

Coding Guidelines
ESOPHAGUS
C150-C155, C158-C159

Primary Site

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, the thoracic esophagus and the abdominal esophagus. The subsites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the SEER *Self Instructional Manual for Tumor Registrars, Book 4* for illustrated descriptions of each system.

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**Esophagus
C150-C155, C158-C159**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Esophagus

C15.0-C15.5, C15.8-C15.9

- C15.0 Cervical esophagus
- C15.1 Thoracic esophagus
- C15.2 Abdominal esophagus
- C15.3 Upper third of esophagus
- C15.4 Middle third of esophagus
- C15.5 Lower third of esophagus
- C15.8 Overlapping lesion of esophagus
- C15.9 Esophagus, NOS

Anatomic Limits of Esophagus:

Cervical Esophagus (C15.0): From the lower border of the cricoid cartilage to the thoracic inlet (suprasternal notch), about 18 cm from the incisors.

Intrathoracic (including abdominal esophagus) (C15.1 - C15.5): Upper thoracic portion (C15.3): From the thoracic inlet to the level of the tracheal bifurcation (18-24 cm). Mid-thoracic portion (C15.4): From the tracheal bifurcation midway to the gastroesophageal (GE) junction (24-32 cm).

Lower thoracic portion (C15.5): From midway between the tracheal bifurcation and the gastroesophageal junction to the GE junction, including the abdominal esophagus (C15.2) between 32-40 cm.

| | | |
|-------------------|---------------------------|---|
| CS Tumor Size | CS Site-Specific Factor 1 | <p>The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage</p> |
| CS Extension | CS Site-Specific Factor 2 | |
| CS TS/Ext-Eval | CS Site-Specific Factor 3 | |
| 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 | | |

Esophagus

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

Note: For esophagus, this field is used for size of tumor/length of involved esophagus.

| 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" |
| 998 | Circumferential |

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CS Staging Schemas

| | |
|-----|--|
| 999 | Unknown; size not stated Not documented in patient record |
|-----|--|

Esophagus

CS Extension (Revised: 03/17/2004)

Note: Ignore intraluminal extension to adjacent segment(s) of esophagus or to cardia of stomach and code depth of invasion or extra-esophageal spread as indicated.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS (including intramucosal, NOS) | T1 | L | L |
| 11 | Invades lamina propria | T1 | L | L |
| 12 | Invades muscularis mucosae | T1 | L | L |
| 16 | Invades submucosa | T1 | L | L |
| 20 | Muscularis propria invaded | T2 | L | L |
| 30 | Localized, NOS | T1 | L | L |
| 40 | Adventitia and/or soft tissue invaded Esophagus is described as "FIXED" | T3 | RE | RE |
| 60 | Tumor invades adjacent structures Cervical esophagus: Blood vessel(s): Carotid artery Jugular vein Subclavian artery Thyroid gland Intrathoracic, upper or mid-portion, esophagus: Blood vessel(s), major: Aorta Azygos vein Pulmonary artery/vein Vena cava Carina Diaphragm Main stem bronchus Trachea Intrathoracic, lower portion (abdominal), esophagus: Blood vessel(s): Aorta Gastric artery/vein Vena cava Diaphragm, not fixed, or NOS Stomach, cardia (via serosa) | T4 | RE | RE |

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CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 65 | Cervical esophagus: Carina Cervical vertebra(e) Hypopharynx Larynx Trachea Intrathoracic esophagus: Lung via bronchus Mediastinal structure(s), NOS Pleura Rib(s) Thoracic vertebra(e) | T4 | RE | RE |
| 78 | Thoracic/middle esophagus: Pericardium | T4 | RE | D |
| 80 | Further contiguous extension: Cervical/upper esophagus: Lung Main stem bronchus Pleura Abdominal/lower esophagus: Diaphragm fixed | 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 |

Esophagus

CS TS/Ext-Eval

SEE STANDARD TABLE

Esophagus

CS Lymph Nodes (Revised: 08/19/2006)

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 (including contralateral or bilateral) For all subsites: Peri-/paraesophageal Cervical esophagus only: Cervical, NOS Anterior deep cervical (laterolateral) (recurrent laryngeal) Internal jugular, NOS: Deep cervical, NOS: Upper, NOS: Jugulodigastric (subdigastric) Intrathoracic esophagus, upper or middle, only: Internal jugular, NOS: Deep cervical, NOS: Lower, NOS: | N1 | RN | RN |

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CS Staging Schemas

| | | | | |
|---------------|--|----|----|----|
| 10, cont'd | <p style="text-align: center;">Jugulo-omohyoid (supraomohyoid)</p> <p style="text-align: center;">Middle</p> <p style="text-align: center;">Upper cervical, NOS:</p> <p style="text-align: center;">Jugulodigastric (subdigastric)</p> <p>Intrabronchial:</p> <p style="text-align: center;">Carinal (tracheobronchial) (tracheal bifurcation)</p> <p style="text-align: center;">Hilar (bronchopulmonary) (proximal lobar) (pulmonary root)</p> <p style="text-align: center;">Peritracheal</p> <p style="text-align: center;">Left gastric (superior gastric):</p> <p style="text-align: center;">Cardiac (cardial)</p> <p style="text-align: center;">Lesser curvature</p> <p style="text-align: center;">Perigastric, NOS</p> <p style="text-align: center;">Posterior mediastinal (tracheoesophageal)</p> <p>Intrathoracic esophagus, lower (abdominal) only:</p> <p style="text-align: center;">Left gastric (superior gastric):</p> <p style="text-align: center;">Cardiac (cardial)</p> <p style="text-align: center;">Lesser curvature</p> <p style="text-align: center;">Perigastric, NOS</p> <p style="text-align: center;">Posterior mediastinal (tracheoesophageal)</p> | | | |
| 20 | <p>Cervical Esophagus only:</p> <p style="text-align: center;">Scalene (inferior deep cervical)</p> <p style="text-align: center;">Supraclavicular (transverse cervical)</p> | N1 | D | RN |
| 22 | <p>Intrathoracic, upper thoracic or middle, only:</p> <p style="text-align: center;">Superior mediastinal</p> | N1 | D | RN |
| 30 | <p>All esophagus subsites:</p> <p style="text-align: center;">Anterior mediastinal</p> <p style="text-align: center;">Mediastinal, NOS</p> <p>Cervical esophagus only:</p> <p style="text-align: center;">Aortopulmonary</p> <p style="text-align: center;">Paratracheal</p> <p style="text-align: center;">Posterior mediastinal</p> <p style="text-align: center;">Superior mediastinal</p> <p>Intrathoracic esophagus, upper or middle, only:</p> <p style="text-align: center;">Aortopulmonary</p> <p style="text-align: center;">Pulmonary ligament</p> <p>Intrathoracic esophagus, lower (abdominal) only:</p> <p style="text-align: center;">Common hepatic</p> <p style="text-align: center;">Diaphragmatic</p> <p style="text-align: center;">Paratracheal</p> <p style="text-align: center;">Splenic</p> <p style="text-align: center;">Superior mediastinal</p> | N1 | RN | RN |
| 50 | Regional lymph node(s), NOS | N1 | RN | RN |
| 80 | Lymph nodes, NOS | N1 | RN | RN |
| 99 | <p>Unknown; not stated</p> <p>Regional lymph node(s) cannot be assessed</p> <p>Not documented in patient record</p> | NX | U | U |

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CS Staging Schemas

Esophagus

CS Reg Nodes Eval

SEE STANDARD TABLE

Esophagus

Reg LN Pos

SEE STANDARD TABLE

Esophagus

Reg LN Exam

SEE STANDARD TABLE

Esophagus

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 | M1NOS | D | D |
| 11 | Upper thoracic esophagus only: Cervical lymph nodes Lower thoracic (abdominal) esophagus only: Celiac lymph nodes | M1a | D | D |
| 12 | Specified distant lymph node(s), other than code 11, including: Cervical esophagus only: Common hepatic Diaphragmatic Pulmonary ligament Splenic Intrathoracic esophagus, upper or middle, only: Common hepatic Diaphragmatic Splenic Lower thoracic (abdominal) esophagus only: Aortopulmonary Pulmonary ligament | M1NOS | D | D |
| 40 | Distant metastases except distant lymph node(s) (codes 10 to 12) Distant metastasis, NOS Carcinomatosis | M1b | D | D |
| 50 | (40) + any of [(10) to (12)] Distant lymph node(s) plus other distant metastases | M1b | D | D |
| 99 | Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record | MX | U | U |

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CS Staging Schemas

Esophagus

CS Mets Eval

SEE STANDARD TABLE

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Esophagus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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Surgery Codes

Esophagus

C150–C159

(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 Partial esophagectomy

- 40 Total esophagectomy, NOS

- 50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
[**SEER Note:** Esophagectomy WITH other procedures may be partial, total, or NOS]
 - 51 WITH laryngectomy
 - 52 WITH gastrectomy, NOS
 - 53 Partial gastrectomy
 - 54 Total gastrectomy
 - 55 Combination of 51 WITH any of 52–54

- 80 Esophagectomy, NOS

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

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**Stomach
C160-C169**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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CS Staging Schemas

Stomach

C16.0-C16.6, C16.8-C16.9

- C16.0 Cardia, NOS
- C16.1 Fundus of stomach
- C16.2 Body of stomach
- C16.3 Gastric antrum
- C16.4 Pylorus
- C16.5 Lesser curvature of stomach, NOS
- C16.6 Greater curvature of stomach, NOS
- C16.8 Overlapping lesion of stomach
- C16.9 Stomach, NOS

| | | |
|--|--|---|
| <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> CS Site-Specific Factor 1 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | <p>The following tables are available at the collaborative staging website:</p> <ul style="list-style-type: none"> Histology Exclusion Table AJCC Stage Lymph Nodes Number Positive Table |
|--|--|---|

Stomach

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

| 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" |
| 998 | Diffuse; widespread; 3/4's or more: linitis plastica |
| 999 | Unknown; size not stated Not documented in patient record |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Stomach

CS Extension (Revised: 12/05/2003)

Note 1: INTRALUMINAL or INTRAMURAL extension to esophagus and duodenum is classified by the depth of greatest invasion in any of these sites, including stomach. (For extension to esophagus or duodenum via serosa, see code 60.)

Note 2: If the diagnosis states "linitis plastica" and no other information regarding extension is available, use code 35.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; noninvasive; intraepithelial | Tis | IS | IS |
| 05 | (Adeno)carcinoma in a polyp, noninvasive | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS (including intramucosal, NOS) | T1 | L | L |
| 11 | Invades lamina propria | T1 | L | L |
| 12 | Invades muscularis mucosae | T1 | L | L |
| 13 | Confined to head of polyp Extension to stalk | T1 | L | L |
| 14 | Confined to stalk of polyp | T1 | L | L |
| 15 | Tumor in polyp, NOS | T1 | L | L |
| 16 | Invades submucosa (superficial invasion) | T1 | L | L |
| 20 | Invades into but not through muscularis propria | T2a | L | L |
| 30 | Localized, NOS Implants inside stomach | T1 | L | L |
| 35 | Linitis plastica (see Note 2) and no other information regarding extension is available. | T2a | RE | L |
| 40 | Invasion through muscularis propria or muscularis, NOS Extension through wall, NOS Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded | T2b | L | L |
| 45 | Extension to adjacent (connective) tissue WITHOUT perforation of visceral peritoneum: Gastric artery Ligaments: Gastrocolic Gastrohepatic Gastrosplenic Omentum, NOS Greater Lesser Perigastric fat | T2b | RE | RE |

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CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 50 | Invasion of/through serosa (mesothelium) (tunica serosa) (visceral peritoneum), including perforation of visceral peritoneum covering the gastric ligaments or the omentum WITHOUT invasion of adjacent structures | T3 | RE | RE |
| 55 | (45) + (50) | T3 | RE | RE |
| 60 | Diaphragm Duodenum via serosa or NOS Esophagus via serosa Ileum Jejunum Liver Pancreas Small intestine, NOS Spleen Transverse colon (including flexures) | T4 | RE | RE |
| 70 | Abdominal wall Adrenal gland Kidney Retroperitoneum | 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 |

Stomach

CS TS/Ext-Eval

SEE STANDARD TABLE

Stomach

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

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 | None; no regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes: Left gastric (superior gastric), NOS: Cardial Cardioesophageal Gastric, left Gastropancreatic, left Lesser curvature Lesser omental Paracardial Pancreaticosplenic (pancreaticolienal) Pancreatoduodenal | * | RN | RN |

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CS Staging Schemas

| | | | | |
|---------------|--|----|----|----|
| 10, cont'd | Perigastric, NOS Peripancreatic Right gastric (inferior gastric), NOS: Gastrocolic Gastroduodenal Gastroepiploic (gastro-omental), right or NOS Gastrohepatic Greater curvature Greater omental Pyloric, NOS Infrapyloric (subpyloric) Suprapyloric Splenic (lienal), NOS: Gastroepiploic (gastro-omental), left Splenic hilar Nodule(s) in perigastric fat | | | |
| 40 | Celiac Hepatic (excluding gastrohepatic, [see code 10] and hepatoduodenal [see code 42]) | * | D | RN |
| 42 | For lesser curvature only: Hepatoduodenal | * | D | D |
| 50 | Regional lymph nodes, 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 10-80 ONLY, the N category is assigned based on the value of the Reg LN Pos using the Lymph Nodes Number Positive table for this site.

Stomach

CS Reg Nodes Eval

SEE STANDARD TABLE

Stomach

Reg LN Pos

SEE STANDARD TABLE

Stomach

Reg LN Exam

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Stomach

CS Mets at DX (Revised: 03/17/2004)

| Code | Description | TNM | SS77 | SS2000 |
|-------------|---|------------|-------------|---------------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s): For all subsites: Inferior mesenteric Para-aortic Porta hepatis (portal) (hilar) (in hilus of liver) Retropancreatic Retroperitoneal Superior mesenteric or mesenteric, NOS For all subsites EXCEPT lesser curvature Hepatoduodenal | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) (code 10) 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 |

Stomach

CS Mets Eval

SEE STANDARD TABLE

Stomach

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

Stomach

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

Stomach

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Stomach

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Stomach

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Stomach

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

Surgery Codes

Stomach

C160–C169

(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 Gastrectomy, NOS (partial, subtotal, hemi-)

31 Antrectomy, lower (distal-less than 40% of stomach)***

32 Lower (distal) gastrectomy (partial, subtotal, hemi-)

33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach

Billroth I: anastomosis to duodenum (duodenostomy)

Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS

41 Near-total gastrectomy

42 Total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach

50 Gastrectomy, NOS WITH removal of a portion of esophagus

51 Partial or subtotal gastrectomy

52 Near total or total gastrectomy

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure

SEER Program Coding and Staging Manual 2007

Surgery Codes

- 60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resection with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

[*SEER Note:* A portion of the duodenum may be removed during this procedure; assign codes 60-63 unless the entire duodenum was removed and a gastrojejunostomy was performed. Codes 60-63 may include omentectomy among the organs/tissues removed. 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]

- 80 Gastrectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

*** Incidental splenectomy NOT included

**Small Intestine
C170-C179**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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CS Staging Schemas

Small Intestine

C17.0-C17.3, C17.8-C17.9

C17.0 Duodenum

C17.1 Jejunum

C17.2 Ileum (excludes ileocecal valve C18.0)

C17.3 Meckel diverticulum (site of neoplasm)

C17.8 Overlapping lesion of small intestine

C17.9 Small intestine, NOS

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage |
|--|--|--|

Small Intestine

CS Tumor Size

SEE STANDARD TABLE

Small Intestine

CS Extension (Revised: 08/21/2006)

Note 1: Ignore intraluminal or lateral extension to adjacent segment(s) of small intestine and code depth of invasion or spread outside the small intestine as indicated.

Note 2: The nonperitonealized perimuscular tissue is, for jejunum and ileum, part of the mesentery and, for duodenum in areas where serosa is lacking, part of the retroperitoneum.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 05 | (Adeno)carcinoma in a polyp, noninvasive | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS, including intramucosal, NOS | T1 | L | L |
| 11 | Invasion of lamina propria | T1 | L | L |
| 12 | Invasion of muscularis mucosae | T1 | L | L |
| 13 | Confined to head of polyp | T1 | L | L |
| 14 | Confined to stalk of polyp | T1 | L | L |
| 15 | Invasion of polyp, NOS | T1 | L | L |
| 16 | Invasion of submucosa (superficial invasion) | T1 | L | L |
| 20 | Muscularis propria invaded | T2 | L | L |
| 30 | Localized, NOS Intraluminal spread to other segments of small intestine or cecum | T1 | L | L |

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CS Staging Schemas

| | | | | |
|----|--|----|----|----|
| 40 | Invasion through muscularis propria or muscularis, NOS Extension through wall, NOS Subserosal tissue/(sub) serosal fat invaded Transmural, NOS | T3 | L | L |
| 42 | Fat, NOS | T3 | RE | RE |
| 45 | Adjacent connective tissue Mesentery, including mesenteric fat, invaded less than or equal to 2 cm in depth or NOS Nonperitonealized perimuscular tissue invaded less than or equal to 2 cm in depth or NOS Retroperitoneum invaded less than or equal to 2 cm in depth or NOS | T3 | RE | RE |
| 50 | Invasion of/through serosa(mesothelium)(tunica serosa) (visceral peritoneum) | T4 | L | RE |
| 55 | (50) + [(42) or (45)] | T4 | RE | RE |
| 60 | For duodenum primary only: Ampulla of Vater Diaphragm Extrahepatic bile ducts Gallbladder Pancreas Pancreatic duct | T4 | RE | RE |
| 65 | For duodenum primary only: Blood vessel(s), major: Aorta Gastroduodenal artery Portal vein Renal vein Superior mesenteric artery or vein Vena cava Greater omentum Hepatic flexure Kidney, NOS Kidney, right Liver, NOS Liver, quadrate lobe Liver, right lobe Omentum, NOS Transverse colon Ureter, right For jejunum or ileum primary only: Colon, including appendix | T4 | RE | RE |
| 66 | For duodenum primary only: Stomach | T4 | RE | RE |
| 67 | For all small intestine sites: Abdominal wall Mesentery invaded greater than 2 cm in depth Non-peritonealized perimuscular tissue invaded greater than 2 cm in depth Retroperitoneum invaded greater than 2 cm in depth | T4 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 68 | For all small intestine sites: Other segments of the small intestine via serosa | T4 | RE | RE |
| 70 | For jejunum or ileum primary only: Bladder Fallopian tube Ovary Uterus | 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 |

Small Intestine

CS TS/Ext-Eval

SEE STANDARD TABLE

Small Intestine

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

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 | N0 | NONE | NONE |
| 10 | Regional lymph node(s): For duodenum primaries only: Duodenal Gastroduodenal Hepatic Infrapyloric (subpyloric) Pancreaticoduodenal Pyloric For jejunum or ileum primaries only: Ileocolic for terminal ileum primary Mesenteric, NOS Posterior cecal (retrocecal) for terminal ileum primary Superior mesenteric | N1 | RN | RN |
| 20 | Regional lymph node(s) for duodenum primaries only: Pericholodochal (common bile duct) Superior mesenteric (See code 11 in CS Mets at DX for other lymph nodes of small intestine) | N1 | D | RN |
| 30 | Regional lymph node(s), NOS | N1 | RN | RN |
| 80 | Lymph nodes, NOS | N1 | RN | RN |
| 99 | Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record | NX | U | U |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Small Intestine

CS Reg Nodes Eval

SEE STANDARD TABLE

Small Intestine

Reg LN Pos

SEE STANDARD TABLE

Small Intestine

Reg LN Exam

SEE STANDARD TABLE

Small Intestine

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

| Code | Description | TNM | SS77 | SS2000 |
|-------------|--|------------|-------------|---------------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s), other than those listed in code 11 including celiac lymph node(s) Distant lymph node(s), NOS | M1 | D | D |
| 11 | For jejunum and ileum primaries only: Pericholodochal (For duodenal primary, see Lymph Nodes field) | M1 | D | RN |
| 40 | Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS Carcinomatosis | M1 | D | D |
| 50 | 40 + any of [(10) or (11)] 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 |

Small Intestine

CS Mets Eval

SEE STANDARD TABLE

Small Intestine

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Small Intestine

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Small Intestine

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Small Intestine

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Small Intestine

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Small Intestine

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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SEER Program Coding and Staging Manual 2007

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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SEER Program Coding and Staging Manual 2007

Coding Guidelines COLON C180–C189

The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

Grade

Colon cancer is often graded using a two-grade system; Low Grade (2) or High Grade (4). If the grade is listed as 1/2 or as low grade, convert to a grade 2. If the grade is listed as 2/2 or as high grade, convert to a code 4.

Code the highest grade given.

| Term | Grade | SEER Code |
|--|--------------|------------------|
| Well differentiated | I | 1 |
| Fairly well differentiated | II | 2 |
| Low grade | I-II | 2 |
| Mid differentiated | II | 2 |
| Moderately differentiated | II | 2 |
| Partially differentiated | II | 2 |
| Partially well differentiated | I-II | 2 |
| Partially well differentiated | II | 2 |
| Relatively or generally well differentiated | II | 2 |
| Medium grade, intermediate grade | II-III | 3 |
| Moderately poorly differentiated | III | 3 |
| Moderately undifferentiated | III | 3 |
| Poorly differentiated | III | 3 |
| Relatively poorly differentiated | III | 3 |
| Relatively undifferentiated | III | 3 |
| Slightly differentiated | III | 3 |
| High grade | III-IV | 4 |
| Undifferentiated, anaplastic, not differentiated | IV | 4 |

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Multiple Primary and Histology Coding Rules 2007: Colon

Equivalent Terms, Definitions and Illustrations C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Introduction

Use these rules only for cases with primary colon cancer.

Ninety-eight percent of colon cancers are adenocarcinoma. Ten to fifteen percent of these cases produce enough mucin to be categorized as mucinous/colloid.* Mixed histologies and specific types other than mucinous/colloid or signet ring cell are rare.

*ACS *Clinical Oncology*

Equivalent or Equal Terms

- Familial polyposis, familial adenomatous polyposis, (FAP)
- Intramucosal, lateral extension
- Invasion through colon wall, extension through colon wall, transmural
- Low grade neuroendocrine carcinoma, carcinoid
- Most invasive, most extensive
- Mucin producing, mucin secreting
- Mucinous, colloid
- Polyp, adenoma
- Serosa, visceral peritoneum
- Tumor, mass, lesion, neoplasm
- Type, subtype, predominantly, with features of, major, or with ____differentiation.

Definitions

Adenocarcinoid (8245/3): A specific histology commonly found in the appendix.

Adenocarcinoma with mixed subtypes (8255): Rarely used for colon primaries (see introduction).

Adenocarcinoma, intestinal type (8144) is a form of stomach cancer. Do not use this code when the tumor arises in the colon.

Multiple Primary and Histology Coding Rules 2007: Colon

Equivalent Terms, Definitions and Illustrations C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Adenoma: A **benign** lesion composed of tubular or villous structures showing **intraepithelial neoplasia** (See definition of **intraepithelial neoplasia**).

Composite carcinoid (8244): One tumor which contains both carcinoid and adenocarcinoma.

Familial polyposis, familial adenomatous polyposis (FAP), adenocarcinoma in: a condition characterized by the development of many adenomatous polyps, often seen in several members of the same family.

Frank adenocarcinoma: Adenocarcinoma arising from the colon wall (no evidence of a polyp)

In Situ: Noninvasive; intraepithelial; (adeno)carcinoma in a polyp or adenoma, noninvasive.

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum.

Intraepithelial neoplasia, high grade may be either severe dysplasia or carcinoma in situ. Report cases of carcinoma in situ only.

Intraepithelial neoplasia, low grade is not a reportable condition. A person with intraepithelial neoplasia is at risk for developing invasive cancer.

Intramucosal tumors may be noninvasive or invasive. The term intramucosal may refer to the surface epithelium, the basement membrane, or the lamina propria..

Invasive tumor: A tumor that penetrates the basement membrane and invades the lamina propria.

Multiple Primary and Histology Coding Rules 2007: Colon

Equivalent Terms, Definitions and Illustrations C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Most invasive: The tumor with the greatest continuous extension through the wall of the colon. The layers of the colon wall in order of least to greatest extension:

- Mucosa (surface epithelium, lamina propria, basement membrane)
- Submucosa
- Muscularis propria
- Subserosa (pericolic fat, subserosal fat)
- Retroperitoneal fat (pericolic fat)
- Mesenteric fat (pericolic fat)
- Serosa (visceral peritoneum).

Mucinous/colloid adenocarcinoma (8480): An adenocarcinoma containing **extra**-cellular mucin comprising more than 50% of the tumor. Note that “mucin-producing” and “mucin-secreting” are not synonymous with mucinous.

Neuroendocrine carcinoma (8246): Neuroendocrine carcinoma is a group of carcinomas that include typical carcinoid tumor (8240), atypical carcinoid tumor (8249).

Pericolic fat: A general term for the fat surrounding the colon. Subserosal fat, retroperitoneal fat and mesenteric fat are pericolic fat.

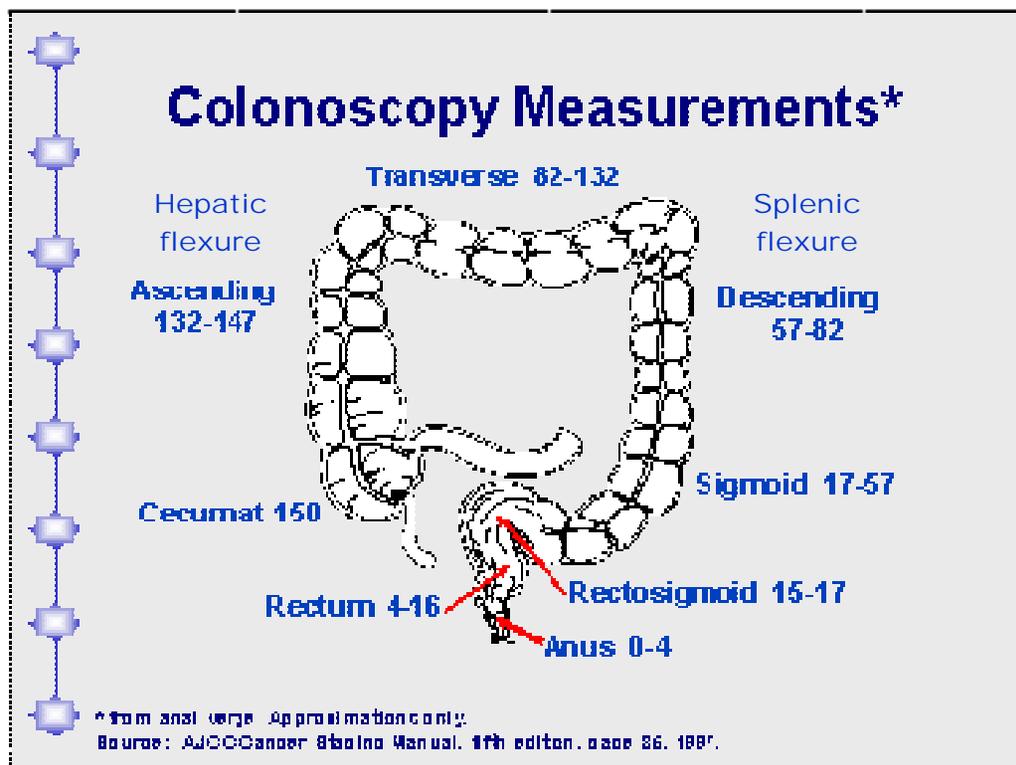
Signet ring cell carcinoma (8490): An adenocarcinoma containing **intra**-cellular mucin comprising more than 50% of the tumor.

Transmural: Through the wall of the colon (the tumor has extended through the colon wall and may invade a regional organ or regional tissue).

Undifferentiated carcinoma (8020): A high grade malignancy lacking glandular structures or other specific features that can be used to better classify the tumor. Undifferentiated carcinoma is not a histologic type; it is a non-specific term.

Multiple Primary and Histology Coding Rules 2007: Colon

Equivalent Terms, Definitions and Illustrations
C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Flowchart

Colon Multiple Primary Rules - Flowchart

(C180-C189)

(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.



| UNKNOWN IF SINGLE OR MULTIPLE TUMORS | DECISION | NOTES |
|--------------------------------------|--|--|
| <p>M1</p> | <p style="text-align: center;">SINGLE Primary*</p> <p>End of instructions for Unknown Number of Tumors.</p> | <p style="text-align: center;">Tumor(s) not described as metastasis</p> <p style="text-align: center;">Use this rule only after all information sources have been exhausted.</p> |
| SINGLE TUMOR | DECISION | NOTES |
| <p>M2</p> | <p style="text-align: center;">SINGLE Primary*</p> <p>End of instructions for Single Tumor.</p> | <p style="text-align: center;">1. Tumor not described as metastasis 2. Includes combinations of in situ and invasive.</p> <p style="text-align: center;">The tumor may overlap onto or extend into adjacent/contiguous site or subsite.</p> |

Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Flowchart

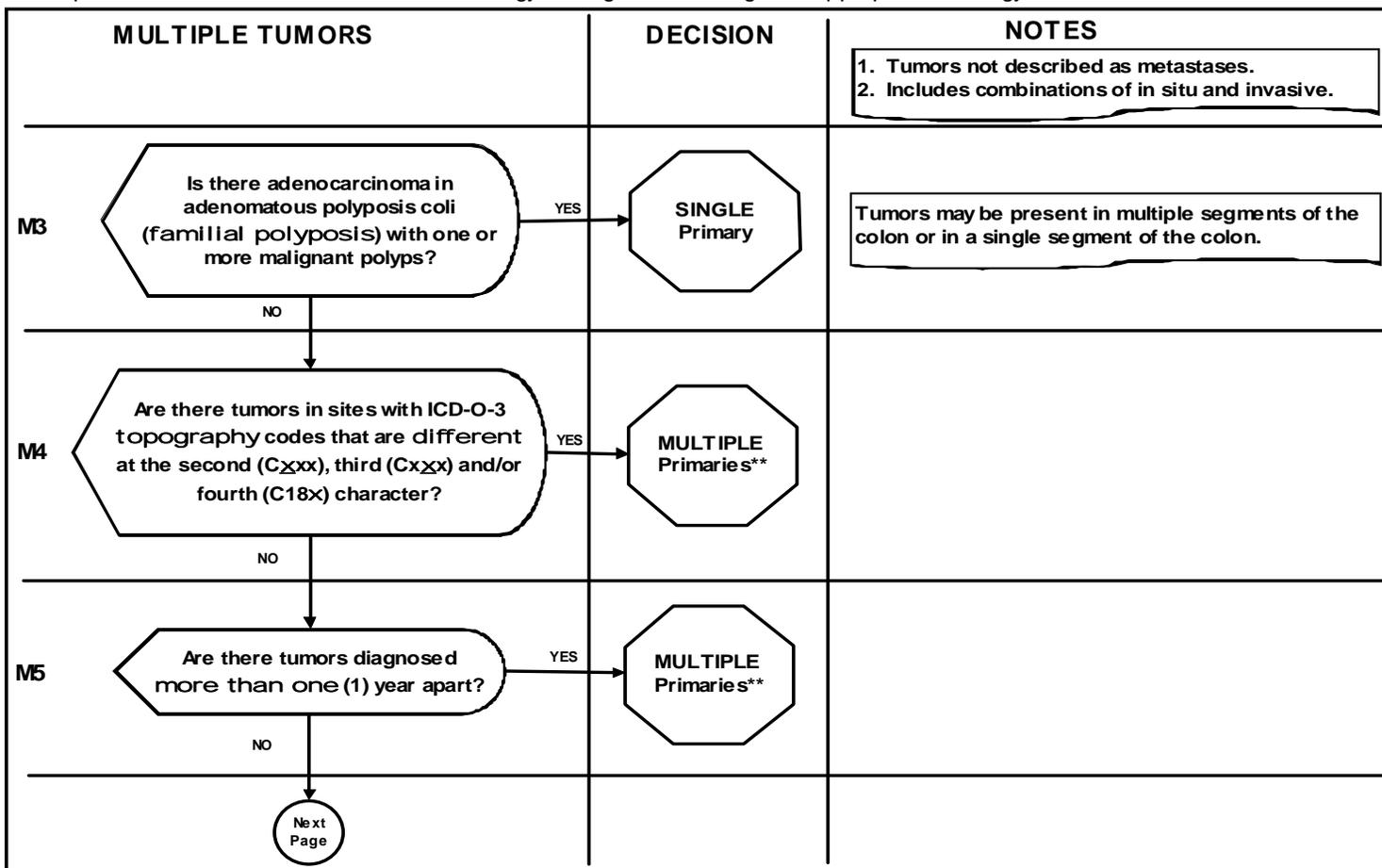
Colon Multiple Primary Rules - Flowchart

(C180-C189)

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

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Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Flowchart

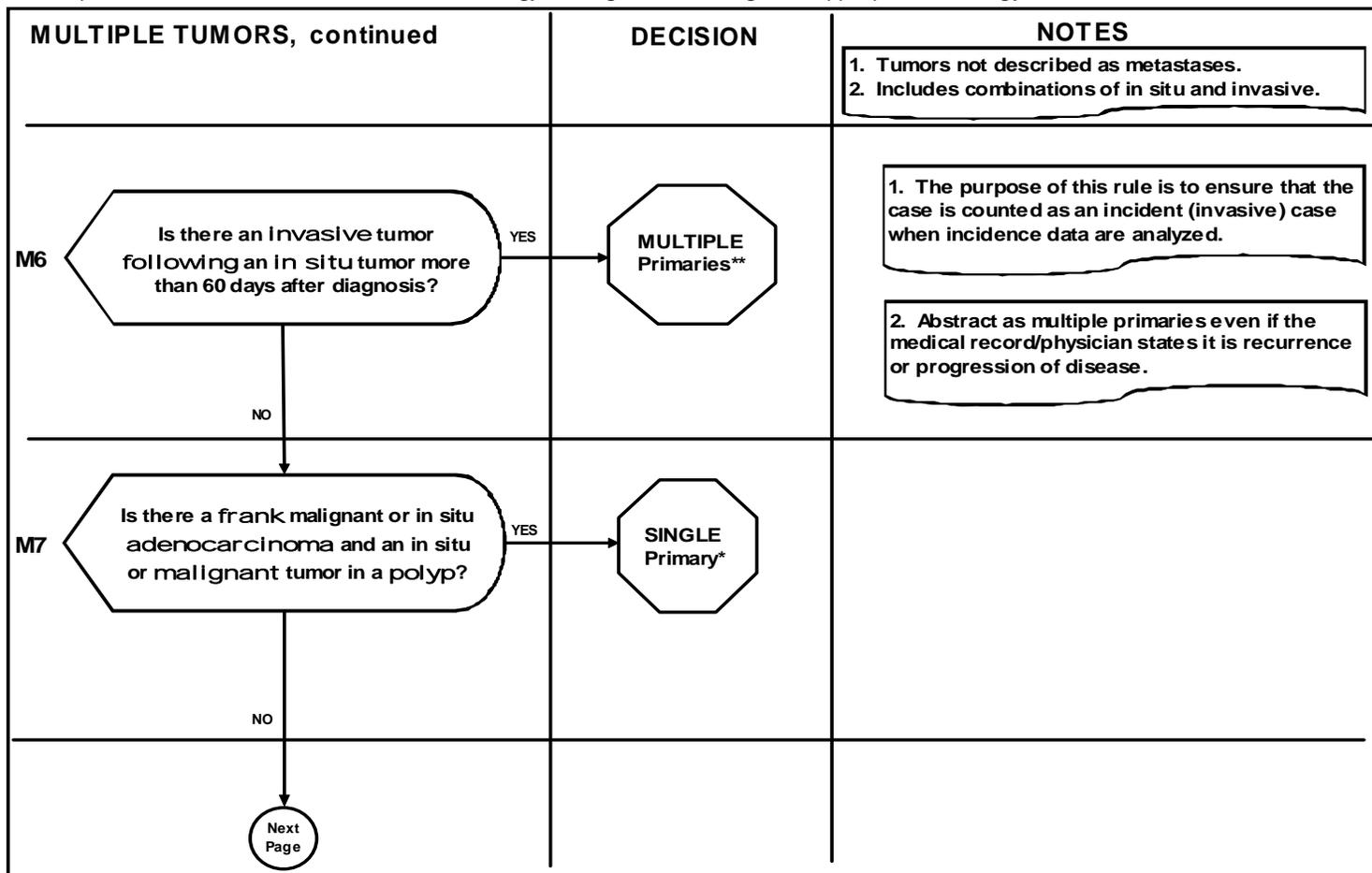
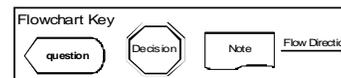
Colon Multiple Primary Rules -Flowchart

(C180-C189)

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

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Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Flowchart

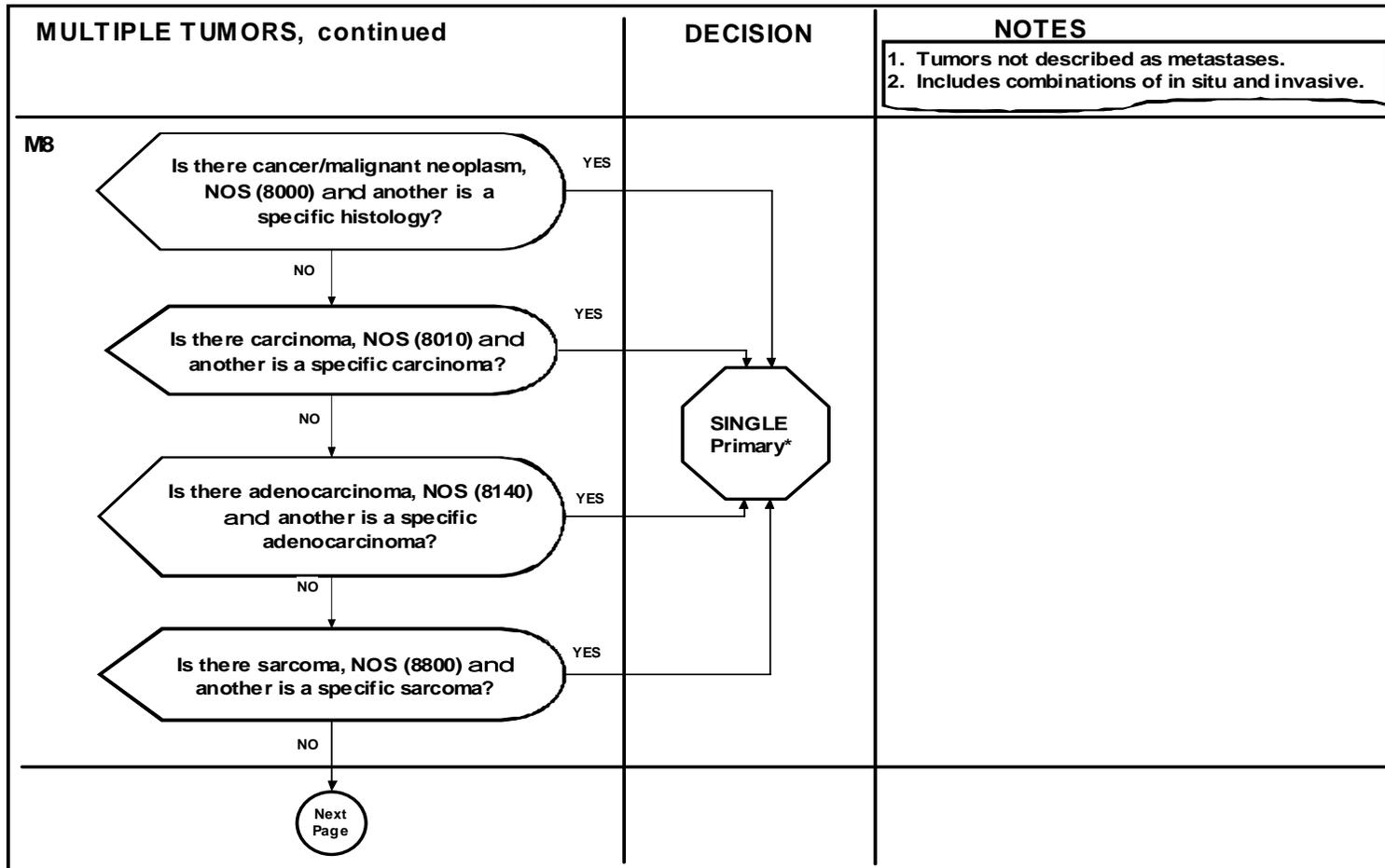
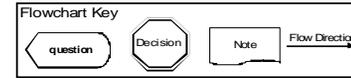
Colon Multiple Primary Rules - Flow chart

(C180-C189)

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

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



Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Flowchart

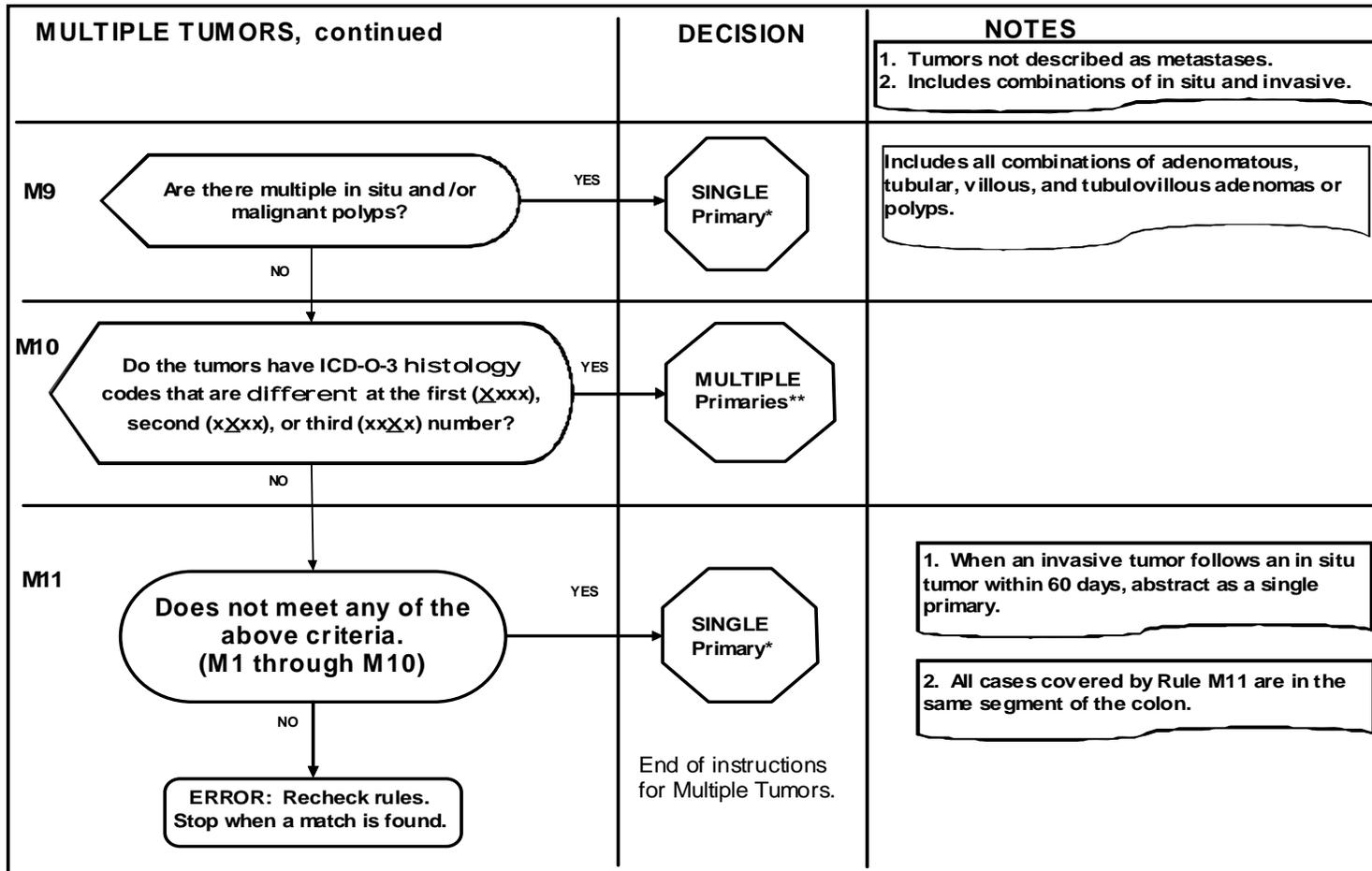
Colon Multiple Primary Rules - Flowchart

(C180-C189)

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

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



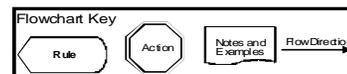
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Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)
(Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)



SINGLE TUMOR

| Rule | Action | Notes and Examples |
|------------------|--------|--|
| <p>H1</p> | | <ol style="list-style-type: none"> 1. Priority for using documents to code the histology <ul style="list-style-type: none"> o Documentation in the medical record that refers to pathologic or cytologic findings o Physician's reference to type of cancer (histology) in the medical record o CT, PET or MRI scans 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. |
| <p>H2</p> | | <p>Code the behavior /3.</p> |
| <p>H3</p> | | <ol style="list-style-type: none"> 1. Intestinal type adenocarcinoma usually occurs in the stomach. 2. When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule. |
| | | |

Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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



SINGLE TUMOR

| Rule | Action | Notes and Examples |
|--|--|---|
| <p>H4</p> <p>Is the final diagnosis adenocarcinoma in a polyp?</p> <p>NO</p> <p>Is the final diagnosis adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report?</p> <p>NO</p> <p>Is final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?</p> <p>NO</p> <p>Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?</p> <p>NO</p> <p>Is there documentation that the patient had a polypectomy?</p> <p>NO</p> | <p>Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma).</p> | <p>It is important to know that the adenocarcinoma originated in the polyp.</p> |
| <p>Next Page</p> | | |

Multiple Primary and Histology Coding Rules 2007: Colon

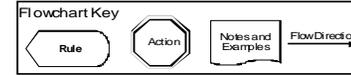
Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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

SINGLE TUMOR



| Rule | Action | Notes and Examples |
|------------------|--------|--------------------|
| <p>H5</p> | | |

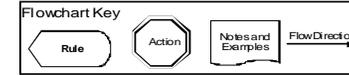
Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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



SINGLE TUMOR

| Rule | Action | Notes and Examples |
|--|--|--------------------|
| <p>H6</p> <p>Is the final diagnosis adenocarcinoma, NOS and the microscopic description states that less than 50% the tumor is mucinous/colloid?</p> <p>NO</p> <p>Is the final diagnosis adenocarcinoma, NOS and the microscopic description states that less than 50% of the tumor is signet ring cell carcinoma?</p> <p>NO</p> <p>Is the final diagnosis adenocarcinoma, NOS and the percentage of mucinous/colloid or signet ring cell carcinoma is unknown?</p> | <p>Code 8140 (adenocarcinoma, NOS).</p> | |
| <p>H7</p> <p>Is there a combination of mucinous/colloid and signet ring cell adenocarcinoma?</p> | <p>Code 8255 (adenocarcinoma with mixed subtypes).</p> | |
| <p>Next Page</p> | | |

Multiple Primary and Histology Coding Rules 2007: Colon

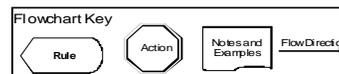
Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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

SINGLE TUMOR



| Rule | Action | Notes and Examples |
|--|--|--------------------|
| <p>H8</p> <p>Is the diagnosis neuroendocrine (8246) and carcinoid tumor (8240)?</p> <p>NO</p> | <p>YES</p> <p>Code 8240 (carcinoid tumor, NOS).</p> | |
| <p>H9</p> <p>Is the diagnosis adenocarcinoma and carcinoid tumor?</p> <p>NO</p> | <p>YES</p> <p>Code 8244 (composite carcinoid).</p> | |
| <p>H10</p> <p>Is the diagnosis <i>exactly</i> "adenocarcinoid"?</p> <p>NO</p> | <p>YES</p> <p>Code 8245 (adenocarcinoid)</p> | |
| <p>H11</p> <p>Is only one histologic type identified?</p> <p>NO</p> | <p>YES</p> <p>Code the histology.</p> | |
| <p>H12</p> <p>Does the tumor have Invasive and In situ components?</p> <p>NO</p> | <p>YES</p> <p>Code the invasive histologic type.</p> | |
| <p>Next Page</p> | | |

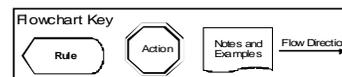
Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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



SINGLE TUMOR

| Rule | Action | Notes and Examples |
|---|--|---|
| <p>H13</p> <p>Is there cancer/malignant neoplasm, NOS (8000) and a more specific histology?</p> <p>NO</p> <p>Is there carcinoma, NOS (8010) and a more specific carcinoma?</p> <p>NO</p> <p>Is there adenocarcinoma, NOS (8140) and a more specific adenocarcinoma?</p> <p>NO</p> <p>Is there sarcoma, NOS (8800) and a more specific sarcoma (invasive only)?</p> | <p>Code the most specific histologic term.</p> | <p>1. The specific histology for In situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____ differentiation.</p> <p>2. The specific histology for Invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation.</p> |
| <p>H14</p> | <p>Code the numerically higher ICD-O-3 histology code.</p> | |

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

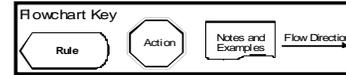
Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

| Rule | Action | Notes and Examples |
|-------------------|--------|--------------------|
| <p>H15</p> | | |
| <p>H16</p> | | |
| | | |

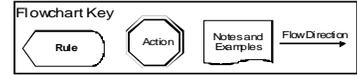
Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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



MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

| Rule | Action | Notes and Examples |
|---|--|--------------------|
| <p>H17</p> <p>Does the clinical history say familial polyposis and the final diagnosis on the pathology report from resection is adenocarcinoma in adenomatous polyps?</p> <p>NO</p> <p>Are there > 100 polyps identified in the resected specimen?</p> <p>NO</p> <p>Is the number of polyps not given and the diagnosis is familial polyposis?</p> <p>NO</p> | <p>YES</p> <p>YES</p> <p>YES</p> <p>Code 8220 (adenocarcinoma in adenomatous polyposis coli)</p> | |
| <p>H18</p> <p>Are there multiple in situ or malignant polyps present, at least one of which is tubulovillous?</p> <p>NO</p> | <p>YES</p> <p>Code 8263 (adenocarcinoma in a tubulovillous adenoma)</p> | |
| <p>Next Page</p> | | |

Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY



| Rule | Action | Notes and Examples |
|--|--|--|
| <p>H19</p> <p>Are there <= 100 polyps identified in the resected specimen?</p> <p>NO</p> <p>Are there multiple polyps and the number is not given and familial polyposis is not mentioned?</p> <p>NO</p> | <p>YES</p> <p>Code 8221 (adenocarcinoma in adenomatous polyps)</p> | |
| <p>H20</p> <p>Is there a frank adenocarcinoma and a carcinoma in a polyp?</p> <p>NO</p> <p>Are there in situ and invasive tumors?</p> <p>NO</p> <p>Are there multiple invasive tumors?</p> <p>NO</p> <p>Next Page</p> | <p>YES</p> <p>Code the histology of the most invasive tumor.</p> | <p>1. See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.</p> <ul style="list-style-type: none"> o If one tumor is in situ and one is invasive, code the histology from the invasive tumor. o If both/all histologies are invasive, code the histology of the most invasive tumor. <p>2. If tumors are equally invasive, go to the next rule.</p> |

Multiple Primary and Histology Coding Rules 2007: Colon

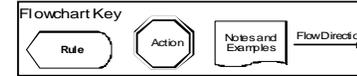
Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY



| Rule | Action | Notes and Examples |
|---|--|---|
| <p>H21</p> <p>Is the final diagnosis adenocarcinoma and the microscopic description or surgical gross describes polyps?</p> <p>NO</p> <p>Is final diagnosis adenocarcinoma and there is reference to a residual or pre-existing polyp?</p> <p>NO</p> <p>Is the final diagnosis mucinous/colloid or signet ring cell adenocarcinoma found in a polyp?</p> <p>NO</p> <p>Is there documentation that the patient had a polypectomy?</p> | <p>Code 8210 (adenocarcinoma in adenomatous polyp), 8261 (adenocarcinoma in villous adenoma), or 8263 (adenocarcinoma in tubulovillous adenoma).</p> | <p>It is important to know that the adenocarcinoma originated in the polyp.</p> |
| <p>H22</p> <p>Is only one histologic type identified?</p> <p>NO</p> | <p>Code the histology.</p> | |
| <p>Next Page</p> | | |

Multiple Primary and Histology Coding Rules 2007: Colon

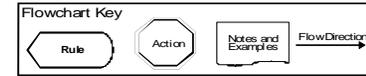
Histology Coding Rules – Flowchart

Colon Histology Coding Rules - Flowchart

(C180-C189)

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

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY



| Rule | Action | Notes and Examples |
|---|---|---|
| <p>H23</p> <p>Is there cancer/malignant neoplasm, NOS (8000) and a specific histology?</p> <p>NO</p> <p>Is there carcinoma, NOS (8010) and a specific carcinoma?</p> <p>NO</p> <p>Is there adenocarcinoma, NOS (8140) and a specific adenocarcinoma?</p> <p>NO</p> <p>Is there sarcoma, NOS (8800) and a specific sarcoma (invasive only)?</p> <p>NO</p> | <p>Code the more specific histologic term.</p> | <p>1. The specific histology for In situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ differentiation.</p> <p>2. The specific histology for Invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation.</p> |
| <p>H24</p> | <p>Code the histology with the numerically higher ICD-O-3 histology code.</p> | |

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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Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Matrix C180-C189 (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 | Single | | | | 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 | |
| M3 | | Adenocarcinoma in adenomatous polyposis (familial polyposis) with one or more malignant polyps | | | Tumors may be present in multiple segments of the colon or in a single segment of the colon. | Single* |
| M4 | Sites with topography codes that are different at the second (Cxxx), third (Cxxx) or fourth (C18x) character | | | | | Multiple** |
| M5 | | | Diagnosed more than one (1) year apart | | | Multiple** |

Multiple Primary and Histology Coding Rules 2007: Colon

**Multiple Primary Rules – Matrix
C180-C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Site | Histology | Timing | Behavior | Notes/Examples | Primary |
|-------------|-------------|--|-----------------------------------|--|---|----------------|
| M6 | | | More than 60 days after diagnosis | An invasive tumor following an in situ tumor | <i>1:</i> The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed. <i>2:</i> Abstract as multiple primaries even if the medical record/physician states it is recurrence or progression of disease. | Multiple** |
| M7 | | A frank in situ or malignant adenocarcinoma and an in situ or malignant tumor in a polyp | | | | Single* |
| M8 | | <ul style="list-style-type: none"> • Cancer/malignant neoplasm, NOS (8000) and a specific histology; OR • Carcinoma, NOS (8010) and a specific carcinoma; OR • Adenocarcinoma, NOS (8140) and a specific adenocarcinoma; OR • Sarcoma, NOS (8800) and a specific sarcoma | | | | Single* |
| M9 | | Multiple in situ and/or malignant polyps | | | Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps. | Single* |
| M10 | | Histology codes are different at the first (xxxx), second (xxxx), or third (xxx) number | | | | Multiple** |

Multiple Primary and Histology Coding Rules 2007: Colon

**Multiple Primary Rules – Matrix
C180-C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Site | Histology | Timing | Behavior | Notes/Examples | Primary |
|-------------|---|------------------|---------------|-----------------|--|----------------|
| M11 | Does not meet any of the above criteria | | | | <i>1:</i> When an invasive lesion follows an in situ within 60 days, abstract as a single primary. <i>2:</i> All cases covered by Rule M11 are in the same segment of the colon | Single* |

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Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|---------------------|--|------------------|-----------------|--|---|
| SINGLE TUMOR | | | | | |
| H1 | No pathology/cytology specimen or the pathology/cytology report is not available | | | <p>I: Priority for using documents to code the histology</p> <ul style="list-style-type: none"> • Documentation in the medical record that refers to pathologic or cytologic findings • Physician’s reference to type of cancer (histology) in the medical record • CT, PET or MRI scans <p>2: Code the specific histology when documented.</p> <p>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</p> | The histology documented by the physician |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|-------------|------------------------------------|---|-----------------|---|--|
| H2 | None from primary site | | | Code the behavior /3 | The histology from metastatic site |
| H3 | | Intestinal type adenocarcinoma or adenocarcinoma, intestinal type | | <i>1:</i> Intestinal type adenocarcinoma usually occurs in the stomach. <i>2:</i> When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule. | 8140 (Adenocarcinoma, NOS) |
| H4 | | Final diagnosis: <ul style="list-style-type: none"> • Adenocarcinoma in a polyp or • Adenocarcinoma and a residual polyp or polyp architecture is recorded in other parts of the pathology report or • Adenocarcinoma and there is reference to a residual or pre-existing polyp within the medical record or • Mucinous/colloid or signet ring cell adenocarcinoma in a polyp or There is documentation that the patient had a polypectomy | | It is important to know that the adenocarcinoma originated in a polyp. | 8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenoma) |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|-------------|------------------------------------|--|-----------------|---------------------------|---|
| H5 | | Final diagnosis is: <ul style="list-style-type: none"> • Mucinous/colloid (8480) or signet ring cell carcinoma (8490) or • Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is mucinous/colloid or • Adenocarcinoma, NOS and microscopic description documents 50% or more of the tumor is signet ring cell carcinoma | | | 8480 (Mucinous/colloid adenocarcinoma) or 8490 (Signet ring cell carcinoma) |
| H6 | | Final diagnosis is adenocarcinoma and: <ul style="list-style-type: none"> • Microscopic description states less than 50% of the tumor is mucinous/colloid, or • Microscopic description states less than 50% of the tumor is signet ring cell carcinoma, or • Percentage of Mucinous/colloid or signet ring cell carcinoma is unknown | | | 8140 (Adenocarcinoma, NOS) |
| H7 | | Combination of mucinous/colloid and signet ring cell carcinoma | | | 8255 (Adenocarcinoma with mixed subtypes) |
| H8 | | Neuroendocrine carcinoma (8246) and carcinoid tumor (8240) | | | 8240 (Carcinoid tumor, NOS) |
| H9 | | Adenocarcinoma and carcinoid tumor | | | 8244 (Composite carcinoid) |
| H10 | | <u>Exactly</u> “adenocarcinoid” | | | 8245 (Adenocarcinoid) |
| H11 | | One type | | | The histology |

Multiple Primary and Histology Coding Rules 2007: Colon

Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|------|--------------------------------------|---|----------------------|---|--|
| H12 | | | Invasive and in situ | | The invasive histologic type |
| H13 | | <ul style="list-style-type: none"> • Cancer/malignant neoplasm, NOS (8000) and a more specific histology or • Carcinoma, NOS (8010) and a more specific carcinoma or • Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or • Sarcoma, NOS (8800) and a more specific sarcoma (invasive only) | | <p><i>1.</i> The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____ differentiation.</p> <p><i>2.</i> The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with _____ differentiation.</p> | The most specific histologic term |
| H14 | None of the above conditions are met | | | | The histology with the numerically higher ICD-O-3 code |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|--|--|------------------|-----------------|---|---|
| MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY | | | | | |
| These rules only apply to multiple tumors that are reported as a single primary | | | | | |
| H15 | No pathology/cytology specimen or the pathology/cytology report is not available | | | <p>1: Priority for using documents to code the histology</p> <ul style="list-style-type: none"> • Documentation in the medical record that refers to pathologic or cytologic findings • Physician’s reference to type of cancer (histology) in the medical record • CT, PET or MRI scans <p>2: Code the specific histology when documented</p> <p>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</p> | The histology documented by the physician |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|-------------|------------------------------------|---|-----------------|---------------------------|---|
| H16 | None from primary site | | | Code the behavior /3 | The histology from a metastatic site |
| H17 | | <ul style="list-style-type: none"> • Clinical history says familial polyposis and final diagnosis on pathology report from resection is adenocarcinoma in adenomatous polyps, or • > 100 polyps in resected specimen or • Number of polyps is not given but the diagnosis is familial polyposis | | | 8220 (Adenocarcinoma in adenomatous polyposis coli) |
| H18 | | Multiple in situ or malignant polyps are present, at least one of which is tubulovillous | | | 8263 (Adenocarcinoma in a tubulovillous adenoma) |
| H19 | | <ul style="list-style-type: none"> • <= 100 polyps in resected specimen, or • Multiple polyps and the number of polyps is not given and familial polyposis is not mentioned | | | 8221 (adenocarcinoma in multiple adenomatous polyps) |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|------|-----------------------------|--|----------|---|---|
| H20 | | <ul style="list-style-type: none"> Frank adenocarcinoma and a carcinoma in a polyp, or In situ and invasive tumors or Multiple invasive tumors | | <p>1: See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.</p> <ul style="list-style-type: none"> One tumor is in situ and one is invasive, code the histology from the invasive tumor. Both/all histologies are invasive, code the histology of the most invasive tumor. <p>2: If tumors are equally invasive, go to the next rule</p> | The histology of the most invasive tumor |
| H21 | | <p>Final diagnosis:</p> <ul style="list-style-type: none"> Adenocarcinoma and the microscopic description or surgical gross describes polyps or Adenocarcinoma and there is reference to residual or pre-existing polyps or Mucinous/colloid or signet ring cell adenocarcinoma in polyps or <p>There is documentation that the patient had a polypectomy</p> | | It is important to know that the adenocarcinoma originated in a polyp. | 8210 (Adenocarcinoma arising in polyp), or 8261 (Adenocarcinoma in a villous adenoma), or 8263 (Adenocarcinoma in a tubulovillous adenocarcinoma) |

Multiple Primary and Histology Coding Rules 2007: Colon

**Histology Coding Rules – Matrix
C180 – C189 (Excludes lymphoma and leukemia M9590 – 9989 and Kaposi sarcoma M9140)**

| Rule | Pathology/Cytology Specimen | Histology | Behavior | Notes and Examples | Code |
|-------------|--------------------------------------|--|-----------------|--|--|
| H22 | | One type | | | The histology |
| H23 | | <ul style="list-style-type: none"> • Cancer/malignant neoplasm, NOS (8000) and a specific histology or • Carcinoma, NOS (8010) and a specific carcinoma or • Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or Sarcoma, NOS (8800) and a specific sarcoma (invasive only) | | <p>1: The specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with _____differentiation</p> <p>2: The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with _____differentiation.</p> | The more specific histologic term |
| H24 | None of the above conditions are met | | | | The histology with the numerically higher ICD-O-3 code |

Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Text C180 - C189 (Excludes lymphoma and leukemia M9590-9989 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 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 M3 Adenocarcinoma in adenomatous polyposis coli (**familial polyposis**) with one or more malignant polyps is a single primary.*

Note: Tumors may be present in multiple segments of the colon or in a single segment of the colon.

Multiple Primary and Histology Coding Rules 2007: Colon

Multiple Primary Rules – Text C180 - C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

- Rule M4** Tumors in sites with **ICD-O-3 topography** codes that are different at the second (Cxxx), third, (Cxxx) or fourth (C18x) character are multiple primaries. **
- Rule M5** Tumors diagnosed **more than one (1) year** apart are multiple primaries. **
- Rule M6** An **invasive** tumor **following** an **in situ** tumor more than 60 days after diagnosis are multiple primaries. **
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 M7** A **frank** malignant or in situ **adenocarcinoma** and an in situ or **malignant** tumor in a **polyp** are a single primary.*
- Rule M8** Abstract as a single primary* when one tumor is:
- **Cancer/malignant neoplasm, NOS (8000)** and another is a **specific histology** or
 - **Carcinoma, NOS (8010)** and another is a **specific carcinoma** or
 - **Adenocarcinoma, NOS (8140)** and another is a **specific adenocarcinoma** or
 - **Sarcoma, NOS (8800)** and another is a **specific sarcoma**
- Rule M9** **Multiple** in situ and/or malignant **polyps** are a single primary.*
Note: Includes all combinations of adenomatous, tubular, villous, and tubulovillous adenomas or polyps.
- Rule M10** Tumors with **ICD-O-3 histology** codes that are **different** at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries. **
- Rule M11** Tumors that **do not meet any** of the above **criteria** are 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 M11 are in the same segment of the colon.

* 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.

Multiple Primary and Histology Rules 2007: Colon

Histology Coding Rules – Text
C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

SINGLE TUMOR

- Rule H1** 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
 - CT, PET or MRI scans
- 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 H2** Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.
- Rule H3** Code **8140** (adenocarcinoma, NOS) when pathology describes only **intestinal type adenocarcinoma** or adenocarcinoma, intestinal type.
Note 1: Intestinal type adenocarcinoma usually occurs in the stomach.
Note 2: When a diagnosis of intestinal adenocarcinoma is further described by a specific term such as type, continue to the next rule.
- Rule H4** Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:
- The final diagnosis is adenocarcinoma in a polyp
 - The final diagnosis is adenocarcinoma **and** a residual polyp or polyp architecture is recorded in other parts of the pathology report.
 - The final diagnosis is adenocarcinoma **and** there is reference to a residual or pre-existing polyp or
 - The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in a polyp or
 - There is documentation that the patient had a polypectomy
- Note:* It is important to know that the adenocarcinoma originated in a polyp.

Multiple Primary and Histology Rules 2007: Colon

Histology Coding Rules – Text C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

- Rule H5** Code **8480** (mucinous/colloid adenocarcinoma) or **8490** (signet ring cell carcinoma) when the final diagnosis is:
- **Mucinous/colloid** (8480) or **signet ring cell** carcinoma (8490) or
 - Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **mucinous/colloid** or
 - Adenocarcinoma, NOS and the microscopic description documents that **50% or more** of the tumor is **signet ring cell** carcinoma
- Rule H6** Code **8140** (adenocarcinoma, NOS) when the final diagnosis is **adenocarcinoma** and:
- The microscopic diagnosis states that **less than 50%** of the tumor is **mucinous/colloid** or
 - The microscopic diagnosis states that **less than 50%** of the tumor is **signet ring cell** carcinoma or
 - The **percentage** of mucinous/colloid or signet ring cell carcinoma is **unknown**
- Rule H7** Code **8255** (adenocarcinoma with mixed subtypes) when there is a **combination** of **mucinous/colloid and signet ring cell** carcinoma.
- Rule H8** Code **8240** (carcinoid tumor, NOS) when the diagnosis is **neuroendocrine carcinoma** (8246) **and carcinoid tumor** (8240).
- Rule H9** Code **8244** (composite carcinoid) when the diagnosis is **adenocarcinoma and carcinoid tumor**.
- Rule H10** Code **8245** (adenocarcinoid) when the diagnosis is **exactly** “**adenocarcinoid.**”
- Rule H11** Code the histology when only **one histologic type** is identified.
- Rule H12** Code the invasive histology when both **invasive and in situ** histologies are present.

Multiple Primary and Histology Rules 2007: Colon**Histology Coding Rules – Text
C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)**

Rule H13 Code the most **specific** histologic **term when** the diagnosis is:

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Adenocarcinoma, NOS (8140) and a more specific adenocarcinoma or
- Sarcoma, NOS (8800) and a more specific sarcoma (invasive only)

Note 1: The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____differentiation

Note 2: The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____differentiation.

Rule H14 Code the histology with the **numerically higher** ICD-O-3 code.

This is the end of instructions for Single Tumor.

Code the histology according to the rule that fits the case.

Multiple Primary and Histology Rules 2007: Colon

Histology Coding Rules – Text C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

MULTIPLE TUMORS ABSTRACTED AS A SINGLE PRIMARY

Note: These rules only apply to multiple tumors that are reported as a **single primary**.

- Rule H15** 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
 - From CT, PET or MRI scans
- 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 H16** Code the histology from a metastatic site when there is **no pathology/cytology specimen from the primary site**.
Note: Code the behavior /3.
- Rule H17** Code **8220** (adenocarcinoma in adenomatous polyposis coli) when:
- **Clinical** history says **familial polyposis** and final diagnosis on the **pathology report** from resection is **adenocarcinoma in adenomatous polyps** or
 - There are **>100 polyps** identified in the resected specimen or
 - The number of polyps is not given but the diagnosis is **familial polyposis**
- Rule H18** Code **8263** (adenocarcinoma in a tubulovillous adenoma) when multiple in situ or malignant polyps are present, at least one of which is tubulovillous
- Rule H19** Code **8221** (adenocarcinoma in multiple adenomatous polyps) when:
- There are **<=100 polyps** identified in the resected specimen or
 - There are multiple polyps and the number is not given and **familial polyposis** is **not mentioned**

Multiple Primary and Histology Rules 2007: Colon

Histology Coding Rules – Text C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

- Rule H20** Code the histology of the **most invasive** tumor when:
- There is a frank adenocarcinoma and a carcinoma in a polyp or
 - There are in situ and invasive tumors or
 - There are multiple invasive tumors
- Note 1:* See the Colon Equivalent Terms, Definitions and Illustrations for the definition of most invasive.
- One tumor is in situ and one is invasive, code the histology from the invasive tumor.
 - Both/all histologies are invasive, code the histology of the most invasive tumor.
- Note 2:* If tumors are equally invasive, go to the next rule
- Rule H21** Code **8210** (adenocarcinoma in **adenomatous polyp**), **8261** (adenocarcinoma in **villous adenoma**), or **8263** (adenocarcinoma in **tubulovillous adenoma**) when:
- The final diagnosis is adenocarcinoma **and** the microscopic description or surgical gross describes polyps or
 - The final diagnosis is adenocarcinoma **and** there is reference to residual or pre-existing polyps or
 - The final diagnosis is mucinous/colloid or signet ring cell adenocarcinoma in polyps or
 - There is documentation that the patient had a polypectomy
- Note:* It is important to know that the adenocarcinoma originated in a polyp.
- Rule H22** Code the histology when only **one histologic type** is identified.
- Rule H23** **Code the more specific histologic term** when the diagnosis is:
- Cancer/malignant neoplasm, NOS (8000) and a specific histology or
 - Carcinoma, NOS (8010) and a specific carcinoma or
 - Adenocarcinoma, NOS (8140) and a specific adenocarcinoma or
 - Sarcoma, NOS (8800) and a specific sarcoma (invasive only)
- Note 1:* The specific histology for **in situ** tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with ____ differentiation
- Note 2:* The specific histology for **invasive** tumors may be identified as type, subtype, predominantly, with features of, major, or with ____ differentiation.

Multiple Primary and Histology Rules 2007: Colon

Histology Coding Rules – Text

C180-C189 (Excludes lymphoma and leukemia M9590-9989 and Kaposi sarcoma M9140)

Rule H24 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.

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Colon

C18.0-C18.9

- C18.0 Cecum
- C18.1 Appendix
- C18.2 Ascending colon
- C18.3 Hepatic flexure of colon
- C18.4 Transverse colon
- C18.5 Splenic flexure of colon
- C18.6 Descending colon
- C18.7 Sigmoid colon
- C18.8 Overlapping lesion of colon
- C18.9 Colon, NOS

| | | |
|--|--|--|
| <ul style="list-style-type: none"> 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 | <p>CS Site-Specific Factor 1 - Carcinoembryonic Antigen (CEA)</p> <ul style="list-style-type: none"> CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | <p>The following tables are available at the collaborative staging website:</p> <ul style="list-style-type: none"> Histology Exclusion Table AJCC Stage Lymph Nodes Number Positive Table |
|--|--|--|

Colon

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

| 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" |
| 998 | Familial/multiple polyposis (M-8220/8221) |
| 999 | Unknown; size not stated Not documented in patient record |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Colon

CS Extension (Revised: 08/14/2006)

Note 1: Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extracolonic spread as indicated.

Note 2: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Note 3: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; noninvasive; intraepithelial | Tis | IS | IS |
| 05 | (Adeno)carcinoma in a polyp or adenoma, noninvasive | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS (including intramucosal, NOS) | Tis | L | L |
| 11 | Lamina propria, including lamina propria in the stalk of a polyp | Tis | L | L |
| 12 | Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp. | Tis | L | L |
| 13 | Confined to head of polyp, NOS | T1 | L | L |
| 14 | Confined to stalk of polyp, NOS | T1 | L | L |
| 15 | Invasive tumor in polyp, NOS | T1 | L | L |
| 16 | Invades submucosa (superficial invasion), including submucosa in the stalk of a polyp | T1 | L | L |
| 20 | Muscularis propria invaded | T2 | L | L |
| 30 | Localized, NOS Confined to colon, NOS | T1 | L | L |
| 40 | Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Non-peritonealized pericolic tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS | T3 | L | L |
| 42 | Fat, NOS | T3 | RE | RE |
| 45 | Extension to: All colon sites: Adjacent tissue(s), NOS Connective tissue Mesenteric fat Mesentery Mesocolon Pericolic fat Ascending and descending colon Retroperitoneal fat Transverse colon/flexures Gastrocolic ligament Greater omentum | T3 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|----|----|
| 46 | Adherent to other organs or structures, but no microscopic tumor found in adhesion(s) | T3 | RE | RE |
| 50 | Invasion of/through serosa (mesothelium) (visceral peritoneum) | T4 | RE | RE |
| 55 | Any of [(42) to (45)] + (50) | T4 | RE | RE |
| 57 | Adherent to other organs or structures, NOS | T4 | RE | RE |
| 60 | All colon sites: Small intestine Cecum and appendix: Greater omentum Ascending colon: Greater omentum Liver, right lobe Transverse colon and flexures: Gallbladder/bile ducts Kidney Liver Pancreas Spleen Stomach Descending colon: Greater omentum Pelvic wall Spleen Sigmoid colon: Greater omentum Pelvic wall | T4 | RE | RE |
| 65 | All colon sites: Abdominal wall Retroperitoneum (excluding fat) | T4 | RE | RE |
| 66 | Ascending colon: Right kidney Right ureter Descending colon: Left kidney Left ureter | T4 | RE | RE |
| 70 | Cecum, appendix, ascending, descending and sigmoid colon: Fallopian tube Ovary Uterus | T4 | D | D |
| 75 | All colon sites unless otherwise stated above: Adrenal (suprarenal) gland Bladder Diaphragm Fistula to skin Gallbladder Other segment(s) of colon via serosa | T4 | D | D |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|---|---|
| 80 | Further contiguous extension: Cecum and appendix: Kidney Liver Ureter Transverse colon and flexures: Ureter Sigmoid colon: Cul de sac (rectouterine pouch) Ureter Other 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 |

Colon

CS TS/Ext-Eval

SEE STANDARD TABLE

Colon

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: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Note 3: Inferior mesenteric nodes are coded in CS Mets at DX for cecum, appendix, ascending colon, transverse colon, and hepatic flexure. Superior mesenteric nodes are coded in CS Mets at DX for all colon sites.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | None; no regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes for all colon sites: Colic (NOS) Epicolic (adjacent to bowel wall) Mesocolic (NOS) Paracolic/pericolic Nodule(s) or foci in pericolic fat/adjacent mesentery/mesocolic fat | * | RN | RN |
| 20 | Regional lymph nodes, for specific subsites: Cecum and appendix: Cecal: anterior (prececal), posterior (retrocecal); NOS Ileocolic Right colic Ascending colon: Ileocolic Middle colic Right colic Transverse colon and flexures: Inferior mesenteric for splenic flexure only | * | RN | RN |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|--------------|---|----|----|----|
| 20 cont'd | Left colic for splenic flexure only Middle colic Right colic for hepatic flexure only Descending colon: Inferior mesenteric Left colic Sigmoid Sigmoid colon: Inferior mesenteric Sigmoidal (sigmoid mesenteric) Superior hemorrhoidal Superior rectal | | | |
| 30 | Regional lymph nodes for all colon sites: Mesenteric, NOS 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 10-80 ONLY, the N category is assigned based on the value of Reg LN Pos, using the Lymph Nodes Number Positive Table for this site.

Colon

CS Reg Nodes Eval

SEE STANDARD TABLE

Colon

Reg LN Pos

SEE STANDARD TABLE

Colon

Reg LN Exam

SEE STANDARD TABLE

Colon

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

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 08 | Cecum, appendix, ascending, hepatic flexure and transverse colon: Superior mesenteric lymph nodes | M1 | RN | D |
| 10 | Distant lymph node(s) other than code 08 For all colon sites: Common iliac Distant lymph node(s), NOS External iliac Para-aortic Retroperitoneal | M1 | D | D |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|--------------|---|----|---|---|
| 10 cont'd | For cecum, appendix, ascending colon, transverse colon, and hepatic flexure: Inferior mesenteric For splenic flexure, descending colon, and sigmoid colon: Superior mesenteric | | | |
| 40 | Distant metastases except distant lymph node(s) (codes 08-10) Distant metastasis, NOS Carcinomatosis | M1 | D | D |
| 50 | (40) + ((08) or (10)) 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 |

Colon

CS Mets Eval

SEE STANDARD TABLE

Colon

CS Site-Specific Factor 1 Carcinoembryonic Antigen (CEA) (Revised: 07/31/2002)

| 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 | Unknown or no information Not documented in patient record |

Colon

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Colon

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Colon

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Colon

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Colon

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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SEER Program Coding and Staging Manual 2007

Surgery Codes

Colon

C180–C189

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

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

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
 - 27 Excisional biopsy
 - 26 Polypectomy, NOS
 - 28 Polypectomy-endoscopic
 - 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH

- 21 Photodynamic therapy (PDT)
 - 22 Electrocautery
 - 23 Cryosurgery
 - 24 Laser ablation
- [**SEER Note:** Codes 21 to 24 above combine 20 Local tumor excision, 27 Excisional biopsy, 26 Polypectomy, NOS, 28 Polypectomy-endoscopic or 29 Polypectomy-surgical excision WITH 21 PDT, 22 Electrocautery, 23 Cryosurgery, or 24 Laser ablation]
- 25 Laser excision

Specimen sent to pathology from surgical events 20–29

- 30 Partial colectomy, [but less than hemicolectomy] segmental resection
 - 32 Plus resection of contiguous organ; example: small bowel, bladder

[**SEER Note:** Codes 30 and 32 include but are not limited to: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection, such as cecectomy or sigmoidectomy. Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ.]
- 40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
 - 41 Plus resection of contiguous organ; example: small bowel, bladder

[**SEER Notes:** Code 40 includes extended (but less than total) right or left colectomy. Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]
- 50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
 - 51 Plus resection of contiguous organ; example: small bowel, bladder

[**SEER Note:** Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]

SEER Program Coding and Staging Manual 2007

Surgery Codes

- 60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
[**SEER Note:** Commonly used for familial polyposis or polyposis coli]
- 61 Plus resection of contiguous organ; example: small bowel, bladder
[**SEER Note:** Removal of a short portion of the distal ileum is not coded as removal of a contiguous organ]
- 70 Colectomy or coloproctectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)
Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.
[**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]
- 80 Colectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SEER Program Coding and Staging Manual 2007

**Rectosigmoid, Rectum
C199, C209**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Rectosigmoid, Rectum

C19.9, C20.9

C19.9 Rectosigmoid junction

C20.9 Rectum, NOS

| | | |
|--|---|---|
| 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 - Carcinoembryonic Antigen (CEA) CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Lymph Nodes Number Positive Table |
|--|---|---|

Rectosigmoid, Rectum

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

| 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 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" |
| 998 | Familial/multiple polyposis (M-8220/8221) |
| 999 | Unknown; size not stated Not documented in patient record |

Rectosigmoid, Rectum

CS Extension (Revised: 08/21/2006)

Note 1: Ignore intraluminal extension to adjacent segment(s) of colon/rectum and code depth of invasion or extracolonic spread as indicated.

Note 2: A tumor nodule in the pericolic adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

Note 3: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

table begins on next page

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Rectosigmoid, Rectum

CS Extension (Revised: 08/21/2006), *continued*

| Code | Description | TNM | SS77 | SS2000 |
|-------------|---|------------|-------------|---------------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 05 | (Adeno)carcinoma in a polyp or adenoma, noninvasive | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS, including intramucosal, NOS | Tis | L | L |
| 11 | Lamina propria, including lamina propria in the stalk of a polyp | Tis | L | L |
| 12 | Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp. | Tis | L | L |
| 13 | Confined to head of polyp, NOS | T1 | L | L |
| 14 | Confined to stalk of polyp, NOS | T1 | L | L |
| 15 | Invasive tumor in polyp, NOS | T1 | L | L |
| 16 | Submucosa (superficial invasion), including submucosa in the stalk of a polyp | T1 | L | L |
| 20 | Muscularis propria invaded | T2 | L | L |
| 30 | Localized, NOS Confined to rectum, NOS | T1 | L | L |
| 40 | Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Non-peritonealized pericolic tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS | T3 | L | L |
| 42 | Fat, NOS | T3 | RE | RE |
| 45 | Adjacent (connective) tissue: For all sites: Perirectal fat For rectosigmoid: Mesentery (including mesenteric fat, mesocolon) Pericolic fat For rectum: Extension to anus Rectovaginal septum | T3 | RE | RE |
| 46 | Adherent to other organs or structures but no tumor found in adhesion(s) | T3 | RE | RE |
| 50 | Invasion of/through serosa (mesothelium) (visceral peritoneum) | T4 | RE | RE |
| 55 | (50) with [(42) or (45)] | T4 | RE | RE |
| 57 | Adherent to other organs or structures, NOS | T4 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|---|---|
| 60 | Rectosigmoid: Cul de sac (rectouterine pouch) Pelvic wall Small intestine Rectum: Bladder for males only Cul de sac (rectouterine pouch) Ductus deferens Pelvic wall Prostate Rectovesical fascia for male only Seminal vesicle(s) Skeletal muscle of pelvic floor Vagina | | | |
| 70 | Rectosigmoid: Bladder Colon via serosa Fallopian tube(s) Ovary(ies) Prostate Ureter(s) Uterus Rectum: Bladder for female only Bone(s) of pelvis Urethra Uterus | 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 |

Rectosigmoid, Rectum

CS TS/Ext-Eval

SEE STANDARD TABLE

Rectosigmoid, Rectum

CS Lymph Nodes (Revised: 08/14/2006)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: A tumor nodule in the perirectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule is classified as a regional lymph node metastasis if the nodule has the form and smooth contour of a lymph node, or if the contour is not described. If the nodule has an irregular contour, it should be coded in CS Extension as code 45.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | None; no regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes: | * | RN | RN |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|--------------|---|----|----|----|
| 10 cont'd | Rectosigmoid: Paracolic/pericolic Perirectal Rectal Nodule(s) or foci in pericolic fat/adjacent mesentery/mesocolic fat Rectum: Perirectal Rectal, NOS Nodule(s) or foci in perirectal fat | | | |
| 20 | Regional lymph node(s): Rectosigmoid: Colic, NOS Left colic Hemorrhoidal, superior or middle Inferior mesenteric Middle rectal Sigmoidal (sigmoid mesenteric) Superior rectal Rectum: Hemorrhoidal, superior, middle or inferior Inferior mesenteric Internal iliac (hypogastric) Obturator Rectal, superior, middle, or inferior Sacral, NOS Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Sacral promontory Sigmoidal (sigmoid mesenteric) | * | RN | RN |
| 30 | Mesenteric, NOS 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 Lymph Nodes codes 10-80 ONLY, the N category is assigned based on the value of Reg LN Pos, using the Lymph Nodes Number Positive Table for this site:

Rectosigmoid, Rectum
CS Reg Nodes Eval
SEE STANDARD TABLE

Rectosigmoid, Rectum
Reg LN Pos
SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Rectosigmoid, Rectum
Reg LN Exam
SEE STANDARD TABLE

Rectosigmoid, Rectum
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 | Rectosigmoid: Internal iliac (hypogastric) Obturator | M1 | RN | D |
| 12 | Other distant lymph node(s), including external iliac or common iliac | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) codes 10-12 Distant metastasis, NOS Carcinomatosis | M1 | D | D |
| 50 | (40)+ any of [(10 or (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 |

Rectosigmoid, Rectum
CS Mets Eval
SEE STANDARD TABLE

Rectosigmoid, Rectum
CS Site-Specific Factor 1 Carcinoembryonic Antigen (CEA) (Revised: 11/18/2003)

Note: The Site-Specific Factors section includes factors that are needed to derive TNM or AJCC stage and also includes items that are considered important but are not needed for AJCC. This includes prognostic and predictive factors and tumor markers. There are many sites for which there are no Site-Specific Factors required at this time.

| Code | Description |
|------|---|
| 000 | Test none 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 | Unknown or no information Not documented in patient record |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Rectosigmoid, Rectum

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Rectosigmoid, Rectum

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Rectosigmoid, Rectum

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Rectosigmoid, Rectum

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Rectosigmoid, Rectum

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

Surgery Codes

Rectosigmoid

C199

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

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

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 ablation

No specimen sent to pathology from surgical events 10–14

20 Local tumor excision, NOS

26 Polypectomy

27 Excisional biopsy

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 Wedge or segmental resection; partial proctosigmoidectomy, NOS

31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection

Hartmann operation

Low anterior resection (LAR)

Partial colectomy, NOS

Rectosigmoidectomy, NOS

Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

[**SEER Note:** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50 Total proctectomy

[**SEER Note:** Procedures coded 50 include but are not limited to: Abdominoperineal resection (A & P resection), anterior/posterior resection (A/P resection)/Miles' operation, Rankin's operation]

SEER Program Coding and Staging Manual 2007

Surgery Codes

- 51 Total colectomy
[**SEER Note:** Removal of the colon from cecum to rectosigmoid or portion of rectum]
- 55 Total colectomy WITH ileostomy, NOS
56 Ileorectal reconstruction
57 Total colectomy WITH other pouch; example: Koch pouch
- 60 **Total proctocolectomy, NOS** [combination of 50 and 51]
65 Total proctocolectomy WITH ileostomy, NOS
66 Total proctocolectomy WITH ileostomy and pouch
[**SEER Note:** Removal of the colon from cecum to the rectosigmoid junction including the entire rectum.]
- 70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration
[**SEER Note:** Procedures that may be part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy. Code 70 includes any colectomy (partial, hemicolectomy or total) with an en bloc resection of any other organs. There may be partial or total removal of other organs in continuity with the primary. 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]
- 80 Colectomy, NOS; Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SEER Program Coding and Staging Manual 2007

Surgery Codes

Rectum

C209

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

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294)

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

27 Excisional biopsy

26 Polypectomy

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

28 Curette and fulguration

Specimen sent to pathology from surgical events 20-28

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:

Anterior resection

Hartmann's operation

Low anterior resection (LAR)

Transsacral rectosigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

[**SEER Note:** Procedures coded 40 include but are not limited to: Altemeier's operation, Duhamel's operation, Soave's submucosal resection, Swenson's operation, Turnbull's operation]

50 Total proctectomy

Procedure coded 50 includes, but is not limited to: Abdominoperineal resection (Miles Procedure)

[**SEER Note:** Also called A & P resection, anterior/posterior (A/P) resection/Miles' operation, Rankin's operation]

60 Total proctocolectomy, NOS

SEER Program Coding and Staging Manual 2007

Surgery Codes

- 70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration
[**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]
- 80 Proctectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

SEER Program Coding and Staging Manual 2007

**Anus
C210-C218**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Anus

Anal Canal; Anus, NOS; Other Parts of Rectum

C21.0-C21.2, C21.8

C21.0 Anus, NOS (excludes skin of anus and perianal skin C44.5)

C21.1 Anal canal

C21.2 Cloacogenic zone

C21.8 Overlapping lesion of rectum, anus and anal canal

Note: Skin of anus is coded separately (C44.5).

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Extension Size Table |
|--|--|--|

Anus

CS Tumor Size

SEE STANDARD TABLE

Anus

CS Extension (Revised: 12/08/2003)

Note: Codes 60-80 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; noninvasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor confined to mucosa, NOS (including intramucosal, NOS) | * | L | L |
| 11 | Invades lamina propria | * | L | L |
| 12 | Invades muscularis mucosae | * | L | L |
| 16 | Invades submucosa (superficial invasion) | * | L | L |
| 20 | Invades muscularis propria (internal sphincter) | * | L | L |
| 30 | Localized, NOS | * | L | L |
| 40 | Ischiorectal fat/tissue Perianal skin Perirectal skin Rectal mucosa or submucosa Rectal wall Skeletal muscles: Anal sphincter (external) Levator ani Subcutaneous perianal tissue | * | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 60 | Perineum Vulva | T4 | RE | RE |
| 70 | Bladder Pelvic peritoneum Urethra Vagina | T4 | D | D |
| 75 | Broad ligament(s) Cervix uteri Corpus uteri Prostate | 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 codes 10-40 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Anus

CS TS/Ext-Eval

SEE STANDARD TABLE

Anus

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

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 | N0 | NONE | NONE |
| 10 | Unilateral and bilateral: For all subsites: Anorectal Inferior hemorrhoidal Lateral sacral (laterosacral) Perirectal | N1 | RN | RN |
| 20 | Unilateral: For anal canal: Internal iliac (hypogastric) Obturator | N2 | RN | RN |
| 21 | Unilateral: For anus: Internal iliac (hypogastric) Obturator | N2 | D | RN |
| 30 | Unilateral: For anal canal: Superficial inguinal (femoral) | N2 | RN | RN |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|----|----|
| 31 | Unilateral: For anus: Superficial inguinal (femoral) | N2 | D | RN |
| 40 | (20) + (30) | N2 | RN | RN |
| 41 | (10) + (30) | N3 | RN | RN |
| 42 | (10) + (31) | N3 | D | RN |
| 50 | Bilateral: For anal canal: Internal iliac (hypogastric) Obturator Superficial inguinal (femoral) | N3 | RN | RN |
| 51 | Bilateral: For anus: Internal iliac (hypogastric) Obturator Superficial inguinal (femoral) | N3 | D | RN |
| 60 | 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 |

Anus

CS Reg Nodes Eval

SEE STANDARD TABLE

Anus

Reg LN Pos

SEE STANDARD TABLE

Anus

Reg LN Exam

SEE STANDARD TABLE

Anus

CS Mets at DX

SEE STANDARD TABLE

Anus

CS Mets Eval

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Anus

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

Surgery Codes

Anus

C210–C218

(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

15 Thermal ablation

No specimen sent to pathology from surgical events 10–15

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

[**SEER Note:** Margins of resection may have microscopic involvement]

60 Abdominal perineal resection, NOS (APR; Miles procedure)

61 APR and sentinel node excision

62 APR and unilateral inguinal lymph node dissection

63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292).

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

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SEER Program Coding and Staging Manual 2007

**Liver, Intrahepatic Bile Ducts
C220-C221**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Liver and Intrahepatic Bile Ducts

C22.0-C22.1

C22.0 Liver

C22.1 Intrahepatic bile duct

| | | |
|--|---|--|
| 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 - Alpha Fetoprotein (AFP) CS Site-Specific Factor 2 - Fibrosis Score CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Extension Size Table |
|--|---|--|

Liver and Intrahepatic Bile Ducts

CS Tumor Size

SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts

CS Extension (Revised: 08/18/2006)

Note 1: In codes 30, 40, and 65, "multiple (satellite) nodules/tumors" includes satellitosis, multifocal tumors, and intrahepatic metastases.

Note 2: Major vascular invasion (code 63) is defined as invasion of the branches of the main portal vein (right or left portal vein, not including sectoral or segmental branches) or as invasion of one or more of the three hepatic veins (right, middle, or left). Invasion of hepatic artery or vena cava is coded to 66.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 10 | Single lesion (one lobe) WITHOUT intrahepatic vascular invasion, including vascular invasion not stated | T1 | L | L |
| 20 | Single lesion (one lobe) WITH intrahepatic vascular invasion | T2 | L | L |
| 30 | Multiple (satellite) nodules/tumors (one lobe) WITHOUT intrahepatic vascular invasion, including vascular invasion not stated | * | L | L |
| 40 | Multiple (satellite) nodules/tumors (one lobe) WITH intrahepatic vascular invasion | * | L | L |
| 50 | Confined to liver, NOS Localized, NOS | T1 | L | L |
| 51 | More than one lobe involved by contiguous growth (single lesion) WITHOUT vascular invasion, including vascular invasion not stated | T1 | RE | RE |
| 52 | More than one lobe involved by contiguous growth (single lesion) WITH vascular invasion | T2 | RE | RE |
| 53 | Extension to gallbladder, extent within liver not stated | T1 | RE | RE |
| 54 | Single lesion with extension to gallbladder + [(10) or (51)] | T1 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 55 | Single lesion with extension to gallbladder + [(20) or (52)] | T2 | RE | RE |
| 56 | Extension to gallbladder + [(30) or (40)] | * | RE | RE |
| 58 | Extrahepatic bile ducts | T2 | RE | RE |
| 63 | Major vascular invasion: major branch(es) of portal or hepatic vein(s) (see Note 2) | T3 | RE | RE |
| 64 | Direct extension/perforation of visceral peritoneum | T4 | RE | RE |
| 65 | Multiple (satellite) nodules/tumors in more than one lobe of liver or on surface of parenchyma Satellite nodules, NOS | * | D | RE |
| 66 | Extension to hepatic artery or vena cava | T4 | RE | RE |
| 67 | (63) + (65) | T3 | D | RE |
| 70 | Diaphragm | T4 | RE | RE |
| 75 | Lesser omentum Ligament(s): Coronary Falciform Hepatoduodenal Hepatogastric Round [of liver] Triangular Parietal peritoneum | T4 | RE | RE |
| 76 | [(65) or (67)] + any of [(64) or (66) or (70) or (75)] | T4 | D | RE |
| 80 | Further contiguous extension: Pancreas Pleura Stomach Other 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 30, 40, 56, and 65 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Liver and Intrahepatic Bile Ducts

CS TS/Ext-Eval (Revised: 08/21/2006)

| 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 |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | |
|---|--|---|
| 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. | p |
| 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. | 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 |

Liver and Intrahepatic Bile Ducts

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

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 | None; no regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes: Hepatic NOS: Hepatic artery Hepatic pedicle Inferior vena cava Porta hepatis (hilar) [in hilus of liver] Hepatoduodenal ligament Periportal Portal vein 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 |

Liver and Intrahepatic Bile Ducts

CS Reg Nodes Eval

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Liver and Intrahepatic Bile Ducts

Reg LN Pos

SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts

Reg LN Exam

SEE STANDARD TABLE

Liver and Intrahepatic Bile Ducts

CS Mets at DX (Revised: 05/31/2006)

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s), NOS | M1 | D | D |
| 11 | Distant lymph nodes: Cardiac Lateral (aortic) (lumbar) Pericardial (pericardiac) Posterior mediastinal (tracheoesophageal) including juxtaphrenic nodes Retroperitoneal, NOS | M1 | RN | D |
| 12 | Distant lymph nodes: Coronary artery Renal artery | M1 | RN | D |
| 13 | Distant lymph node(s): Aortic (para-, peri-) Diaphragmatic, NOS Peripancreatic (near head of pancreas only) | M1 | D | D |
| 15 | Distant lymph node(s) other than codes 10-13, including inferior phrenic nodes | M1 | D | D |
| 40 | Distant metastasis except distant lymph node(s) (codes 10-15) Distant metastasis, NOS Carcinomatosis | M1 | D | D |
| 50 | (40)+ any of [(10) or (11) or (15)] Distant lymph node(s) plus other distant metastases | M1 | D | D |
| 52 | (40)+ [(12) or (13)] Distant lymph node(s) plus other distant metastases | M1 | D | D |
| 99 | Unknown if distant metastasis Primary tumor cannot be assessed Not documented in patient record | MX | U | U |

Liver and Intrahepatic Bile Ducts

CS Mets Eval

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Liver and Intrahepatic Bile Ducts

CS Site-Specific Factor 1 Alpha Fetoprotein (AFP) (Revised: 03/17/2004)

| 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 | Unknown or no information Not documented in patient record |

Liver and Intrahepatic Bile Ducts

CS Site-Specific Factor 2 Fibrosis Score (Revised: 11/18/2002)

Note: AJCC classifies fibrosis scores 0-4 (none to moderate fibrosis) as F0, and fibrosis scores 5-6 (severe fibrosis or cirrhosis) as F1. Fibrosis score is also called Ishak score.

| Code | Description |
|------|---|
| 000 | F0: Fibrosis score 0-4 (none to moderate fibrosis) |
| 001 | F1: Fibrosis score 5-6 (severe fibrosis or cirrhosis) |
| 999 | Fibrosis score not recorded Insufficient information Not documented in patient record |

Liver and Intrahepatic Bile Ducts

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Liver and Intrahepatic Bile Ducts

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Liver and Intrahepatic Bile Ducts

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Liver and Intrahepatic Bile Ducts

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

Surgery Codes

Liver and Intrahepatic Bile Ducts

C220–C221

(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
 - 15 Alcohol (Percutaneous Ethanol Injection-PEI)
[**SEER Note:** Code 15 Alcohol (Percutaneous Ethanol Injection-PEI) can also be described as an “intratumoral injection of alcohol” or “alcohol ablation”]
 - 16 Heat-Radio-frequency ablation (RFA)
 - 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17

- 20 Wedge or segmental resection, NOS
 - 21 Wedge resection
 - 22 Segmental resection, NOS
 - 23 One
 - 24 Two
 - 25 Three
 - 26 Segmental resection AND local tumor destruction

Specimen sent to pathology from surgical events 20–26

- 30 Lobectomy, NOS
 - 36 Right lobectomy
 - 37 Left lobectomy
 - 38 Lobectomy AND local tumor destruction
[**SEER Note:** Code 30 also referred to as simple lobectomy]

- 50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
 - 51 Right lobectomy
 - 52 Left lobectomy
 - 59 Extended lobectomy AND local tumor destruction

- 60 Hepatectomy, NOS
 - 61 Total hepatectomy and transplant

- 65 Excision of a bile duct (for an intrahepatic bile duct primary only)
 - 66 Excision of a bile duct PLUS partial hepatectomy

- 75 Bile duct and hepatectomy WITH transplant

- 90 Surgery, NOS

- 99 Unknown if surgery performed; death certificate ONLY

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SEER Program Coding and Staging Manual 2007

**Gallbladder, Extrahepatic Bile Ducts, Ampulla of Vater
C239, C240-249**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Gallbladder

C23.9

C23.9 Gallbladder

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage |
|--|--|--|

Gallbladder

CS Tumor Size

SEE STANDARD TABLE

Gallbladder

CS Extension (Revised: 03/17/2004)

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-------|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion) | T1a | L | L |
| 20 | Muscularis propria | T1b | L | L |
| 30 | Localized, NOS | T1NOS | L | L |
| 40 | Perimuscular connective tissue | T2 | RE | RE |
| 50 | Invasion of/through serosa (visceral peritoneum) | T3 | L | RE |
| 55 | (40) + (50) | T3 | RE | RE |
| 60 | Extension into liver, NOS | T3 | RE | RE |
| 61 | Extension into liver less than or equal to 2 cm | T3 | RE | RE |
| 62 | Extension to ONE of the following: Ampulla of Vater Duodenum Extrahepatic bile duct(s) Omentum, NOS Greater Lesser Pancreas Small intestine, NOS | T3 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 65 | Extension to ONE of the following WITHOUT extension to any structure in (62): Colon Stomach | T3 | RE | RE |
| 66 | Extension to cystic artery/vein WITHOUT extension to any structure in [(62) to (65)] | T3 | RE | D |
| 67 | [(60) or (61)] PLUS extension to ONE structure in codes [(62) to (65)] | T3 | RE | RE |
| 68 | 66 + [(60) or (61)] | T3 | RE | D |
| 71 | Extension into liver greater than 2 cm WITHOUT extension to any structure in [(62) to (66)] | T3 | D | D |
| 72 | Extension into liver greater than 2 cm PLUS extension to ONE structure in [(62) to (66)] | T3 | D | D |
| 73 | Extension to two or more structures in [(62) to (66)], with or without extension into liver of any depth | T4 | D | D |
| 75 | Extension to: Hepatic artery Portal vein | T4 | RE | D |
| 78 | (75) + any of [(60) to (73)] | T4 | D | D |
| 80 | Further contiguous extension, including: Abdominal wall Diaphragm | 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 |

Gallbladder

CS TS/Ext-Eval

SEE STANDARD TABLE

Gallbladder

CS Lymph Nodes (Revised: 01/10/2005)

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX. Also note that celiac and superior mesenteric nodes are listed in this field rather than Mets at DX, because AJCC classifies them as N1 and not M1.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | None; no regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes: Cystic duct (Calot's node) Node of foramen of Winslow (omental) (epiploic) Pericholedochal (common bile duct) | N1 | RN | RN |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|----|----|
| 11 | Regional lymph nodes: Porta hepatis (portal)(periportal) (hilar) (in hilus of liver) | N1 | D | RN |
| 20 | Regional lymph node(s): Pancreaticoduodenal | N1 | RN | RN |
| 21 | Regional lymph node(s): Periduodenal Peripancreatic (near head of pancreas only) | N1 | D | RN |
| 25 | (11) + (20) | N1 | D | RN |
| 30 | Regional lymph node(s), NOS | N1 | RN | RN |
| 50 | Celiac lymph node(s) | N1 | D | RN |
| 60 | Superior mesenteric lymph node(s) | N1 | D | 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 |

Gallbladder

CS Reg Nodes Eval

SEE STANDARD TABLE

Gallbladder

Reg LN Pos

SEE STANDARD TABLE

Gallbladder

Reg LN Exam

SEE STANDARD TABLE

Gallbladder

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: Para-aortic Peripancreatic (along body and tail of pancreas only) 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 |
| 50 | (10) + (40) Distant lymph node(s) plus other distant metastases | M1 | D | D |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|---|---|
| 99 | Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record | MX | U | U |
|----|--|----|---|---|

Gallbladder

CS Mets Eval

SEE STANDARD TABLE

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Gallbladder

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Extrahepatic Bile Duct(s)

C24.0

C24.0 Extrahepatic bile duct

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage |
|--|--|--|

Extrahepatic Bile Duct(s)

CS Tumor Size

SEE STANDARD TABLE

Extrahepatic Bile Duct(s)

CS Extension (Revised: 08/02/2004)

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor of extrahepatic bile duct(s) (choledochal, common, cystic, and hepatic) confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion) | T1 | L | L |
| 20 | Muscularis propria | T1 | L | L |
| 30 | Localized, NOS | T1 | L | L |
| 40 | Beyond wall of bile duct Periductal/fibromuscular connective tissue | T2 | RE | RE |
| 60 | Gallbladder Liver, porta hepatis Pancreas | T3 | RE | RE |
| 61 | Unilateral branches of portal vein (right or left) Unilateral branches of hepatic artery (right or left) | T3 | RE | RE |
| 65 | Colon, NOS Transverse including flexure Duodenum, NOS Omentum, NOS Lesser Stomach, distal | T4 | RE | RE |
| 66 | Main portal vein or its branches bilaterally Common hepatic artery Hepatic artery, NOS Portal vein, NOS | T4 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|---|----|
| 70 | Other parts of colon Greater omentum Stomach, proximal | T4 | D | RE |
| 75 | Abdominal wall | 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 |

Extrahepatic Bile Duct(s)

CS TS/Ext-Eval

SEE STANDARD TABLE

Extrahepatic Bile Duct(s)

CS Lymph Nodes (Revised: 12/08/2003)

Note: Code only regional nodes and nodes, NOS, in this field.

| Code | Description | TNM | SS77 | SS2000 |
|-------------|--|------------|-------------|---------------|
| 00 | No regional lymph node involvement | N0 | NONE | NONE |
| 15 | Regional lymph nodes: Cystic duct (node of the neck of the gallbladder) (Calot's node) Hepatic Hilar (in the hepatoduodenal ligament) Node of the foramen of Winslow (omental) (epiploic) Pancreaticoduodenal Pericholedochal (node around common bile duct) Periduodenal Peripancreatic (near head of pancreas only) Periportal Porta hepatis (portal) (hilar) (in hilus of liver) Regional lymph nodes, NOS | N1 | RN | RN |
| 35 | Regional lymph nodes: Celiac Superior mesenteric | N1 | D | D |
| 80 | Lymph nodes, NOS | N1 | RN | RN |
| 99 | Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record | NX | U | U |

Extrahepatic Bile Duct(s)

CS Reg Nodes Eval

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Extrahepatic Bile Duct(s)

Reg LN Pos

SEE STANDARD TABLE

Extrahepatic Bile Duct(s)

Reg LN Exam

SEE STANDARD TABLE

Extrahepatic Bile Duct(s)

CS Mets at DX (Revised: 08/21/2006)

| Code | Description | TNM | SS77 | SS2000 |
|-------------|--|------------|-------------|---------------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) including: Para-aortic Peripancreatic (along body and tail of pancreas only) Distant lymph nodes, NOS | M1 | D | D |
| 40 | Distant metastases except distant lymph nodes (code 10) Distant metastases, NOS Carcinomatosis | M1 | D | D |
| 50 | (10) + (40) | M1 | D | D |
| 99 | Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record | MX | U | U |

Extrahepatic Bile Duct(s)

CS Mets Eval

SEE STANDARD TABLE

Extrahepatic Bile Duct(s)

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

Extrahepatic Bile Duct(s)

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Extrahepatic Bile Duct(s)

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Extrahepatic Bile Duct(s)

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Extrahepatic Bile Duct(s)

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Extrahepatic Bile Duct(s)

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Ampulla of Vater

C24.1

C24.1 Ampulla of Vater

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage |
|--|--|--|

Ampulla of Vater

CS Tumor Size

SEE STANDARD TABLE

Ampulla of Vater

CS Extension (Revised: 08/18/2006)

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor confined/limited to ampulla of Vater or extending to sphincter of Oddi | T1 | L | L |
| 30 | Localized, NOS | T1 | L | L |
| 42 | Duodenal wall | T2 | RE | RE |
| 52 | Pancreas | T3 | RE | RE |
| 62 | Common bile duct | T4 | RE | RE |
| 65 | Extrahepatic bile ducts other than common bile duct or sphincter of Oddi | T4 | RE | RE |
| 70 | Extension to other adjacent organs or tissues: Blood vessels(major): Hepatic artery Portal vein Gallbladder Hepatic flexure Lesser omentum Liver including porta hepatis Peripancreatic soft tissues Stomach, NOS: Distal Transverse colon | T4 | RE | RE |
| 75 | Stomach, proximal | T4 | RE | D |
| 80 | Further contiguous extension Other adjacent organs | T4 | D | D |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|---|---|
| 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 |

Ampulla of Vater

CS TS/Ext-Eval

SEE STANDARD TABLE

Ampulla of Vater

CS Lymph Nodes (Revised: 12/08/2003)

Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Note 2: Splenic lymph nodes and those located at the tail of the pancreas are not considered regional and should be coded under Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | No regional lymph node involvement | N0 | NONE | NONE |
| 10 | Regional lymph nodes: Hepatic Hepatic artery Node of the foramen of Winslow (epiploic) (omental) Pancreaticoduodenal Peripancreatic (except at tail of pancreas, see CS Mets at DX) Periportal Lymph nodes: Anterior to the ampulla of Vater Inferior to the ampulla of Vater Posterior to the ampulla of Vater Superior to the ampulla of Vater Regional lymph node(s), NOS | N1 | RN | RN |
| 11 | Regional lymph nodes: Celiac Infrapyloric (subpyloric) Lateral aortic (lumbar) Proximal mesenteric Retroperitoneal Superior mesenteric | N1 | D | RN |
| 80 | Lymph nodes, NOS | N1 | RN | RN |
| 99 | Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record | NX | U | U |

Ampulla of Vater

CS Reg Nodes Eval

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Ampulla of Vater

Reg LN Pos

SEE STANDARD TABLE

Ampulla of Vater

Reg LN Exam

SEE STANDARD TABLE

Ampulla of Vater

CS Mets at DX (Revised: 08/21/2006)

| Code | Description | TNM | SS77 | SS2000 |
|-------------|---|------------|-------------|---------------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) Node(s) at the tail of the pancreas Para-aortic Splenic lymph node(s) Distant lymph nodes, NOS | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) (code 10) Carcinomatosis Distant metastasis, NOS (Includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) | 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 |

Ampulla of Vater

CS Mets Eval

SEE STANDARD TABLE

Ampulla of Vater

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

Ampulla of Vater

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

| Code | Description |
|-------------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Ampulla of Vater

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Ampulla of Vater

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Ampulla of Vater

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Ampulla of Vater

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Other Biliary and Biliary, NOS

C24.8-C24.9

C24.8 Overlapping lesion of biliary tract (neoplasms involving both intrahepatic and extrahepatic bile ducts)

C24.9 Biliary tract, NOS

| | | |
|--|--|--|
| 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 CS Site-Specific Factor 2 CS Site-Specific Factor 3 CS Site-Specific Factor 4 CS Site-Specific Factor 5 CS Site-Specific Factor 6 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage |
|--|--|--|

Other Biliary and Biliary, NOS

CS Tumor Size

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

CS Extension (Revised: 04/12/2004)

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | Tis | IS | IS |
| 10 | Invasive tumor confined to: Lamina propria Mucosa, NOS Submucosa (superficial invasion) | T1 | L | L |
| 20 | Muscularis propria | T1 | L | L |
| 30 | Localized, NOS Tumor confined to bile duct | T1 | L | L |
| 40 | Perimuscular connective tissue Tumor invades beyond the wall of the bile duct | T2 | RE | RE |
| 50 | Invasion of/through serosa | T2 | L | RE |
| 55 | (40) + (50) | T2 | RE | RE |
| 60 | Extension into liver, NOS | T3 | RE | RE |
| 61 | Extension into liver less than or equal to 2 cm | T3 | RE | RE |
| 62 | Extension to ONE of the following: Ampulla of Vater Omentum, NOS Greater Lesser Pancreas Small intestine, NOS | T3 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 63 | Gallbladder Unilateral branches of the right or left hepatic artery Unilateral branches of the right or left portal vein | T3 | RE | RE |
| 65 | Extension to ONE of the following: Colon Stomach | T4 | D | D |
| 66 | Abdominal wall Duodenum | T4 | RE | RE |
| 70 | Extension into liver greater than 2 cm Extension to two or more adjacent organs listed in codes [(60)-(63)] | T3 | D | D |
| 71 | Extension to two or more adjacent organs any of which are in codes [(65)-(66)] | T4 | D | D |
| 75 | Common hepatic artery Cystic artery/vein Hepatic artery, NOS Portal vein or its branches bilaterally Portal vein, NOS | T4 | RE | 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 |

Other Biliary and Biliary, NOS

CS TS/Ext-Eval

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

CS Lymph Nodes (Revised: 01/10/2005)

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 node(s): Cystic duct (Calot's node) Node of foramen of Winslow (epiploic)(omental) Pericholedochal (common bile duct) | N1 | RN | RN |
| 11 | Regional lymph node(s): Porta hepatis (portal) (hilar) [in hilus of liver] | N1 | D | RN |
| 20 | Regional lymph node(s): Pancreaticoduodenal Periportal | N1 | RN | RN |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|--|----|----|----|
| 21 | Regional lymph node(s): Periduodenal Peripancreatic (near head of pancreas only) | N1 | D | RN |
| 30 | Regional lymph node(s), NOS | N1 | RN | RN |
| 50 | Celiac | N1 | D | RN |
| 60 | Superior mesenteric | N1 | D | 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 |

Other Biliary and Biliary, NOS

CS Reg Nodes Eval

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

Reg LN Pos

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

Reg LN Exam

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

CS Mets at DX (Revised: 12/08/2003)

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) including: Para-aortic | M1 | D | D |
| 40 | Distant metastases except distant lymph nodes (code 10) Distant metastases, 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 |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Other Biliary and Biliary, NOS

CS Mets Eval

SEE STANDARD TABLE

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other Biliary and Biliary, NOS

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

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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SEER Program Coding and Staging Manual 2007

**Pancreas
C250-C259**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Pancreas: Head

C25.0

C25.0 Head of pancreas

Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and the corresponding Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified.

| | | |
|-------------------|---------------------------|--|
| CS Tumor Size | CS Site-Specific Factor 1 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Extension Size Table |
| CS Extension | CS Site-Specific Factor 2 | |
| CS TS/Ext-Eval | CS Site-Specific Factor 3 | |
| 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 | | |

Pancreas: Head

CS Tumor Size

SEE STANDARD TABLE

Pancreas: Head

CS Extension (Revised: 11/19/2004)

Note 1: Islets of Langerhans are distributed throughout the pancreas, and, therefore, any extension code can be used.

Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive PanIn III Pancreatic Intraepithelial Neoplasia III | Tis | IS | IS |
| 10 | Confined to pancreas | * | L | L |
| 30 | Localized, NOS | * | L | L |
| 40 | Extension to peripancreatic tissue, NOS Fixation to adjacent structures, NOS | T3 | RE | RE |
| 44 | Ampulla of Vater Duodenum Extrahepatic bile duct(s) | T3 | RE | RE |
| 50 | Adjacent stomach Stomach, NOS | T3 | RE | RE |
| 54 | Blood vessel(s) (major): Gastroduodenal artery Hepatic artery Pancreaticoduodenal artery Portal vein Superior mesenteric vein Transverse colon, including hepatic flexure | T3 | RE | RE |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 55 | Mesenteric fat Mesentery Mesocolon Peritoneum | T3 | RE | D |
| 57 | Gallbladder | T3 | RE | D |
| 58 | Body of stomach | T3 | D | RE |
| 59 | (58) + [(55) or (57)] | T3 | D | D |
| 60 | Tumor is inseparable from the superior mesenteric artery Superior mesenteric artery | T4 | RE | RE |
| 61 | Omentum | T4 | RE | D |
| 63 | Liver (including porta hepatis) | T4 | RE | D |
| 65 | (60) + [(55) or (57)] | T4 | RE | D |
| 66 | (60) + (58) | T4 | D | RE |
| 67 | (60) + (59) OR Any of [(61) to (65)] + [(58) or (59)] OR (66) + any of [(55) or (57) or (59) or (61) or (63) or (65)] | T4 | D | D |
| 68 | Tumor is inseparable from the celiac axis Aorta Celiac artery | T4 | D | D |
| 69 | Colon (other than transverse colon including hepatic flexure) Spleen | T4 | D | D |
| 78 | Adrenal (suprarenal) gland Ileum Jejunum Kidney Retroperitoneum Ureter | 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 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Pancreas: Head
CS TS/Ext-Eval
SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Pancreas: Head

CS Lymph Nodes (Revised: 11/19/2003)

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 | Regional lymph nodes: Celiac Gastroepiploic (gastro-omental), left Hepatic Infrapyloric (subpyloric) Lateral aortic (lumbar) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Superior mesenteric Regional lymph node(s), NOS | N1 | RN | RN |
| 20 | Pancreaticosplenic (pancreaticolienal) Splenic (lienal), NOS Superior hilum Suprapancreatic | N1 | D | D |
| 80 | Lymph nodes, NOS | N1 | RN | RN |
| 99 | Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record | NX | U | U |

Pancreas: Head

CS Reg Nodes Eval

SEE STANDARD TABLE

Pancreas: Head

Reg LN Pos

SEE STANDARD TABLE

Pancreas: Head

Reg LN Exam

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Pancreas: Head

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

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) 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 |

Pancreas: Head

CS Mets Eval

SEE STANDARD TABLE

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Head

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Pancreas: Body and Tail

C25.1-C25.2

C25.1 Body of pancreas

C25.2 Tail of pancreas

Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and corresponding Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified.

| | | |
|-------------------|---------------------------|--|
| CS Tumor Size | CS Site-Specific Factor 1 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Extension Size Table |
| CS Extension | CS Site-Specific Factor 2 | |
| CS TS/Ext-Eval | CS Site-Specific Factor 3 | |
| 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 | | |

Pancreas: Body and Tail

CS Tumor Size

SEE STANDARD TABLE

Pancreas: Body and Tail

CS Extension (Revised: 08/21/2006)

Note 1: Islets of Langerhans are distributed throughout the pancreas, and, therefore, any extension code can be used.

Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | In situ; non-invasive PanIn III Pancreatic Intraepithelial Neoplasia III | Tis | IS | IS |
| 10 | Confined to pancreas | * | L | L |
| 30 | Localized, NOS | * | L | L |
| 40 | Extension to peripancreatic tissue, NOS Fixation to adjacent structures, NOS | T3 | RE | RE |
| 44 | Duodenum | T3 | RE | RE |
| 48 | Ampulla of Vater Extrahepatic bile duct(s) | T3 | RE | RE |
| 50 | Spleen | T3 | RE | RE |
| 56 | Blood vessel(s): Hepatic artery Portal vein Splenic artery/vein Superior mesenteric vein Splenic flexure of colon | T3 | RE | RE |

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CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 57 | Kidney, NOS Left adrenal (suprarenal) gland Left kidney Left ureter | T3 | RE | D |
| 58 | Mesenteric fat Mesentery Mesocolon Peritoneum | T3 | RE | D |
| 59 | Retroperitoneal soft tissue (retroperitoneal space) | T3 | D | D |
| 60 | Tumor is inseparable from the celiac axis or superior mesenteric artery Aorta Celiac artery Superior mesenteric artery | T4 | RE | RE |
| 62 | Stomach | T4 | RE | RE |
| 70 | [(60) or (62)] + [(57) or (58)] | T4 | RE | D |
| 71 | Ileum Jejunum | T4 | RE | D |
| 73 | Gallbladder Liver (including porta hepatis) | T4 | RE | D |
| 75 | (59) + any of [(60) or (62) or (71) or (73)] | T4 | D | D |
| 77 | Colon (other than splenic flexure) | T4 | D | D |
| 78 | Diaphragm Right adrenal (suprarenal) gland Right kidney Right ureter | 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 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Pancreas: Body and Tail
CS TS/Ext-Eval
SEE STANDARD TABLE

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CS Staging Schemas

Pancreas: Body and Tail

CS Lymph Nodes (Revised: 08/14/2006)

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 | Regional lymph node(s): Hepatic Lateral aortic (lumbar) Pancreaticosplenic (pancreaticolienal) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Splenic (lienal) Gastroepiploic Splenic hilum Suprapancreatic Superior mesenteric Regional lymph node(s), NOS | N1 | RN | RN |
| 20 | Regional lymph node(s): Celiac Infrapyloric (subpyloric) | N1 | D | D |
| 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 |

Pancreas: Body and Tail

CS Reg Nodes Eval

SEE STANDARD TABLE

Pancreas: Body and Tail

Reg LN Pos

SEE STANDARD TABLE

Pancreas: Body and Tail

Reg LN Exam

SEE STANDARD TABLE

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CS Staging Schemas

Pancreas: Body and Tail

CS Mets at DX (Revised: 08/21/2006)

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) Distant lymph node(s) , NOS | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) 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 |

Pancreas: Body and Tail

CS Mets Eval

SEE STANDARD TABLE

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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CS Staging Schemas

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Body and Tail

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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CS Staging Schemas

Pancreas: Other and Unspecified

C25.3-C25.4, C25.7-C25.9

C25.3 Pancreatic duct

C25.4 Islets of Langerhans

C25.7 Other specified parts of pancreas

C25.8 Overlapping lesion of pancreas

C25.9 Pancreas, NOS

Note: For tumors of the islet cells, determine which subsite of the pancreas is involved and use that primary site code and the corresponding Collaborative Stage scheme. If the subsite cannot be determined, use the general code for Islets of Langerhans, C25.4, and use the Collaborative Stage scheme for Pancreas, Other and Unspecified.

| | | |
|-------------------|---------------------------|--|
| CS Tumor Size | CS Site-Specific Factor 1 | The following tables are available at the collaborative staging website: Histology Exclusion Table AJCC Stage Extension Size Table |
| CS Extension | CS Site-Specific Factor 2 | |
| CS TS/Ext-Eval | CS Site-Specific Factor 3 | |
| 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 | | |

Pancreas: Other and Unspecified

CS Tumor Size

SEE STANDARD TABLE

Pancreas: Other and Unspecified

CS Extension (Revised: 12/09/2003)

Note 1: Islets of Langerhans are distributed throughout the pancreas, and, therefore, any extension code can be used.

Note 2: Codes 40-80 are used for contiguous extension of tumor from the site of origin. Discontinuous involvement is coded in CS Mets at DX.

| Code | Description | TNM | SS77 | SS2000 |
|------|--|-----|------|--------|
| 00 | In situ; non-invasive PanIn III Pancreatic intraepithelial neoplasia III | Tis | IS | IS |
| 10 | Confined to pancreas | * | L | L |
| 30 | Localized, NOS | * | L | L |
| 40 | Peripancreatic tissue | T3 | RE | RE |
| 45 | Ampulla of Vater Duodenum Extra hepatic bile duct(s) | T3 | RE | RE |
| 50 | Adjacent large vessel(s) (except as listed in code 60) Colon Spleen Stomach | T3 | RE | RE |

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CS Staging Schemas

| | | | | |
|----|---|----|----|----|
| 60 | Tumor is inseparable from the celiac axis or superior mesenteric artery Aorta Celiac artery Superior mesenteric artery | T4 | RE | 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 and 30 ONLY, the T category is assigned based on the value of CS Tumor Size, as shown in the Extension Size Table for this site.

Pancreas: Other and Unspecified

CS TS/Ext-Eval

SEE STANDARD TABLE

Pancreas: Other and Unspecified

CS Lymph Nodes (Revised: 08/14/2006)

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 | Regional lymph node(s): Celiac Hepatic Infrapyloric (subpyloric) Lateral aortic (lumbar) Pancreaticosplenic (pancreaticolienal) Peripancreatic, NOS: Anterior, NOS: Anterior pancreaticoduodenal Anterior proximal mesenteric Pyloric Inferior to the head and body of pancreas Posterior, NOS: Pericholedochal (common bile duct) Posterior pancreaticoduodenal Posterior proximal mesentery Superior to the head and body of pancreas Retroperitoneal Splenic (lienal), NOS Gastroepiploic (gastro-omental), left Splenic hilum Suprapancreatic Superior mesenteric Regional lymph node(s), NOS | N1 | RN | RN |
| 80 | Lymph nodes, NOS | N1 | RN | RN |

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CS Staging Schemas

| | | | | |
|----|--|----|---|---|
| 99 | Unknown; not stated Regional lymph nodes cannot be assessed Not documented in patient record | NX | U | U |
|----|--|----|---|---|

Pancreas: Other and Unspecified

CS Reg Nodes Eval

SEE STANDARD TABLE

Pancreas: Other and Unspecified

Reg LN Pos

SEE STANDARD TABLE

Pancreas: Other and Unspecified

Reg LN Exam

SEE STANDARD TABLE

Pancreas: Other and Unspecified

CS Mets at DX (Revised: 08/21/2006)

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | No; none | M0 | NONE | NONE |
| 10 | Distant lymph node(s) Distant lymph node(s), NOS | M1 | D | D |
| 40 | Distant metastases except distant lymph node(s) (code 10) Distant metastasis, NOS (includes seeding of peritoneum, even if limited to the lesser sac region; positive peritoneal cytology) 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 |

Pancreas: Other and Unspecified

CS Mets Eval

SEE STANDARD TABLE

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

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CS Staging Schemas

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Pancreas: Other and Unspecified

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

Surgery Codes

Pancreas

C250–C259

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

Codes

- 00 None; no surgery of primary site; autopsy ONLY
- 25 Local excision of tumor, NOS
- 30 Partial pancreatectomy, NOS; example: distal
- 35 Local or partial pancreatectomy and duodenectomy
 - 36 **WITHOUT** distal/partial gastrectomy
 - 37 **WITH** partial gastrectomy (Whipple)
- 40 Total pancreatectomy
- 60 Total pancreatectomy and subtotal gastrectomy or duodenectomy
- 70 Extended pancreatoduodenectomy
- 80 Pancreatectomy, NOS
- 90 Surgery, NOS
- 99 Unknown if surgery performed; death certificate ONLY

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**Other Digestive
C260-C269**

Note: For Multiple Primary and Histology Coding Rules: see Other Sites (pg C-1079)

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CS Staging Schemas

Other and Ill-Defined Digestive Organs

C26.0, C26.8-C26.9

C26.0 Intestinal tract, NOS

C26.8 Overlapping lesion of digestive system

C26.9 Gastrointestinal 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: Histologies for Which AJCC Staging Is Not Generated AJCC Stage |
| CS Extension | CS Site-Specific Factor 2 | |
| CS TS/Ext-Eval | CS Site-Specific Factor 3 | |
| 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 | | |

Other and Ill-Defined Digestive Organs

CS Tumor Size

SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs

CS Extension (Revised: 03/17/2004)

Note 1: Definition of Adjacent Connective Tissue: Some of the schemes for ill-defined or non-specific sites in this manual contain a code 40, adjacent connective tissue, which is defined here as the unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this code when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs.

Note 2: Definition of Adjacent Structures: Connective tissues large enough to be given a specific name would be considered adjacent structures. For example, the brachial artery has a name, as does the broad ligament. Continuous tumor growth from one organ into an adjacent named structure would be coded to 60 in the schemes for ill-defined or non-specific sites.

| Code | Description | TNM | SS77 | SS2000 |
|------|---|-----|------|--------|
| 00 | In situ; non-invasive; intraepithelial | NA | IS | IS |
| 10 | Invasion of submucosa | NA | L | L |
| 30 | Localized, NOS | NA | L | L |
| 40 | Adjacent connective tissue (see Note 1) | NA | RE | RE |
| 60 | Adjacent organs/structures (see Note 2) | NA | RE | RE |
| 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 |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Other and Ill-Defined Digestive Organs

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

| Code | Description | Staging Basis |
|------|------------------------------|---------------|
| 9 | Not applicable for this site | NA |

Other and Ill-Defined Digestive 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 | None; no regional lymph node involvement | NA | NONE | NONE |
| 10 | Regional lymph nodes Intra-abdominal Paracaval Pelvic Subdiaphragmatic Regional lymph nodes, 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 Ill-Defined Digestive Organs

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

| Code | Description | Staging Basis |
|------|------------------------------|---------------|
| 9 | Not applicable for this site | NA |

Other and Ill-Defined Digestive Organs

Reg LN Pos

SEE STANDARD TABLE

Other and Ill-Defined Digestive Organs

Reg LN Exam

SEE STANDARD TABLE

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Other and Ill-Defined Digestive 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 |
| 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 Ill-Defined Digestive Organs

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

| Code | Description | Staging Basis |
|------|------------------------------|---------------|
| 9 | Not applicable for this site | NA |

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

CS Staging Schemas

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

Other and Ill-Defined Digestive Organs

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

| Code | Description |
|------|------------------------------|
| 888 | Not applicable for this site |

SEER Program Coding and Staging Manual 2007

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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