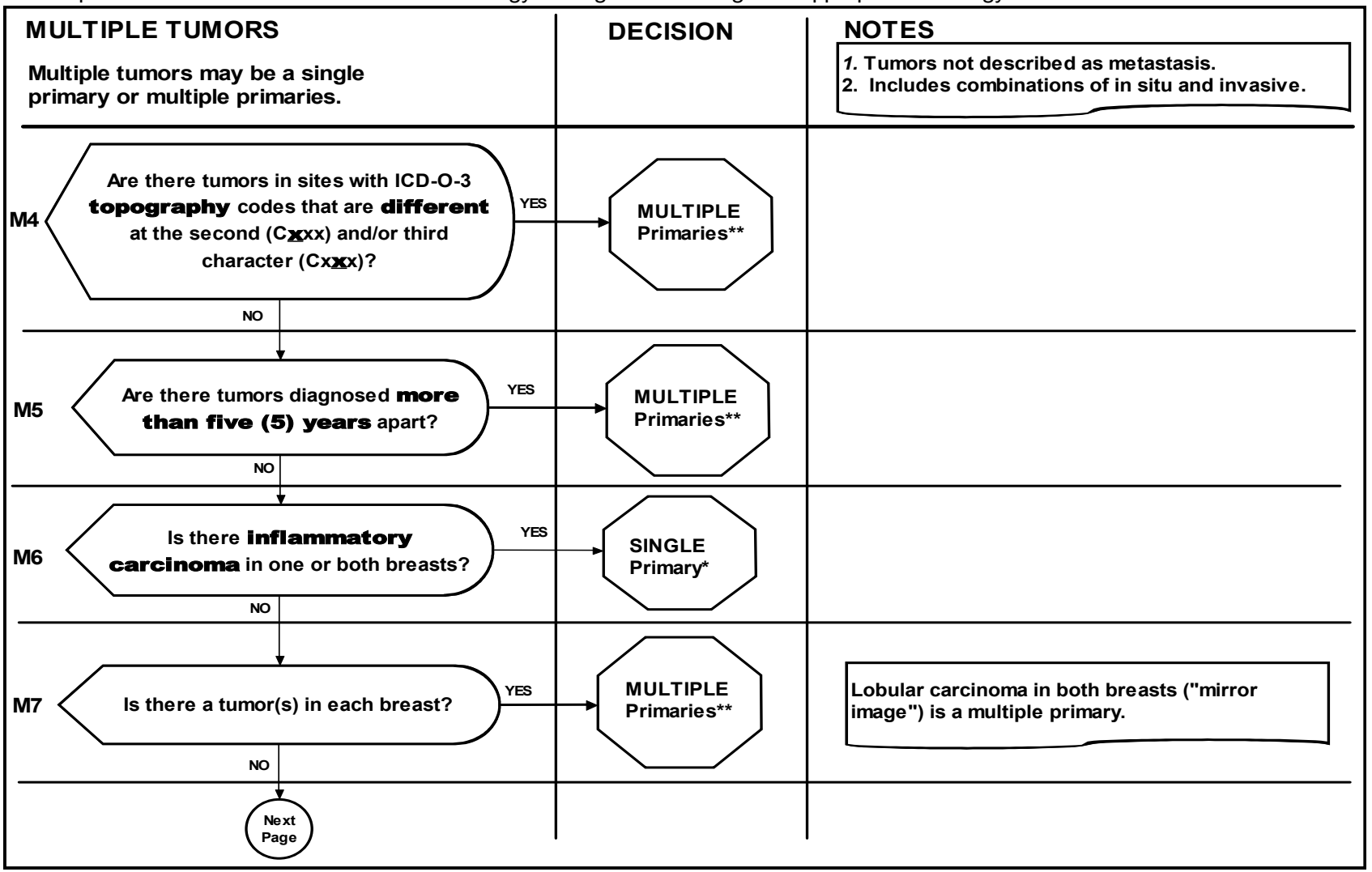

Breast Multiple Primary Rules - Flowchart

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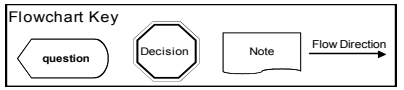

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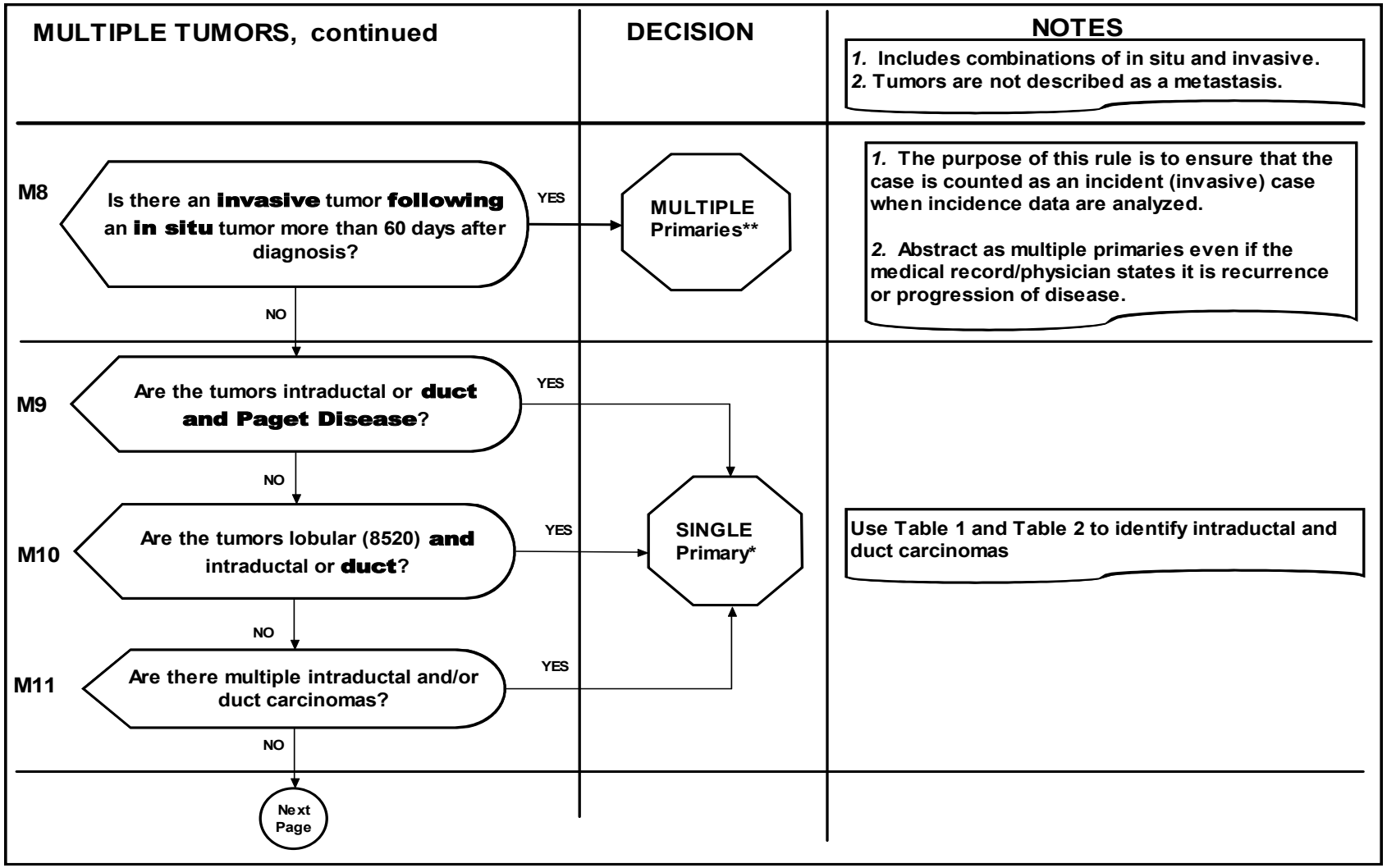
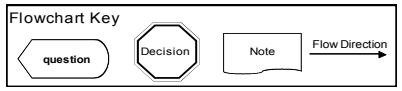


Breast MP

Breast Multiple Primary Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

MULTIPLE TUMORS, continued

M12

Do the tumors have ICD-O-3 histology codes that are different at the first (Xxxx), second (xXxx), or third (xxXx) number?

YES → **MULTIPLE Primaries****

NO

M13

Does not meet any of the above criteria (M1 through M12).

YES → **SINGLE Primary***

NO → **ERROR: Recheck rules. Stop when a match is found.**

End of instructions for Multiple Tumors.

DECISION

NOTES

1. **Includes combinations of in situ and invasive.**
2. **Tumors are not described as a metastasis.**

1. **When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.**

2. **All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code.**

Rule M13 Examples: The following are examples of cases that use Rule M13.
This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary.
Warning: **Using only these case examples to determine the number of primaries can result in major errors.**

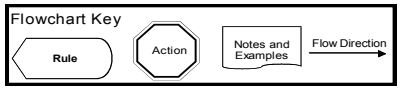
Example 1. Invasive duct and intraductal carcinoma in the same breast	Example 2. Multicentric lobular carcinoma, left breast

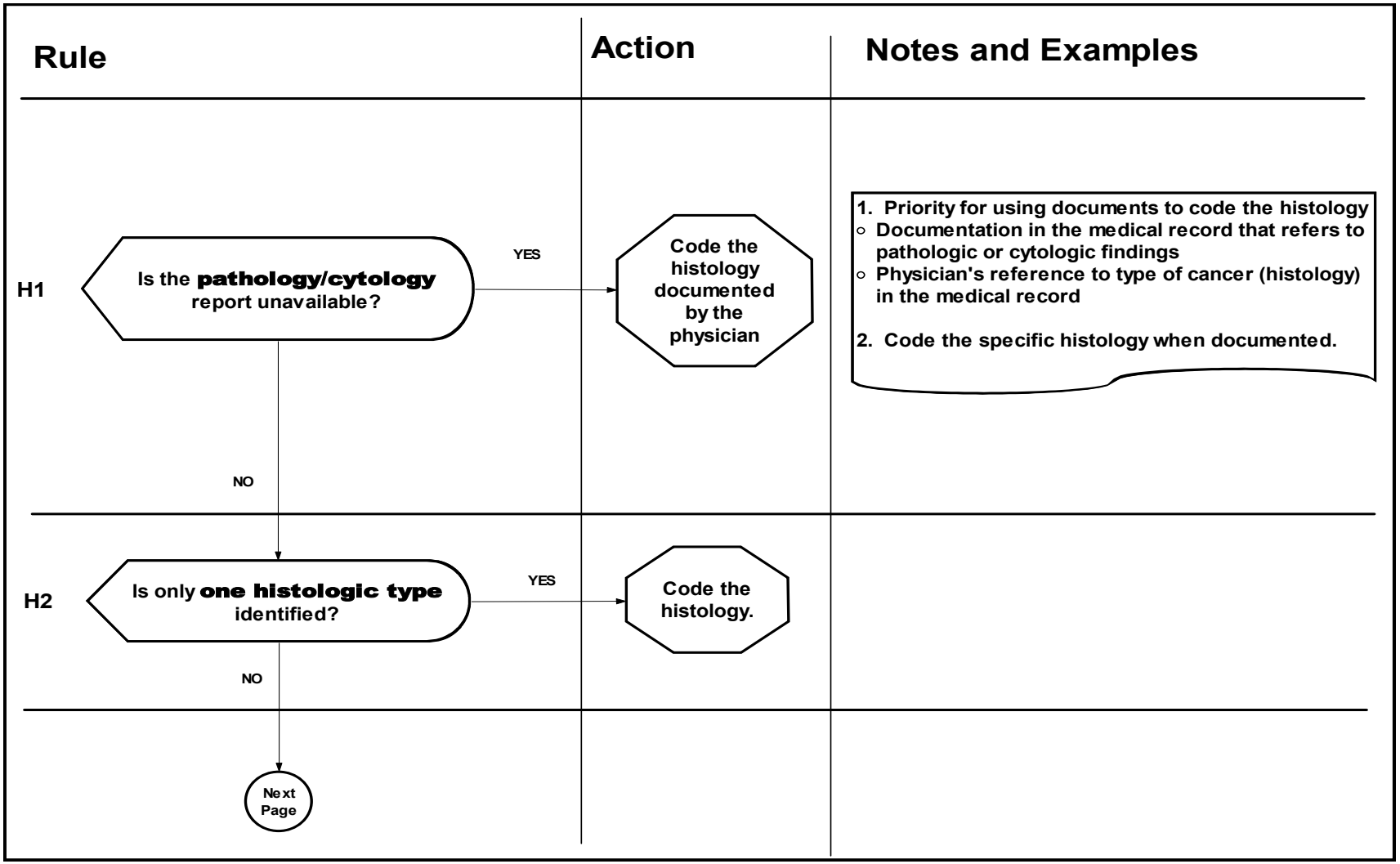
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)



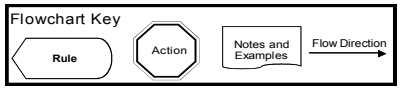


Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)



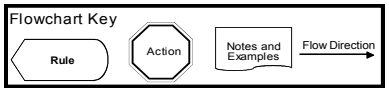
Rule	Action	Notes and Examples
H3 Is there carcinoma in situ, NOS (8010) and a specific carcinoma in situ? YES → Code the more **specific** histologic **term**.		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.
NO → Is there adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ? YES → Code the more **specific** histologic **term**.		
NO → Is there intraductal NOS (8500) and a specific intraductal carcinoma (Table1)? YES → Code the more **specific** histologic **term**.		
NO → **H4** Does the tumor have **non-infiltrating comedocarcinoma and any** other intraductal carcinoma (Table 1)? YES	Code **8501/2** (comedo-carcinoma, non-infiltrating).	***Example:*** Pathology report reads intraductal carcinoma with comedo and solid features. Code comedocarcinoma (8501/2).
NO → **H5** Does the tumor have a combination of **in situ lobular (8520) and intraductal** carcinoma (Table 1)? YES	Code **8522/2** (intraductal and lobular carcinoma in situ) (Table 3).	
NO → Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)



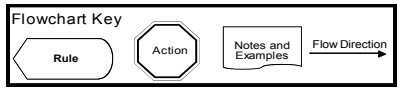
Rule	Action	Notes and Examples
H6 Is there a combination of intraductal carcinoma and two or more specific intraductal types OR are there **two or more specific intraductal** carcinomas? YES	Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) (Table 3).	1. Use Table 1 to identify the histologies. 2. Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).
NO		
H7 Is there **in situ lobular** (8520) and any **in situ** carcinoma **other than intraductal** carcinoma (Table 1)? YES	Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) (Table 3).	Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).
NO		
H8 Is there a **combination** of in situ/non-invasive histologies that **does not include** either **intraductal** carcinoma (Table 1) or **in situ lobular** (8520)? YES	Code **8255/2** (adenocarcinoma in situ with mixed subtypes (Table 3).	Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histo

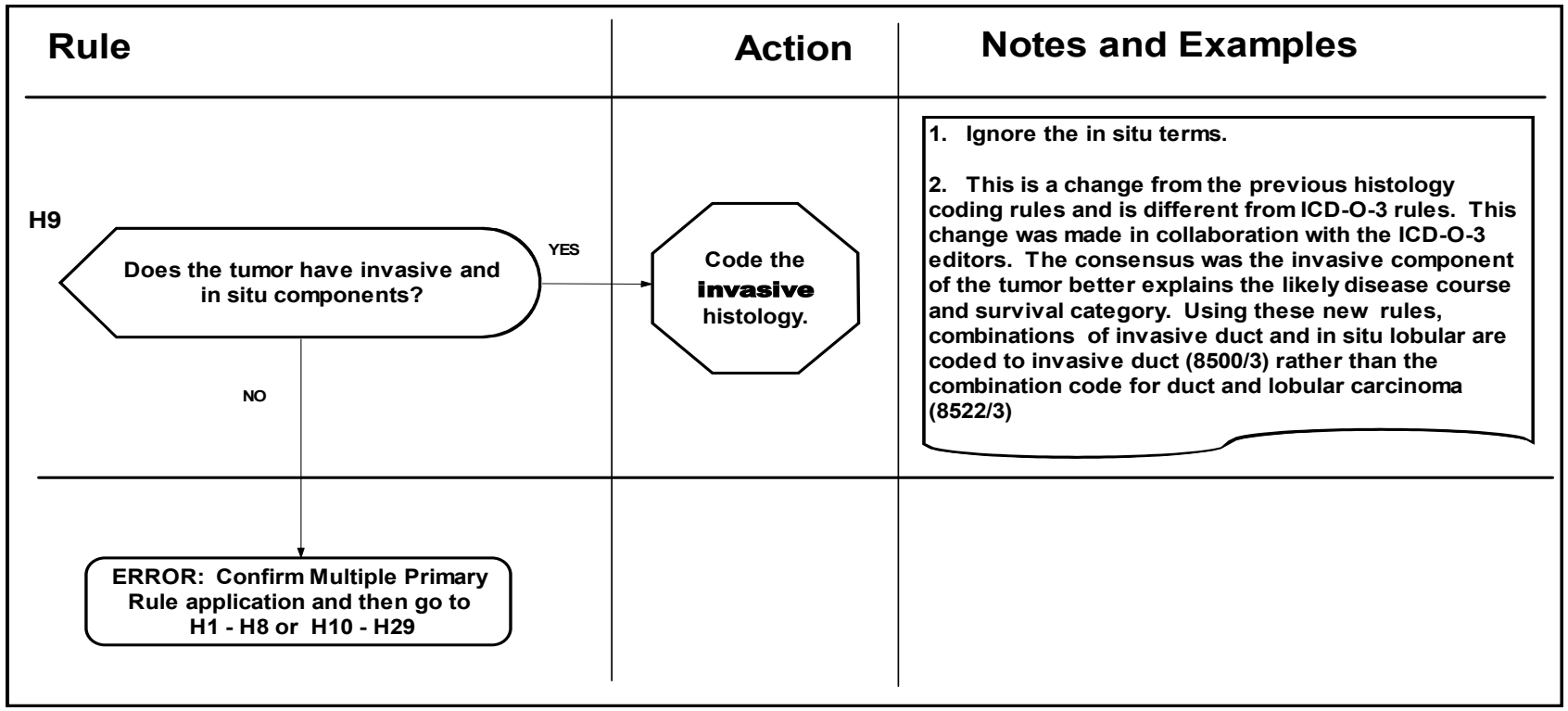
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA

(Single Tumor; in situ and invasive components)



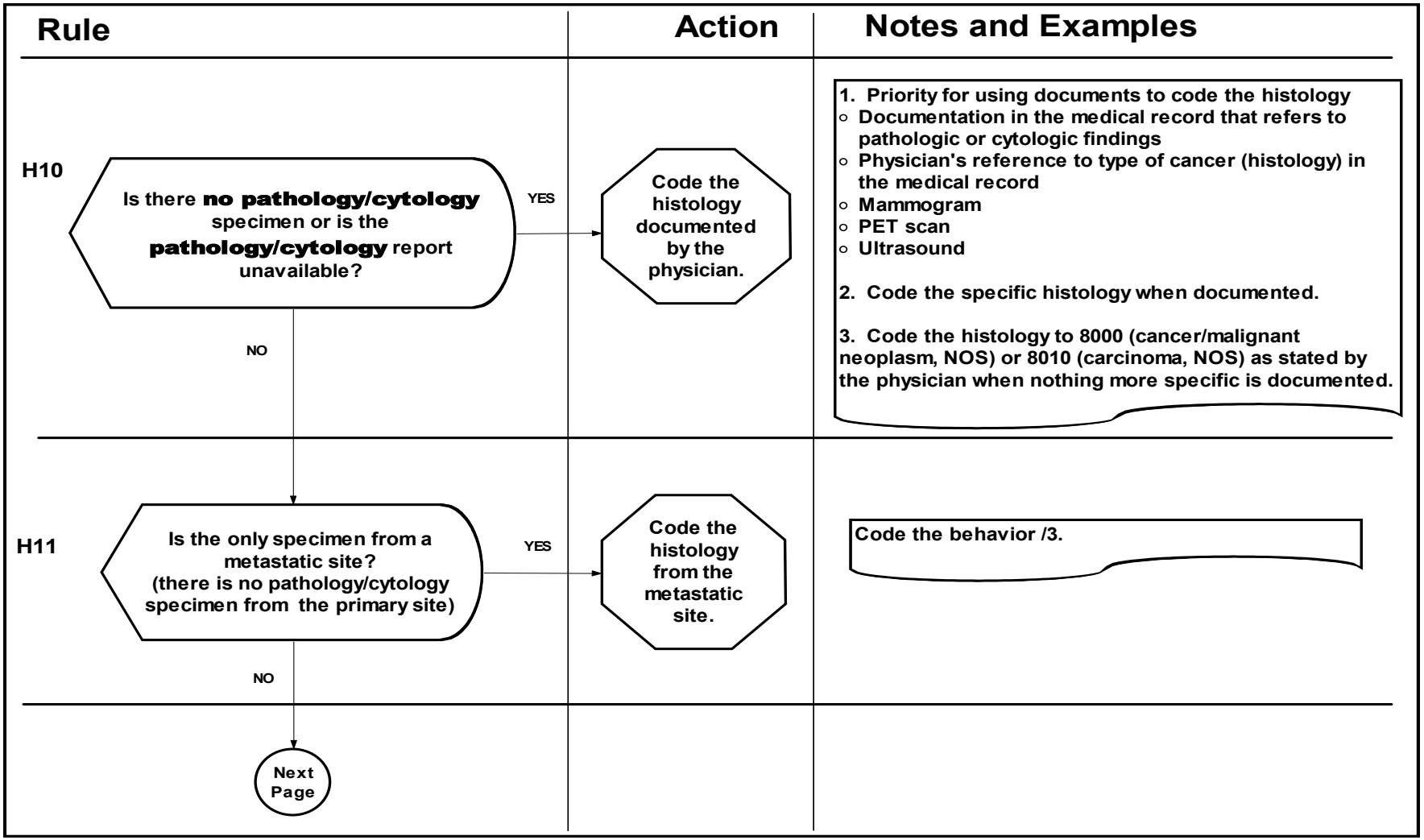
This is the end of instructions for Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: INVASIVE CARCINOMA ONLY

(Single Tumor; all parts are invasive)

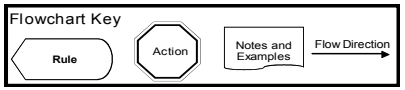


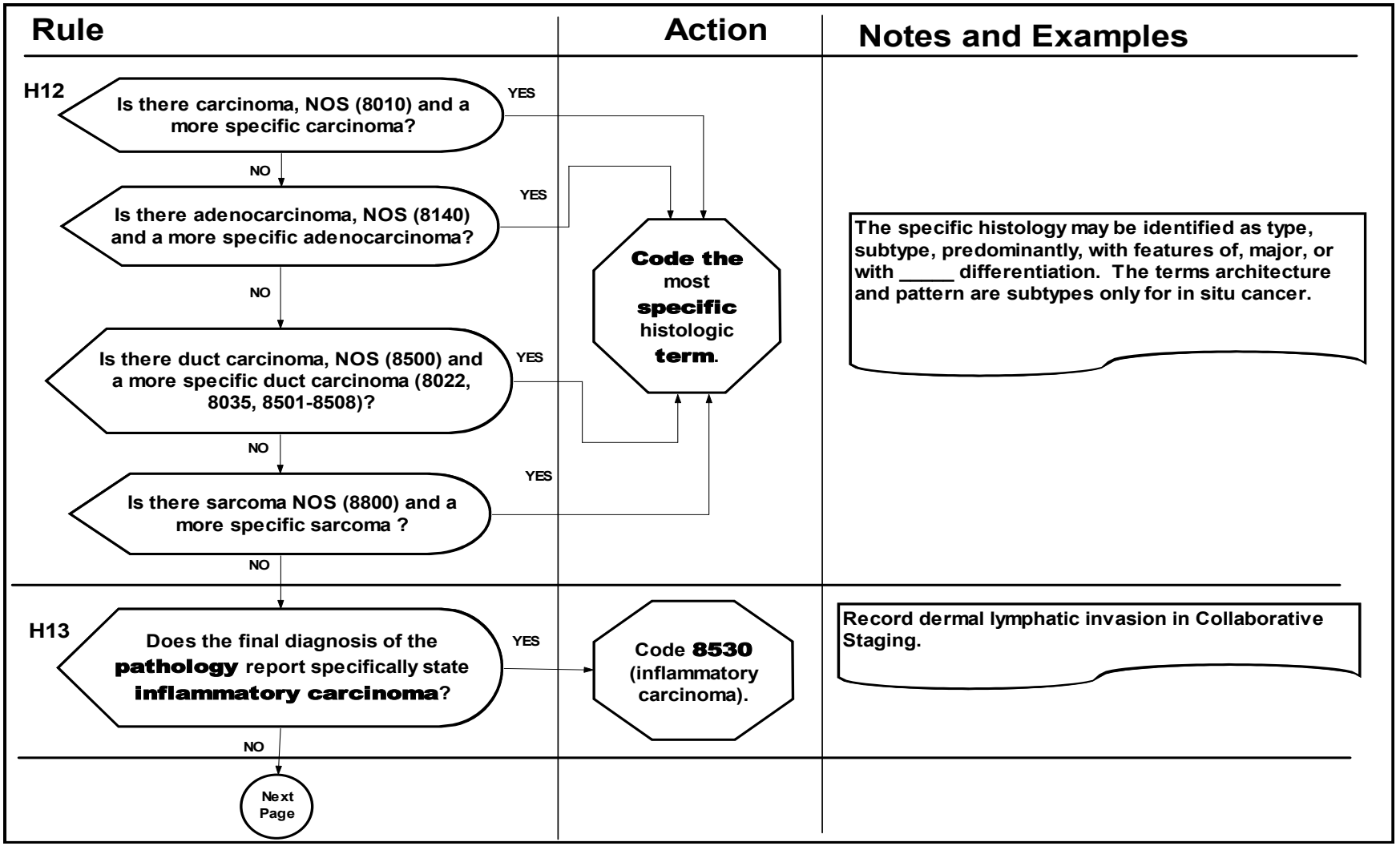
Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: INVASIVE CARCINOMA ONLY

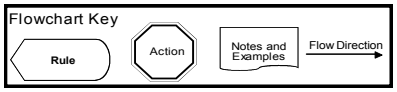
(Single Tumor; all parts are invasive)





Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



SINGLE TUMOR: INVASIVE CARCINOMA ONLY

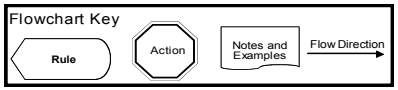
(Single Tumor; all parts are invasive)

Rule	Action	Notes and Examples
H14 Is only **one histologic type** identified? YES	Code the histology.	
NO		
H15 Are there **two or more** specific **duct** carcinomas? YES	Code the **numerically higher** ICD-O-3 histology code.	Use Table 2 to identify duct carcinomas
NO		
H16 Is there a combination of **lobular** (8520) **and duct** carcinoma (Table 3)? YES	Code **8522** (duct and lobular).	Use Table 2 to identify duct carcinomas
NO		
Next Page		

Breast Histo

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



SINGLE TUMOR: INVASIVE CARCINOMA ONLY

(Single Tumor; all parts are invasive)

Rule	Action	Notes and Examples
H17 Is there a combination of **duct and** any **other** carcinoma (Table 3)? YES	Code **8523** (duct mixed with other types of carcinoma).	1. Use Table 2 to identify duct carcinomas. 2. Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.
NO		
H18 Does the tumor have **lobular** (8520) **and** any **other carcinoma** (Table 3)? YES	Code **8524** (lobular mixed with other types of carcinoma).	Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.
NO		
H19 Are there multiple **histologies** that **do not include duct or lobular** (8520)? YES	Code **8255** (adeno-carcinoma with mixed subtypes) (Table 3).	Use Table 2 to identify duct carcinomas

This is the end of instructions for Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules - Flowchart

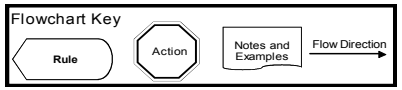
(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H20 Is there **no pathology/cytology** specimen or is the **pathology/cytology** report unavailable? YES	Code the histology documented by the physician.	1. Priority for using documents to code the histology ◦ Documentation in the medical record that refers to pathologic or cytologic findings ◦ Physician's reference to type of cancer (histology) in the medical record ◦ Mammogram ◦ PET Scan ◦ Ultrasound 2. Code the specific histology when documented. 3. Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.
NO		
H21 Is the only specimen from a metastatic site? (there is no pathology/cytology specimen from the primary site YES	Code the histology from a metastatic site.	Code the behavior /3.
NO		
H22 Does the final diagnosis of the **pathology** report specifically **state inflammatory carcinoma**? YES	Code **8530** (inflammatory carcinoma).	Record dermal lymphatic invasion in Collaborative Staging.
NO		
Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

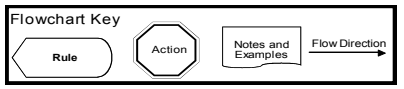


MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H23 Is only **one histologic type** identified?	YES → Code the histology.	
NO		
H24 Does the pathology report **specifically state** that the Paget disease is **in situ and** the underlying tumor is **intraductal** carcinoma (Table 1)?	YES → Code **8543/2** (in situ Paget disease and intraductal carcinoma (Table 3).	Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).
NO		
H25 Is there **Paget disease and intraductal** carcinoma (Table 3)?	YES → Code **8543/3** (Paget disease and intraductal carcinoma).	*1.* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). *2.* Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 1 to identify intraductal carcinomas.
NO		
H26 Is there **Paget disease and** invasive **duct** carcinoma (Table 3)?	YES → Code **8541/3** (Paget disease and infiltrating duct carcinoma).	*1.* ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). *2.* Includes both invasive Paget disease and Paget disease with behavior not stated. 3. Use Table 2 to identify duct carcinomas.
NO		
Next Page		

Breast Histology Coding Rules - Flowchart

(C500-C509)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule	Action	Notes and Examples
H27 Are there invasive and in situ components? YES	Code the **invasive** histology.	*1.* Ignore the in situ terms. *2.* This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3)
H28 Is there any combination of lobular (8520) and duct carcinoma (Table 3)? YES	Code **8522** (duct and lobular).	Use Table 2 to identify duct carcinomas.
H29 NO	Code the **numerically higher** ICD-O-3 histology code.	

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

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Breast Multiple Primary Rules – Matrix
C500 – C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

* Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.
** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
UNKNOWN IF SINGLE OR MULTIPLE TUMORS					Tumor(s) not described as metastasis	
M1					Use this rule only after all information sources have been exhausted.	Single*
SINGLE TUMOR					***1:*** Tumor not described as metastasis ***2:*** Includes combinations of in situ and invasive	
M2	One or both breasts	Inflammatory carcinoma				Single*
M3	Single				The tumor may overlap onto or extend into adjacent/contiguous site or subsite	Single*
MULTIPLE TUMORS **Multiple tumors may be a single primary or multiple primaries**					***1:*** Tumors not described as metastases ***2:*** Includes combinations of in situ and invasive	
M4	Topography codes different at the second (C**x**xx) and/or third (Cx**x**x) character					Multiple**
M5			Diagnosed more than five (5) years apart			Multiple**
M6	One or both breasts	Inflammatory carcinoma				Single*
M7	Both breasts				Lobular carcinoma in both breasts ("mirror image") is a multiple primary	Multiple**
M8			More than 60 days after diagnosis	An invasive tumor following an in situ tumor	***1:*** The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. ***2:*** Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.	Multiple**

Breast MP

Breast MP

Breast Multiple Primary Rules – Matrix
C500 – C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Site	Histology	Timing	Behavior	Notes/Examples	Primary
M9		Intraductal and/or duct and Paget Disease			Use Table 1 and Table 2 to identify intraductal and duct carcinomas	Single*
M10		**Lobular** (8520) **and** intraductal or **duct**			Use Table 1 and Table 2 to identify intraductal and duct carcinomas	Single*
M11		Multiple intraductal and/or duct carcinomas			Use Table 1 and Table 2 to identify intraductal and duct carcinomas	Single*
M12		Histology codes are different at the first (**x**xxx), second (x**x**xx), or third (xx**x**x) number				Multiple**
M13	Does not meet any of the above criteria				***1:*** When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary. ***2:*** All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code **Rule M13 Examples** The following are examples of the types of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.*** **Example 1**: Invasive duct and intraductal carcinoma in the same breast **Example 2**: Multi-centric lobular carcinoma, left breast	Single*

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR: IN SITU ONLY (Single tumor; all parts are in situ)					
H1	The pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • From clinician reference to type of cancer (histology) in the medical record ***2:*** Code the specific histology when documented.	The histology documented by the physician
H2		One type			The histology
H3		• Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or • Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or • Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.	The more specific histologic term
H4		Non-infiltrating comedocarcinoma and any other intraductal carcinoma (Table 1)		***Example:*** Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).	**8501/2** (comedocarcinoma, non-infiltrating)
H5		In situ lobular (8520) and intraductal carcinoma (Table 1)			**8522/2** (intraductal carcinoma and lobular carcinoma in situ) **(Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H6		• Combination of intraductal carcinoma and two or more specific intraductal types OR • **Two or more specific intraductal** carcinomas		***1:*** Use Table 1 to identify the histologies ***2:*** Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) **(Table 3)**.
H7		In situ lobular (8520) and any in situ carcinoma other than intraductal carcinoma (Table 1)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8524/2** (in situ lobular mixed with other types of in situ carcinoma) **(Table 3)**.
H8		Combination of in situ/non-invasive histologies that does not include either intraductal carcinoma (Table 1) or in situ lobular (8520)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	**8255/2** (adenocarcinoma in situ with mixed subtypes) **(Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
SINGLE TUMOR: INVASIVE AND IN SITU (Single tumor; in situ and invasive components)					
H9			Invasive and in situ	***1.*** Ignore the in situ terms. ***2.*** This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).	The invasive histology
SINGLE TUMOR: INVASIVE ONLY (Single tumor; all parts are invasive)					
H10	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • Mammogram • PET scan • Ultrasound ***2:*** Code the specific histology when documented ***3:*** Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H11	None from primary site			Code the behavior /3	The histology from a metastatic site

Breast Histo

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H12		• Carcinoma, NOS (8010) and a more specific carcinoma or • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or • Sarcoma, NOS (8800) and a more specific sarcoma		The specific histology may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation. The terms architecture and pattern are subtypes only for in situ cancer.	The most specific histologic term
H13		Final diagnosis of the pathology report specifically states inflammatory carcinoma		Record dermal lymphatic invasion in Collaborative Staging	**8530** (inflammatory carcinoma)
H14		One type			The histology
H15		Two or more specific duct carcinomas		Use Table 2 to identify duct carcinomas	The histology with the numerically higher ICD-O-3 code
H16		Combination of lobular (8520) and duct carcinoma		Use Table 2 to identify duct carcinomas	**8522** (duct and lobular) (**Table 3)**.
H17		Combination of **duct and** any other carcinoma		***1***: Use Table 2 to identify duct carcinomas ***2***: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.	**8523** (duct mixed with other types of carcinoma) (**Table 3)**.

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H18		Lobular (8520) and any other carcinoma		Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2	**8524** (lobular mixed with other types of carcinoma) **(Table 3)**.
H19		Multiple histologies that do not include duct or lobular (8520)		Use Table 2 to identify duct carcinomas	**8255** (adenocarcinoma with mixed subtypes) **(Table 3)**.
MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY					
H20	No pathology/cytology specimen or the pathology/cytology report is not available			***1:*** Priority for using documents to code the histology • Documentation in the medical record that refers to pathologic or cytologic findings • Physician's reference to type of cancer (histology) in the medical record • Mammogram • PET scan • Ultrasound ***2:*** Code the specific histology when documented ***3:*** Code the histology to cancer/malignant neoplasm, NOS (8000) or carcinoma, NOS (8010) as stated by the physician when nothing more specific is documented	The histology documented by the physician
H21	None from primary site			Code the behavior /3	The histology from a metastatic site
H22		Final diagnosis of the pathology report specifically states inflammatory carcinoma		***Note***: Record dermal lymphatic invasion in Collaborative Staging	**8530** (inflammatory carcinoma)
H23		One type			The histology

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H24		Pathology report specifically states Paget disease is in situ and the underlying tumor is intraductal carcinoma (Table 1)		Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F.)	Code **8543/2** (in situ Paget disease and intraductal carcinoma) **(Table 3)**.
H25		Paget disease and intraductal carcinoma		***1.*** ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). ***2.*** Includes both invasive Paget disease and Paget disease with behavior not stated. ***3***: Use Table 1 to identify intraductal carcinomas	**8543/3** (Paget disease and intraductal carcinoma) **(Table 3)**.
H26		Paget disease and invasive duct carcinoma		***1.*** ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3). ***2.*** Includes both invasive Paget disease and Paget disease with behavior not stated. ***3***: Use Table 2 to identify duct carcinomas	Code **8541/3** (Paget disease and infiltrating duct carcinoma) **(Table 3).**
H27			Invasive and in situ	***1.*** Ignore the in situ terms. ***2.*** This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3)	The invasive histology

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

Rule	Pathology/Cytology Specimen	Histology	Behavior	Notes and Examples	Code
H28		Lobular (8520) and duct carcinoma		Use Table 2 to identify duct carcinomas	**8522** (duct and lobular) **(Table 3)**.
H29	None of the conditions are met				The histology with the numerically higher ICD-O-3 code

Breast Histology Coding Rules – Matrix
C500-C509
(Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

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Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

UNKNOWN IF SINGLE OR MULTIPLE TUMORS

Note: Tumor(s) not described as metastasis

Rule M1 When it is not possible to determine if there is a **single** tumor **or multiple** tumors, opt for a single tumor and abstract as a single primary. *
Note: Use this rule only after all information sources have been exhausted.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Unknown if Single or Multiple Tumors.

SINGLE TUMOR

Note 1: Tumor not described as metastasis
Note 2: Includes combinations of in situ and invasive

Rule M2 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M3 A **single tumor** is always a single primary. *
Note: The tumor may overlap onto or extend into adjacent/contiguous site or subsite.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
This is the end of instructions for Single Tumor.

MULTIPLE TUMORS

Multiple tumors may be a single primary or multiple primaries.
Note 1: Tumors not described as metastases
Note 2: Includes combinations of in situ and invasive

Rule M4 Tumors in sites with ICD-O-3 **topography** codes (Cxxx) with **different** second (C**x**xx) and/or third characters (Cx**x**x) are multiple primaries. **

Rule M5 Tumors diagnosed **more than five (5) years** apart are multiple primaries. **

Breast MP

Breast Multiple Primary Rules- Text
C500-C509
(Excludes lymphoma and leukemia – M-9590 – 9989 and Kaposi sarcoma M9140)

Rule M6 **Inflammatory carcinoma** in one or both breasts is a single primary. *

Rule M7 Tumors on both sides (**right and left breast**) are multiple primaries. **
Note: Lobular carcinoma in both breasts ("mirror image") is a multiple primary.

Rule M8 An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis is a multiple primary. **
Note 1: The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.
Note 2: Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease.

Rule M9 Tumors that are intraductal or **duct and Paget Disease** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M10 Tumors that are **lobular** (8520) **and** intraductal or **duct** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M11 **Multiple intraductal and/or duct carcinomas** are a single primary. *
Note: Use Table 1 and Table 2 to identify intraductal and duct carcinomas

Rule M12 Tumors with ICD-O-3 **histology** codes that are **different** at the first (**x**xxx), second (x**x**xx) or third (xx**x**x) number are multiple primaries. **

Rule M13 Tumors that **do not meet any** of the above **criteria** are abstracted as a single primary. *
Note 1: When an invasive tumor follows an in situ tumor within 60 days, abstract as a single primary.
Note 2: All cases covered by Rule M13 have the same first 3 numbers in ICD-O-3 histology code.

*** Prepare one abstract. Use the histology coding rules to assign the appropriate histology code.**
**** Prepare two or more abstracts. Use the histology coding rules to assign the appropriate histology code to each case abstracted.**
This is the end of instructions for Multiple Tumors.

Rule M13 Examples: The following are examples of cases that use Rule M13. This is NOT intended to be an exhaustive set of examples; there are other cases that may be classified as a single primary. ***Warning: Using only these case examples to determine the number of primaries can result in major errors.***

Example 1: Invasive duct and intraductal carcinoma in the same breast	**Example 2:** Multi-centric lobular carcinoma, left breast

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR: IN SITU CARCINOMA ONLY

(Single Tumor; all parts are in situ)

Rule H1 Code the histology documented by the physician when the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record

Note 2: Code the specific histology when documented.

Rule H2 Code the histology when only **one histologic type** is identified

Rule H3 **Code the** more **specific** histologic **term when** the diagnosis is:
- Carcinoma in situ, NOS (8010) and a specific carcinoma in situ or
- Adenocarcinoma in situ, NOS (8140) and a specific adenocarcinoma in situ or
- Intraductal carcinoma, NOS (8500) and a specific intraductal carcinoma (Table 1)

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation, architecture or pattern. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H4 Code **8501/2** (comedocarcinoma, non-infiltrating) when there is **non-infiltrating comedocarcinoma and any** other **intraductal** carcinoma (Table 1).
Example: Pathology report reads intraductal carcinoma with comedo and solid features. Code 8501/2 (comedocarcinoma).

Rule H5 Code **8522/2** (intraductal carcinoma and lobular carcinoma in situ) **(Table 3)** when there is a combination of **in situ lobular** (8520) **and intraductal** carcinoma (Table 1).

Rule H6 Code **8523/2** (intraductal carcinoma mixed with other types of in situ carcinoma) **(Table 3**) when there is a combination of intraductal carcinoma and **two** or more specific intraductal types OR there are **two or more specific intraductal** carcinomas..

Rule H7 Code **8524/2** (in situ lobular mixed with other types of in situ carcinoma) **(Table 3**) when there is **in situ lobular** (8520) **and any in situ** carcinoma **other than intraductal** carcinoma (Table 1).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H8 Code **8255/2** (adenocarcinoma in situ with mixed subtypes) **(Table 3)** when there is a **combination** of in situ/non-invasive histologies that **does not include** either **intraductal** carcinoma (Table 1) **or in situ lobular** (8520).
Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

This is the end of instructions for a Single Tumor: In Situ Carcinoma Only.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE AND IN SITU CARCINOMA
(Single Tumor; in situ and invasive components)

Rule H9 **Code the invasive histology** when both invasive and in situ components are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive duct and in situ lobular are coded to invasive duct (8500/3) rather than the combination code for duct and lobular carcinoma (8522/3).

This is the end of instructions for a Single Tumor: Invasive and In Situ Carcinoma.
Code the histology according to the rule that fits the case.

SINGLE TUMOR: INVASIVE CARCINOMA ONLY
(Single Tumor; all parts are invasive)

Rule H10 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.
Note 1: Priority for using documents to code the histology
- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.
Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H11 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.

Rule H12 **Code the** most **specific** histologic **term when** the diagnosis is:
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Duct carcinoma, NOS (8500) and a more specific duct carcinoma (8022, 8035, 8501-8508) or
- Sarcoma, NOS (8800) and a more specific sarcoma

Note: The specific histology may be identified as type, subtype, predominantly, with features of, major, with ___ differentiation. The terms architecture and pattern are subtypes only for in situ cancer.

Rule H13 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma**.
Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H14 Code the histology when only **one histologic type** is identified.

Rule H15 Code the histology with the numerically **higher ICD-O-3 code** when there are **two or more** specific **duct** carcinomas.
Note: Use Table 2 to identify duct carcinomas

Rule H16 Code **8522** (duct and lobular) when there is a combination of **lobular** (8520) **and duct** carcinoma (**Table 3)**.
Note: Use Table 2 to identify duct carcinomas

Rule H17 Code **8523** (duct mixed with other types of carcinoma) when there is a combination of **duct and** any **other** carcinoma (**Table 3)**.
Note 1: Use Table 2 to identify duct carcinomas
Note 2: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table

Rule H18 Code **8524** (lobular mixed with other types of carcinoma) when the tumor is **lobular** (8520) **and** any **other carcinoma (Table 3)**.
Note: Other carcinomas exclude lobular and any duct carcinoma listed on Table 1 or Table 2.

Rule H19 Code **8255** (adenocarcinoma with mixed subtypes) **(Table 3)** for multiple **histologies** that **do not include duct or lobular** (8520).
Note: Use Table 2 to identify duct carcinomas

This is the end of instructions for a Single Tumor: Invasive Carcinoma Only.
Code the histology according to the rule that fits the case.

Breast Histo

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Rule H20 Code the histology documented by the physician when there is **no pathology/cytology specimen** or the **pathology/cytology** report is **not available**.

Note 1: Priority for using documents to code the histology

- Documentation in the medical record that refers to pathologic or cytologic findings
- Physician's reference to type of cancer (histology) in the medical record
- Mammogram
- PET scan
- Ultrasound

Note 2: Code the specific histology when documented.

Note 3: Code the histology to 8000 (cancer/malignant neoplasm, NOS) or 8010 (carcinoma, NOS) as stated by the physician when nothing more specific is documented.

Rule H21 Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.

Note: Code the behavior /3.

Rule H22 Code **8530** (inflammatory carcinoma) only when the final diagnosis of the **pathology** report specifically **states inflammatory carcinoma.**

Note: Record dermal lymphatic invasion in Collaborative Staging

Rule H23 Code the histology when only **one histologic type** is identified.

Rule H24 Code **8543/2** (in situ Paget disease and intraductal carcinoma) **(Table 3)** when the **pathology** report **specifically states** that the **Paget disease** is **in situ and** the **underlying tumor** is **intraductal** carcinoma (Table 1).

Note: Change the behavior to 2 (in situ) in accordance with the ICD-O-3 matrix principle (ICD-O-3 Rule F).

Rule H25 Code **8543/3** (Paget disease and intraductal carcinoma) for **Paget disease and intraductal** carcinoma **(Table 3)**.

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 1 to identify intraductal carcinomas.

Rule H26 Code **8541/3** (Paget disease and infiltrating duct carcinoma) for **Paget disease and** invasive **duct** carcinoma.**(Table 3)**.

Note 1: ICD-O-3 classifies all mammary Paget disease as a malignant process with a malignant behavior (/3).

Note 2: Includes both invasive Paget disease and Paget disease with behavior not stated.

Note 3: Use Table 2 to identify duct intraductal carcinomas

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H27 Code the invasive histology when **both invasive and in situ** tumors are present.
Note 1: Ignore the in situ terms.
Note 2: This is a change from the previous histology coding rules and is different from ICD-O-3 rules. This change was made in collaboration with the ICD-O-3 editors. The consensus was that coding the invasive component of the tumor better explains the likely disease course and survival category. Using these rules, combinations of invasive lobular and in situ duct carcinoma are coded to invasive lobular (8520/3) rather than the combination code for duct and lobular carcinoma (8522/3).

Rule H28 Code **8522** (duct and lobular) when there is any combination of **lobular** (8520) **and duct** carcinoma. **(Table 3)**.
Note: Use Table 2 to identify duct carcinomas

Rule H29 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Multiple Tumors Abstracted as a Single Primary.
Code the histology according to the rule that fits the case.

Breast Histology Coding Rules – Text
C500-C509
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

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Breast
C50.0-C50.6, C50.8-C50.9

C50.0 Nipple
C50.1 Central portion of breast
C50.2 Upper-inner quadrant of breast
C50.3 Lower-inner quadrant of breast
C50.4 Upper-outer quadrant of breast
C50.5 Lower-outer quadrant of breast
C50.6 Axillary Tail of breast
C50.8 Overlapping lesion of breast
C50.9 Breast, NOS
Note: Laterality must be coded for this site.

CS Tumor Size CS Extension CS TS/Ext-Eval CS Lymph Nodes CS Reg Nodes Eval Reg LN Pos Reg LN Exam CS Mets at DX CS Mets Eval	**CS Site-Specific Factor 1 -** Estrogen Receptor Assay (ERA) **CS Site-Specific Factor 2 -** Progesterone Receptor Assay (PRA) **CS Site-Specific Factor 3 -** Number of Positive Ipsilateral Axillary Lymph Nodes **CS Site-Specific Factor 4 -** Immunohistochemistry (IHC) of Regional Lymph Nodes **CS Site-Specific Factor 5 -** Molecular Studies of Regional Lymph Nodes **CS Site-Specific Factor 6 -** Size of Tumor--Invasive Component	**The following tables are available at the collaborative staging website:** Histology Exclusion Table AJCC Stage Extension Size Table Extension Behavior Table Lymph Nodes Positive Axillary Node Table IHC MOL Table Lymph Nodes Pathologic Evaluation Table Lymph Nodes Clinical Evaluation Table

Breast
CS Tumor Size (Revised: 07/28/2006)

Note 1: For tumor size, some breast cancers cannot be sized pathologically.
Note 2: When coding pathologic size, code the measurement of the invasive component. For example, if there is a large in situ component (e.g., 4 cm) and a small invasive component see Site-Specific Factor 6 to code more information about the reported tumor size. If the size of invasive component is not given, code the size of the entire tumor and record what it represents in Site-Specific Factor 6.
Note 3: Microinvasion is the extension of cancer cells beyond the basement membrane into the adjacent tissues with no focus more than 0.1 cm in greatest dimension. When there are multiple foci of microinvasion, the size of only the largest focus is used to classify the microinvasion. (Do not use the sum of all the individual foci.)

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microinvasion; microscopic focus or foci only, no size given; described as less than 1 mm
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	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"

Code	Description
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	Mammographic/xerographic diagnosis only, no size given; clinically not palpable
997	Paget's Disease of nipple with no demonstrable tumor
998	Diffuse
999	Unknown; size not stated Not documented in patient record

Breast

CS Extension (Revised: 08/15/2006)

Note 1: Changes such as dimpling of the skin, tethering, and nipple retraction are caused by tension on Cooper's ligament(s), not by actual skin involvement. They do not alter the classification.
Note 2: Consider adherence, attachment, fixation, induration, and thickening as clinical evidence of extension to skin or subcutaneous tissue, code '20'.
Note 3: Consider "fixation, NOS" as involvement of pectoralis muscle, code '30'.
Note 4: If extension code is 00, then Behavior code must be 2; if extension code is 05 or 07, then behavior code may be 2 or 3; and, if extension code is 10, then behavior code must be 3.
Note 5: Inflammatory Carcinoma. AJCC includes the following text in the 6th edition Staging Manual (p. 225-6), "Inflammatory carcinoma is a clinicopathologic entity characterized by diffuse erythema and edema (peau d'orange) of the breast, often without an underlying palpable mass. These clinical findings should involve the majority of the skin of the breast. Classically, the skin changes arise quickly in the affected breast. Thus the term of inflammatory carcinoma should not be applied to a patient with neglected locally advanced cancer of the breast presenting late in the course of her disease. On imaging, there may be a detectable mass and characteristic thickening of the skin over the breast. This clinical presentation is due to tumor emboli within dermal lymphatics, which may or may not be apparent on skin biopsy. The tumor of inflammatory carcinoma is classified T4d. It is important to remember that inflammatory carcinoma is primarily a clinical diagnosis. Involvement of the dermal lymphatics alone does not indicate inflammatory carcinoma in the absence of clinical findings. In addition to the clinical picture, however, a biopsy is still necessary to demonstrate cancer either within the dermal lymphatics or in the breast parenchyma itself."
Note 6: For Collaborative Staging, the abstractor should record a stated diagnosis of inflammatory carcinoma, and also record any clinical statement of the character and extent of skin involvement in the text area. Code 71 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in less than 50% of the skin of the breast. Code 73 should be used if there is a stated diagnosis of inflammatory carcinoma and a clinical description of the skin involvement in more than 50% (majority) of the skin of the breast. Cases with a stated diagnosis of inflammatory carcinoma but no such clinical description should be coded 71. A clinical description of inflammation, erythema, edema, peau d'orange, etc. without a stated diagnosis of inflammatory carcinoma should be coded 51 or 52, depending on described extent of the condition.

Code	Description	TNM	SS77	SS2000
00	In situ: noninfiltrating; intraepithelial Intraductal WITHOUT infiltration Lobular neoplasia	Tis	IS	IS
05	Paget Disease of nipple (WITHOUT underlying tumor)	Tis	**	**
07	Paget Disease of nipple (WITHOUT underlying invasive carcinoma pathologically)	Tis	**	**

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
10	Confined to breast tissue and fat including nipple and/or areola Localized, NOS	*	L	L
20	Invasion of subcutaneous tissue Local infiltration of dermal lymphatics adjacent to primary tumor involving skin by direct extension Skin infiltration of primary breast including skin of nipple and/or areola	*	RE	RE
30	Attached or fixation to pectoral muscle(s) or underlying tissue Deep fixation Invasion of (or fixation to) pectoral fascia or muscle	*	RE	RE
40	Invasion of (or fixation to): Chest wall Intercostal or serratus anterior muscle(s) Rib(s)	T4a	RE	RE
51	Extensive skin involvement, including: Satellite nodule(s) in skin of primary breast Ulceration of skin of breast Any of the following conditions described as involving not more than 50% of the breast, or amount or percent of involvement not stated: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
52	Any of the following conditions described as involving more than 50% of the breast WITHOUT a stated diagnosis of inflammatory carcinoma: Edema of skin En cuirasse Erythema Inflammation of skin Peau d'orange ("pigskin")	T4b	RE	RE
61	(40) + (51)	T4c	RE	RE
62	(40) + (52)	T4c	RE	RE
71	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., involving not more than 50% of the skin of the breast, or percent of involvement not stated, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS	T4d	RE	RE

Code	Description	TNM	SS77	SS2000
72	OBSOLETE - Description: Diagnosis of inflammatory WITH a clinical diagnosis of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the breast, WITH or WITHOUT dermal lymphatic infiltration Inflammatory carcinoma, NOS NOTE: Code 72 has been combined with code 71. Any cases coded to 72 should be re-coded to code 71.	T4d	RE	RE
73	Diagnosis of inflammatory carcinoma WITH a clinical description of inflammation, erythema, edema, peau d'orange, etc., of more than 50% of the skin of the breast, WITH or WITHOUT dermal lymphatic infiltration	T4d	RE	RE
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 20, and 30 ONLY, the T category is assigned based on value of CS Tumor Size as shown in the Extension Size Table for this site.
** For codes 05 and 07 ONLY, summary stage is assigned based on the value of Behavior Code ICD-0-3 as shown in the Extension Behavior Table for this site.

Breast
CS TS/Ext-Eval
SEE STANDARD TABLE

Breast
CS Lymph Nodes (Revised: 10/15/2007)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field. Use code 60 in the absence of other information about regional nodes.
Note 3: If no lymph nodes were removed for evaluation (Reg Nodes Eval code 0, 1, or 9), or if neoadjuvant therapy was given and clinical lymph node involvement is AS extensive or MORE extensive than pathologic lymph node involvement (Reg Nodes Eval code 5), then use only the following codes for clinical evaluation of regional nodes: 0, 29, 51, 60, 74, 75, 76, 77, 78, 80, and 99. Do not use codes 29 and 51 under any other circumstances (Reg Nodes Eval 2, 3, 6, or 8).
Note 4: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters not greater than 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction). Lymph nodes with ITCs only are not considered positive lymph nodes.
Note 5: Codes 13-52 are used for positive axillary nodes without internal mammary nodes.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement, or ITCs detected by immunohistochemistry or molecular methods ONLY. (See Note 5 and Site-specific Factors 4 and 5.)	*	NONE	NONE
05	None; no regional lymph node(s) but with (ITCs) detected on routine H and E stains. (See Note 5)	N0(i+)	NONE	NONE

Code	Description	TNM	SS77	SS2000
13	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected by immunohistochemical (IHC) means ONLY (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm)	N1mi	RN	RN
15	Axillary lymph node(s), ipsilateral, micrometastasis ONLY detected or verified on H&E (at least one micrometastasis greater than 0.2 mm and all micrometastases less than or equal to 2 mm) Micrometastasis, NOS	N1mi	RN	RN
25	Movable axillary lymph node(s), ipsilateral, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm)	**	RN	RN
26	Stated as N1, NOS	**	RN	RN
28	OBSOLETE - Stated as N2, NOS	**	RN	RN
29	Fixed/matted ipsilateral axillary nodes, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm) Fixed/matted ipsilateral axillary nodes, NOSClinically stated only as N2, NOS (clinical assessment because of neoadjuvant therapy or no pathology)	**	RN	RN
30	Pathologically stated only as N2 NOS; no information on which nodes were involved	**	RN	RN
50	OBSOLETE - Fixed/matted ipsilateral axillary nodes, positive with more than micrometastasis (i.e., at least one metastasis greater than 2 mm) Fixed/matted ipsilateral axillary nodes, NOS	**	RN	RN
51	Fixed/matted ipsilateral axillary nodes clinically (clinical assessment because of neoadjuvant therapy or no pathology) Stated clinically as N2a, NOS (clinical assessment because of neoadjuvant therapy or no pathology)	**	RN	RN
52	Fixed/matted ipsilateral axillary nodes clinically with pathologic involvement of lymph nodes at least one metastasis greater than 2mm	**	RN	RN
60	Axillary/regional lymph node(s), NOS Lymph nodes NOS	**	RN	RN
71	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N1b	RN	RN
72	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) WITH axillary lymph node(s), ipsilateral	**	RN	RN

Code	Description	TNM	SS77	SS2000
73	Internal mammary node(s), ipsilateral, positive on sentinel nodes but not clinically apparent (no positive imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N1b	RN	RN
74	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITHOUT axillary lymph node(s), ipsilateral	N2b	RN	RN
75	Infraclavicular lymph node(s)(subclavicular)	N3a	D	RN
76	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) WITH axillary lymph node(s), ipsilateral, codes 15 to 60 WITH or WITHOUT infraclavicular lymph nodes	N3b	RN	RN
77	Internal mammary node(s), ipsilateral, clinically apparent (on imaging or clinical exam) UNKNOWN if positive axillary lymph node(s), ipsilateral	N2b	RN	RN
78	(75) + (77)	N3a	D	RN
79	Stated as N3, NOS	N3NOS	RN	RN
80	Supraclavicular node(s)	N3c	D	D
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For code 00 ONLY, the N category is assigned based on the coding of Site-Specific Factors 4 and 5 using the IHC MOL Table for this site.

** For codes 25, 26, 28, 29, 30, 50, 51, 52, 60, and 72 ONLY, the N category is assigned based on the values of Site-Specific Factor 3 (Number of Positive Ipsilateral Axillary Lymph Nodes) and CS Reg Nodes Eval. If the Eval code is 2 (p), 3 (p), 6 (y), or 8 (a), the N category is determined by reference to the Lymph Nodes Pathologic Evaluation Table. If the Eval code is 0 (c), 1(c), 5(c), or 9 (c), the N category is determined by reference to the Lymph Nodes Clinical Evaluation Table. If the Eval field is not coded, the N category is determined by reference to the Lymph Nodes Positive Axillary Node Table.

Breast
CS Reg Nodes Eval
SEE STANDARD TABLE

Breast
Reg LN Pos (Revised: 08/21/2006)

Note 1: Record this field even if there has been preoperative treatment.

Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are > 0.2mm and code the lymph nodes as positive in this field.

Note 3: Record all positive regional lymph nodes in this field. Record the number of positive regional axillary nodes separately in the appropriate Site-Specific Factor field.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Breast
Reg LN Exam
SEE STANDARD TABLE

Breast
CS Mets at DX (Revised: 05/06/2004)
Note: Supraclavicular (transverse cervical) is moved to CS Lymph Nodes.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) Cervical, NOS Contralateral/bilateral axillary and/or internal mammary Other than above Distant lymph node(s), NOS	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D
42	Further contiguous extension: Skin over: Axilla Contralateral (opposite) breast Sternum Upper abdomen	M1	D	D
44	Metastasis: Adrenal (suprarenal) gland Bone, other than adjacent rib Contralateral (opposite) breast - if stated as metastatic Lung Ovary Satellite nodule(s) in skin other than primary breast	M1	D	D
50	(10) + any of [(40 to 44)] Distant lymph node(s) plus other distant metastases	M1	D	D

Code	Description	TNM	SS77	SS2000
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Breast
CS Mets Eval
SEE STANDARD TABLE

Breast
CS Site-Specific Factor 1 Estrogen Receptor Assay (ERA) (Revised: 09/07/2007)
Note 1:

A. In cases where ER and PR are reported on more than one tumor specimen, record the highest value (if any sample is positive, record as positive).
B. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.
C. If neoadjuvant therapy is given and there are no ER or PR results from pre-treatment specimens, report the findings from post-treatment specimens.
Note 2: In general, ER/PR is only done on one sample. In cases where it is done on more than one sample, there is not necessarily any reason to think that the most accurate is the test done on the "largest" tumor specimen. Clinically, treatment will be based on any positive test - in other words, given the benefit and minimal toxicity of hormonal therapy, most patients will be given the "benefit of the doubt" and given hormonal therapy if any ER test is positive.

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Breast
CS Site-Specific Factor 2 Progesterone Receptor Assay (PRA) (Revised: 09/07/2007)
Note 1:

A. In cases where ER and PR are reported on more than one tumor specimen, record the highest value (if any sample is positive, record as positive).
B. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.
C. If neoadjuvant therapy is given and there are no ER or PR results from pre-treatment specimens, report the findings from post-treatment specimens.
Note 2: In general, ER/PR is only done on one sample. In cases where it is done on more than one sample, there is not necessarily any reason to think that the most accurate is the test done on the "largest" tumor specimen.

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Breast

CS Site-Specific Factor 3 Number of Positive Ipsilateral Axillary Lymph Nodes (Revised: 07/29/2004)

Note 1: Record this field even if there has been preoperative treatment.

Note 2: Lymph nodes with only isolated tumor cells (ITCs) are NOT counted as positive lymph nodes. Only lymph nodes with metastases greater than 0.2 mm (micrometastases or larger) should be counted as positive. If the pathology report indicates that nodes are positive but size of the metastases is not stated, assume the metastases are greater than 0.2 mm and code the lymph nodes as positive in this field.

Note 3: This field is based on pathologic information only. If no ipsilateral axillary nodes were removed for examination, or if an ipsilateral axillary lymph node drainage area was removed but no lymph nodes were found, code 098.

Note 4. The general coding instructions in Part I for Regional Nodes Positive also apply to this field (although the codes in Regional Nodes Positive are 2 digits rather than 3). When positive ipsilateral axillary lymph nodes are coded in this field, the number of positive ipsilateral axillary lymph nodes must be less than or equal to the number coded in Regional Nodes Positive (i.e., the number of positive ipsilateral axillary nodes will always be a subset of the number of positive regional nodes.)

Code	Description
000	All ipsilateral axillary nodes examined negative
001-089	1 - 89 nodes positive (code exact number of nodes positive)
090	90 or more nodes positive
095	Positive aspiration of lymph node(s)
097	Positive nodes - number unspecified
098	No axillary nodes examined
099	Unknown if axillary nodes are positive; not applicable Not documented in patient record

Breast

CS Site-Specific Factor 4 Immunohistochemistry (IHC) of Regional Lymph Nodes (Revised: 03/17/2004)

Note 1: Use codes 000-009 only to report results of IHC on otherwise histologically negative lymph nodes on routine H and E stains., i.e., only when CS Lymph Nodes is coded 00. Otherwise code 888 in this field.
Note 2: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods (RT-PCR: Reverse Transcriptase Polymerase Chain Reaction) but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction.)
Note 3: If it is unstated whether or not IHC tests were done, assume they were not done.

Code	Description
000	Regional lymph nodes negative on H and E, no IHC studies done or unknown if IHC studies done Nodes clinically negative, not examined pathologically
001	Regional lymph nodes negative on H and E, IHC studies done, negative for tumor
002	Regional lymph nodes negative on H and E, IHC studies done, positive for ITCs (tumor cell clusters not greater than 0.2mm)
009	Regional lymph nodes negative on H and E, positive for tumor detected by IHC, size of tumor cell clusters or metastases not stated
888	Not applicable CS Lymph Nodes not coded 00

Breast

CS Site-Specific Factor 5 Molecular Studies of Regional Lymph Nodes (Revised: 12/03/2003)

Note 1: Use codes 000-002 only to report results of molecular studies on otherwise histologically negative lymph nodes on routine H and E stains., i.e., only when CS Lymph Nodes is coded 00. Otherwise code 888 in this field.
Note 2: Isolated tumor cells (ITC) are defined as single tumor cells or small clusters less than or equal to 0.2 mm, usually detected only by immunohistochemical (IHC) or molecular methods (RT-PCR: Reverse Transcriptase Polymerase Chain Reaction) but which may be verified on H and E stains. ITCs do not usually show evidence of malignant activity (e.g., proliferation or stromal reaction.)
Note 3: If it is not stated whether molecular tests were done, assume they were not done.

Code	Description
000	Regional lymph nodes negative on H and E, no RT-PCR molecular studies done or unknown if RT-PCR studies done Nodes clinically negative, not examined pathologically
001	Regional lymph nodes negative on H and E, RT-PCR molecular studies done, negative for tumor
002	Regional lymph nodes negative on H and E, RT-PCR molecular studies done, positive for tumor
888	Not applicable CS Lymph Nodes not coded 00

Breast

CS Site-Specific Factor 6 Size of Tumor--Invasive Component (Revised: 02/03/2005)

Note 1: Record the code that indicates how the pathological tumor size was coded in CS Tumor Size.
Note 2: For this field, "mixed" indicates a tumor with both invasive and in situ components. Such a "mixed" tumor may be a single histology such as mixed infiltrating ductal and ductal carcinoma in situ or combined histology such as mixed infiltrating ductal and lobular carcinoma in situ. "Pure" indicates a tumor that contains only invasive or only in situ tumor.
Note 3: This information is collected for analytic purposes and does not affect the stage grouping algorithm. Different codes in this field may explain differences in outcome for patients in the same T category or stage group. Example: Patient 1 has a "mixed" (see Note 2) tumor measuring 2.5 cm with extensive areas of in situ tumor, and the size of the invasive component is not stated. This would be coded 025 in CS Tumor Size, and would be classified as T2. It would be coded 040 in Site-Specific Factor 6. Patient 2 has a purely invasive tumor measuring 2.5 cm. This would also be coded 025 in CS Tumor Size and would also be classified as T2. However, it would be coded 000 in Site-Specific Factor 6. Patient 1's tumor would probably have a better survival than Patient 2's tumor, since it would more likely be a T1 lesion if the true dimensions of the invasive component were known.

Code	Description
000	Entire tumor reported as invasive (no in situ component reported)
010	Entire tumor reported as in situ (no invasive component reported)
020	Invasive and in situ components present, size of invasive component stated and coded in CS Tumor Size
030	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND in situ described as minimal (less than 25%)
040	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND in situ described as extensive (25% or more)
050	Invasive and in situ components present, size of entire tumor coded in CS Tumor Size because size of invasive component not stated AND proportions of in situ and invasive not known
060	Invasive and in situ components present, unknown size of tumor (CS Tumor Size coded 999)
888	Unknown if invasive and in situ components present, unknown if tumor size represents mixed tumor or a "pure" tumor. (See Note 2.) Clinical tumor size coded.

Surgery Codes

Breast
C500–C509
Except for M-9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy
A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin

[***SEER Note:*** This procedure is rarely used to treat malignancies]

40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction, NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 Reconstruction, NOS
  - 48 Tissue
  - 49 Implant
  - 75 Combined (Tissue and implant)

[***SEER Notes:*** If axillary lymph nodes are present in the specimen, code the Surgery of Primary Site field to 51. If there are no axillary lymph nodes present in the specimen, code the Surgery of Primary Site field to 41. Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment.]

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294**)**

If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Surgery Codes

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
  - 58 Tissue
  - 59 Implant
  - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If **contralateral breast** reveals a **second primary**, each beast is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294)

[***SEER Notes:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment. Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy.]

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
  - 69 Tissue
  - 73 Implant
  - 74 Combined (Tissue and Implant)

[***SEER Notes:*** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes en bloc axillary dissection. Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.]

Surgery Codes

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

[***SEER Note:*** Removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, pectoralis major. Includes removal of internal mammary nodes and en bloc axillary dissection.]

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Vulva, Vagina
C510-C519, C529

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Vulva (incl. Skin of Vulva)
[excl. Melanoma of Vulva, Kaposi Sarcoma of Vulva, Mycosis Fungiodes of Vulva, Sezary Disease of Vulva, and Other Lymphomas of Vulva]
C51.0-C51.2, C51.8-C51.9

C51.0 Labium majus
C51.1 Labium minus
C51.2 Clitoris
C51.8 Overlapping lesion of vulva
C51.9 Vulva, NOS

Note: This schema is NOT used for Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, or Other Lymphomas. Each of these diseases has a separate schema.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	Special Extension Size Table 1
CS Reg Nodes Eval	CS Site-Specific Factor 5	Special Extension Size Table 2
Reg LN Pos	CS Site-Specific Factor 6	Special Extension Size Table 3
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Vulva (incl. Skin of Vulva)
CS Tumor Size
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Extension (Revised: 12/03/2003)

Note 1: FIGO Stage 1, 1A and 1B are defined by size of tumor (less than or equal to 2 cm), involvement of vulva or vulva and perineum, and depth of stromal invasion as defined in codes 10, 11, 12, 30, 40, 41, and 42. FIGO Stage II is greater than 2 cm, but would be coded in the same range of codes.

Note 2: The depth of invasion is defined as the measurement of the tumor from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.

Code	Description	TNM	SS77	SS2000
00	In situ: Noninvasive; intraepithelial Bowen's disease, intraepidermal; preinvasive carcinoma FIGO Stage 0	Tis	IS	IS
10	Invasive cancer confined to: Musculature Submucosa Vulva including skin	*	L	L
11	Vulva only: Stromal invasion less than or equal to 1 mm	**	L	L
12	Vulva only: Stromal invasion greater than 1 mm	***	L	L
30	Localized, NOS	*	L	L
40	Vulva and perineum, level of invasion in mm not stated	*	RE	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
41	Vulva and perineum, stromal invasion less than or equal to 1 mm	**	RE	RE
42	Vulva and perineum, stromal invasion greater than 1 mm	***	RE	RE
60	Anus Perianal skin Urethra (See code 75 for upper urethral mucosa) Vagina FIGO Stage III	T3	RE	RE
62	Bladder wall or bladder, NOS excluding mucosa Rectal wall or rectum, NOS excluding mucosa	T3	D	RE
70	Perineal body Rectal mucosa	T4	D	D
75	Bladder mucosa Fixed to pubic bone Upper urethral mucosa FIGO Stage IVA	T4	D	RE
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 10, 30, and 40 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 1 for this site.
** For Extension codes 11 and 41 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 2 for this site.
*** For Extension codes 12 and 42 ONLY, the T category is assigned based on the value of CS Tumor Size as shown in the Special Extension Size Table 3 for this site.

Vulva (incl. Skin of Vulva)
CS TS/Ext-Eval
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Lymph Nodes (Revised: 08/15/2006)
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
10	Unilateral regional lymph nodes: Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph nodes, NOS (unilateral) FIGO Stage III	N1	RN	RN
50	Bilateral or contralateral regional lymph nodes: Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph nodes, NOS (bilateral/contralateral) FIGO Stage IVA	N2	RN	RN
60	Regional lymph node(s), NOS (not stated if unilateral, bilateral or contralateral)	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Vulva (incl. Skin of Vulva)
CS Reg Nodes Eval
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
Reg LN Pos
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
Reg LN Exam
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph node(s): External iliac	M1	RN	D

Code	Description	TNM	SS77	SS2000
12	Distant lymph node(s): Internal iliac (hypogastric) Obturator Pelvic, NOS	M1	D	D
13	Distant lymph node(s) other than code 11 and 12, including common iliac	M1	D	D
40	Distant metastases other than distant lymph node(s) (codes 10 to 13) Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) to (13)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Vulva (incl. Skin of Vulva)
CS Mets Eval
SEE STANDARD TABLE

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vulva (incl. Skin of Vulva)
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vagina
C52.9

C52.9 Vagina, NOS

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Vagina
CS Tumor Size
SEE STANDARD TABLE

Vagina
CS Extension (Revised: 08/21/2006)

Note: According to AJCC, pelvic wall is defined as muscle, fascia, neurovascular structures, or skeletal portions of the bony pelvis

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial FIGO Stage 0	Tis	IS	IS
10	Invasive cancer confined to Submucosa (stroma) (vagina) FIGO Stage I	T1	L	L
20	Musculature involved	T1	L	L
30	Localized, NOS	T1	L	L
40	Cervix Paravaginal soft tissue Rectovaginal septum Vesicovaginal septum Vulva FIGO Stage II	T2	RE	RE
50	Cul de sac (rectouterine pouch) FIGO Stage II	T2	RE	RE
52	Extension to bladder wall or bladder, NOS excluding mucosa Rectal wall or rectum, NOS excluding mucosa	T3	D	RE
60	Extension to pelvic wall Described clinically as "frozen pelvis", NOS FIGO Stage III	T3	D	RE
70	Extension to bladder mucosa (excluding bullous edema) or rectal mucosa FIGO Stage IVA	T4	D	D

Code	Description	TNM	SS77	SS2000
80	Extension beyond true pelvis Extension to urethra FIGO Stage IVA, not further specified	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Vagina
CS TS/Ext-Eval
SEE STANDARD TABLE

Vagina
CS Lymph Nodes (Revised: 08/15/2006)
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	All parts of vagina, regional nodes: Pelvic lymph nodes: Iliac, NOS: Common External Internal (hypogastric) Obturator Middle sacral (promontorial) (Gerota's node)	N1	RN	RN
20	Lower third of vagina, regional nodes: Ipsilateral: Inguinal, NOS: Superficial inguinal (femoral)	N1	D	RN
30	Lower third of vagina, regional nodes: Bilateral: Inguinal, NOS: Superficial inguinal (femoral)	N1	D	RN
40	Upper two-thirds of vagina, regional nodes: Pelvic lymph node(s), NOS	N1	D	RN
50	Regional lymph node(s), unknown whether primary is in upper or lower vagina Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Vagina
CS Reg Nodes Eval
SEE STANDARD TABLE

Vagina
Reg LN Pos
SEE STANDARD TABLE

Vagina
Reg LN Exam
SEE STANDARD TABLE

Vagina
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
11	Distant lymph nodes: Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Inguinal (for primary in upper two-thirds of vagina only) Retroperitoneal, NOS	M1	D	D
12	Distant lymph node(s) other than code 11	M1	D	D
40	Distant metastases except distant lymph nodes (Codes 10 to 12) FIGO Stage IVB Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(40) + any of [(10) to (12)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Vagina
CS Mets Eval
SEE STANDARD TABLE

Vagina
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Vagina
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vagina
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vagina
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vagina
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Vagina
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, **C510–C519**, **C529**, C570–C579**,** C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Cervix Uteri
C530-C539

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Cervix Uteri
C53.0-C53.1, C53.8-C53.9

C53.0 Endocervix
C53.1 Exocervix
C53.8 Overlapping lesion of cervix
C53.9 Cervix uteri

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histology Exclusion Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	AJCC Stage
Reg LN Pos	CS Site-Specific Factor 6	Extension Size Table
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Cervix Uteri
CS Tumor Size (Revised: 07/31/2007)

Note: Code the largest measurement of horizontal spread or surface diameter in this field. Depth of invasion is coded in CS Extension.

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only, no size of focus 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	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"
999	Unknown; size not stated Not documented in patient record

Cervix Uteri
CS Extension (Revised: 07/20/2006)

Note 1: Involvement of anterior and/or posterior septum is coded as involvement of the vaginal wall.
Note 2: Record positive pelvic or peritoneal washings as information only. Not to be coded as metastatic disease.

Code	Description	TNM	SS77	SS2000
00	In situ: preinvasive; noninvasive; intraepithelial Cancer in situ WITH endocervical gland involvement FIGO Stage 0	Tis	IS	IS

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
01	CIN (Cervical intraepithelial neoplasia) Grade III	Tis	IS	IS
11	Minimal microscopic stromal invasion less than or equal to 3 mm in depth and less than or equal to 7 mm in horizontal spread FIGO Stage IA1	T1a1	L	L
12	"Microinvasion" Tumor WITH invasive component greater than 3 mm and less than or equal to 5 mm in depth, taken from the base of the epithelium, and less than or equal to 7 mm in horizontal spread FIGO Stage IA2	T1a2	L	L
20	Invasive cancer confined to cervix and tumor larger than that in code 12 FIGO Stage IB	*	L	L
25	Invasive cancer confined to cervix and clinically visible lesion	*	L	L
30	Localized, NOS Confined to cervix uteri or uterus, NOS, except corpus uteri, NOS (Not clinically visible or unknown if clinically visible.)	*	L	L
31	FIGO Stage I, not further specified	*	L	L
35	Corpus uteri, NOS	T1NOS	RE	RE
36	Code (35) + (11)	T1a1	RE	RE
37	Code (35) + (12)	T1a2	RE	RE
38	Code (35) + [(20) or (25)]	*	RE	RE
39	Code (35) + [(30) or (31)]	*	RE	RE
40	Extension to: Cul de sac (rectouterine pouch) Upper 2/3's of vagina including fornices Vagina, NOS Vaginal wall, NOS FIGO Stage IIA FIGO Stage II, NOS	T2a	RE	RE
50	Extension to: Ligament(s): Broad Cardinal Uterosacral Parametrium (paracervical soft tissue) FIGO Stage IIB	T2b	RE	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
60	Extension to: Bladder wall Bladder, NOS excluding mucosa Bullous edema of bladder mucosa Lower 1/3 of vagina Rectal wall Rectum, NOS excluding mucosa FIGO Stage IIIA	T3a	RE	RE
62	Extension to: Ureter, intra- and extramural Vulva FIGO Stage IIIA	T3a	D	RE
63	Tumor causes hydronephrosis or nonfunctioning kidney FIGO Stage IIIB	T3b	RE	RE
65	Extension to pelvic wall(s) (Described clinically as "frozen pelvis", NOS) FIGO Stage IIIB	T3b	D	RE
68	Extension to: Fallopian tube Ovary(ies) Urethra FIGO Stage III, NOS	T3NOS	D	RE
70	Extension to rectal or bladder mucosa (Note: for bullous edema of bladder mucosa, see code 60.) FIGO Stage IVA	T4	D	D
80	Further contiguous extension beyond true pelvis Sigmoid colon Small intestine FIGO Stage IVA, not further specified	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For Extension codes 20, 25, 30, 31, 38 and 39, the T category is assigned based on the CS Tumor Size, as shown in the Extension Size Table for this site.

Cervix Uteri

CS TS/Ext-Eval (Revised: 07/31/2007)

Note: If a cone biopsy removes all of the tumor, (for example, negative margins) code CS TS/Ext eval as 3. If there is residual tumor after a cone biopsy, (for example, positive margins) code CS TS/Ext eval as 1.

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c

CS Staging Schemas

Code	Description	Staging Basis
1	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. Does not meet criteria for AJCC pathological T staging.	c
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. Meets criteria for AJCC pathologic T staging.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on clinical evidence.	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.	y
8	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	c

Cervix Uteri

CS Lymph Nodes (Revised: 05/06/2004)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory or definitive surgery is done with no mention of lymph nodes, assume nodes are negative, code 00.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE

Code	Description	TNM	SS77	SS2000
10	Regional lymph nodes: Iliac, NOS: Common External Internal (hypogastric) Obturator Paracervical Parametrial Pelvic, NOS Sacral, NOS: Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Uterosacral Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Cervix Uteri
CS Reg Nodes Eval
SEE STANDARD TABLE

Cervix Uteri
Reg LN Pos
SEE STANDARD TABLE

Cervix Uteri
Reg LN Exam
SEE STANDARD TABLE

Cervix Uteri
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s) including: Aortic (para-, peri-, lateral) Inguinal (femoral) Mediastinal Distant lymph node(s), NOS FIGO Stage IV	M1	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	M1	D	D

Code	Description	TNM	SS77	SS2000
50	(10) to (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Cervix Uteri
CS Mets Eval
SEE STANDARD TABLE

Cervix Uteri
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Cervix Uteri
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Cervix Uteri
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Cervix Uteri
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Cervix Uteri
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Cervix Uteri

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Cervix Uteri
C530–C539
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

[***SEER Note:*** ***Do not code*** dilation and curettage as Surgery of Primary Site **for invasive cancers**]

Codes
00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

[***SEER Note:*** Codes 21 to 23 above combine 20 Local tumor excision, 24 Cone biopsy WITH gross excision of lesion, 26 Excisional biopsy, NOS, 27 Cone biopsy or 29 Trachelectomy, removal of cervical stump; cervicectomy with 21 Electrocautery, 22 Cryosurgery, 23 Laser ablation or excision]

- 25 Dilatation and curettage; endocervical curettage (for insitu only)
- 28 Loop electrocautery excision procedure (LEEP)

[***SEER Notes:*** Margins of resection may have microscopic involvement. Procedures in code 20 include but are not limited to: cryosurgery, electrocautery, excisional biopsy, laser ablation, thermal ablation.]

Specimen sent to pathology from surgical events 20–29

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

Surgery Codes

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration
  Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
  [***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 72 Posterior exenteration
  Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
  [***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 73 Total exenteration
  Includes removal of all pelvic contents and pelvic lymph nodes.
  [***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 74 Extended exenteration
  Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Corpus Uteri, Uterus, NOS
C540-C549, C559

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Corpus Uteri; Uterus, NOS (excluding Placenta)
C54.0-C54.3, C54.8-C54.9, C55.9

C54.0 Isthmus uteri
C54.1 Endometrium
C54.2 Myometrium
C54.3 Fundus uteri
C54.8 Overlapping lesion of corpus uteri
C54.9 Corpus uteri
C55.9 Uterus, NOS

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Tumor Size
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Extension (Revised: 01/25/2005)

Note 1: According to the AJCC, extension to the bowel or bladder mucosa must be proven by biopsy in order to rule out bullous edema.
Note 2: Since "cancer cells in ascites or in peritoneal washings" was not specifically categorized in the 1977 Summary Stage Guide, is unclear to which stage previous cases may have been coded.

Code	Description	TNM	SS77	SS2000
00	In situ: preinvasive; noninvasive; intraepithelial Cancer in situ FIGO Stage 0	Tis	IS	IS
10	FIGO Stage I not further specified Invasive cancer confined to corpus uteri	T1NOS	L	L
11	Confined to endometrium (stroma) FIGO Stage IA	T1a	L	L
12	Tumor invades less than one-half of myometrium Invasion of inner half of myometrium FIGO Stage IB	T1b	L	L
13	Tumor invades one-half or more of myometrium Invasion of outer half of myometrium FIGO Stage IC	T1c	L	L
14	Invasion of myometrium, NOS	T1NOS	L	L
16	Tunica serosa of the visceral peritoneum (serosa covering the corpus)	T1NOS	L	L

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
40	Localized, NOS	T1NOS	L	L
50	Cervix uteri, NOS, but not beyond uterus FIGO Stage II, NOS	T2NOS	RE	RE
51	Endocervical glandular involvement only FIGO Stage IIA	T2a	RE	RE
52	Cervical stromal invasion FIGO Stage IIB	T2b	RE	RE
60	Extension or metastasis within true pelvis: Adnexa Fallopian tube(s) Ligaments: Broad, round, uterosacral Ovary(ies) Parametrium Pelvic serosa Tunica serosa (parietal lining of the pelvic or abdominal cavity) FIGO Stage IIIA FIGO Stage III, NOS	T3a	RE	RE
61	Cancer cells in ascites Cancer cells in peritoneal washings FIGO Stage IIIA	T3a	RE	RE
62	Ureter and vulva	T3a	D	RE
64	Extension or metastasis to vagina FIGO Stage IIIB	T3b	D	RE
65	Extension or metastasis to pelvic wall(s) Described clinically as "frozen pelvis", NOS FIGO Stage IIIB	T3b	RE	RE
66	Extension or metastasis to: Bladder wall Bladder, NOS excluding mucosa Rectal wall Rectum, NOS excluding mucosa FIGO Stage IIIB	T3b	RE	RE
67	[(65) or (66)] and [(62) or (64)]	T3b	D	RE
70	Extension to bowel mucosa or bladder mucosa (excluding bullous edema) FIGO Stage IVA FIGO Stage IV, NOS	T4	D	D
80	Further contiguous extension Abdominal serosa (peritoneum) Cul de sac Sigmoid colon Small intestine	T4	D	D
95	No evidence of primary tumor	T0	U	U

Code	Description	TNM	SS77	SS2000
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS TS/Ext-Eval
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Lymph Nodes (Revised: 08/15/2006)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes include bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Paracervical Parametrial Pelvic, NOS Sacral, NOS: Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Uterosacral	N1	RN	RN
20	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic	N1	RN	RN
50	Regional lymph node(s): FIGO Stage IIIC, NOS	N1	RN	RN
80	Regional lymph node(s), NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Reg Nodes Eval
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
Reg LN Pos
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
Reg LN Exam
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s): Superficial inguinal	M1	RN	D
12	Distant lymph node(s) other than code 11: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph node(s) (codes 11 to 12) Distant metastasis, NOS Carcinomatosis Stage IVB Stage IV, NOS	M1	D	D
50	(40) + any of [(11) to (12)] Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Mets Eval
SEE STANDARD TABLE

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Corpus Uteri; Uterus, NOS (excluding Placenta)
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Corpus Uteri
C540–C559
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

[***SEER Note:*** ***Do not code*** dilation and curettage as Surgery of Primary Site **for invasive cancers**]

Codes
00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10–16

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24–26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

[***SEER Note:*** Codes 21 to 23 above combine 20 Local tumor excision, 24 Excisional biopsy, 25 Polypectomy, or 26 Myomectomy with 21 Electrocautery, 22 Cryosurgery or 23 Laser ablation or excision]

Specimen sent to pathology from surgical events 20–26
[***SEER Note:*** Margins of resection may have microscopic involvement]

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) nd ovary(ies)
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

[***SEER Note:*** For these procedures, the cervix is left in place]

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

Surgery Codes

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
  [***SEER Note:*** Use code 63 for "Type III" hysterectomy]
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration
- 76 Anterior exenteration
  Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
  [***SEER Note*:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 77 Posterior exenteration
  Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
  [***SEER Note***: Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 78 Total exenteration
  Includes removal of all pelvic contents and pelvic lymph nodes.
  [***SEER Note*:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]
- 79 Extended exenteration
  Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Ovary
C569

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Ovary
C56.9

C56.9 Ovary
Note: Laterality must be coded for this site.

CS Tumor Size	**CS Site-Specific Factor 1 -** Carbohydrate Antigen 125 (CA-125)	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Ovary
CS Tumor Size
SEE STANDARD TABLE

Ovary
CS Extension (Revised: 09/17/2007)

Note 1: Ascites WITH malignant cells changes FIGO stages I and II to IC and IIC, respectively. Ascites, NOS is considered negative.
Note 2: Both extension to and discontinuous metastasis to any of the following pelvic organs is considered FIGO Stage II and coded in the range 50-65: adnexae, NOS; bladder, bladder serosa; broad ligament (mesovarium); cul-de-sac; fallopian tubes; parametrium; pelvic peritoneum; pelvic wall; rectum; sigmoid colon; sigmoid mesentery; ureter; uterus; uterine serosa.
Note 3: Peritoneal implants outside the pelvis (codes 70-73) must be microscopically confirmed. Peritoneal implants may also be called seeding, salting, talcum powder appearance, or studding.
Note 4: If implants are mentioned, determine whether they are in the pelvis or in the abdomen and code appropriately (60-64) or (70-73). If the location is not specified, code as 75.
Note 5: Both extension to and discontinuous metastasis to any of the following abdominal organs is considered FIGO Stage III and coded in the range 70-75: abdominal mesentery; diaphragm; gallbladder; infracolic omentum; kidneys; large intestine except rectum and sigmoid colon; liver (peritoneal surface); omentum; pancreas; pericolic gutter; peritoneum, NOS; small intestine; spleen; stomach; ureters.
Note 6: Excludes parenchymal liver nodules, which are coded in CS Mets at DX
Note 7: Since "cancer cells in ascites or in peritoneal washings" was not specifically categorized in the 1977 Summary Stage Guide, it is unclear to which stage previous cases may have been coded.
Note 8: In some registries benign/borderline ovarian tumors are reportable by agreement. If the tumor being reported is benign or borderline, code CS Extension to 99.

Code	Description	TNM	SS77	SS2000
00	In situ; pre-invasive; non-invasive; intraepithelial	Tis	IS	IS
10	Tumor limited to one ovary, capsule intact, no tumor on ovarian surface, no malignant cells in ascites or peritoneal washings FIGO Stage IA	T1a	L	L
20	Tumor limited to both ovaries, capsule(s) intact, no tumor on ovarian surface, no malignant cells in ascites or peritoneal washings FIGO Stage IB	T1b	L	L

Code	Description	TNM	SS77	SS2000
30	Tumor limited to ovaries, unknown if capsule(s) ruptured or if one or both ovaries involved Localized, NOS FIGO Stage I, NOS	T1NOS	L	L
35	Tumor limited to ovary(ies), capsule(s) ruptured FIGO Stage 1C	T1c	L	RE
36	Tumor on ovarian surface FIGO Stage 1C	T1c	D	RE
41	Tumor limited to ovary(ies) WITH malignant cells in ascites or peritoneal washings FIGO Stage IC	T1c	RE	RE
43	(35) + (41) FIGO Stage IC	T1c	RE	RE
44	(36) + any of [(35) or (41)] FIGO Stage 1C	T1c	D	RE
50	Extension to or implants on (but no malignant cells in ascites or peritoneal washings): Adnexa, NOS, ipsilateral or NOS Fallopian tube(s), ipsilateral or NOS FIGO Stage IIA	T2a	RE	RE
52	Extension to or implants on (but no malignant cells in ascites or peritoneal washings): Adnexa, NOS, contralateral Fallopian tube(s), contralateral Uterus FIGO Stage IIA	T2a	D	RE
60	Extension to or implants on other pelvic structures (but no malignant cells in ascites or peritoneal washings): Pelvic tissue: Adjacent peritoneum Ligament(s): Broad, ipsilateral, NOS Ovarian Round Suspensory Mesovarium, ipsilateral, NOS Pelvic wall FIGO Stage IIB	T2b	RE	RE
61	Extension to or implants on other pelvic structures (but no malignant cells in ascites or peritoneal washings): Broad ligament(s), contralateral Mesovarium, contralateral FIGO Stage IIB	T2b	D	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
62	[(50) and/or (60)] WITH malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	RE	RE
63	[(52 and/or 60)] WITH malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	D	RE
64	(61) WITH malignant cells in ascites or peritoneal washings FIGO IIC	T2c	D	RE
65	Tumor involves one or both ovaries with pelvic extension, NOS FIGO Stage II, NOS	T2NOS	RE	RE
70	Microscopic peritoneal implants beyond pelvis, including peritoneal surface/capsule of liver FIGO Stage IIIA (See Note 5)	T3a	D	D
71	Macroscopic peritoneal implants beyond pelvis, less than or equal to 2 cm in diameter, including peritoneal surface of liver FIGO Stage IIIB (See Note 5)	T3b	D	D
72	Peritoneal implants beyond pelvis, greater than 2 cm in diameter, including peritoneal surface of liver (liver capsule) FIGO Stage IIIC (See Note 5)	T3c	D	D
73	Tumor involves one or both ovaries with microscopically confirmed peritoneal metastasis outside the pelvis, NOS FIGO Stage III, NOS (See Note 5)	T3NOS	D	D
75	Peritoneal implants, NOS (See Note 5)	T3NOS	D	D
80	Further contiguous extension	T3NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Ovary
CS TS/Ext-Eval
SEE STANDARD TABLE

Ovary
CS Lymph Nodes (Revised: 08/15/2006)
Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved, code "00".

Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes includes bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric), NOS Obturator Pelvic, NOS	N1	RN	RN
12	Regional lymph node(s): Lateral sacral (laterosacral)	N1	D	RN
20	Regional lymph node(s): Aortic (para-, peri-, lateral) Retroperitoneal, NOS	N1	RN	RN
30	Regional lymph node(s): Inguinal	N1	D	RN
40	(10) + (20)	N1	RN	RN
42	[(12) or (30)] + [(10) or (20)]	N1	D	RN
50	Regional lymph nodes, NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Ovary
CS Reg Nodes Eval
SEE STANDARD TABLE

Ovary
Reg LN Pos
SEE STANDARD TABLE

Ovary
Reg LN Exam
SEE STANDARD TABLE

Ovary
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph node(s) (code 10), including: Liver parenchymal metastasis Pleural effusion WITH positive cytology Distant metastasis, NOS Carcinomatosis Stage IV, NOS	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Ovary
CS Mets Eval
SEE STANDARD TABLE

Ovary
CS Site-Specific Factor 1 Carbohydrate Antigen 125 (CA-125) (Revised: 05/06/2004)

Code	Description
000	Test not done
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Not documented in patient record Unknown or no information

Ovary
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ovary
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ovary
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ovary
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Ovary
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Ovary
C569
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 17

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

Specimen sent to pathology from surgical events 25–28

35 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy
  [***SEER Note:*** Use code 37 for current unilateral (salpingo-) oophorectomy with previous history of hysterectomy]

50 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy
  [***SEER Note:*** Use code 52 for current bilateral (salpingo-) oophorectomy with previous history of hysterectomy]

55 Unilateral or bilateral (salpingo-) oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A debulking is usually followed by another treatment modality such as chemotherapy.

[***SEER Note:*** Debulking or cytoreductive surgery is implied by the following phrases (This is not intended to be a complete list. Other phrases may also imply debulking).

Adjuvant treatment pending surgical reduction of tumor
Ovaries, tubes buried in tumor
Tumor burden
Tumor cakes
Very large tumor mass

Do not code multiple biopsies alone as debulking or cytoreductive surgery. Do not code debulking or cytoreductive surgery based only on the mention of "multiple tissue fragments" or "removal of multiple implants." Multiple biopsies and multiple specimens confirm the presence or absence of metastasis].

70 Pelvic exenteration, NOS

Surgery Codes

71 Anterior exenteration
Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.
[***SEER Note*:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.
[***SEER Note*:** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.
[***SEER Note:*** Do not code removal of pelvic lymph nodes under Surgical Procedure/Other Site]

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis

80 (Salpingo-) oophorectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Fallopian Tube, Ligaments, Adnexa
C570, C571-C574

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Fallopian Tube
C57.0

C57.0 Fallopian tube
Note: Laterality must be coded for this site.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Fallopian Tube
CS Tumor Size
SEE STANDARD TABLE

Fallopian Tube
CS Extension (Revised: 09/25/2007)

Note 1: Positive regional lymph nodes (FIGO Stage IIIC) are coded in the CS Lymph Nodes field.
Note 2: Codes 13 and 66: Since "malignant ascites or malignant peritoneal washings" was not specifically categorized in the 1977 Summary Staging Guide, it is unclear to which stage previous cases may have been coded.
Note 3: Liver capsule metastases are coded to 75-78 in the Extension field; liver parenchymal metastases are coded in the Mets at DX field.
Note 4: Both extension to and discontinuous metastasis to any of the following PELVIC organs is considered FIGO Stage II and coded in the range 35-66: adnexae, NOS; bladder, bladder serosa; broad ligament (mesovarium); cul-de-sac; fallopian tubes; parametrium; pelvic peritoneum; pelvic wall; rectum; sigmoid colon; sigmoid mesentery; ureter; uterus; uterine serosa.
Note 5: Both extension to and discontinuous metastasis to any of the following ABDOMINAL organs is considered FIGO Stage III and coded in the range 69-78: abdominal mesentery; diaphragm; gallbladder; infracolic omentum; kidneys; large intestine except rectum and sigmoid colon; liver (peritoneal surface); omentum; pancreas; pericolic gutter; peritoneum, NOS; small intestine; spleen; stomach; ureters.
Note 6: From the AJCC Manual 6th Edition (page 285): "It may be preferable to classify a patient as TX (primary tumor cannot be assessed) if inadequate staging biopsies and/or a lack of peritoneal cytology make it inaccurate to classify the patient with confidence as early stage (Stage T3a/IIIA has not been excluded by adequate staging biopsies)."

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive, intraepithelial Limited to tubal mucosa FIGO Stage 0	Tis	IS	IS
10	Confined to fallopian tube, NOS FIGO Stage I	T1NOS	L	L
11	Confined to one fallopian tube WITHOUT penetrating serosal surface; no ascites FIGO Stage IA	T1a	L	L
12	Confined to both fallopian tubes WITHOUT penetrating serosal surface; no ascites FIGO Stage IB	T1b	L	L

Code	Description	TNM	SS77	SS2000
13	Extension onto or through tubal serosa Malignant ascites Malignant peritoneal washings FIGO Stage IC	T1c	L	L
30	Localized, NOS FIGO Stage 1	T1NOS	L	L
35	Pelvic extension, NOS with no malignant cells in ascites or peritoneal washings FIGO Stage II	T2NOS	RE	RE
40	Extension or metastasis to (but no malignant cells in ascites or peritoneal washings): Corpus uteri Ovary, ipsilateral Uterus, NOS FIGO Stage IIA	T2a	RE	RE
50	Extension or metastasis to (but no malignant cells in ascites or peritoneal washings): Broad ligament, ipsilateral Mesosalpinx, ipsilateral Adjacent peritoneum FIGO Stage IIB	T2b	RE	RE
60	Ovary, contralateral (but no malignant cells in ascites or peritoneal washings) FIGO Stage IIA	T2a	D	RE
61	(60) + (50)	T2b	D	RE
65	Extension or metastasis to (but no malignant cells in ascites or peritoneal washings): Broad ligament, contralateral Cul de sac (rectouterine pouch) Mesosalpinx, contralateral Rectosigmoid Sigmoid FIGO IIB	T2b	D	RE
66	Pelvic extension (codes 35-65) WITH malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	D	D
68	Peritoneal implants or metastasis(size of metastases not stated; unknown if microscopic or macroscopic) Omentum Small intestine FIGO Stage III	T3NOS	D	D
69	Microscopic peritoneal implants or metastasis: Omentum Small intestine FIGO Stage IIIA	T3a	D	D

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
70	OBSOLETE: converted to 68 Extension or metastasis to: than or equal to 2 cm outside the pelvis Omentum FIGO Stage IIB	T2b	D	RE
71	OBSOLETE: converted to 66 Pelvic extension (codes 35-70) with malignant cells in ascites or peritoneal washings FIGO Stage IIC	T2c	D	D
72	Further contiguous extension Macroscopic peritoneal implants or metastasis less than or equal to 2cm Omentum Small intestine FIGO Stage IIIB	T3b	D	D
73	Macroscopic peritoneal implants or metastasis greater than 2cm Omentum Small intestine FIGO Stage IIIC	T3c	D	D
75	Peritoneal implants outside the pelvis, NOS (size of metastases not stated; unknown if microscopic or macroscopic), except code 68 (See Note 5) FIGO Stage III	T3NOS	D	D
76	Microscopic peritoneal metastasis outside the pelvis, except code 69 (See Note 5) FIGO Stage IIIA	T3a	D	D
77	Macroscopic peritoneal metastasis less than or equal to 2 cm outside the pelvis, except code 72 (See Note 5) FIGO Stage IIIB	T3b	D	D
78	Peritoneal metastases greater than 2 cm, except code 73 (See Note 5) FIGO Stage IIIC	T3c	D	D
80	Further contiguous extension FIGO Stage III	T3NOS	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed (See Note 6) Not documented in patient record	TX	U	U

Fallopian Tube
CS TS/Ext-Eval
SEE STANDARD TABLE

Fallopian Tube

CS Lymph Nodes (Revised: 08/15/2006)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.
Note 4: Regional nodes include bilateral and contralateral involvement of named nodes.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric) Obturator Pelvic, NOS	N1	RN	RN
12	Regional lymph node(s): Lateral sacral (laterosacral) Presacral	N1	D	RN
20	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Retroperitoneal, NOS	N1	RN	RN
22	(12) + (20)	N1	D	RN
30	Regional lymph node(s): Inguinal	N1	D	RN
50	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Fallopian Tube
CS Reg Nodes Eval
SEE STANDARD TABLE

Fallopian Tube
Reg LN Pos
SEE STANDARD TABLE

Fallopian Tube
Reg LN Exam
SEE STANDARD TABLE

Fallopian Tube
CS Mets at DX (Revised: 05/06/2004)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Distant lymph node(s), NOS	M1	D	D
40	Distant metastases, except distant lymph nodes (code 10), including: Liver parenchymal metastasis Pleural effusion WITH positive cytology Distant metastasis, NOS Carcinomatosis	M1	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Fallopian Tube
CS Mets Eval
SEE STANDARD TABLE

Fallopian Tube
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Fallopian Tube
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Fallopian Tube
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Fallopian Tube
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Fallopian Tube
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Fallopian Tube
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa C57.1-C57.4

C57.1 Broad ligament
C57.2 Round ligament
C57.3 Parametrium
C57.4 Uterine adnexa
Note: AJCC does not define TNM staging for this site.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histologies for Which AJCC Staging Is Not Generated
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	AJCC Stage
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Broad and Round Ligaments, Parametrium, Uterine Adnexa CS Tumor Size

SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa CS Extension (Revised: 03/17/2004)

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Confined to tissue or organ of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Corpus uteri Ovary, ipsilateral Uterus, NOS	NA	RE	RE
50	Fallopian tube for ligaments Mesosalpinx, ipsilateral Peritoneum	NA	RE	RE
70	Cervix uteri Cul de sac (rectouterine pouch) Omentum Ovary, contralateral Rectosigmoid Sigmoid Small intestine	NA	D	D
80	Further contiguous extension	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS TS/Ext-Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Lymph Nodes (Revised: 08/15/2006)

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Iliac, NOS: Common External Internal (hypogastric): Obturator Inguinal Lateral sacral (laterosacral) Pelvic, NOS Retroperitoneal, NOS Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NA	U	U

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Reg Nodes Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Broad and Round Ligaments, Parametrium, Uterine Adnexa
Reg LN Pos
SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa

Reg LN Exam
SEE STANDARD TABLE

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Mets at DX (Revised: 12/09/2003)

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Mets Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Broad and Round Ligaments, Parametrium, Uterine Adnexa
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, **C570–C579**, C589, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 25 Laser excision

Specimen sent to pathology from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Other and Unspecified Female Genital Organs, Placenta
C577-C579, C589

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Other and Unspecified Female Genital Organs
C57.7-C57.9

C57.7 Other specified parts of female genital organs
C57.8 Overlapping lesion of female genital organs
C57.9 Female genital tract, NOS
Note: AJCC does not define TNM staging for this site.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histologies for Which AJCC Staging Is Not Generated
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	AJCC Stage
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Other and Unspecified Female Genital Organs
CS Tumor Size

SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
CS Extension (Revised: 03/17/2004)

Code	Description	TNM	SS77	SS2000
00	In situ; non-invasive; intraepithelial	NA	IS	IS
10	Confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (See definition in General Instructions)	NA	RE	RE
60	Adjacent organs/structures: Female genital organs: Adnexa Broad ligament(s) Cervix uteri Corpus uteri Fallopian tube(s) Ovary(ies) Parametrium Round ligament(s) Uterus, NOS Vagina	NA	RE	RE
80	Further contiguous extension: Other organs of pelvis	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Female Genital Organs
CS TS/Ext-Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Female Genital Organs
CS Lymph Nodes (Revised: 03/17/2004)

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN
99	Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Female Genital Organs
CS Reg Nodes Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Female Genital Organs
Reg LN Pos
SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
Reg LN Exam
SEE STANDARD TABLE

Other and Unspecified Female Genital Organs
CS Mets at DX (Revised: 12/09/2003)

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D

Code	Description	TNM	SS77	SS2000
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Female Genital Organs
CS Mets Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Female Genital Organs
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Placenta
C58.9

C58.9 Placenta

Note 1: This schema correlates to the AJCC's Gestational Trophoblastic Tumors scheme. In most cases, gestational trophoblastic tumors (ICD-O-3 morphology codes 9100-9105) are coded to placenta, C58.9.

Note 2: If a trophoblastic tumor is not associated with a pregnancy and arises in another site, such as ovary, use the primary site code and Collaborative Staging schema for that site.

CS Tumor Size	**CS Site-Specific Factor 1 -**	**The following tables are available at the collaborative staging website:**
CS Extension	Prognostic Scoring Index Table 1	
CS TS/Ext-Eval	CS Site-Specific Factor 2	Histology Exclusion Table
CS Lymph Nodes	CS Site-Specific Factor 3	AJCC Stage
CS Reg Nodes Eval	CS Site-Specific Factor 4	
Reg LN Pos	CS Site-Specific Factor 5	
Reg LN Exam	CS Site-Specific Factor 6	
CS Mets at DX		
CS Mets Eval		

Placenta
CS Tumor Size

SEE STANDARD TABLE

Placenta
CS Extension (Revised: 05/06/2004)

Note 1: Substaging of gestational trophoblastic tumors are determined by the value coded in the Prognostic Scoring Index Table, using Site Specific Factor 1. See note in Site Specific Factor 1, Prognostic Index Table to determine the prognostic index score.

Note 2: For this schema, according to AJCC, involvement of genital structures may be either by direct extension or metastasis and is still T2. For Collaborative Staging, metastasis to genital structures should be coded 70 in CS Extension and not coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial FIGO Stage 0	Tis	IS	IS
10	Confined to placenta FIGO Stage I	T1	L	L
30	Localized, NOS FIGO Stage 1	T1	L	L
40	Adjacent connective tissue, NOS FIGO Stage II	T2	RE	RE
60	Other genital structures by direct extension or NOS: Broad ligament Cervix Corpus uteri Fallopian tube(s) Genital structures, NOS Ovary(ies) Uterus, NOS Vagina FIGO Stage II	T2	RE	RE

Code	Description	TNM	SS77	SS2000
70	Other genital structures, by metastasis: Broad ligament Cervix Corpus uteri Fallopian tube(s) Genital structures, NOS Ovary(ies) Uterus, NOS Vagina FIGO Stage II	T2	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Note: For codes 10 - 80, the substaging is determined by using the Risk Scores in the Prognostic Scoring Index in Site Specific Factor 1 Table.

Placenta
CS TS/Ext-Eval
SEE STANDARD TABLE

Placenta
CS Lymph Nodes (Revised: 05/07/2004)

Code	Description	TNM	SS77	SS2000
88	Not applicable	NA	U	U

Placenta
CS Reg Nodes Eval (Revised: 03/17/2004)

Code	Description	
9	Does not apply	NA

Placenta
Reg LN Pos (Revised: 05/17/2006)

Code	Description
99	Not applicable

Placenta
Reg LN Exam (Revised: 05/17/2006)

Code	Description
99	Not applicable

Placenta
CS Mets at DX (Revised: 08/15/2006)

Note 1: All lymph node involvement is considered M1 in TNM, so all lymph node involvement, whether regional or distant nodes, is coded in the field Mets at DX.

Note 2: According to AJCC, metastasis to genital structures is considered T2 and not M1 for GTT. For this Collaborative Staging schema, metastasis to genital structures is coded 70 in CS Extension and not coded in CS Mets at DX.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
10	Metastasis to lung(s) only, NOS FIGO III	M1a	D	D
20	Regional lymph node(s): Iliac, NOS: Common External Internal (hypogastric), NOS Obturator Parametrial Pelvic, NOS Sacral, NOS: Lateral Presacral Promontory (Gerota's) Uterosacral	M1b	RN	RN
30	Regional lymph node(s): Aortic, NOS: Lateral Para-aortic Periaortic	M1b	RN	RN
35	(20) + (30)	M1b	RN	RN
40	Regional lymph node(s), NOS	M1b	RN	RN
50	Distant lymph node(s), NOS	M1b	D	D
51	Distant lymph node(s): Superficial inguinal (femoral)	M1b	D	D
52	Specified distant lymph node(s) other than in code 51	M1b	D	D
60	Lymph nodes, NOS	M1b	D	D
70	Distant metastases, other than lymph nodes or lung Distant metastasis, NOS Carcinomatosis	M1b	D	D

Code	Description	TNM	SS77	SS2000
80	(70) + any of [(10) to (60)]	M1b	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Placenta
CS Mets Eval
SEE STANDARD TABLE

Placenta
CS Site-Specific Factor 1 Prognostic Scoring Index Table 1 (Revised: 08/18/2006)

Note: Clinician scoring is recommended. If any one of the factors is unknown, stop trying to assign score, unless you have already determined with the factors you have - low risk or high risk. The score on the Prognostic Scoring Index is used to substage patients. Substage A (low risk) and Substage B (high risk) are assigned on the basis of a non-anatomic risk factor scoring system: AGE [Score 0: age less than or equal to 40; Score 1: age 40 or more]; ANTECEDENT PREG [Score 0: Hydatidiform mole; Score 1: Abortion; Score 2: Term pregnancy]; MONTHS FROM INDEX PREG [Score 0: less than 4; Score 1: 4 months and less than 7 months; Score 2: 7 months to 12 months; Score 4: More than 12 months]; PRETREATMENT SERUM hCG(IU/ml) [Score 0: <10 to 3rd power, (1,000); Score 1: 10-3rd power to 10-4th power (1,000 to less than 10,000); Score 2: 10-4th power to less than 10-5th power (10,000 to less than 100,000); Score 4: greater than or equal to 10-5th power (100,000 or greater)]; LARGEST TUMOR SIZE, INCLUDING UTERUS [Score 0: < 3 cm; Score 1: 3-<5 cm; Score 2: greater than or equal to 5 cm]; SITES OF METS [Score 0: Lung only or None; Score 1: Spleen, kidney; Score 2: Gastrointestinal tract; Score 4: Liver, brain]; NUMBER OF METS [Score 0: 0; Score 1: 1-4; Score 2: 5-8; Score 4: >8]; PREVIOUS FAILED CHEMOTHERAPY [Score 2: Single drug; Score 4: 2 or more drugs]. Sum the score of each prognostic risk factor(s) to determine the final Prognostic Scoring Index in the table below:

Code	Description
000	Clinician stated no risk factors
001	Clinician stated low risk (sum score of 7 or less) Stated to be substage A, but score not specified
002	Clinician stated high risk (sum score of 8 or greater or NOS) Stated to be substage B, but score not specified
200	Clinician stated to have risk factors, but unknown whether low or high risk
999	Unknown Risk factors cannot be assessed Not documented in patient record

Placenta
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Placenta
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Placenta
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Placenta
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Placenta
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, **C570–C579**, **C589**, C600–C609, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 25 Laser excision

Specimen sent to pathology from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Penis
C600-C609

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
C60.0-C60.2, C60.8-C60.9

C60.0 Prepuce
C60.1 Glans penis
C60.2 Body of penis
C60.8 Overlapping lesion of penis
C60.9 Penis, NOS

Note: This schema is NOT used for Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, or Other Lymphomas. Each of these diseases has a separate schema.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Tumor Size

SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Extension (Revised: 08/15/2006)

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; Bowen disease; intraepithelial	Tis	IS	IS
05	Non-invasive verrucous carcinoma	Ta	IS	IS
10	Invasive tumor limited to subepithelial connective tissue, but not involving corpus spongiosum or cavernosum If primary is skin: invasive tumor limited to skin of penis, prepuce (foreskin) and/or glans	T1	L	L
30	Localized, NOS	T1	L	L
35	For body of penis ONLY: Corpus cavernosum Corpus spongiosum Tunica albuginea of corpus spongiosum	T2	L	L
40	Corpus cavernosum except for tumor in body of penis Corpus spongiosum except for tumor in body of penis Tunica albuginea of corpus spongiosum except for tumor in body of penis	T2	RE	RE
50	Satellite nodule(s) on prepuce or glans	T1	RE	RE

Code	Description	TNM	SS77	SS2000
60	Prostate Urethra	T3	RE	RE
70	Adjacent structures: Muscle, NOS: Bulbospongiosus Ischiocavernosus Superficial transverse perineal Skin: Abdominal Perineum Pubic Scrotal	T4	RE	RE
80	Further contiguous extension Testis	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]

CS TS/Ext-Eval

SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]

CS Lymph Nodes (Revised: 05/06/2004)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
Note 2: If the clinician says "adnexa palpated" but doesn't mention lymph nodes, assume lymph nodes are not involved.
Note 3: If either exploratory/definitive surgery is done with no mention of lymph nodes, assume nodes are negative.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	SINGLE superficial inguinal (femoral) regional lymph node	N1	RN	RN
20	Multiple OR bilateral superficial inguinal (femoral) regional lymph nodes	N2	RN	RN
30	Regional lymph node: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal)	N3	RN	RN

Code	Description	TNM	SS77	SS2000
40	Regional lymph Nodes: External iliac Internal iliac (hypogastric) Obturator Pelvic nodes, NOS	N3	RN	RN
50	Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Reg Nodes Eval
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
Reg LN Pos
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
Reg LN Exam
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Mets at DX
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Mets Eval
SEE STANDARD TABLE

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Penis [excl Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease and Other Lymphomas]
CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, **C600–C609**, C630–C639, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 **Local** tumor **excision**, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

- 25 Laser excision

Specimen sent to pathology from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 **Total surgical removal** of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "**debulking**"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 **Unknown** if surgery performed; **death certificate** ONLY

Prostate
C619

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Prostate
C61.9

C61.9 Prostate gland

Note: Transitional cell carcinoma of the prostatic urethra is to be coded to primary site C68.0, Urethra, and assigned Collaborative Stage codes according to the urethra scheme.

CS Tumor Size CS Extension-Clinical Extension CS TS/Ext-Eval CS Lymph Nodes CS Reg Nodes Eval Reg LN Pos Reg LN Exam CS Mets at DX CS Mets Eval	**CS Site-Specific Factor 1 -** Prostatic Specific Antigen (PSA) Lab Value **CS Site-Specific Factor 2 -** Prostatic Specific Antigen (PSA) **CS Site-Specific Factor 3 -** CS Extension - Pathologic Extension **CS Site-Specific Factor 4 -** Prostate Apex Involvement (OBSOLETE: Prostatic Acid Phosphatase (PAP)) **CS Site-Specific Factor 5 -** Gleason's Primary Pattern and Secondary Pattern Value **CS Site-Specific Factor 6 -** Gleason's Score	**The following tables are available at the collaborative staging website:** Histology Exclusion Table AJCC Stage

Prostate
CS Tumor Size

SEE STANDARD TABLE

Prostate
CS Extension-Clinical Extension (Revised: 09/25/2007)

Note 1: This field and Site-Specific Factor 3, CS Extension - Pathologic Extension, must both be coded, whether or not a prostatectomy was performed. Information from prostatectomy is EXCLUDED from this field and coded only in Site-Specific Factor 3, including cases diagnosed at autopsy.

Note 2:

A. A clinically inapparent tumor is one that is neither palpable nor reliably visible by imaging. An apparent tumor is palpable or visible by imaging.

Do not infer inapparent or apparent tumor based on the registrar's interpretation of terms in the DRE or imaging reports. A physician assignment of cT1 or cT2 is a clear statement of inapparent or apparent respectively. Code to 30 (which maps to T2 NOS) in the absence of a clear physician's statement of inapparent or apparent.

B. Codes 10-15: CODES 10 to 15 are used only for clinically inapparent tumor not palpable or visible by imaging and incidentally found microscopic carcinoma (latent, occult) in one or both lobes. Within this range, give priority to codes 13-15 over code 10. When tumor is found in one lobe, both lobes or in prostatic apex by needle biopsy but is not palpable or visible by imaging, use code 15.

C. CODES 20 to 24 are used only for clinically/radiographically apparent tumor, i.e., that which is palpable or visible by imaging. To decide among codes 20-24, use only physical exam or imaging information, and not biopsy information. Codes 21 and 22 have precedence over code 20. Code 20 has precedence over code 24. Use code 24 if the physician assigns cT2 without a subcategory of a, b, or c.

D. CODE 30 is used for localized cancer when it is unknown if clinically or radiographically apparent. An example would be when a diagnosis is made prior to admission for a prostatectomy with no details provided on clinical findings prior to admission.

E. CODES 31, 33 and 34 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the "T" classification.

F. CODES 41 to 49 are used for extension beyond the prostate.

Note 3: Prostate Apex Involvement: This field and Site-Specific Factor 4, Prostate Apex Involvement, are both coded whether or not a prostatectomy was performed.
Note 4: Use codes 13-14 when a TURP is done, not for a biopsy only. Do not use code 15 when a TURP is done.
Note 5: Involvement of the prostatic urethra does not alter the extension code.
Note 6: "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 60.
Note 7: AUA stage. Some of the American Urological Association (AUA) stages A-D are provided as guidelines for coding in the absence of more specific information in the medical record. If physician-assigned AUA stage D1-D2 is based on involvement of lymph nodes only, code under CS Lymph Nodes or CS Mets at DX, not CS Extension.
Note 8: This schema includes evaluation of other pathologic tissue such as a biopsy of the rectum.
Note 9: For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c, p, y, or a indicator (staging basis) are assigned based on the values in CS Extension, CS TS/Eval, and Site-Specific Factor 3. The calculation is performed differently depending on whether clinical information or pathological information takes precedence in a specific case. Note that for prostate, AJCC pathologic staging usually requires a prostatectomy. Pathologic staging information from a prostatectomy takes precedence EXCEPT when neoadjuvant treatment has been given and the clinical staging information is either AS extensive or MORE extensive than the pathologic information. The Collaborative Staging algorithm implements this logic as described below. Some combinations of codes may be errors. The CS algorithm will still calculate stage outputs if possible, and another edit program will need to identify the errors for correction. FOR CALCULATION OF DERIVED AJCC T FOR INVASIVE CANCERS (If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ cancer on a prostatectomy specimen), see the In Situ logic below.) If the value of Site-Specific Factor 3 is greater than 000 (invasive cancer on prostatectomy, or prostatectomy not done or unknown), AND if the TS/Ext-Eval code is 0, 1, 2, 3, 5, 8, or 9, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (invasive cancer on prostatectomy), AND if the TS/Ext-Eval code is 4 or 6, then the mapping value for Derived AJCC T is taken from SSF3 mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (invasive cancer on prostatectomy), AND if the TS/Ext-Eval code is blank or not collected, then the mapping value for Derived AJCC T is taken from the SSF3 mapping, and the staging basis indicator is not derived. If the value of Site-Specific Factor 3 is 095 or greater (prostatectomy not done or unknown), AND if the TS/Ext-Eval code is 4 or 6, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. (This combination of codes is probably in error.) If the value of Site-Specific Factor 3 is 095 or greater (prostatectomy not done or unknown), AND if the TS/Ext-Eval code is blank or not collected, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is not derived. FOR CALCULATION OF DERIVED AJCC T FOR IN SITU CANCERS If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ), and if the value of CS Extension (Clinical Extension) is greater than 00 and less than 95 (not in situ), then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the CS TS/Ext Eval mapping (but if the Eval field is blank, no staging basis will be derived). If the value of Site-Specific Factor 3 is 000 (in situ) and the value of CS Extension code is 00 (in situ) or 95 or greater, the mapping value is taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT (but if the Eval field is blank, no staging basis will be derived). FOR CALCULATION OF SS77 AND SS2000 If the value of Site-Specific Factor 3 (Pathologic Extension) is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), then the mapping values for SS77 and 2000 are taken from the Site-Specific Factor 3 mapping. If the value of Site-Specific Factor 3 (Pathologic Extension) is 095 or greater (meaning that prostatectomy was not performed, or it was performed but the information is not usable for staging), then the mapping values for SS77 and SS2000 are taken from the CS Extension (Clinical Extension) mapping. If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ), and if the value of CS Extension (Clinical Extension) is greater than 00 and less than 95 (not in situ), then the SS77 and SS2000 mapping values are taken from the CS Extension (Clinical Extension) mapping. If both Site-Specific Factor 3 and CS Extension indicate in situ (codes 000 and 00 respectively), then the mapping values are taken from the Site-Specific Factor 3.

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial	Tis	IS	IS

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
10	Clinically inapparent tumor, number of foci or percent involved tissue not specified Stage A, NOS	T1NOS	L	L
13	Incidental histologic finding in 5% or less of tissue resected (clinically inapparent) Stated as cT1a	T1a	L	L
14	Incidental histologic finding more than 5% of tissue resected (clinically inapparent) Stated as cT1b	T1b	L	L
15	Tumor identified by needle biopsy, e.g., for elevated PSA (clinically inapparent) Stated as cT1c	T1c	L	L
20	Involvement in one lobe, NOS (clinically apparent only)	T2NOS	L	L
21	Involves one half of one lobe or less (clinically apparent only) Stated as cT2a	T2a	L	L
22	Involves more than one half of one lobe, but not both lobes (clinically apparent only) Stated as cT2b	T2b	L	L
23	Involves both lobes (clinically apparent only) Stated as cT2c	T2c	L	L
24	Clinically apparent tumor confined to prostate, NOS Stated as cT2 without subcategory a, b, or c Stage B, NOS	T2NOS	L	L
30	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Not stated if Stage A or B, T1 or T2, clinically apparent or inapparent	T2NOS	L	L
31	OBSOLETE - Into prostatic apex/arising in prostatic apex, NOS (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
33	OBSOLETE - Arising in prostatic apex (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
34	OBSOLETE - Extending into prostatic apex (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
41	Extension to periprostatic tissue (Stage C1) Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3NOS	RE	RE
42	Unilateral extracapsular extension	T3a	RE	RE
43	Bilateral extracapsular extension	T3a	RE	RE
45	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
49	Periprostatic extension, NOS (Unknown if seminal vesicle(s) involved) Stage C, NOS	T3NOS	RE	RE
50	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
52	Levator muscles Skeletal muscle, NOS Ureter(s)	T4	D	RE
60	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 6)	T4	D	D
70	Further contiguous extension (Stage D2) including to: Bone Other organs Penis Sigmoid colon Soft Tissue other than periprostatic	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Prostate

CS TS/Ext-Eval (Revised: 09/18/2007)

Note 1: For this site, use this item to evaluate the coding of tumor size and extension as coded in both CS Extension (clinical for prostate) and Site-Specific Factor 3, Pathologic Extension if prostatectomy was performed.
Note 2: The codes for this item for prostate differ from the codes used for most other sites. AJCC allows pathologic staging to be assigned on the basis of some biopsies without resection. According to the AJCC manual, "In general, total prostatoseminal-vesiculectomy, including regional node specimen, and histologic confirmation are required for pathologic T classification. However, under certain circumstances, pathologic T classification can be determined with other means. For example, (1) positive biopsy of the rectum permits a pT4 classification without prostatoseminal-vesiculectomy, and (2) a biopsy revealing carcinoma in extraprostatic soft tissue permits a pT3 classification, as does a biopsy revealing adenocarcinoma infiltrating the seminal vesicles." (P. 310)
Note 3: For this site, the T category and its associated c, p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 3. For details, see Note 9 under CS Extension.
Note 4: According to AJCC, staging basis for transurethral resection of prostate (TURP) is clinical and is recorded as CS TS/Ext-Eval "1" (c).

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c

CS Staging Schemas

Code	Description	Staging Basis
1	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. Does not meet criteria for AJCC pathological T staging.	c
2	No surgical resection done, but positive biopsy of extraprostatic tissue allows assignment to CS Extension Codes 41-70 (see Note 2).	p
3	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
4	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. Meets criteria for AJCC pathologic T staging.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on clinical evidence.	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.	y
8	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	c

Prostate

CS Lymph Nodes (Revised: 08/15/2006)

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional nodes, including contralateral or bilateral lymph nodes: Iliac, NOS External Internal (hypogastric), NOS: Obturator Pelvic, NOS Periprostatic Sacral, NOS Lateral (laterosacral) Middle (promontorial)(Gerota's node) Presacral Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN

Code	Description	TNM	SS77	SS2000
99	Unknown; not stated Regional lymph nodes cannot be assessed	NX	U	U

Prostate
CS Reg Nodes Eval
SEE STANDARD TABLE

Prostate
Reg LN Pos
SEE STANDARD TABLE

Prostate
Reg LN Exam
SEE STANDARD TABLE

Prostate
CS Mets at DX (Revised: 07/26/2007)

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s): Common iliac	M1a	RN	D
12	Distant lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Cervical Inguinal, NOS Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) Retroperitoneal, NOS Scalene (inferior deep cervical) Supraclavicular (transverse cervical) Distant lymph node(s), NOS	M1a	D	D
30	Metastasis in bone(s)	M1b	D	D
35	(30) + [(11) or (12)]	M1b	D	D
40	Distant metastasis, other than distant lymph nodes (codes 11 or 12) or bone(s) Carcinomatosis	M1c	D	D
45	Distant metastasis, NOS Stage D2, NOS	M1NOS	D	D

Code	Description	TNM	SS77	SS2000
50	(40) + any of [(11) or (12)]	M1c	D	D
55	(40) + any of [(30) or (35)]	M1c	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Prostate
CS Mets Eval
SEE STANDARD TABLE

Prostate
CS Site-Specific Factor 1 Prostatic Specific Antigen (PSA) Lab Value (Revised: 07/28/2006)
Note 1: Record the highest PSA lab value recorded in the medical record prior to diagnostic biopsy or treatment. Lab value may be recorded in the lab report, history and physical, or clinical statement in the pathology report, etc. For example, a pretreatment PSA of 20.0 ng/ml would be recorded as 200.
Note 2: Lab values for SSFs 1 and 2 should be from the same laboratory test.

Code	Description
000	Test not done (test was not ordered and was not performed)
001	0.1 or less ng/ml (actual value with implied decimal point)
002-989	0.2 - 98.9 ng/ml (actual value with implied decimal point)
990	99.0 or greater ng/ml
999	Unknown or no information Not documented in patient record

Prostate
CS Site-Specific Factor 2 Prostatic Specific Antigen (PSA) (Revised: 07/28/2006)
Note 1: Use the highest PSA lab value recorded in the medical record prior to diagnostic biopsy or treatment. This lab value may be recorded in the lab report, history and physical, or clinical statement in the pathology report, etc.
Note 2: Lab values for SSFs 1 and 2 should be from the same laboratory test.

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Prostate

CS Site-Specific Factor 3 CS Extension - Pathologic Extension (Revised: 09/17/2007)

Note 1: Include information from prostatectomy in this field and not in CS Extension - Clinical Extension. Use all histologic information including the prostatectomy if it was done within the first course of treatment. Code 097 if there was no prostatectomy performed within the first course of treatment.
Note 2: Limit information in this field to first course of treatment in the absence of disease progression.
Note 3: Involvement of the prostatic urethra does not alter the extension code.
Note 4: When the apical margin, distal urethral margin, bladder base margin, or bladder neck margin is involved and there is no extracapsular extension, use code 040.
Note 5: CODES 031, 033 and 034 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the "T" classification.
Note 6: When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found (for example, one lobe, or both lobes, or more).
Note 7: "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 060.
Note 8: AUA stage. Some of the American Urological Association (AUA) stages A-D are provided as guidelines for coding in the absence of more specific information in the medical record. If physician-assigned AUA stage D1-D2 is based on involvement of lymph nodes only, code under CS Lymph Nodes or CS Mets at DX, not CS Extension - Pathologic Extension.
Note 9: For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c, p, y, or a indicator (staging basis) are assigned based on the values in CS Extension, CS TS/Eval, and Site-Specific Factor 3. The calculation is performed differently depending on whether clinical information or pathological information takes precedence in a specific case. Note that for prostate, AJCC pathologic staging usually requires a prostatectomy. Pathologic staging information from a prostatectomy takes precedence EXCEPT when neoadjuvant treatment has been given and the clinical staging information is either AS extensive or MORE extensive than the pathologic information. The Collaborative Staging algorithm implements this logic as described below. Some combinations of codes may be errors. The CS algorithm will still calculate stage outputs if possible, and another edit program will need to identify the errors for correction. FOR CALCULATION OF DERIVED AJCC T FOR INVASIVE CANCERS (If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ cancer on a prostatectomy specimen), see the In Situ logic below.) If the value of Site-Specific Factor 3 is greater than 000 (invasive cancer on prostatectomy, or prostatectomy not done or unknown), AND if the TS/Ext-Eval code is 0, 1, 2, 3, 5, 8, or 9, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (invasive cancer on prostatectomy), AND if the TS/Ext-Eval code is 4 or 6, then the mapping value for Derived AJCC T is taken from SSF3 mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (invasive cancer on prostatectomy), AND if the TS/Ext-Eval code is blank or not collected, then the mapping value for Derived AJCC T is taken from the SSF3 mapping, and the staging basis indicator is not derived. If the value of Site-Specific Factor 3 is 095 or greater (prostatectomy not done or unknown), AND if the TS/Ext-Eval code is 4 or 6, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the TS/Ext Eval mapping. (This combination of codes is probably in error.) If the value of Site-Specific Factor 3 is 095 or greater (prostatectomy not done or unknown), AND if the TS/Ext-Eval code is blank or not collected, then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is not derived. FOR CALCULATION OF DERIVED AJCC T FOR IN SITU CANCERS If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ), and if the value of CS Extension (Clinical Extension) is greater than 00 and less than 95 (not in situ), then the mapping value for Derived AJCC T is taken from the CS Extension (Clinical Extension) mapping, and the staging basis indicator is taken from the CS TS/Ext Eval mapping (but if the Eval field is blank, no staging basis will be derived). If the value of Site-Specific Factor 3 is 000 (in situ) and the value of CS Extension code is 00 (in situ) or 95 or greater, the mapping value is taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT (but if the Eval field is blank, no staging basis will be derived). FOR CALCULATION OF SS77 AND SS2000 If the value of Site-Specific Factor 3 (Pathologic Extension) is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), then the mapping values for SS77 and 2000 are taken from the Site-Specific Factor 3 mapping. If the value of Site-Specific Factor 3 (Pathologic Extension) is 095 or greater (meaning that prostatectomy was not performed, or it was

performed but the information is not usable for staging), then the mapping values for SS77 and SS2000 are taken from the CS Extension (Clinical Extension) mapping. If the value of Site-Specific Factor 3 (Pathologic Extension) is 000 (in situ), and if the value of CS Extension (Clinical Extension) is greater than 00 and less than 95 (not in situ), then the SS77 and SS2000 mapping values are taken from the CS Extension (Clinical Extension) mapping. If both Site-Specific Factor 3 and CS Extension indicate in situ (codes 000 and 00 respectively), then the mapping values are taken from the Site-Specific Factor 3.

Note 10: Code 045, extension to seminal vesicle(s) (Stage C2), takes priority over Code 048, extracapsular extension and margins involved, if both are present.

Code	Description	TNM	SS77	SS2000
000	In situ; non-invasive; intraepithelial	Tis	IS	IS
020	Involvement in one lobe, NOS	T2NOS	L	L
021	Involves one half of one lobe or less	T2a	L	L
022	Involves more than one half of one lobe, but not both lobes	T2b	L	L
023	Involves both lobes	T2c	L	L
030	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Stage B, NOS	T2NOS	L	L
031	OBSOLETE - Into prostatic apex/arising in prostatic apex, NOS (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
032	Invasion into (but not beyond) prostatic capsule	T2NOS	L	L
033	OBSOLETE - Arising in prostatic apex (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
034	OBSOLETE - Extending into prostatic apex (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
040	No extracapsular extension but margins involved (See Note 4)	T2NOS	L	RE
041	Extension to periprostatic tissue (Stage C1): Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3a	RE	RE
042	Unilateral extracapsular extension	T3a	RE	RE
043	Bilateral extracapsular extension	T3a	RE	RE
045	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
048	Extracapsular extension and margins involved (Excluding seminal vesicle margins-- See code 045)	T3a	RE	RE

Code	Description	TNM	SS77	SS2000
050	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
052	Levator muscle Skeletal muscle, NOS Ureter	T4	D	RE
060	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 7)	T4	D	D
070	Further contiguous extension (Stage D2) including to: Bone Penis Sigmoid colon Soft tissue other than periprostatic tissue Other organs	T4	D	D
095	No evidence of primary tumor	T0	U	U
096	Unknown if prostatectomy done	TX	U	U
097	No prostatectomy done within first course of treatment	TX	U	U
098	Prostatectomy performed, but not considered first course of treatment because of for example; disease progression.	TX	U	U
099	Prostatectomy done: Extension unknown Not documented in patient record Primary tumor cannot be assessed	TX	U	U

Prostate

CS Site-Specific Factor 4 Prostate Apex Involvement (OBSOLETE: Prostatic Acid Phosphatase (PAP)) (Revised: 09/17/2007)

Note: Historically, apex involvement has affected the stage classification, although it does not affect the AJCC 6th edition. This item allows collection of information about the involvement of the prostate apex with cancer, both clinically and at prostatectomy. In codes 110-550, the first digit represents the clinical status of apex involvement, and the second digit represents apex involvement found at prostatectomy, following these definitions: 1 - No involvement of prostatic apex 2 - Into prostatic apex/arising in prostatic apex, NOS 3 - Arising in prostatic apex 4 - Extension into prostatic apex 5 - Apex extension unknown When abstracting and coding apex involvement, try to determine if the cancer has extended into the apex from another part of the prostate or has arisen in the apex.

Code	Description
000	OBSOLETE PAP: Test not done (test was not ordered and was not performed)
010	OBSOLETE PAP: Positive/elevated
020	OBSOLETE PAP: Negative/normal; within normal limits

Code	Description
030	OBSOLETE PAP: Borderline; undetermined whether positive or negative
080	OBSOLETE PAP: Ordered, but results not in chart
110	No involvement of prostatic apex.
120	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Into/arising in, NOS.
130	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Arising in
140	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Extension into
150	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Unknown
210	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: No involvement
220	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Into/arising in, NOS
230	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Arising in
240	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Extension into
250	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Unknown
310	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: No involvement
320	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Into/arising in, NOS
330	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Arising in
340	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Extension into
350	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Unknown
410	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: No involvement
420	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Into/arising in, NOS
430	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Arising in

Code	Description
440	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Extension into
450	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Unknown
510	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: No involvement
520	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Into/arising in, NOS
530	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Arising into
540	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Extension into
550	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Unknown
999	OBSOLETE PAP: Unknown or no information. Not documented in patient record

Prostate

CS Site-Specific Factor 5 Gleason's Primary Pattern and Secondary Pattern Value (Revised: 02/23/2005)

Note 1: Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern that is, the pattern occupying greater than 50% of the cancer is usually indicated by the first number of the Gleason's grade and the secondary pattern is usually indicted by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary and the second number being the secondary) and sum them to obtain the score. If only one number is given and it is less than or equal to 5, assume that it describes a pattern and uses the number as the primary pattern and code the secondary as '9'. If only one number is given and it is greater than 5, assume that it is a score. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.

Note 2: Following AJCC guidelines for coding multiple Gleason's Scores in prostate cancer, if there is more than one primary and secondary pattern value, the value to be coded is the one based on the larger tumor specimen. Please note that this rule is not the same as the rule for coding grade.

Code	Description
000	Test not done (test was not ordered and was not performed)
011	Primary pattern 1, secondary pattern 1
012	Primary pattern 1, secondary pattern 2
013	Primary pattern 1, secondary pattern 3
014	Primary pattern 1, secondary pattern 4
015	Primary pattern 1, secondary pattern 5

Code	Description
019	Primary pattern 1, secondary pattern 9
021	Primary pattern 2, secondary pattern 1
022	Primary pattern 2, secondary pattern 2
023	Primary pattern 2, secondary pattern 3
024	Primary pattern 2, secondary pattern 4
025	Primary pattern 2, secondary pattern 5
029	Primary pattern 2, secondary pattern unknown
031	Primary pattern 3, secondary pattern 1
032	Primary pattern 3, secondary pattern 2
033	Primary pattern 3, secondary pattern 3
034	Primary pattern 3, secondary pattern 4
035	Primary pattern 3, secondary pattern 5
039	Primary pattern 3, secondary pattern unknown
041	Primary pattern 4, secondary pattern 1
042	Primary pattern 4, secondary pattern 2
043	Primary pattern 4, secondary pattern 3
044	Primary pattern 4, secondary pattern 4
045	Primary pattern 4, secondary pattern 5
049	Primary pattern 4, secondary pattern unknown
051	Primary pattern 5, secondary pattern 1
052	Primary pattern 5, secondary pattern 2
053	Primary pattern 5, secondary pattern 3
054	Primary pattern 5, secondary pattern 4
055	Primary pattern 5, secondary pattern 5
059	Primary pattern 5, secondary pattern unknown
099	Primary pattern unknown, secondary pattern unknown
999	Unknown or no information Not documented in patient record

Prostate

CS Site-Specific Factor 6 Gleason's Score (Revised: 08/21/2006)

Note 1: Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, that is, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade and the secondary pattern is usually indicted by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If only one number is given and it is less than or equal to 5, code the total score to 999, unknown or no information. If only one number is given and it is greater than 5, assume that it is a score. If there are two numbers, assume that they refer to two patterns (the first number being the primary and the second number being the secondary) and sum them to obtain the score. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.
Note 2: Record the Gleason's score based on the addition of the primary and secondary pattern.
Note 3: Following AJCC guidelines for coding multiple Gleason's Scores in prostate cancer, if there is more than one primary and secondary pattern value, the value to be coded is the one based on the larger tumor specimen. Please note that this rule is not the same as the rule for coding grade.

Code	Description
000	Test not done (test was not ordered and was not performed)
002-010	Gleason's Score (See Notes 1, 2 and 3)
999	Unknown or no information Not documented in patient record

Surgery Codes

Prostate
C619
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item "Hematologic Transplant and Endocrine Procedures" (NAACCR Item # 3250).

Codes
00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS
Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003)

10 Local tumor destruction, [or excision] NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10–17
[***SEER Notes:*** Code Transurethral Microwave Thermotherapy (TUMT) as 16. Code High Intensity Focused Ultrasonography (HIFU) as 17. Code Transurethral Needle Ablation (TUNA) as 17]

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS
- 22 TURP—cancer is incidental finding during surgery for benign disease
- 23 TURP—patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

[***SEER Note:*** Codes 24 to 26 above combine 20 Local tumor excision, NOS, 21 TURP, NOS, 22 TURP incidental or 23 TURP suspected/known cancer with 24 Cryosurgery, 25 Laser or 26 Hyperthermia]
Specimen sent to pathology from surgical events 20–26

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to,, cystoprostatectomy, radical cystectomy, and prostatectomy.
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

Surgery Codes

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Testis
C620-C629

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Testis
C62.0-C62.1, C62.9

C62.0 Undescended testis
C62.1 Descended testis
C62.9 Testis, NOS
Note: Laterality must be coded for this site.

CS Tumor Size	**CS Site-Specific Factor 1 -** Alpha Fetoprotein (AFP)	**The following tables are available at the collaborative staging website:**
CS Extension	**CS Site-Specific Factor 2 -** Human chorionic gonadotropin (hCG)	Histology Exclusion Table
CS TS/Ext-Eval	**CS Site-Specific Factor 3 -** LDH	AJCC Stage
CS Lymph Nodes	**CS Site-Specific Factor 4 -** Radical Orchiectomy Performed	Serum Marker S Value Table
CS Reg Nodes Eval	**CS Site-Specific Factor 5 -** Size of Metastasis in Lymph Nodes	Extension Orchiectomy Table
Reg LN Pos	CS Site-Specific Factor 6	Number Positive Lymph Nodes and Size of Metastasis in Lymph Nodes
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Testis
CS Tumor Size
SEE STANDARD TABLE

Testis
CS Extension (Revised: 07/26/2007)

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

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial Intratubular germ cell neoplasia	Tis	IS	IS
10	Invasive tumor WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion not stated Body of testis Rete testis Tunica albuginea	*	L	L
15	Invasive tumor WITH vascular/lymphatic invasion Body of testis Rete testis Tunica albuginea	*	L	L
20	Tunica vaginalis involved Surface implants	*	L	L
30	Localized, NOS	*	L	L
31	Tunica, NOS	TX	L	L
40	Epididymis involved WITHOUT vascular/lymphatic invasion, or presence of vascular/lymphatic invasion not stated	*	RE	RE

Code	Description	TNM	SS77	SS2000
45	Epididymis involved WITH vascular/lymphatic invasion	*	RE	RE
50	Spermatic cord, ipsilateral Vas deferens	*	RE	RE
60	Dartos muscle, ipsilateral Scrotum, ipsilateral	T4	RE	RE
70	Extension to scrotum, contralateral Ulceration of scrotum	T4	D	D
75	Penis	T4	D	D
80	Further contiguous extension	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For extension codes 10, 15, 20, 30, 40, 45, and 50, the T category is assigned based on the values of CS Extension and Site-Specific Factor 4 (Radical Orchiectomy Performed), using the Extension/Orchiectomy extra table.

Testis
CS TS/Ext-Eval
SEE STANDARD TABLE

Testis
CS Lymph Nodes (Revised: 08/15/2006)

Note 1: Regional nodes in codes 10-30 include contralateral and bilateral nodes.
Note 2: Involvement of inguinal, pelvic, or external iliac lymph nodes in the absence of previous scrotal or inguinal surgery is coded in CS Mets at DX, as distant lymph node involvement.

Code	Description	TNM	SS77	SS2000
00	No regional lymph node involvement	N0	NONE	NONE
10	Regional lymph node(s) (bilateral and contralateral): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Preaortic Retroaortic Retroperitoneal, NOS Spermatic vein	*	RN	RN
20	Regional lymph node(s) (bilateral and contralateral): Pericaval, NOS: Interaortocaval Paracaval Precaval Retrocaval	*	D	RN

CS Staging Schemas

Code	Description	TNM	SS77	SS2000
30	Regional lymph node(s) (bilateral and contralateral): Pelvic, NOS External iliac WITH previous scrotal or inguinal surgery	*	RN	RN
40	Inguinal nodes, NOS: Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITH previous scrotal or inguinal surgery	*	D	D
50	Regional lymph node(s), NOS	*	RN	RN
80	Lymph nodes, NOS	*	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

* For codes 10, 20, 30, 40, 50, and 80 the N category is assigned from the Number Positive Lymph Nodes and Size of Metastasis in Lymph Nodes extra table using the values of Site Specific Factor 5 (Size of Metastasis in Lymph Nodes) and Reg LN Pos.

Testis
CS Reg Nodes Eval
SEE STANDARD TABLE

Testis
Reg LN Pos
SEE STANDARD TABLE

Testis
Reg LN Exam
SEE STANDARD TABLE

Testis
CS Mets at DX (Revised: 08/15/2006)
Note: Involvement of inguinal, pelvic, or external iliac lymph nodes after previous scrotal or inguinal surgery is coded under CS Lymph Nodes, as regional node involvement.

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s): Pelvic, NOS External iliac WITHOUT previous scrotal or inguinal surgery, or unknown if previous scrotal or inguinal surgery	M1a	RN	RN

Code	Description	TNM	SS77	SS2000
12	Distant lymph node(s): Inguinal nodes, NOS: Deep, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial (femoral) WITHOUT previous scrotal or inguinal surgery, or unknown if previous scrotal or inguinal surgery	M1a	D	D
13	Specified distant lymph nodes, other than code (11) or (12) Distant lymph node(s), NOS	M1a	D	D
20	Distant metastasis to lung	M1a	D	D
25	Distant metastases to lung and lymph nodes (20) + any of [(10) to (13)]	M1a	D	D
40	Metastasis to other distant sites (with or without metastasis to lung and/or distant lymph node(s)) Carcinomatosis	M1b	D	D
45	Distant metastasis, NOS	M1NOS	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

Testis
CS Mets Eval
SEE STANDARD TABLE

Testis
CS Site-Specific Factor 1 Alpha Fetoprotein (AFP) (Revised: 05/06/2004)

Code	Description
000	Test not done (SX)
020	Within normal limits (S0)
040	Range 1 (S1) less than 1,000 ng/ml
050	Range 2 (S2) 1,000 -10,000 ng/ml
060	Range 3 (S3) greater than 10,000 ng/ml
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Testis
CS Site-Specific Factor 2 Human chorionic gonadotropin (hCG) (Revised: 05/06/2004)

Code	Description
000	Test not done (SX)
020	Within normal limits (S0)
040	Range 1 (S1) less than 5,000 mIU/ml
050	Range 2 (S2) 5,000 - 50,000 mIU/ml
060	Range 3 (S3) greater than 50,000 mIU/ml
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Testis
CS Site-Specific Factor 3 LDH (Revised: 07/20/2006)

Code	Description
000	Test not done (SX)
020	Within normal limits (S0)
040	Range 1 (S1) less than 1.5 x N (N equals the upper limit of normal for LDH)
050	Range 2 (S2) 1.5 - 10 x N (N equals the upper limit of normal for LDH)
060	Range 3 (S3) greater than 10 x N (N equals the upper limit of normal for LDH)
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Testis
CS Site-Specific Factor 4 Radical Orchiectomy Performed (Revised: 05/06/2004)

Code	Description
000	Radical orchiectomy not performed
001	Radical orchiectomy performed
999	Unknown if radical orchiectomy performed

Testis

CS Site-Specific Factor 5 Size of Metastasis in Lymph Nodes (Revised: 02/16/2005)

Note 1: For CS Lymph Nodes codes 10, 20, 30, 40 and 50, the N category is assigned based on the values in the Site Specific Factor 5 Table below and the Number Lymph Nodes Positive and Size of Lymph Node Metastasis Extra Table.

Note 2: When coding cases with clinically positive lymph nodes, use Code 001 for clinical N1, Code 002 for clinical N2, and Code 003 for clinical N3.

Code	Description
000	No lymph node metastasis
001	Lymph node metastasis mass 2 cm or less in greatest dimension AND no extranodal extension of tumor
002	Lymph node metastasis mass more than 2 cm but not more than 5 cm in greatest dimension Extranodal extension of tumor
003	Lymph node metastasis mass more than 5cm in greatest dimension
998	Regional lymph nodes involved, size of lymph node mass not stated
999	Unknown if regional nodes involved Not documented in patient record

Testis

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

Testis
C620–C629
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 12

20 Local or partial excision of testicle
Specimen sent to pathology from surgical event 20

30 Excision of testicle, WITHOUT cord
[***SEER Note***: Orchiectomy not including spermatic cord]

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)
[***SEER Note***: Orchiectomy with or without spermatic cord]

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

90 Surgery, NOS

99 Unknown if surgery performed; death certificate only

Other and Unspecified Male Genital Organs
C630-C639

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1011)

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
C63.0-C63.1, C63.7-C63.9

C63.0 Epididymis
C63.1 Spermatic cord
C63.7 Other specified parts of male genital organs
C63.8 Overlapping lesion of male genital organs
C63.9 Male genital organs, NOS

Note 1: AJCC does not define TNM staging for this site.
Note 2: Laterality must be coded for C63.0-C63.1.
Note 3: Carcinoma of the scrotum is included in the scrotum schema. Melanoma (M-8720-8790) of scrotum is included in the melanoma skin schema. Mycosis fungoides (M-9700) or Sezary disease (M-9701) of scrotum is included in the mycosis fungoides schema. Melanoma, mycosis fungoides, or Sezary disease of any other site listed is coded using this schema. Kaposi sarcoma of all sites is included in the Kaposi sarcoma schema, and lymphomas of all sites are included in the lymphoma schema.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	
CS TS/Ext-Eval	CS Site-Specific Factor 3	
CS Lymph Nodes	CS Site-Specific Factor 4	Histologies for Which AJCC Staging Is Not Generated
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	AJCC Stage
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Tumor Size

SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)
CS Extension (Revised: 03/17/2004)

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial	NA	IS	IS
10	Confined to site of origin	NA	L	L
30	Localized, NOS	NA	L	L
40	Adjacent connective tissue (See definition of connective tissue in the general instructions.)	NA	RE	RE

Code	Description	TNM	SS77	SS2000
60	Adjacent organs/structures: Male genital organs: Penis Prostate Testis Sites in this schema which are not the primary	NA	RE	RE
80	Further contiguous extension Other organs and structures in male pelvis: Bladder Rectum Urethra	NA	D	D
95	No evidence of primary tumor	NA	U	U
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS TS/Ext-Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Lymph Nodes (Revised: 08/15/2006)

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	NA	NONE	NONE
10	Regional lymph node(s) Iliac, NOS: External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep inguinal, NOS: Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Pelvic, NOS Regional lymph node(s), NOS	NA	RN	RN
80	Lymph nodes, NOS	NA	RN	RN

Code	Description	TNM	SS77	SS2000
99	Unknown; not stated Regional lymph node(s) cannot be assessed	NA	U	U

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Reg Nodes Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

Reg LN Pos

SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

Reg LN Exam

SEE STANDARD TABLE

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Mets at DX (Revised: 12/09/2003)

Code	Description	TNM	SS77	SS2000
00	No; none	NA	NONE	NONE
10	Distant lymph node(s), NOS	NA	D	D
40	Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis	NA	D	D
50	(10) + (40) Distant lymph node(s) plus other distant metastases	NA	D	D
99	Unknown if distant metastasis Cannot be assessed Not documented in patient record	NA	U	U

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Mets Eval (Revised: 03/17/2004)

Code	Description	Staging Basis
9	Not applicable for this site	NA

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Other and Unspecified Male Genital Organs (excluding for Scrotum: Malignant Melanoma, Mycosis Fungoides, and Sezary Disease, and for all sites: Kaposi Sarcoma and Lymphoma)

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
C63.2

C63.2 Scrotum, NOS

Note: Melanoma (M-8720-8790) of scrotum is included in the melanoma schema. Mycosis Fungoides (M-9700) or Sezary disease (M-9701) of scrotum is included in the Mycosis Fungoides schema. Kaposi sarcoma of the scrotum is included in the Kaposi Sarcoma schema. Lymphoma of the scrotum is included in the lymphoma schema.

CS Tumor Size	CS Site-Specific Factor 1	**The following tables are available at the collaborative staging website:**
CS Extension	CS Site-Specific Factor 2	Histology Exclusion Table
CS TS/Ext-Eval	CS Site-Specific Factor 3	AJCC Stage
CS Lymph Nodes	CS Site-Specific Factor 4	Extension Size Table
CS Reg Nodes Eval	CS Site-Specific Factor 5	
Reg LN Pos	CS Site-Specific Factor 6	
Reg LN Exam		
CS Mets at DX		
CS Mets Eval		

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Tumor Size

SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Extension (Revised: 08/15/2006)

Code	Description	TNM	SS77	SS2000
00	In situ; noninvasive; intraepidermal	Tis	IS	IS
10	Confined to scrotum	*	L	L
30	Localized, NOS	*	L	L
40	Adjacent connective tissue (See definition of connective tissue in general instructions)	*	RE	RE
60	Adjacent organs/structures Male genital organs: Epididymis Penis Prostate Spermatic cord Testis	T4	RE	RE
80	Further contiguous extension Other organs and structures in male pelvis: Bladder Rectum Urethra	T4	D	D
95	No evidence of primary tumor	T0	U	U

Code	Description	TNM	SS77	SS2000
99	Unknown extension Primary tumor cannot be assessed Not documented in patient record	TX	U	U

* For CS Extension codes 10, 30 and 40 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size table for this site.

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS TS/Ext-Eval
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Lymph Nodes (Revised: 08/15/2006)
Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional lymph nodes Iliac, NOS: External Internal (hypogastric), NOS: Obturator Inguinal, NOS: Deep inguinal, NOS Node of Cloquet or Rosenmuller (highest deep inguinal) Superficial inguinal (femoral) Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	U	U

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Reg Nodes Eval
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
Reg LN Pos
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]

Reg LN Exam
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Mets at DX
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Mets Eval
SEE STANDARD TABLE

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Site-Specific Factor 1 (Revised: 03/27/2003)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Site-Specific Factor 2 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Site-Specific Factor 3 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Site-Specific Factor 4 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]
CS Site-Specific Factor 5 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Scrotum [excl. Malignant Melanoma, Kaposi Sarcoma, Mycosis Fungoides, Sezary Disease, and Other Lymphomas]

CS Site-Specific Factor 6 (Revised: 03/31/2002)

Code	Description
888	Not applicable for this site

Surgery Codes

All Other Sites
C142–C148, C170–C179, C239, C240–C249, C260–C269, C300–C301, C310–C319, C339, C379, C380–C388, C390–C399, C480–C488, C510–C519, C529, C570–C579, C589, C600–C609, **C630–C639**, C680–C689, C690–C699, C740–C749, C750–C759
(Except for M9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

[***SEER Note:*** Codes 21 to 24 above combine 20 local tumor excision, 26 Polypectomy or 27 Excisional biopsy with 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]

25 Laser excision

Specimen sent to pathology from surgical events 20–27

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be "debulking"

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs
[***SEER Note:*** In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen]

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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