END RESULTS GROUP 1967 CODE MANUAL

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
National Institutes of Health

1967 CODE MANUAL

of the
END RESULTS GROUP

as prepared for the End Results Group
by the
End Results Section
National Cancer Institute

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INTRODUCTION

This Manual of instruction was developed to meet the specific requirements of the End Results Evaluation Program, which is sponsored and supported in part by the National Cancer Institute, U. S. Public Health Service. It can however be adapted to the needs of individual tumor registries. The basic information called for is applicable both to centralized registries and to registries in individual hospitals.

The definitions and codes contained in this manual are not proposed as national standards. They are, however, based on more than 10 years of experience in a collaborative program which has collected information on more than 500,000 cancer patients treated in more than 100 hospitals. The present code revision (1967) reflects the lessons learned from this experience. Some definitions have been clarified or modified; some descriptive schemes have been extended.

The End Results Evaluation Program is designed to describe trends in patient and disease characteristics, methods of treatment, and patient survival experience. The information called for is geared to hospital records as they are currently constituted, and to the ability of technical personnel to abstract meaningful and reliable information from these records. The philosophy of the program has been to limit routine analysis to the description of general trends and to the identification of issues for further exploration through special studies. As questions arise that require more detailed information than is routinely collected, appropriate samples of cases are selected for intensive review of patient records.

This revision of the Manual contains an expansion of the amount of detail collected regarding several items of information. The most important expansion pertains to the description of Extent of Disease at initiation of definitive treatment. For each site of origin of malignant neoplasm a detailed descriptive code has been developed which can be telescoped into a limited number of classes. The detailed categories of the code may then be used as a set of inclusion terms for the summary classes.

The Manual is printed in loose-leaf form so that revisions and additions can be inserted. We are currently exploring the feasibility of a site-specific descriptive system for Surgery.

EDITORIAL NOTE

The 1967 ERG punchcard code is an expansion of the 1959 code without change in the column assignment of the basic items. New information has been added at the end of the earlier code and a few changed concepts have been substituted for some previous ideas.

The original items which remain have often been modified toward greater precision. In fact almost all of the expansion in the 1967 code is directed at more emphasis upon objective and detailed inventory of the location of the neoplasm and the evidence of its spread at the time of decision for specific therapy. An innovation is the new Field P which is ERG's first attempt at coding non-definitive therapy.

Date of First Definitive Therapy, coded in Field I, represents a change in concept from the previous "Date of Admission". The new information will be of more analytic importance than the previous data.

Supplementary information added to the earlier code includes "Paired Organ Involvement" and "Multiplicity Within Primary Site" which amplify and extend the precision of the primary site code. In Field Z is preserved the clinician's appraisal of the palpability of regional lymph nodes as well as the pathologist's assessment of whether the nodes contained malignant tissue.

Revision of the ERG code will continue. Future editions of this Manual will probably contain a changed histology code and more emphasis upon the type and extent of therapy. To complete the picture of the patient's characteristics, there may be added a field concerned with the patient's other diseases which affect the choice or effectiveness of cancer therapy.

In keeping with the increased emphasis upon detailed objective description, this Manual is concerned with the coding of only the information stated in the patient's medical record. The definitions are more rigidly tied to observable criteria and not to implied "intent" or "policy". There is here an insistence that in the quest for desirable details the coder must not infer or "read into" the record any information which is omitted. The precise detailed codes will then have a clear meaning and will be useful even if the necessary precision is found in but a fraction of current patient charts.

OUTLINE OF 1967 ERG CODE *

Field	*Column*	*Title of Field*
		IDENTIFICATION OF THE PATIENT
A	1– 2	ERG Registry Number
B	3– 5	Hospital Number
C	6–11	Case Number
D	12	Sex
E	13	Race or Color
F	14–15	Age at Diagnosis
G	16	Class of Case
		DESCRIPTION OF THE TUMOR
H	17–20	Date of Initial Diagnosis
I	21–24	Date of First Definitive Therapy
J	25	Malignancy
K	26–28	Primary Site
L	29	Sequence Number
M	30–32	Histological Type
N	33	Diagnostic Confirmation
O	34–36	Extent of Disease
		DESCRIPTION OF TREATMENT
P	37	Supportive Treatment Before Definitive Therapy
Q	38–40	First Course of Definitive Treatment **
R	41–43	Subsequent Courses of Definitive Treatment **
		FOLLOW-UP
S	44–47	Date of Last Follow-Up or Death
T	48	Follow-Up Status or Death
U	49–52	Survival Time Since Diagnosis
V	53–56	Cause of Death
W	57	Autopsy
		SUPPLEMENTARY INFORMATION
X	58	Paired Organ Involvement
Y	59	Regional Lymph Node Assessment
Z	60	*Multiplicity Within Primary Site*
XX	77	ICD Revision Used In Field V
YY	78	Review Status of Fields I, K, and O
ZZ	79–80	Year of Submission of Punchcard Deck
		FOR NON-ANALYTIC CASES ONLY
O(NA)	34	Extent of Disease
P(NA)	35–37	Tumor Treatment—Prior to Admission

* An abridged summary of the detailed code begins on the next right-hand page.

** Detailed definitions of definitive treatment categories are presented in a section between the instructions for Field P and Field Q.

ABBREVIATIONS AND SELECTED TECHNICAL TERMS OFTEN USED IN THIS MANUAL

COL — column of the 80 column IBM punchcard. The columns are numbered 1 to 80 beginning at the left of the punchcard. Each column holds twelve punches whose positions are identified from top to bottom by the following code: &, –, 0, 1, 2, 3, 4, 5, 6, 7, 8, 9. The (&) is sometimes referred to as the "twelve punch" and the (–) as the "eleven punch". Both (&) and (–) are also referred to as "overpunches". In the 1967 code, no "blanks" (absence of a punch) are assigned a specific meaning. In most instances a single punch is used per assigned column. In one column, Column 36, the assigned code uses letters as well as numbers. Letters are indicated by specific combinations of two punches in the same column. Thus, Column 36 is the only assigned column in which more than one punch is legitimate.

ERG End Results Group. The group of cooperating cancer registries for whose joint basic studies this code was devised.

ERS End Results Section of the National Cancer Institute which serves as the secretariat of the End Results Group. To the ERS is sent periodically a deck of punchcards punched according to this code and with the latest follow-up information. The End Results Section processes the punchcards and produces analyses based upon the combined data of all members of ERG.

FIELD This term indicates the use of one or more specified columns to code a particular item of information. In this Manual the fields are assigned letters. Field F is a two-column field (Columns 14 and 15) which denotes the age of the patient. Field Q is a three-column field (Columns 38, 39, 40) which contains the code for the patient's first course of definitive therapy.

ICD The International Statistical Classification of Diseases, Injuries, and Causes of Death, published by the World Health Organization.

MNS Malignancy not specified.

NEC Not elsewhere classified

NOS Not otherwise specified

TNM A system of classification and staging of the extent of disease established by the International Union Against Cancer and adapted by the American Joint Committee For Cancer Staging and End Results Reporting. T=tumor; N=nodes; M=metastases.

(–) "Eleven punch". See COL. above.

(&) "Twelve punch". See COL. above.

FIELD A **ERG REGISTRY NUMBER**
Cols. 1–2

01 California State Department of Health, Berkeley
02 Connecticut State Department of Health, Hartford
03 Massachusetts State Department of Health, Boston
04 University of California Medical Center, San Francisco
05 University of Chicago Hospitals and Clinics, Chicago
07 Indiana University Medical Center, Indianapolis
08 State University of Iowa Hospitals, Iowa City
09 Charity Hospital of Louisiana, New Orleans
10 University of Michigan Medical Center, Ann Arbor
11 New York Medical College, New York City
13 University of Virginia Medical Center, Charlottesville
18 Albert Einstein Medical Center, Philadelphia

FIELD B **HOSPITAL IDENTIFICATION**
Cols. 3–5

000 Single institution registry
001 … **998** Identifying code for specific hospital in registry system
999 Class 8 case, no hospital record

FIELD C **CASE NUMBER**
Cols. 6–11

No blanks, use zeros. Case #7034 is coded 007034.

FIELD D **SEX**
Col. 12

1 Male
2 Female
3 Other (Hermaphrodite)
9 Not Stated

FIELD E **RACE OR COLOR**
Col. 13

1 White
2 Negro
3 Other
9 Not Stated

FIELD F **AGE AT DIAGNOSIS (Completed years, age at last birthday)**
Cols. 14–15

00 Less than one year
01 … **97** Specified number of years
98 98 years or older
99 Unknown Age

FIELD G **CLASS OF CASE**
Col. 16

1 Analytic case in which *all* coding uses the 1967 ERG code and is based upon direct examination of the case record.
2 Analytic case coded partly or completely by mechanical conversion from old punchcard containing codes in use prior to the 1967 ERG code. (See Field YY)
5 At least one course of definitive therapy (elsewhere) before admission to registry system.
6 Unknown whether treated definitively for this cancer before admission to registry system.
7 Consultation Only; not assignable to other categories.
8 Death Certificate the only source of information for this cancer.
9 This cancer first diagnosed at autopsy.

FIELD H **DATE OF INITIAL DIAGNOSIS**
Cols. 17–20

Cols. 17–18 *Month*
01 January

12 December
99 Unknown month
Cols. 19–20 *Year* (last two digits of year)
99 Unknown year

FIELD I **DATE OF FIRST DEFINITIVE THERAPY**
Cols. 21–24

Cols. 21–22 *Month*
01 January

12 December
99 Unknown month
Cols. 23–24 *Year* (last two digits of year)
99 Unknown year

FIELD J **MALIGNANCY**
Col. 25

1 Malignant
2 Reportable by agreement
3 Followed for special interest (do not submit).
8 Originally reportable by agreement, but malignant at a later time.
9 Malignant (originally) with known discrepancy between the codes for primary site and histological type.

FIELD K **PRIMARY SITE**
Cols. 26–28

The code is based upon the Seventh or 1955 Revision of the International Statistical Classification, WHO by dropping the first digit of the Malignant Neoplasm Section (140.0 to 209.9). However, many of the code categories have been subdivided. Please see the detailed instructions for Field K. Most of the categories of the Eighth Revision of ICD have been provided but not the numbering system.

FIELD L **SEQUENCE NUMBER**
Col. 29

0 One primary only
1 First of two or more primaries
2 Second of two or more primaries
3 Third or later primary
9 Unspecified sequence number

FIELD M **HISTOLOGICAL TYPE**
Cols. 30–32

Code according to the "Manual of Tumor Nomenclature and Coding", American Cancer Society, 1953—as modified. See detailed instructions. Departures from the coding in the "Red Book" include the following:

446 bronchial adenoma, carcinoid type
066 bronchial adenoma, cylindromatous type
088 bronchial adenoma, type not specified
086 mixed papillary and follicular carcinoma of thyroid
082 mixed papillary and follicular adenoma of thyroid
086 acantho-adenocarcinoma (malignant adeno-acanthoma)
768 Do not use. Assign to 318 instead.

For summary punchcards coded 4–7 in Field Z for authorized sites, the histology for all lesions of the first episode is summarized in Field M. Two additional "Red Book" categories have been created to code mixtures of specific histologies:

15 Tumors of squamous and of basal epithelium
16 Tumors of transitional and of squamous epithelium

See Field M instructions for specific coding of summary card histology.

FIELD N **DIAGNOSTIC CONFIRMATION**
Col. 33

1 Positive histology
2 Positive exfoliative cytology in the absence of positive histology. Includes positive "pap" smear.
4 Positive microscopic confirmation, method not specified.
6 Direct observation at surgical exploration, but no microscopic confirmation. Includes gross autopsy findings.
8 Not microscopically confirmed (other than code 6)
9 Unspecified whether or not microscopically confirmed.

FIELD O **EXTENT OF DISEASE AT FIRST DEFINITIVE TREATMENT**
Cols. 34–36 (Objective description of specific disease manifestations for well defined sites. See Field O instructions for code schemes for specific sites.)

Cols. 34–35 *Principal Description.* GENERAL OUTLINE:

SITE SPECIFIC CODE	Description of Primary Tumor: Carcinoma In Situ Only	Local Invasive Tumor Only	With Local Vessel Invasion	Limited Direct Extension	Further Extension	Involved Regional Lymph Nodes	Involved Distant Node or Distant Site
00 to 09	yes	no	no	no	no	no	no
10 to 29		yes	no	no	no	no	no
30 to 49		yes	yes	no	no	no	no
50 to 69		yes	yes or no	no	no	YES	no
70 to 79				yes	no	no	no
80 to 89				yes	no	YES	no
90 to 99					yes	no	no
–0 to –9					yes	YES	no
&0 to &4						no	YES
&5 to &9						YES	YES

NON-SPECIFIC CODE
0– carcinoma in situ
4– "localized" NOS
8– "regional" NOS
&– "distant" NOS
9– non-localized NOS
– – unstaged

Col. 36 *Supplementary Description* (See pages O-6 and O-7.)

FIELD P **SUPPORTIVE TREATMENT BEFORE DEFINITIVE THERAPY**
Col. 37

0 No non-definitive therapy before first definitive therapy
1 Bypass surgery only
2 Bypass surgery and any of the treatments coded 3–7

No bypass surgery, but
3 surgical procedures only to remove fluid and/or relieve pressure
4 poudrage
5 blood transfusion
6 antibiotics or other non-definitive systemic therapy
7 any combination of codes 3–6

8 None of the above, but neurosurgical procedures for the relief of pain

9 Only non-definitive therapy not described above

– Information not submitted

FIELD Q **DEFINITIVE TREATMENT—FIRST COURSE**
Cols. 38–40

FIELD R **DEFINITIVE TREATMENT—SUBSEQUENT COURSES**
Cols. 41–43

Column ***a*** (Cols. 38, 41, 35*) Surgery or radiation to cancer tissue

1 Surgery
2 Radiation—beam therapy
3 (1+2) Surgery and beam radiation
4 Radiation—other
5 (1+4) Surgery and other radiation
6 (2+4) Beam radiation and other radiation
7 (1+2+4) Surgery and beam radiation and other radiation
9 Not specified, not recorded, or information unknown
0 None of the above

Column ***b*** (Cols. 39, 42, 36*) Treatment other than surgery or radiation

1 Chemotherapy
2 Hormonal treatment
3 (1+2) Chemotherapy and hormonal treatment
4 Other cancer-directed therapy
5 (1+4) Chemotherapy and other therapy
6 (2+4) Hormonal treatment and other therapy
7 (1+2+4) Chemotherapy and hormonal treatment and other therapy
9 Not specified, not recorded, or information unknown
0 None of the above

Column ***c*** (Cols. 40, 43, 37*) Type of hormonal treatment

1 Hormones, anti-hormones, steroids
2 Endocrine surgery when cancer originates at another site
3 (1+2) Hormones and endocrine surgery
4 Endocrine radiation when cancer originates at another site
5 (1+4) Hormones and endocrine radiation
6 (2+4) Endocrine surgery and endocrine radiation
7 (1+2+4) Hormones and endocrine surgery and endocrine radiation
0 None of the above

For definitions of all categories see the DEF section of the Manual after Field P.

FIELD S **DATE OF LAST FOLLOW-UP OR DEATH**
Cols. 44–47

Cols. 44–45 *Month*

01 January
.
.
12 December
99 Unknown

Cols. 46–47 *Year* (last two digits of year)

* Non-analytic cases only. Field P(NA), TUMOR TREATMENT PRIOR TO ADMISSION, is assigned columns 35–37.

FIELD T **FOLLOW-UP STATUS OR DEATH**
Col. 48

1 Alive at last contact—no evidence of cancer
2 Alive at last contact—with any cancer
3 Alive at last contact—cancer status unknown
4 Dead—no evidence of cancer at death
5 Dead—*this* cancer present at death
6 Dead—no evidence of this cancer, but *another* cancer present at death
7 Dead—cancer present at death, but whether it was this cancer or another cannot be established
8 Dead—indeterminate whether cancer was present at death

FIELD U **SURVIVAL TIME SINCE DIAGNOSIS**
Cols. 49–52

Cols. 49–50 *Completed Years of Survival*
00 Less than one year

Cols. 51–52 *Completed Months "Left Over"*
00 Less than one month
01 One month, but less than two

11 Eleven months, but less than twelve
99 Unknown, years estimated

FIELD V **CAUSE OF DEATH**
Cols. 53–56

This field contains the ICD coding for the patient's official death certificate. Field V is supplemented by Field XX which identifies the specific revision of ICD used in coding Field V.

Use all four digits of ICD. If ICD does not make use of the fourth or decimal digit, use code (–) for the fourth digit.

For violent or accidental deaths, use the E series in ICD without coding the letter.

	ICD Revision	
Supplement ICD as follows:	***Seventh***	***Eighth***
Patient alive at last contact	0000	6600
Death Certificate available, cause of death unknown	7955	7969
Death Certificate not available	7777	6677
Information not being submitted	6666	6666

FIELD W **AUTOPSY FINDINGS**
Col. 57

0 Alive, does not apply
1 Autopsy performed and information available
2 Autopsy performed, information not available
3 Dead, autopsy known not to have been performed
9 Dead, unknown whether autopsy was performed

FIELD X **PAIRED ORGAN INVOLVEMENT**
Col. 58

0 Not a paired organ, therefore not applicable
1 Right organ involvement only
2 Left organ involvement only
3 Only one organ involved, unspecified whether right or left
4 Both organs involved simultaneously
5 Left organ involved after previous involvement of right organ
6 Right organ involved after previous involvement of left organ
7 Both organs involved at different times, unknown which was first
9 Paired organ, but no information concerning lateral involvement
– Not submitted

FIELD Y **ASSESSMENT OF REGIONAL NODES BY PATHOLOGIST AND BY**
Col. 59 **CLINICIAN**

	Regional Lymph Node Involvement as Assessed by:	
	Pathologist	*Clinician*
0	unknown	unknown
1		not palpable*
2		palpable
3	*negative*	*unknown*
4		not palpable
5		palpable
6	positive	unknown
7		not palpable
8		palpable
–	not submitted	

Field Y is intended as a supplement to Field O for cancers** of Head and Neck, Breast, Skin, and Melanoma of Skin.

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* includes cases clinically localized for which no node specimens were examined.
** except lymphomas.

FIELD Z — **MULTIPLICITY WITHIN PRIMARY SITE—AUTHORIZED SITES ONLY**
Col. 60

0–3	Originally single focus
4–7	Originally multiple within same sub-site code number
9	Unauthorized site
–	Information not submitted

For details see instructions for Field Z. Authorized sites at this time are urinary bladder (papillomas, papillary carcinomas, epidermoid carcinomas and carcinoma NOS) and skin (malignant melanomas; malignant basal cell, baso-squamous, squamous neoplasms; carcinoma NOS)

Punchcards with codes 4–7 are summary punchcards with specific reference to multiple neoplastic areas present at time of first treatment. There are specific codes in Field M for such summary punchcards.

FIELD AA — **TYPE AND EXTENT OF SURGERY—SITE SPECIFIC**
Cols. 61–64

This code not completely developed at this time. These columns are reserved for this information.

FIELD BB — **TYPE AND EXTENT OF RADIATION—SITE SPECIFIC**
Cols. 65–68

Code not developed yet. Space reserved.

FIELD XX — **ICD REVISION USED IN FIELD V**
Col. 77

Code the number of the ICD Revision which is used in Field V, columns 53–56, of this punchcard.

FIELD YY — **REVIEW STATUS OF FIELDS I, K, AND O**
Col. 78

See instructions for Field YY.

FIELD ZZ — **YEAR OF SUBMISSION OF PUNCHCARD DECK**
Cols. 79–80

Last two digits of year of submission.

NOTE: In addition to Fields AA and BB there is a likelihood of future expansion to cover at least two other items of information:

a. Classification of Chemotherapeutic Agents Used.

b. Other Diseases Present at Diagnosis which affect the Choice of Therapy or its Effectiveness.

General:

Each registry participating in the End Results Evaluation Program is assigned a specific two-digit number. Gang-punch into columns 1 and 2 of every punchcard the number assigned to your registry.

Specific:

01 California State Department of Health, Berkeley
02 Connecticut State Department of Health, Hartford
03 Massachusetts State Department of Health, Boston
04 University of California Medical Center, San Francisco
05 University of Chicago Hospitals and Clinics, Chicago
07 Indiana University Medical Center, Indianapolis
08 State University of Iowa Hospitals, Iowa City
09 Charity Hospital of Louisiana, New Orleans
10 University of Michigan Hospital, Ann Arbor
11 New York Medical College, New York City
13 University of Virginia Medical Center, Charlottesville
18 Albert Einstein Medical Center, Philadelphia

General:

Field B, columns 3–5, generally identifies the hospital at which the patient was first diagnosed, or first reported, within the local registry system for this cancer. However, registries requiring more than six digits for Case Number (Field C) may use Field B to provide the required additional digits. Thus, Fields B and C together provide complete identification of the individual patient.

Each central registry is to develop its own code for identifying individual hospitals, and is to file at least one copy of this code with the End Results Section, NCI.

Specific:

Do not leave any column blank.

Single institution registries normally enter 000. If this field is used to provide additional digits for Case Number, so notify the End Results Section in each transmittal letter referring to a shipment of punchcards.

Central registries will enter a code to identify each specific hospital or clinic, e.g., 001, 002, etc. At least one copy of the code will be filed with the End Results Section.

For a Class 8 cancer (Field G) usually the hospital code will be 999 which indicates that the death certificate is the *only* source of information about *this* cancer. Presumably, if the death certificate mentioned a hospital within the registry system as the place of death, more information would be obtained from the hospital—and the case would not end up as a Class 8 case. Code 999, therefore, stands for "unknown" or for a hospital not identified in the central registry hospital code. If, however, the patient is already registered with a different cancer it is permissible to use the same hospital code that appears on the punchcard for the earlier cancer. In some central registries this practice may facilitate the matching of all cards for the same patient and speed the review to ensure that all cards are for different primary cancers.

General:

Field C indicates the case number used to identify the patient by the registry concerned. In most instances the six digits of Field C are sufficient provision for such an identification number. In certain registries, however, the case number requires more than six digits. In such cases Field B can be used to provide the necessary extra digits. If such an arrangement is utilized, the codes for Field B and C are to be filed with the End Results Section, NCI.

It is important that each patient always be identified by the same number. Each punchcard pertaining to the same individual must have the identical entry in Field C regardless of the number of cancers, the number of institutions consulted by him, or the number of admissions at any institution.

Certain registries number each *cancer* separately. So long as the patient has but one primary malignancy there is no difference between a cancer identification number and a patient identification number. Once, however, the patient is known to have or to have had more than one cancer, whether occurring concurrently or at different times, a problem arises concerning a *patient* identification number. If the registry assigns a new number to serve as a patient identification number, the ERS must be informed yearly, at the time of submission of the punchcards, which case numbers for patients previously reported have been changed and what number replaces the old number. Of course, if a new patient is diagnosed as having more than one cancer at his first appearance in the hospital and thus immediately assigned a patient identification number, this number would be used for even the first punchcard. In such a situation, it is not necessary to call any special attention to the case because there is no change necessary on the records or punchcards already submitted to ERS.

Specific:

Enter the patient identification number in columns 6 to 11. If the identification number is less than six digits, precede the number with zeros. For example, Case #7034 would be coded and punched 007034. Thus no column is left blank.

General:

No comment.

Specific:

1 Male
2 Female
3 Other (Hermaphrodite)
9 Not Stated (Do *not* leave blank)

General:

This code follows U.S. Census Bureau practice.

Specific:

1 White
2 Negro
3 Other
9 Not Stated (Do *not* leave blank)

White includes Puerto Ricans, Other West Indians, Mexicans, Other Central Americans, and South Americans.

Other includes all patients identified as "Asiatic" and also includes all "American Indians". Thus, East Indians, Chinese, Japanese, Koreans, etc., are coded 3.

Persons of mixed parentage are classified according to the race of the non-white parent. Mixtures of non-white races are generally classified according to the race of the father.

General:

Field F represents the age of the patient at diagnosis for *this cancer*. Age is measured in completed years of life—age at last birthday. Most hospital records contain the patient's date of birth which is often more reliable than the statement concerning age. Therefore, it is advisable to use the date of birth to check the age entry recorded in Field F.

Code:

Number of years of age at last birthday

00 less than one year old
01 one year old, but less than two years old

97 ninty-seven years old, but less than ninety-eight
98 ninety-eight years old or older
99 unknown age

Specific:

For all analytic cases (See Field G) the age coded in Field F is the age at diagnosis of this cancer. The age entered in all punchcards is the age at the date coded in *Field H*.

For multiple cancer at the same primary site (see Field Z), the entry in Field F refers to the age at the time of the first lesion covered by the card.

If, for a particular study, the age at first treatment is needed instead of the age at diagnosis, the difference between the dates coded in Field H and I provides a basis for "correcting" the age of the analytic cases for such study purposes.

General:

The primary purpose of this field is to provide a means of dividing the punchcards into two decks: The ANALYTIC DECK and the NON-ANALYTIC DECK. The Analytic Deck consists of punchcards suitable for survival analysis. The Non-Analytic Deck contains punchcards which are not appropriate for survival analyses, but which may be useful in other studies such as the analysis of incidence.

As the code descriptions suggest, the Non-Analytic Deck punchcards are not used for survival analyses in the evaluation of treatment because of a biased selection of patients (Classes 5 and 7), missing information concerning the first course of definitive therapy (Classes 6 and 8), or the fact that the patient could not have been treated for this cancer (Class 9).

Definition of Analytic Cases (Code 1 or 2 in Field G):

The following types of cases are included in the Analytic Deck and are described as Analytic Cases in the code below and throughout this Manual:

a) Received *all* of the first course of definitive (tumor-directed) therapy for this cancer *within* the facilities of the reporting registry system.

b) Received *part* of the first course of tumor-directed treatment *within* the facilities of the reporting registry system. The part given elsewhere may have been received before or after the patient's admission to the registry system.

c) Received *all* of the first course of definitive therapy *elsewhere*, but *after* patient admitted to the registry system for this or earlier cancer.

d) *Received no definitive therapy anywhere*, but patient admitted to the registry system for diagnosis or non-definitive treatment of this cancer or admitted because of another cancer (usually at an earlier date).

The basic assumption is that all registries in ERG have excellent follow-up. As is implicit in (b), (c), and (d), above, it is further assumed that the registry is informed about all aspects of the patient's cancer history after first admission to the follow-up system. It is also presumed that the registry has complete knowledge of the entire course of treatment during which the patient is admitted to the registry system—including any part given elsewhere prior to admission.

For their own studies some registries may identify separately these various groups of cases, but they are combined as the Analytic Deck for ERS purposes with no possibilities of separation.

The Need for Code 2:

Either by addition of greater detail in traditional information areas or by addition of entirely new areas of information, the 1967 ERG code asks for some items of information completely lacking in previous codes. Although it is possible to convert mechanically most of the old punchcards to conform with the 1967 system, the new information cannot be obtained without a review and recoding of the patient's record. At the beginning, of course, there will be many cases for which no review has been possible by the time of submission of the punchcard deck. It is likely that there will always be some cases for which there is no real justification for review even if time permits. Therefore, it is necessary to identify those cases whose coding can only approximate the 1967 code because the punchcard coding is based on old punchcards in at least one of the added or expanded fields. If the code details for any one of these items of information are missing, the case is to be coded as Class 2. (Field YY will indicate which new field has not been reviewed.)

Code for Class of Case:

ANALYTIC DECK

1. Analytic case in which *all* coding uses the 1967 ERG code and is based upon direct examination of the case record.

2. Analytic case coded partly or completely by mechanical conversion from old punchcard containing codes in use prior to the 1967 ERG code.

NON-ANALYTIC DECK

5. At least one course of definitive therapy (elsewhere) before admission to registry system.

6. Unknown whether treated definitively for this cancer before admission to registry system.

7. Consultation Only; not assignable to other categories.

8. Death Certificate the only source of information for this cancer.

9. This cancer first diagnosed at autopsy.

Summary Card for Multiple Cancers:

For primary sites 810–819, 900–909, and 910–919 a single punchcard may summarize the information for more than one cancer. These cases will be indicated in Field Z by codes 1–7. For such summary punchcards, the entry in Field G represents the code for the *first* lesion of bladder, melanoma of skin, carcinoma of skin, respectively. For example, if the first bladder tumor was treated elsewhere and would be coded as a Class 5 case, the entire card is coded 5 in column 16 even though some of the later lesions were treated at the reporting registry and would have been classified as Class 1 cases if coded separately. If the first lesion fits the definition of a Class 1 case, the entry in Column 16 is a 1.

Different Definition of "registry system" for a Population-Based Registry:

For population-based registries, the definition of "registry system" is somewhat different from that used in the usual hospital registry which does not attempt to cover all persons in a defined population. In a population-based registry, every person in the defined population is *in* the "system" regardless of the place of diagnosis or treatment, or of the completeness or accuracy of the information. In the most common type of population-based registry the "defined population" consists of the residents of a particular political or geographic unit such as a state or county.

A complete state or county registry must consider as "analytic cases" all residents with cancer—even if the entire diagnosis and all of the cancer treatment took place outside the area. In addition to the information from hospitals and doctors, the registry must collect data on all cancer deaths in the area and also on cancer deaths of residents occuring outside the area. For such population-based registries residents would always be coded 1, 2, 8, or 9.

A state or county complete registry also usually covers the cancers of non-residents diagnosed, treated, or dying within its area. Non-residents may also receive the codes 1, 2, 8, and 9. In addition, codes, 5, 6, and 7 are used for non-resident cases to identify those non-residents whose first definitive treatment was received outside the state or county. Codes 5, 6, and 7 are not used for residents.

As is obvious from the above, such a registry must have on its punchcards a code for place of usual residence. This code is not necessary for most hospital registries which are not part of a population-based reporting system.

General:

This is a four-digit field in which the first two digits identify the month and the last two digits identify the year of diagnosis. This field is to be punched for all cases, irrespective of the code in Field G, Class of Case. If necessary, approximate according to the rules below.

The date in Field H refers to the *first* diagnosis of *this* cancer by any recognized medical practitioner. This is often a clinical diagnosis and may not ever be confirmed histologically. Even if later confirmed, the date in Field H refers to the date of the *first clinical diagnosis* and not to the date of confirmation.

Code:

Cols. 17–18 *Month*

01 January
.
.
.
09 September
10 October
11 November
12 December
99 Unknown Month

Cols. 19–20 *Year*

last two digits of year
99 Unknown Year

Specific:

In columns 17 and 18 code the month of diagnosis (01–12) using 99 for unknown month. For example, April is coded 04.

In columns 19 and 20 code the last two digits of the year of diagnosis. For example, 1958 would be coded 58.

Month and Year of first diagnosis (often clinical) is to be recorded for this cancer, regardless whether diagnosed in or out of the registry system. In the absence of an

Specific (continued):

"exact" date of diagnosis, the best approximation on the basis of available information will be acceptable. *Approximation,* if possible, *is preferred to coding the date as unknown.*

a) For patients diagnosed while in a hospital, the date of admission may be used as best estimate of date of diagnosis.

b) For patients diagnosed before entering a hospital, the date of first admission may be used as an acceptable estimate of date of initial diagnosis if it seems that the patient was hospitalized within a "reasonable time" (approximately one month or less) from the true date of diagnosis by the referring doctor.

c) If the only information is "Spring of", "Middle of the Year", "Fall", approximate these as April, July, and October respectively. For "Winter of" it is important to discover whether the beginning or end of the year is meant before approximating the month.

d) If there is no basis for an approximation, code the *month* of diagnosis as 99 in columns 17 and 18. Leave no blank columns.

e) If necessary, also approximate the year. If no approximation is possible, code *year* of diagnosis as 99 in columns 19 and 20. If code 99 is used in columns 19 and 20, code 99 should also be used in columns 17 and 18. There is no utility in coding the month if the year is unknown. Therefore, if the year is unknown, Field H will be coded 9999.

For specified multiple cancer cases (810–819, 900–909, 910–919 in Field K with a code of 1–7 in Field Z) a single summary punchcard is prepared rather than a punchcard for each lesion. On such a summary card, enter in Field H the date of diagnosis for the lesion(s) of the first episode (the *first* lesion diagnosed).

General:

This is a four-digit field representing the date of initiation of the patient's first definitive treatment for this cancer. The first two digits indicate the month; the last two digits identify the year. In conjunction with Field S (Follow-Up-Date), Field I provides the basic data for computation of survival time from initiation of therapy as a means of assessing the effectiveness of the treatment.

Definition:

The date of admission for that hospitalization during which the first definitive therapy was begun is an acceptable entry in Field I. If definitive treatment was first received on an out-patient basis, code the precise date.

Code:

Cols. 21–22 *Month*

01 January
.
.
.
.
09 September
10 October
11 November
12 December
(99 Unknown Month)

Cols. 23–24 *Year*

last two digits of year
(99 Unknown Year)

Specific:

The codes for unknown month and unknown year are in parentheses since it is almost impossible to envision an analytic case for which definitive treatment is known, but its

***Specific* (continued):**

date is unknown. Should there be an acceptable case with unknown year of definitive treatment, the entire field should be coded 9999.

For the patient who has not received definitive treatment (000 in Field Q) the code in Field I will be the same as that in Field H—the date of diagnosis. For such a patient, Field I is obviously a *follow-up* item. Until the patient's death there is always the possibility that definitive treatment will be received. Should definitive therapy be given, the date of that treatment will replace the date of diagnosis in Field I so that Field H and I will then contain different dates. The type of definitive treatment will be coded in Field Q in place of the 000 coded originally.

For the "summary cards" (1–7 in Field Z) representing more than one cancer within certain sites, the entry in Field I is the date of the *first* definitive treatment of *any* of the lesions covered by the summary card. If none of the cancers represented by the card receives definitive therapy, the date in Field I is the date of diagnosis of the first lesion as in Field H.

Caution: If a case receives non-definitive therapy but no definitive therapy, the date of the non-definitive therapy is *not* to be entered in Field I; the date of diagnosis is to be entered. (There is at present no reserved punchcard space for the date of non-definitive therapy even if the description of non-definitive therapy is entered in Field P.)

General:

For a few tumors the cooperating registries within the End Results Group differ in policy so that a specific tumor might be considered benign at one registry and malignant at another. To be consistent, therefore, all cases of designated diagnoses are reported whether specified as benign or malignant at the member registry. The code in Field J identifies the local usage and at the same time makes possible uniformity within the End Results Program. It also provides a basis for the selection of cases for certain studies.

In addition, this field provides a code for the member registries to use to identify "premalignant" neoplasms and non-neoplastic conditions which they follow for research interest but which are not reportable to ERS.

It must be emphasized that the coding of Field J is not dependent upon histological confirmation (except for code 9). Pertinent clinical diagnoses must be coded even if not confirmed by histology.

Code:

1. Malignant
2. Reportable by Agreement
3. Followed for Special Interest. (Not to be submitted.)
8. Originally Reportable by Agreement, but Malignant at Later Time.
9. Malignant (Originally) with Known Discrepancy between the Codes for Primary Site and Histological Type

All cases which are classifiable as codes 1, 2, 8, or 9, are routinely reportable within the End Results Program. Code 3 cases are not to be submitted except by specific directive of the Project Officer.

From time to time the list of designated diagnoses which are included in code 2 will change. The changes will be the result usually of two factors: new studies to be attempted and increased awareness of specific differences in policy between the member registries.

Definitions:

Code 1. Malignant.

This category includes diagnoses commonly accepted as denoting malignancy, or specified by the word "malignant" in the diagnostic phrase, or otherwise considered malignant at the reporting registries.

Among the diagnoses accepted as malignant without use of the word "malignant" are the following: Diagnoses containing terms or suffixes like *carcinoma, sarcoma,*

***Definitions* (continued):**

blastoma, leukemia, cancer of . . . . . or containing the associated adjectives *carcinomatous, sarcomatous, leukemic, cancerous,* etc. Note, however, that there are a few exceptions such as "cystosarcoma phyllodes" which require additional specification by the word "malignant" to be considered as cancer.

Except as specifically indicated in Fields J, K, and M of this Manual or in later directives of the Medical and Technical Advisory Committee, the "Red Book" is the principal reference for malignancy. (See page M-1 for "Red Book" details.)

Code 2. Reportable by Agreement:

This category includes only the diagnoses designated below which are identified as benign, have undetermined malignancy, or are otherwise not considered malignant at the reporting registry. (If considered malignant, the code should be 1.) In the lists below, "MNS" means "malignancy not specified".

A.

papilloma of the urinary bladder, MNS or benign
papillary adenoma of the thyroid, MNS or benign (including mixed papillary and follicular adenoma)
bronchial adenoma, MNS or benign
Kaposi's sarcoma, benign (including Kaposi's disease, MNS or benign)
polycythemia vera
lymphoma, specified benign (except of orbit)

B.

brain tumor, MNS or benign
tumor of intracranial nerve, MNS or benign
cranial meningioma, MNS or benign (not spinal)
any glioma or astrocytoma which is specified as benign (not including glioma of the nose) Note that a glioma, MNS is coded to 1.

C.

pinealoma, MNS or benign
carcinoid tumor of G.I. tract (including appendix), MNS or benign
all tumors coded 851 or 852 in Field M:
mixed tumor of salivary gland type, MNS or benign
muco-epidermoid tumor of salivary gland type, MNS or benign
myo-epithelial tumor of salivary gland type, MNS or benign
chemodectoma, MNS or benign
carotid body tumor, MNS or benign
aortic body tumor, MNS or benign
tumor of glomus jugulare, MNS or benign
tumor of glomus ciliare, MNS or benign
tumor of glomus intravagale, MNS or benign

In the lists above are tumors made reportable for several reasons. All in list A will be considered malignant within the End Results Program and included in any statistics

***Definitions* (continued):**

resulting from pooling the data of all member registries. In list B are the brain tumor diagnoses which are not specified as malignant, but which have traditionally been combined with malignant brain tumors in vital statistics data. The code in Field J will permit testing whether such a practice is justified. List C covers diagnoses designated for general study by ERG concerning whether there is difference in the survival of tumors specified malignant and those not so specified.

Any diagnosis mentioned here is routinely reportable from every registry until notice of change in this requirement. However, unless listed under code 2, no benign neoplasms are to be reported to ERS.

Code 8. Originally Reportable by Agreement, but Malignant at Later Time:

Occasionally a tumor which was previously classified as "Reportable by Agreement" is later reported as malignant. To simplify the coding in other fields it is easiest to identify such cases with a specific code in Field J. Cases coded 8 will retain the original date of diagnosis (Field H) for the tumor which was coded as reportable by agreement as well as the original histology code (Field M), and usually the codes for first course of definitive therapy (Field Q) and for extent of disease at first definitive therapy (Field O).

There may be doubt whether the new malignant tumor is actually the original apparently benign tumor since the first tumor is likely to have been treated. One advantage of this code is to identify such cases for further study. Therefore, use code 8 in such situations unless the histology is not consistent with a malignant version of the first tumor. If the histology is not consistent, the new malignancy should be considered an independent primary cancer and described by a separate punchcard.

The phrase "malignant at later time" is not intended to cover the problems of arriving at the first diagnosis wherein various reports have to be reconciled. It refers usually to a recurrence or new tumor near the original site and also involves a time lapse that is fairly lengthy.

***Definitions* (continued):**

Code 9. Malignant (Originally) with Known Discrepancy between the Codes for Primary Site and Histological Type.

For certain diagnoses, the site code uses histology rather than location within the body as the primary basis for classification. Examples are the hematopoietic neoplasms (000 to 05–) and malignant melanoma of skin (900 to 909). This means that for these diagnoses there is an "overlap" in the codes for Primary Site (Field K) and Histological Type (Field M). This overlap is used in routine checking of each punch-card for internal consistency since for these specific site codes there are equivalent specific histology codes. Code 9 provides a mechanism for signalling that there is an intentional inconsistency which need not be referred back to the registry for review.

There are several types of known or intentional discrepancies that are expected to be coded as 9. The most frequent occurs in lymphomas with a changing histologic description at different "phases" of the disease process. For example, a malignancy described originally as "lymphosarcoma" is described eighteen months later as "acute lymphatic leukemia" without any implication that there are two neoplasms present. To provide as much useful information as possible, a specific rule has been devised for coding the malignant hematopoietic neoplasms:

The code in Field K will present the initial diagnosis and will not be changed; the code in Field M will reflect the latest description of the neoplasm.

If the codes in Field K and M describe different histologies, then a code of 9 in Field J will signal that this difference is known and that an accidental mistake has not been made. If the codes in Field K and M are compatible Field J will show the usual code 1.

Another use of code 9 concerns the occasional instance where the codes for Field K and Field M do not quite agree. (Future revisions of these two fields may remedy this matter.) One example in which code 9 is proper is "Hodgkin's sarcoma". In the site code this is included under *Hodgkin's Disease.* In the "Red Book" which is the present basis for the histology code, Hodgkin's sarcoma is not listed under *Hodgkin's Disease,* but rather under *Reticulum Cell Sarcoma.* Thus, this particular diagnostic phrase is "officially" coded under two different headings and might be selected as a possible coding error every time. Use of code 9 in Field J makes possible an easy programming mechanism to avoid this.

Code 9 is to be used only where the original neoplasm is malignant and can be properly classified as code 1. A code of 2 or 8 is *not* to be changed to a 9.

General:

The Seventh or 1955 Revision of the *International Classification of Disease* published by the World Health Organization is the *basis* for the primary site code in the ERG system. Some of the deviations are due to the fact that ERG can code topography (location of primary tumor) separately and independently from histology whereas in ICD some cancers are coded only according to topography, some only on the basis of histology, and a few using both site and morphology. Obviously, if by the use of several fields the ERG system can devote more code numbers to identification of a tumor it can provide a more detailed and precise description than can ICD alone.

This detailed identification method is not unique to ERG nor did it originate with ERG. The American Medical Association's *Standard Nomenclature* used the independent topography-etiology classification from its inception. There are other classification systems, too. The point of emphasis is that all are being revised in the direction of providing more detail in the coding of primary site as well as histology and in organizing the codes to fit computer neeeds.

It is therefore not surprising that the 1967 version of Field K also provides more detailed coding of topography than previous editions. Many of the earlier categories have been subdivided to provide the specific information needed for the ERG's research needs. Some of the newer codes became necessary in conjunction with the new Extent of Disease codes in Field O. Other changes reflect the needs to keep up with changes in ICD and other important classification systems.

Relation to ICD Code Structure:

The ICD is a four-digit code system, a three-digit number with a supplementary decimal digit which is not always used. The ICD covers all diseases, with blocks of numbers assigned to groups of diseases with some specific similarity. The segment of numbers devoted to malignant neoplasms is 140.0 to 209.9, but not every available number is used. By dropping the first digit of ICD, the hundreds integer, a three-digit number system is obtained which is sufficient to cover all the code categories pertaining to malignant neoplasms. This is the origin of the code in Field K. Columns 26 and 27 correspond to the second and third digits of the ICD Seventh Revision code number; column 28 represents the decimal digit. If there is no assigned decimal digit, an "eleven punch" symbolized by a dash (–) is the code used in column 28. However, the specific ERG code listing should be used. Some ICD numbers have not been used and others have been added, many of the (–) codes having been replaced by specific codes for sub-sites.

Relation to New Revision of ICD:

A new revision of ICD is to take effect in 1968 in the Vital Statistics offices throughout this country. In this Eighth or 1965 Revision of ICD the same segment of numbers (140.0 to 209.9) will be used for malignant neoplasms as in the Seventh and Sixth Revisions. However, a drastic renumbering has occurred because of the adoption of a different systematic outline of anatomic sites as well as the expansion of categories within some anatomic systems. Over 75% of the previously useful categories have been assigned different numbers. In the 1967 ERG code, no attempt has been made to adapt to the changed *numbers* of the Eighth Revision. Field K remains based upon the Seventh ICD Revision.

However, an attempt has been made to provide all the meaningful descriptive *categories* of the Eighth Revision. Where necessary, new code numbers have been created —usually by employing column 28 to subdivide the sites of the Seventh Revision if ERG had not already subdivided them. By use of Field K alone or by combined use of Fields K and M, all information requested in the Eighth Revision of ICD may be obtained as well as additional information.

Relation to New Revision of "Red Book":

A Committee of the American Cancer Society has been working for several years upon a revision of the *Manual of Tumor Nomenclature and Coding* which is the present basis for the code in Field M. Because the committee is utilizing the ICD Eighth Revision, and the Morphology section of the *Systematized Nomenclature of Pathology* (SNOP), it is expected to produce not only a new histology code but a primary site code to be used with it. It is likely, therefore, that when the Committee's results are published there will be need for further revision in Field K to add any categories needed to insure compatibility with this important classification.

Temporary Status of 1967 Primary Site Code:

In a future revision of Field K it may be desirable to develop a numbering system which is independent of any other code and yet provides all information compatible with the other national and international classifications in existence. An independent code could mean a more efficient usage of the 1000 numbers available in Field K.

1967 ERG Primary Site Code:

The following listing is arranged in the order of the ICD Seventh Revision codes 140.0 to 209.9 (with the first digit omitted). Please note that following the listing are specific coding rules and suggestions.

BUCCAL CAVITY AND PHARYNX (400–499)

Lip (labial mucosa), excluding "skin of lip" (910)

400 upper lip, not specified as midline
401 lower lip, not specified as midline
403 commissure
405 upper lip, midline tumor
406 lower lip, midline tumor
409 lip, unspecified (including "both lips" NOS with site of primary not determined.)

Tongue

Base of Tongue (Tongue posterior to circumvallate papillae. Includes "posterior third" NOS)

410 midline tumor
411 other than midline, and "base NOS"

Anterior Two-Thirds of Tongue (Tongue anterior to circumvallate papillae)

dorsal surface of tongue (top)

412 midline tumor
413 other than midline, and "dorsal" NOS

ventral surface of tongue (underside)

414 midline tumor
415 other than midline, and "underside" NOS

416 tip of tongue
417 border(s) of tongue
418 "anterior two-thirds" NOS
419 *Tongue, Unspecified*

Salivary Gland

420 parotid gland
421 submaxillary gland
422 sublingual gland
429 "salivary gland" NOS (*Not* to include salivary gland type tumors in sites other than the major salivary glands coded 420–422. Code salivary gland type tumors in other sites to the site where they appear.)

Floor of Mouth (including Lower Gum)

431 floor of mouth
432 lower gum (gingiva covering lower alveolar ridge)
439 both 431 and 432—cannot determine which is site of origin

Other Mouth and Mouth NOS

441 buccal mucosa

442 upper gum (gingiva covering upper alveolar ridge)
443 gum NOS (gingiva not specified as upper or lower)

444 hard palate
445 soft palate, including uvula
446 palate NOS

447 retromolar trigone (area of mucous membrane posterior to lower alveolar ridge and not coded in 431 or 432)

449 mouth NOS

Oral Mesopharynx

450 tonsil, including fossa but excluding pillars (451)
451 tonsillar pillars (pillars of fauces)

452 lateral wall
453 anterior wall (including lingual surface of epiglottis)
454 posterior wall
455 wall NOS

456 vallecula

457 branchial cleft

459 oral mesopharynx NOS

46– **Nasopharynx** (wall)

Hypopharynx

470 postcricoid region
471 pyriform fossa
478 other specified parts (posterior pharyngeal wall)
479 hypopharynx NOS

48– **Pharynx NOS**

DIGESTIVE ORGANS AND PERITONEUM (500–599)

Esophagus

501 upper third (cervical)
502 junction of upper and middle thirds
503 middle third (thoracic) at level of aortic arch
504 junction of middle and lower thirds
505 lower third (distal), including "abdominal esophagus"
506 cardio-esophageal junction (If not specified whether stomach or esophagus is the primary site, code here if *not* adenocarcinoma.)
509 esophagus NOS

Stomach

510 cardio-esophageal junction, including cardia. (If junction is not specified whether stomach or esophagus is the primary site, code here if adenocarcinoma of any type.)
511 fundus

body
512 greater curvature of body, greater curvature NOS
513 lesser curvature of body
514 body NOS

antrum and pylorus (including prepylorus)
515 greater curvature of antrum
516 lesser curvature of antrum
517 antrum NOS, pylorus NOS, prepylorus

518 lesser curvature NOS

519 stomach NOS

Small Intestine Including Duodenum

520 duodenum
521 jejunum
522 ileum excluding ileocecal valve (536)
529 "small intestine" NOS

Large Intestine Except Rectum

530 ascending colon (See 534–536)
531 transverse colon, including hepatic and splenic flexures
532 descending colon
533 sigmoid colon, excluding recto-sigmoid colon and junction (544)
534 cecum, including caput coli (Coded previously in 530)
535 appendix (Coded previously in 530)
536 ileocecum, ileocecal valve (Coded previously in 530)
537 familial polyposis with at least one malignancy (any part of colon)
538 . . . unassigned (reserved for possible future use for multiple cancers)
539 large intestine NOS, colon NOS (Previously coded 538; old 539 now 591.)

Rectum

541 peri-anal skin
542 anal canal, anus, anal mucosa

If "skin of anus" NOS, consult pathologist. Otherwise, assign squamous and basal to 541 and adenocarcinoma to 542.

543 rectum
544 rectosigmoid (specified), including junction
547 cloacogenic zone
549 ano-rectal region NOS

Liver, Gallbladder, Biliary Passages

551 gallbladder
552 ampulla of Vater (Coded previously in 551)
553 extrahepatic bile ducts, including common duct (Coded previously in 551)
liver and intrahepatic bile ducts (Coded previously in 550)
555 right lobe
556 left lobe
557 liver NOS, including "both lobes" not specified which lobe was origin
559 biliary tract NOS

Pancreas

571 head
578 body, tail
579 pancreas NOS

58– **Peritoneum** excluding "retroperitoneum" (See 974, 934), but including omentum, mesentery, mesocolon

Unspecified Digestive Organs

591 "intestinal tract" NOS (Previously coded as 539)
599 "digestive organs" NOS, "digestive tract" NOS

RESPIRATORY SYSTEM (600–649)

Nose, Nasal Cavities, Middle Ear, Accessory Sinuses

600 internal nose and nasal cavities, including nose NOS, and nasal septum

601 eustachian tube and middle ear

602 maxillary sinus, maxillary antrum, antrum of Highmore
603 ethmoid sinus
604 sphenoid sinus
605 frontal sinus
609 "accessory sinus" NOS, paranasal sinus NOS

Note: Excluded from this group of codes are the following sites:

skin of nose (913)	cartilage of ear (970)	ear NOS (99–)
bone of nose (960)	skin of ear (912)	external auricular canal (912)

Larynx

611 supraglottic region [epiglottis (laryngeal surface and NOS), arytenoids, false vocal cords, ventricular bands, ventricular cavities]
612 glottic region (glottis, true vocal cords)
613 subglottic region
619 larynx NOS

Bronchus, Trachea, Pleura, Lung

620 trachea, including carina
622 pleura

623 main bronchus (specified), including hilus
624 upper lobe, including segmental bronchus (Code Pancoast's tumor here.)
625 middle lobe or lingula, including segmental bronchus
626 lower lobe, including segmental bronchus
629 lung NOS, bronchus NOS

Mediastinum and Respiratory NOS

641 mediastinum
649 "respiratory organs" NOS

BREAST AND REPRODUCTIVE ORGANS (700–799)

70– **Breast,** excluding skin of breast (915)

71– **Cervix Uteri**
711 Cervical Stump

72– **Corpus Uteri,** including fundus uteri, endometrium

73– **Female Trophoblastic Tumors,** including chorionepithelioma (Excludes malignant fibroid tumors which are coded usually to 72–)

74– **Uterus NOS**

Ovary, Fallopian Tube, Broad Ligament

750 ovary
751 fallopian tube and broad ligament (Can usually be separated by histology. Sarcomas coded here are usually of the broad ligament.)
759 uterine adnexa NOS

Vulva, Vagina, and Other Female Genital Organs

760 vulva, including clitoris, labia, Bartholin's gland, skin of vulva, and also "pudendum"
761 vagina
767 other specified female genital sites, including parametrium
769 "female genital organ" NOS

77– **Prostate**

78– **Testis** (Including male chorionepithelioma if no primary site is stated.)

Penis, and Other Male Genital Organs

790 penis, including glans, prepuce, skin of penis
791 skin of scrotum, scrotum NOS
792 tunica vaginalis
793 epididymis
797 other specified male genital sites, including seminal vesicle, spermatic cord, vas deferens, ductus deferens
799 "male genital organ" NOS

URINARY SYSTEM (800–839)

Kidney

800 kidney parenchyma
801 renal pelvis
802 ureter
809 kidney NOS

Bladder

810 floor of bladder, base, trigone (not including areas of any orifice)
811 areas of ureteral orifices
812 neck of bladder, including area of urethral orifice
813 fundus, vertex, dome, roof (not including area of any orifice)
814 wall (any and NOS) with no mention of orifice
817 abnormality as primary site of tumor. (i.e., diverticulum, extrophy) Note that old code 817 is now 820–821
818 lesions in more than one sub-site 810–817 at first episode (See Field Z)
819 bladder NOS

Other Urinary Organs (previously code 817)

820 urethra
821 urachus

839 Lower Genitourinary Tract NOS

OTHER AND UNSPECIFIED SITES (900–999)

Malignant Melanoma of Skin

900 lip
901 eyelid, including canthi
902 external ear and auricular canal
903 other and unspecified parts of face
904 scalp and skin of neck
905 trunk, including skin of breast but excluding peri-anal skin (541), anus (542), and skin of genital organs (760, 790, 791)
906 skin of upper limb including skin of shoulder
907 skin of lower limb including skin of hip
908 lesions in more than one sub-site 900–907 at first episode (See Field Z)
909 melanoma of skin NOS, including melanoma NOS of unspecified site

Skin Except Melanoma

910 lip
911 eyelid, including canthi
912 external ear and auricular canal
913 other and unspecified parts of face
914 scalp and skin of neck
915 trunk including skin of breast but excluding peri-anal skin (541), anus (542), and skin of genital organs (760, 790, 791)
916 skin of upper limb including skin of shoulder
917 skin of lower limb including skin of hip
918 lesions in more than one sub-site 910–917 at first episode (See Field Z)
919 skin sub-site unspecified, including "skin" NOS

92– **Eye,** including optic nerve but excluding skin and cartilage of eyelid (911, 970)

Brain and Other Parts of Nervous System

930 brain and cranial nerves, excluding optic nerve (92–)
931 spinal cord
932 . . . unassigned; see 937.
933 peripheral nerves
934 sympathetic nervous system, including retroperitoneal neuroblastoma
935 cranial meninges except of optic nerve (part of 930 in previous code)
936 spinal meninges (part of 931 in previous code)
937 meninges NOS (previously coded 932)
939 unspecified nervous system site

94– Thyroid Gland

Other Endocrine Glands

950 suprarenal gland (adrenal gland)
951 parathyroid gland
952 thymus
953 pituitary gland and craniopharyngeal duct
954 pineal gland
955 chemoreceptor gland or organ, including carotid body, aortic body, glomus jugulare, glomus ciliare, glomus intravagale, and chemodectoma with site not specified.
957 other endocrine gland NEC

Bone

960 skull and bones of face, including maxilla
961 lower jaw bone, including mandible
962 vertebral column, excluding sacrum and coccyx (966)
963 ribs, sternum, and clavicle
964 scapula and long bones of upper limb (humerus, radius, ulna)
965 bones of fingers, hand, and wrist
966 pelvic bones, sacrum, coccyx (ilium, ischium, pubis, sacral vertebra)
967 long bones of lower limb (femur, fibula, tibia)
968 bones of toes, foot, ankle, knee cap
969 "bone" NOS

Connective and Other Soft Tissue

970 head, face, and neck
971 trunk, including heart
972 upper limb, including shoulder
973 lower limb, including hip
974 retroperitoneum, including retroperitoneal tumor NOS; but excluding retroperitoneal neuroblastoma (934)
979 connective tissue, site unspecified; muscle NOS

Ill-Defined Sites

99– primary site completely unspecified or not specified enough to be classified to more specific code. (Including carcinomatosis NOS, sarcomatosis NOS, generalized NOS, etc.

LYMPHATIC AND HEMATOPOIETIC TISSUES (000–099)

000 Reticulum-cell Sarcoma

001 Lymphosarcoma

002 Other Primary Malignant Neoplasms of Lymphoid Tissue

01– Hodgkin's Disease

020 Giant Follicular Lymphoma (Brill-Symmers' Disease)

021 Other Forms of Lymphoma or Reticulosis NEC

03– Multiple Myeloma

Leukemia, Acute Erythremia, and Polycythemia Vera

040 lymphatic leukemia, chronic or unspecified (See 048)
041 myeloid leukemia, chronic or unspecified (See 049)
042 monocytic leukemia (any)
043 acute leukemia not coded to 042, 048, 049. (Includes acute leukemia NOS)
044 other or unspecified leukemia not classifiable as acute

045 acute erythraemia (Di Guglielmos' Disease)
046 polycythemia vera
047 erythroleukemia

048 acute lymphatic leukemia
049 acute myeloid leukemia not identified as monocytic

05– Mycosis Fungoides

09– Myelofibrosis. This diagnosis is now included among the malignant neoplasms in ICD. However, to date there have been no reports among members of the ERG of cases with this diagnosis which are considered to be malignant nor has myelofibrosis been listed among those diagnoses considered "reportable by agreement". (See Field J.) Therefore, this number, while reserved for this condition, is not expected to be used on punchcards currently submitted by the ERG members.

Note concerning determination of sub-sites:

In the code above there is emphasis upon identification of specific sub-sites. However, there is no reason not to use the NOS category (like 519 for stomach NOS) if the detailed information is not clearly identified in the record. No undue time need be spent in trying to read into the record any information the doctor has not entered. It will never be possible to obtain precise sub-site information for all cases, but in time enough information will be collected from the well defined cases to provide meaningful information about differences in survival, in treatment, or in the course of disease.

Basic ERG Code Differences from ICD:

There are two principal differences between the ERG coding system and the ICD code from which it is derived. Both differences arise from the emphasis in the ERG system upon coding the **primary** site of a tumor.

The first difference is that metastatic sites are not coded in the ERG system. If the primary site is unknown, the code is 99– (site completely unspecified) even though a metastatic site may be well described. Those codes in the ICD Seventh Revision, for example, which identified diagnoses which are "unspecified whether primary or secondary", "secondary or unspecified", or "secondary" have no counterpart in the ERG code. It is suggested that the reporting registry make every attempt to have a doctor decide whether the cancer is primary or secondary and then use the most definitive code. If arbitrary decisions must be made, it is required that they be made at the reporting level rather than by an analyst using secondary information on the punched card.

The second major difference is due to the fact that the ICD classifies lymphomas and myelomas according to histology and, therefore, omits whatever primary site information may be available. While the site information in many instances is of meager utility, in other cases it is useful and possibly of importance. Since in the ERG system there is an independent coding of histology (Field M), the primary site information need not be sacrificed where it is pertinent. As an example, a lymphosarcoma of the stomach might be coded in ICD only as primary site 200.1 (lymphosarcoma) whereas in the ERG system it would be coded as primary site 519 (stomach NOS) in Field K and as histology 308 (lymphosarcoma NOS) in Field M. This will permit, using the same general example, more precise study of all stomach cancers than with sole use of ICD in which the lymphomas of the stomach cannot be identified.

The Use of Histology Information in the Coding of Primary Site:

It is the entire cancer diagnosis which is represented by the coding on the punchcard. Primary site, histology, the extent of disease, and multiplicity may all be considered components of the diagnosis. Even though coded in separate fields on the punchcard these components should not be considered as independent variables. Precise coding of the various components is more likely if the entire diagnostic description is considered when coding one component. For example, in the primary site code listing above, codes 506 and 510 illustrate how the assignment may be influenced by the histology information available.

There are other similar situations not indicated in the code listing. Following are further examples of the use of the pathology report in the absence of detailed information concerning primary site:

Sites 400–409 vs. site 910: In regard to "lip" versus "skin of lip", the following rules are applicable. If tumor is primary in the mucous membrane (including vermilion) assign to "lip". If the mucous membrane is known not to be the primary location, assign to "skin of lip". If it is unknown whether or not the mucous membrane is the seat of the cancer, assign squamous cell carcinoma to "lip" and assign basal cell and baso-squamous tumors to "skin of lip".

Sites 909, 939, 969, 979, vs. site 99–: When the site is ill-defined or completely unspecified, it is still possible to assign to a more definitive category than 99– if the histology is one of those associated with a particular site. Examples are melanoma, neurosarcoma, chondrosarcoma, osteosarcoma, and the various sarcomas included under the term "tumor of connective tissue". (However, fibrosarcoma and sarcoma NOS should be left as 99–.)

Of course, there are some histologic diagnoses which are so site-specific that the precise site is often not indicated. Examples of these are hypernephroma, Wilm's tumor, choriocarcinoma (female), multiple myeloma.

Change in Diagnosis:

It is not uncommon for new information or a special review to result in a changed assessment of the primary site of a specific cancer. In the ERG program it is expected that every punchcard will represent the latest thinking on the case and will contain codes appropriate to the latest decisions. (Occasionally a case previously reported as cancer is even deleted after review as never having been cancer.) The difficulties arising from such changes are not coding problems, but rather those of checking and of keeping accurate counts by primary sites.

Exception to the above Rule—Hematopoietic Sites:

There is, however, one situation in which the site code, Field K, is not changed according to the most recent information. This involves a change of histology in a neoplasm of a hematopoietic site—usually a lymphoma. The exception is based upon the fact that for *generalized* lymphomas and for leukemias the primary site code is essentially a histology code and, therefore, there are two punchcard fields in which to code histology. Field K is to show the original diagnosis; Field M will indicate the latest histology; Field J will indicate when there are discrepancies between the codes in Fields K and M. For example, the original diagnosis is lymphosarcoma, but eighteen months later the diagnosis is acute lymphatic leukemia. In this case Field K will indicate lymphosarcoma; Field M will indicate acute lymphatic leukemia; Field J will have code 9 to show a known discrepancy between Fields K and M.

This special rule is to be used only when the original diagnosis is coded in Field K in the range 000 to 05–. It is not to be used in the case of a lymphoma originating in a primary site with a code 400–979 such as in the example of a lymphosarcoma of the stomach. Here the original codes for primary site and histologic type will both remain unchanged.

Thus, the general rule for Field K for lymphomas, leukemias, and polycythemia vera is "don't change the code of the original diagnosis". Any changes on the basis of more information will be in other punchcard fields such as M and J.

Multiple Lesions at Primary Site (Sites 810–819, 900–909, 910–919):

For the sites for which Field Z is authorized, Field K describes the location of the lesions present at the first episode. The entry in Field K does not change. Information concerning the later appearance of other lesions within the organ will be reflected in the coding of Field Z which may change according to the latest information.

For sites for which Field Z is not authorized, a new punchcard is expected for each independent cancer including additional new cancers in the same site.

General:

The purpose of Sequence Number is to distinguish between patients who have one malignancy and those who have more than one. This item thus makes possible ready identification of patients for special study of multiple primaries. Field L also facilitates analyses based on the number of patients rather than on the number of tumors.

It should be emphasized that this field relates to independent primary malignancies, regardless of whether the tumors exist at the same time or at different times. The sequence number refers to the *chronological order* of the diagnoses of independent malignancies over the life-span of the patient's medical history.

For every patient having a history of more than one independent primary malignancy, one cancer must be designated as "first". Usually this creates no problem. However, when two independent primaries are diagnosed simultaneously, the selection of the "first" one may be arbitrary. It is suggested that in such a situation the tumor of the generally more malignant type be selected.

The End Results Group has recently been submitting punchcards routinely for only the "Analytic Deck" and not for the entire roster of cancers. This means that in some situations the "first" cancer is not represented by a punchcard since it is a non-analytic case.

Specific:

0 One Primary Only
1 First of Two or More Primaries
2 Second of Two or More Primaries
3 Third or Later Primary
9 Unspecified Sequence Number

As indicated in the instructions for Field Z there are "summary punchcards" which represent more than one lesion for certain skin and bladder histologies and for any cases of multiple melanomas of the skin. These summary punchcards, which may be identified by a code 1–7 in Field Z, indicate multifocal or multiple lesions *within* a major primary site. In Field L, such a summary card is treated as a single malignancy. If the only malignancies for a specific patient are those represented by the summary card, use code 0 in Field L.

***Specific* (continued):**

When a second independent primary is diagnosed for a patient already registered, the first punchcard coded 0 in Field L must be changed and coded 1. A second punchcard for the new primary should be prepared, coded 2 in Field L.

Occasionally, additional information concerning the patient's medical history will reveal a malignancy earlier than the one registered. In this case, the earlier malignancy will be coded 1 in Field L; the registered case will be recoded from 0 to 2 in Field L.

Separate punchcards are expected for all malignancies with different codes in Field K, Primary Site. Occasionally a patient will have an additional independent cancer which would have the same site code number as one previously registered. If this happens not to be an authorized site for a summary card or if it is a histology such as a sarcoma which is not coded on a summary card, then separate punchcards should be prepared for each malignancy.

General:

The diagnosis is coded essentially in three fields—Primary Site (Field K), Histological Type (Field M), and Extent of Disease (Field O). Another field, Field N (Diagnostic Confirmation), notes the important qualification of whether the diagnosis of cancer has ever been microscopically confirmed. The main point is that a diagnosis can be coded and should be coded, whether or not based on histology.

Some doctors routinely use histologic terms in phrasing the diagnosis despite the absence of microscopic evidence. Therefore, some registries took the position that Field M should code only those diagnoses based on histology. The End Results Section, to the contrary, maintained that *all* diagnoses should be coded in Field M with Field N denoting the histologic validity. The Medical and Technical Committee of the End Results Group ruled that Field M shall code the diagnosis even if the pathologist did not supply the specific terms used.

Records will contain varying diagnostic phrases. The general rule is to try to code the most detailed descriptive diagnostic phrase that is consistent with the patient's history. It is preferable to code "squamous cell carcinoma" rather than "carcinoma", and "acute lymphatic leukemia" rather than "acute leukemia"

Although there have been some additions and modifications, the code for Field M is the code in the 1953 edition of the *Manual of Tumor Nomenclature and Coding* published by the American Cancer Society. This "Red Book" code is used in many tumor registries. It is also the basis for the New Growth Section of the Etiology Code (second set of numbers) in the *Standard Nomenclature of Diseases and Operations* used by most medical record librarians and in use in most hospitals in the United States. Thus, registries which utilize this hospital diagnostic code are likely to have on their records a code mechanically convertible to the code of Field M.

Recently there appeared a new code called SNOP (*Systematized Nomenclature of Pathology*). The possible revision of the "Red Book" to utilize some of the principles and new terms contained in SNOP is now being considered by a special committee of the American Cancer Society. At this time, however, the 1953 edition of the "Red Book" is still the histology reference for ERG.

The first two digits of the code identify the tissue or cell of origin and the third digit designates the "degree of differentiation" of the tumor. In general, except for cases coded 2 or 8 in Field J, the codes for Field M will have 5, 6, 7, or 8 in the third digit. In occasional circumstances at particular registries, the 9 has been used with specific meaning. The 9 is not generally used without permission of ERS. (See instructions for Summary Punchcards for a specific use of code 9.)

***General* (continued):**

If a tumor has once been reported as "reportable by agreement", the histology code is *not* to be changed if eventually this specific tumor is reported to have become malignant. However, any codes in Field M with a 1, 2, or 4 in the third digit are likely to have a 2 or 8 in Field J.

Sometimes a problem arises in the coding of lymphomas and leukemias. A patient diagnosed originally as suffering from a lymphoma may later on exhibit the symptoms associated with a leukemia. The question is whether the later diagnosis should be identified—especially in view of the widespread thesis that the terms "lymphoma" and "leukemia" may in many cases refer to different phases of the same underlying disease process. On the other hand, each new ERG punchcard is supposed to represent the latest thinking concerning the diagnosis. The present solution (as mentioned also on page K-15) is that the primary site code identifying a lymphoma (Field K) should not be changed, but that the histology code in Field M will be changed to identify the type of leukemia. A similar procedure may be found suitable for certain cases with polycythemia vera.

Departures from the Coding in the "Red Book":

Departures from the Coding in the "Red Book" include the following:

446 bronchial adenoma,* carcinoid type
066 bronchial adenoma,* cylindromatous type**
088 bronchial adenoma,* type not specified

086 mixed papillary and follicular carcinoma of thyroid
082 mixed papillary and follicular adenoma of thyroid

086 acantho-adenocarcinoma (malignant adeno-acanthoma)

768 Do not use. Assign reticulum cell sarcoma of bone to 318.

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* The diagnoses listed under 09.1 on page 37 of the Red Book which occur in lung or bronchus are reassigned to these three ERG code numbers.

** The cylindromatous type of bronchial adenoma is also called "cyclindroma, pseudo-adenomatous basal cell type" or "adenoid cystic carcinoma". It is suggested that "except of bronchus" be added to the entries on Red Book pages 38, 79, and 84 where "adenoid cystic carcinoma" is assigned a code of 126.

Summary Punchcards for Bladder and Skin:

If Field Z is coded 1–7, the punchcard represents more than one lesion. Since the lesions may be of different histologic type (or at least described differently in the patient's record), special coding rules become necessary.

For the sites for which summary cards are authorized, it must be emphasized that Field M (Histological Type) refers only to the lesions present during the first episode —just as do Fields K (Primary Site) and O (Extent of Disease). Therefore, the following specific coding rules for Field M are pertinent to those cases coded 4–7 in Field Z and not to those coded 1–3. Field Z will indicate whether there are later lesions of the type acceptable on the summary card, but *Field M will only describe those of the first episode.* This means that *Field M does not change* as new lesions appear.

It does not seem necessary to have special rules for multiple melanotic lesions of the skin. Therefore, the following rules apply to other lesions of the skin (910–919 in Field K) and to lesions of the bladder (810–819 in Field K).

The summary punchcards are restricted to mixtures of specific histologies. For skin these are tumors of basal cell, baso-squamous, and squamous epithelium and also "carcinoma NOS"—all malignancies whose codes begin with 12, 13, 14, and 19. All other histologies including adenocarcinoma, melanoma, lymphoma, sarcoma require separate and independent punchcards.

For bladder, the acceptable diagnoses on the summary card include all tumors of transitional epithelium and squamous epithelium as well as "carcinoma NOS". These are histology code numbers whose first two digits are 11, 14, and 19. All other histologies should be described on separate punchcards. Specific rules for coding Field M for bladder and skin summary punchcards are:

1. If all the lesions have the same histologic type, use the histology code that would have been used for a single lesion with this histology. For example, if every lesion is described as "baso-squamous carcinoma of the skin" use code 136 in Field M.

2. If at least one of the lesions has a different histology code number, the procedure is to find the two-digit category that describes the mixture of specific histologies and add as third digit either an 8 or 9. The 9 indicates that in addition to the well defined tumor(s) there is at least one lesion described as "carcinoma NOS". The 8 means that there is no "carcinoma NOS" but just a mixture of specific lesions: Some examples are:

118 "benign" papilloma (115) and transitional cell carcinoma (116)
198 all lesions of first episode are "carcinoma NOS" (195–198)
148 carcinoma in situ (145) and anaplastic epidermoid carcinoma (147)
149 squamous cell carcinoma (146) and carcinoma NOS (198)
139 anaplastic carcinoma NOS (147) and baso-squamous carcinoma (136)
119 papillary carcinoma (118), "benign" papilloma (115), and carcinoma NOS (198)
129 basal cell carcinoma (126) and carcinoma NOS (198)

***Summary Punchcards for Bladder and Skin* (continued):**

3. To accomplish the coding scheme as outlined, two code categories have been added to those of the "Red Book". These are:

15: Tumors of Squamous and of Basal Epithelium. Included here are any tumor(s) coded 145–148 plus one or more of the tumors coded 126 or 136. As outlined above, the third digit will be either an 8 or 9. Examples are:

158 basal cell carcinoma and squamous cell carcinoma
159 baso-squamous carcinoma, carcinoma in situ, and carcinoma NOS
158 basal cell carcinoma, and baso-squamous carcinoma, and squamous cell carcinoma

16: Tumors of Transitional and of Squamous Epithelium. In this category are tumors coded 115–118 mixed with tumors coded 145–148. In general, the third digit will be an 8 or 9 depending upon the presence of any additional tumors coded 195–198. Examples are:

168 squamous cell carcinoma and "benign" papilloma of bladder
169 papillary transitional cell carcinoma, and epidermoid carcinoma, and carcinoma NOS

However, a special code has been added here which is an exception to the general rule above: **If the codes for every tumor end in a 5, the composite code will be 165.** A "benign" bladder papilloma (115) and any carcinoma in situ (whether coded 145 or 195) will be coded 165 on the summary card.

It is expected that the 15 category will be restricted to skin summary cards and that category 16 will be found only on bladder summary cards.

4. An additional arbitrary ruling is necessary to provide for the simultaneous appearance of tumors coded to 126 and to 136, basal cell and baso-squamous carcinoma. The assignment is as follows:

128 basal cell carcinoma and baso-squamous carcinoma
129 basal cell carcinoma, baso-squamous carcinoma, and carcinoma NOS

General:

Field N indicates whether at any time during the patient's medical history there has been microscopic confirmation of the malignancy of *this* cancer. Confirmation of the fact of malignancy is all that is meant. The code in Field N does *not* indicate confirmation of the primary site or the histologic type as coded in Fields K and M, respectively. Although the accuracy of the entries in these fields, especially Field M, is closely associated with the availability of microscopic evidence, a strict interpretation of Field N is only in relation to the *fact* of cancer.

This field indicates not only the fact of microscopic confirmation but the nature of the best evidence available. Thus, this is a priority series with code 1 taking precedence. Each number takes priority roughly over all higher numbers.

Specific:

1 Positive histology.
2 Positive exfoliative cytology in the absence of positive histology. (Includes positive "pap" smear.)
4 Positive microscopic confirmation, method not specified.
6 Direct observation at surgical exploration, but no microscopic confirmation. (Includes gross autopsy findings.)
8 Not microscopically confirmed (other than code 6).
9 Unspecified whether or not microscopically confirmed.

Category 1, *Positive histology* includes microscopic diagnoses based upon specimen from biopsy, frozen section, surgery, autopsy, or D & C. Positive hematological findings relative to leukemia are also included in 1. Bone marrow specimens are included under 1.

Category 2, *Positive exfoliative cytology* includes essentially diagnoses based on microscopic examination of cells as contrasted with tissue. Included are smears from sputum, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment. Cervical and vaginal smears are common examples. Also included are diagnoses based upon paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.

Category 4, *Positive microscopic confirmation, method not specified:* If cases diagnosed or confirmed only by exfoliative cytology cannot be separated from those diagnosed or confirmed by histology, all confirmed cases from such a registry should be coded as 4. Also, individual cases which are stated to be microscopically confirmed can be coded here in the absence of more detailed information. However, mere use of

***Specific* (continued):**

histological terms does not in itself indicate microscopic examination. For example, the term "carcinoma" is often used even though no miscroscopic examination has been made.

Category 6, *Direct observation at surgical exploration, but no microscopic confirmation:* The diagnosis of cancer is made on the basis of visualization and/or palpation during a surgical exploration, but microscopic confirmation of the diagnosis is not obtained. Most of the cases in this category will be those in which there is widespread inoperable cancer. A case may fall into this group if a biopsy or a surgical specimen taken during the exploration fails to reveal cancer. Also included in category 6 are those cases in which the *gross* autopsy findings provide the only positive information.

Category 8, *Not microscopically confirmed (other than code 6)* includes cases diagnosed by radiology, by endoscopy without positive histology, and by other laboratory or clinical methods.

If both positive exfoliative cytology and positive histology are obtained, the code should be to positive histology, 1.

Most Class 9 cases should be coded 1 in Field N; a few will be coded 6.

Most Class 8 cases should be coded 9 in Field N; occasionally, however, the death certificate will indicate autopsy findings in enough detail that another code assignment is warranted—usually 1.

Since this field refers to microscopic confirmation during the entire medical history of the patient it becomes a follow-up item for the case not coded originally as 1. Autopsy, for example, may provide the first histologic examination even though the patient may have been treated for this cancer for a long time.

General:

The ERG code in the past contained a crude assessment of prognosis in terms of three "stages"—local, regional, and distant spread of disease. Experience with this seemingly simple classification proved it to be imprecise in practice and pointed to a need for obtaining detailed descriptive data as a basis for a more meaningful summary classification system. Field O in the 1967 ERG Code represents, therefore, a change in emphasis since it provides identification of many objectively defined descriptive categories with the necessary resultant expansion of the code-number system.

Field O has expanded to a three-column field with major emphasis upon a two-digit summary code to be found in columns 34 and 35 with a supplementary code in column 36. For most well-defined sites a separate page will be found which contains a highly detailed site-specific classification. On the "right hand" side of the page is the code for columns 34–35; on the reverse side is the code for column 36. To code a site for which such a site-specific code has not been issued (usually not a well-defined site), the "Non-Specific Code" is to be used. This code, which is compatible with the site-specific system, is described later on in the instructions for Field O.

A quick description of the summary code in columns 34–35 is that it provides for especially detailed description of the primary tumor and direct extensions therefrom while also noting the presence or absence of involvement of regional lymph nodes or distant metastases. For each site there is a statement defining which particular lymph node chains are considered "regional" for that primary site. Of primary benefit is the fact that precise definitions are clearly stated.

Column 36 provides for the identification of which of the specified regional lymph nodes were involved and of some other characteristics such as fixation or laterality—in the absence of distant metastases. It also permits identification of the involvement of specific distant nodes or distant sites. The code in column 36 is a more exploratory and less analytically useful code than the summary code because it cannot provide regional lymph node information for all cases. Nevertheless, it will provide information necessary for planning future studies of patients whose disease is far advanced when diagnosed—as well as very detailed information for patients without distant metatases.

After a few years' experience with survival data, it should be possible to combine the descriptive categories of the summary code in columns 34–35 into meaningful prognostic groupings. Presumably, codes with similar survival rates might be grouped together. At such a time, depending upon the results, it is conceivable that the phrase "stage of disease" will again be useful. However, the present Field O is *not* a "stage" code—as indicated by the title "*Extent of Disease*"; it is a site-specific set of descriptive categories.

***General* (continued):**

In any discussion of "staging" there arises the question of compatibility with the various TNM systems. The site-specific codes in Field O can be compared with individual TNM categories, but not with the TNM stages. As indicated above, until experience permits, there are no groupings in the ERG scheme parallel to the "Clinical Stages" or "Pathologic-Clinical Stages". Furthermore, Field O is based upon all the information available to the doctor by the end of the first series of treatments. In many instances this includes a pathology report stating which and how many lymph nodes in the operative specimen were found to be cancerous; in other instances the unsupported clinical impression is all that the record contains. Field O does *not* provide data for a completely clinical staging nor for an entirely pathologic staging. However, Field Y when used in conjunction with Field O makes possible a fairly close approximation to the categories of both the clinical and pathologic-clinical classification schemes. (Field Y contains the assessment of regional node involvement from both the clinician and the pathologist.)

It might also be mentioned that in general the ERG scheme permits the consideration of much more detail than do most TNM schemes. It also defines the regional lymph nodes more precisely.

Definitional Discussion:

In coding Extent of Disease at first treatment, ERG definitions do not limit the data to pure clinical observations, but include all information of any nature. The code reflects pathologic, radiologic, or other laboratory data as well as clinical observation. Such technical information may become available at various times in the diagnostic work-up and in the course of the disease. In many instances, the pathologic report concerning the operative specimen is most important in refining the assessment of extent of disease. However, if too long a period of time is used in determining the "true" extent of disease, the result will not be realistic in describing the known factors at the time of treatment choice. Therefore, a pragmatic rule is used:

In coding Field O all information will be used which is available to the doctor by the end of the first hospitalization for surgery or by the end of the first series of other treatment. This will permit changes in appraisal by the surgeon in that he may consider information gained during surgery and from the operative specimen. Should a new manifestation of the disease develop during treatment, the radiologist may also reconsider his assessment of the extent of disease.

As an illustration, radiation was selected as the first attack upon a cancer apparently limited to the larynx. However, during the initial course of radiation some involved

***Definitional Discussion* (continued):**

regional lymph nodes appeared. The radiation was completed and a radical neck dissection was performed. It is proper to code the first course of definitive therapy as radiation and surgery and to code the extent of disease to reflect the presence of involved regional nodes.

If the regional lymph nodes had been detected after the radiation had been completed, this additional information should *not* be considered in the coding of Field O. Extent of Disease should be coded as one of the "localized" categories. Because of the four month rule, the first course of treatment would still be radiation and surgery if a neck dissection were performed.

The above definition should be interpreted to include the pathology report about the operative specimen—even if the patient was not hospitalized for the surgery. In skin cancer and in cancer of some other sites, the surgery is often performed in the doctor's office.

In cases of planned combination therapy wherein different modalities of treatment are given in sequence, the definition permits use of information gained by the end of the first type of therapy in coding Field O, but not any later.

Site-Specific Code for Columns 34–35, General Outline:

On the next page is a general outline of the number scheme used in the site-specific code for columns 34–35. While not every available number is used for each site, the various ranges of numbers have general meaning. Within each range, a particular code number will have a precise and different connotation for each site.

The code to be selected is the one describing the greatest extent of disease according to the available information as defined on page 0–2. Absence of information concerning a particular descriptive item will sometimes be indicated by a specific code number; if not, absent or missing description is coded as not being present. In other words, code what is known.

Pertinent comments and definitions concerning the headings in the general outline are as follows:

Carcinoma in Situ: Only synonyms for carcinoma in situ such as those listed under code 14.5 in the "Red Book" will be accepted. (See Field M instructions.) Do not accept "basal cell hyperplasia", "squamous metaplasia", "atypical epithelial proliferation" or the like. The only exception is that in the female genital organs (sites 71– to 761) "pre-invasive" is acceptable as carcinoma in situ in Field O although not in Field M. Note that any pathological diagnosis qualified as "micro-invasive" is not acceptable as carcinoma in situ, but must be coded in one of the "localized" categories. Note also that in the intestinal tract sites there are distinctions made beween whether the carcinoma in situ is specified as being on an adenomatous polyp or on the intestinal wall.

***Site-Specific Code for Columns 34–35, General Outline* (continued):**

SITE-SPECIFIC CODE	Description of Primary Tumor: Carcinoma In Situ Only	Local Invasive Tumor Only	With Local Vessel Invasion	Limited Direct Extension	Further Extension	Involved Regional Lymph Nodes	Involved Distant Node or Distant Site
00 to 09	yes	no	no	no	no	no	no
10 to 29		yes	no	no	no	no	no
30 to 49		yes	yes	no	no	no	no
50 to 69		yes	yes or no	no	no	YES	no
70 to 79				yes	no	no	no
80 to 89				yes	no	YES	no
90 to 99					yes	no	no
–0 to –9					yes	YES	no
&0 to &4						no	YES
&5 to &9						YES	YES

Local Vessel Invasion refers to any vascular invasion *limited to the primary site*—including artery or vein invasion, lymphatic invasion, and "nerve" involvement (perineural lymphatic invasion).

Limited Direct Extension varies with the site of origin and the usual spread of disease for that site. Only the organs or tissues specified are to be coded as limited extension.

Further Extension is extension beyond the sites specified as limited direct extension, but not so far as to be classified as distant involvement. Any extensive involvement not specified as further extension for a particular site is to be coded as "distant site".

For most sites, further extension represents involvement by direct extension of the primary tumor. However, for digestive tract sites, codes 90–99 and –0 to –9 often refer to a type of involvement described as "spillage". This occurs where the tumor has apparently bridged the space to a neighboring organ. In the digestive tract, spillage is especially noted where the peritoneum is discontinuous and the tumor has crossed a "bare area".

For melanoma of the skin, this code section indicates the presence of skin metastasis beyond the margin of the primary tumor, but still within the original sub-site.

***Site-Specific Code for Columns 34–35, General Outline* (continued):**

Involved Regional Lymph Nodes are defined as involved nodes in the first chains of drainage of the primary site and are specified for each site. Nodal involvement not included in the definition for each site is second or third chain of drainage or a remote lymph node; all of these are classified as "distant node".

If the precise name for the involved lymph nodes are not found in the medical record, a statement that a "regional lymph node" is involved will be accepted—but not a statement of involvement of an unspecified node. "Lymph node" NOS must be coded as a "distant node". (See code Q for column 36.)

Note that for paired organs (such as breast, ovary, lung, etc.) a bilateral or contralateral involvement of the specified regional lymph nodes is classified as distant involvement. In any question of laterality, the code for column 36 for the specific site will give the answer if it is not indicated in a note to the code for columns 34–35. If a pathologist makes a definite statement concerning whether apparently involved regional nodes contain cancer or not, this statement takes precedence over clinical opinions. In the absence of histological evidence to the contrary, the clinician's judgment rules. Field Y indicates whether a pathologist and a clinician have given independent assessments of the regional node involvement and preserves both opinions. Column 59 is, therefore, an important supplement to the coding of columns 34–35.

Involved Distant Node or Distant Site: In essence these categories contain all descriptions of extent of disease which have not been specifically defined in earlier parts of the code. In any question, the code for column 36 will provide guidance.

For paired organ sites, column 58 (Field X) adds to the precision of the coding of Field O by identifying which side is involved or whether both sides are involved. Field X was not developed as a supplement to Field O, but to answer questions concerning how often both organs become cancerous. However, without changing the meanings of the codes in Field X, the required supplementary information can be obtained. If but one of the paired organs is involved, the code in column 58 will specify. If both organs are involved at the time of first treatment, use code 4 in column 58 and code as "distant involvement" in columns 34–35.

It will be noted that the distribution of code numbers emphasizes localized and early regional disease. Since a principal objective of the ERG is to study and evaluate cancer treatment, it is quite logical to concentrate attention where there appears to be a better chance for successful therapy.

Site-Specific Code for Column 36, General Outline:

Column 36 contains information supplementing the data classified in columns 34–35. On page O–7 is the outline of the code scheme for column 36 which pertains to all sites except lymphoms. (For lymphomas, see below.) The first or numerical section contains more precise information about the location and description of the lymph node involvement defined as "regional" for columns 34–35. In the later or alphabetic sections are codes describing the involvement of "distant" nodes and sites.

The following remarks contain a further definition and explanation of some of the code concepts:

Bilateral Nodal Involvement: In codes 8 and J, bilateral involvement includes both of the following meanings

a) involvement of a defined lymph node chain on both right and left sides of the body.
b) involvement of one of the defined lymph node chains on the right side and involvement of a different defined lymph node chain on the left.

Code Q: As indicated on page O–5, "lymph node" NOS must be coded as distant involvement in the absence of a statement that it is a regional node. Code Q identifies the cases where this is the only apparently distant involvement. Such a symbol will permit special review to see whether a further refinement of the coding rule would be useful. At the same time, it permits the other codes to be kept clearly defined by not including these vaguely defined cases.

Breast Cancer: The numerical section of the code is changed slightly from that of other sites to permit an emphasis on known involvement of the internal mammary or parasternal lymph node chain.

Lymphomas: For the lymphomas, sites 000–021, some of the supplementary information of Column 36 concerns signs and symptoms—factors not contained in the codes for other sites. Thus, the structure of the Column 36 code is completely different for the lymphomas than for the other primary sites.

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***Site-Specific Code for Column 36, General Outline* (continued):**

0 **DOES NOT APPLY.** No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1–5 lymph nodes defined as regional for each specific primary site.

6 more than one of the categories 1–5.

7 any **fixed** regional lymph node. Takes precedence over 1–6, 8, and 9.

8 bilateral or contralateral involvement of head and neck sites. Takes precedence over 1–6 and 9, but not over 7. See codes J and K for paired organs.

9 "regional lymph node(s)" NOS (See discussion on page O–5).

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.

B lung, other than A; lung NOS

C liver

D bone

E brain

F implants on pleura and/or peritoneum, malignant cells in pleural or ascitic fluid; for certain sites other implantation as defined.

G specific assignment for certain sites.

H more than one of the categories A-G.

& distant site other than A-G when it is the only distant site involvement; also "distant site" NOS

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J reserved for paired organ sites to indicate any bilateral involvement of the lymph nodes in categories 1–6, even if fixed.

K reserved for paired organ sites to indicate *only* contralateral involvement of any of the defined regional lymph nodes of categories 1–6, even if fixed.

L supraclavicular node(s) the ONLY distant node(s) whether of right, left, or both sides and whether fixed or not fixed. Takes precedence over codes J and K.

M-N specific assignment for certain sites.

P more than one of the categories J-N.*

Q "lymph node(s)" NOS (when "regional" or "distant" not stated, assume to be distant and use this code.) See pages O–5 and O–6.

– distant node other than J-N, also "distant node(s)" NOS. Takes precedence over all other codes J-Q in this section.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED.** Also, no information or "unstaged." Used, in addition, when "Non-Specific Code" is used in columns 34–35.

* Note that the letters I and O are not used in Column 36 to avoid confusion with the numbers 1 and 0 (zero) which are used in the first two code sections.

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Non-Specific Code for Columns 34–35:

When classifying sites for which a Site-Specific Code has not been issued, the code to be used in columns 34–35 is termed the Non-Specific Code and is as follows:

0– carcinoma in situ
4– "localized"
8– "regional"
9– non-localized NOS
&– "distant"
– – unstaged, no information

It will be noted that this code reflects the earlier classification for "Stage" of Disease, but is not specific so far as "Extent" of Disease is concerned. The Non-Specific Code may, therefore, be used to convert all punchcards containing the previous one-column classification for Stage of Disease—i.e., some Class 2 cases.

In any instance where the Non-Specific Code is used in columns 34–35, the code for column 36 is Z.

Following is a list of primary site codes (Field K) for which no Site-Specific Codes have been issued to date and for which the Non-Specific Code is mandatory:

409 lip, unspecified
419 tongue, unspecified
422 sublingual gland
429 salivary gland, NOS
439 floor of mouth and lower gum
443 gum NOS
446 palate NOS
449 mouth NOS
455 wall NOS (oral mesopharynx)
456 vallecula (oral mesopharynx)
457 branchial cleft
459 oral mesopharynx, NOS
479 hypopharynx NOS
48– pharynx NOS
502 junction of upper and middle thirds of esophagus
504 junction of middle and lower thirds of esophagus
506 cardio-esophageal junction
509 esophagus NOS
510 cardio-esophageal junction, including cardia
529 small intestine, NOS
535 appendix
536 ileocecum, ileocecal valve
537 familial polyposis
539 large intestine, NOS
541 peri-anal skin
547 cloacogenic zone
549 ano-rectal region, NOS
559 billiary tract, NOS
579 pancreas NOS
58– peritoneum
591 intestinal tract, NOS
599 digestive organs, NOS
600–605, 609 nose, nasal cavities, etc.
619 larynx NOS
620 trachea
622 pleura
641 mediastinum
649 respiratory organs, NOS
73– trophoblastic tumors (female)

***Non-Specific Code for Columns 34–35* (continued):**

74–	uterus NOS
759	uterine adnexa, NOS
767	other specified female genital sites
769	"female genital organ" NOS
791	skin of scrotum
792	tunica vaginalis
793	epididymis
797	other specified male genital organs
799	"male genital organ" NOS
809	kidney NOS
820	urethra
821	urachus
839	lower genito-urinary tract, NOS
909	melanoma of skin, NOS
919	skin NOS
92–	eye
930–937, **939**	brain and other parts of nervous system
950–955, **957**	other endocrine glands
970–974, **979**	connective tissue
99–	ill-defined sites
03–	multiple myeloma
040–049	leukemias
05–	mycosis fungoides
09–	myelofibrosis

Further Remarks about the Coding of Field O:

The "untreated" case: As the previous discussion indicates, the usual definition for Field O is the extent of disease *at first definitive treatment.* A question naturally arises concerning how to code Field O for the patient who received no definitive therapy.

> The rule is to code the extent of disease at the time the decision was first made not to treat the patient definitively. If this information can not be determined from the patient's record, code the extent of disease at first diagnosis.

Field O is a follow-up item for the living patient who has not yet received any definitive therapy. A future punchcard will indicate the extent of disease at the time any definitive treatment is administered.

FIELD O—EXTENT OF DISEASE
Columns 34–35

UPPER LIP*
400, 405

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in mm.) *5.0 or less*	*5.1 to 10.0*	*More than 10.0*	*Size not known*
vermilion only	no	no	10	15	20	25
superficial extension onto:						
skin	no	no	11	16	21	26
labial mucosa	no	no	12	17	22	27
skin and labial mucosa	no	no	13	18	23	28
"localized", no detailed information	no	no	14	19	24	4–
vermilion only	yes	no	30	35	40	45
superficial extension onto:						
skin	yes	no	31	36	41	46
labial mucosa	yes	no	32	37	42	47
skin and labial mucosa	yes	no	33	38	43	48
"localized", no detailed information	yes	no	34	39	44	49
vermilion only		yes	50	55	60	65
superficial extension onto:						
skin		yes	51	56	61	66
labial mucosa		yes	52	57	62	67
skin and labial mucosa		yes	53	58	63	68
no detailed information of above		yes	54	59	64	69

LIMITED DIRECT EXTENSION

both lips involved by contiguous growth	no	70	71	72	74
extension into musculature (including both lips)	no	75	76	77	79
both lips involved by contiguous growth	yes	80	81	82	84
extension into musculature (including both lips)	yes	85	86	87	89

FURTHER DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
gingiva	90	–0
maxilla	91	–1
gingiva and maxilla	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement; buccinator; parotid group, including preauricular; submaxillary

NOTE: Loss of mobility or function in the affected part is clinical evidence that musculature is involved and is coded 75–79 or 85–89 in the absence of additional information.

"Neck" or "neck mass" is to be coded as Distant Involvement.

When both lips are involved and origin unknown (409) code Field O by using the appropriate NON-SPECIFIC CODE.

* See "NOTE" on reverse side for anatomic limits of upper lip.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 buccinator.
2 parotid group including preauricular.
3 submaxillary.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

> Lips (upper and lower) form the upper and lower anterior wall of the oral cavity. They consist of an exposed surface of modified epidermis commonly referred to as the vermilion surface, which extends from commissure to commissure and from buccal mucosa to skin. The lip includes only the vermilion surface or that portion of the lips that come in contact with the opposing lip.

CARCINOMA IN SITU — **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in mm.) *5.0 or less*	*5.1 to 10.0*	*More than 10.0*	*Size not known*
vermilion only	no	no	**10**	**15**	**20**	**25**
superficial extension onto:						
skin	no	no	**11**	**16**	**21**	**26**
labial mucosa	no	no	**12**	**17**	**22**	**27**
skin and labial mucosa	no	no	**13**	**18**	**23**	**28**
"localized", no detailed information	no	no	**14**	**19**	**24**	**4–**
vermilion only	yes	no	**30**	**35**	**40**	**45**
superficial extension onto:						
skin	yes	no	**31**	**36**	**41**	**46**
labial mucosa	yes	no	**32**	**37**	**42**	**47**
skin and labial mucosa	yes	no	**33**	**38**	**43**	**48**
"localized", no detailed information	yes	no	**34**	**39**	**44**	**49**
vermilion only		yes	**50**	**55**	**60**	**65**
superficial extension onto:						
skin		yes	**51**	**56**	**61**	**66**
labial mucosa		yes	**52**	**57**	**62**	**67**
skin and labial mucosa		yes	**53**	**58**	**63**	**68**
no detailed information of above		yes	**54**	**59**	**64**	**69**

LIMITED DIRECT EXTENSION

both lips involved by contiguous growth	no		**70**	**71**	**72**	**74**
extension into musculature (including both lips)	no		**75**	**76**	**77**	**79**
both lips involved by contiguous growth	yes		**80**	**81**	**82**	**84**
extension into musculature (including both lips)	yes		**85**	**86**	**87**	**89**

FURTHER DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
gingiva	**90**	**–0**
mandible	**91**	**–1**
gingiva and mandible	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: *submental*; *submaxillary, including single mandibular facial node*; *upper deep jugular chain*; *"upper cervical"* NOS

NOTE: Loss of mobility or function in the affected part is clinical evidence that musculature is involved and is coded 75–79 or 85–89 in the absence of additional information.

"Neck" or "neck mass" is to be coded as Distant Involvement.

When both lips are involved and origin unknown (409), code Field O by using the appropriate NON-SPECIFIC CODE.

* See "NOTE" on reverse side for anatomic limits of lower lip.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submental.
2 submaxillary, including single mandibular facial node.
3 upper deep jugular chain.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, or 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Lips (upper and lower) form the upper and lower anterior wall of the oral cavity. They consist of an exposed surface of modified epidermis, commonly referred to as the vermilion surface, which extends from commissure to commissure and from buccal mucosa to skin. The lip includes only the vermilion surface or that portion of the lips that come in contact with the opposing lip.

CARCINOMA IN SITU **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in mm.) *5.0 or less*	*5.1 to 10.0*	*More than 10.0*	*Size not known*
vermilion only	no	no	**10**	**15**	**20**	**25**
superficial extension onto:						
skin	no	no	**11**	**16**	**21**	**26**
labial mucosa	no	no	**12**	**17**	**22**	**27**
skin and labial mucosa	no	no	**13**	**18**	**23**	**28**
"localized", no detailed information	no	no	**14**	**19**	**24**	**4–**
vermilion only	yes	no	**30**	**35**	**40**	**45**
superficial extension onto:						
skin	yes	no	**31**	**36**	**41**	**46**
labial mucosa	yes	no	**32**	**37**	**42**	**47**
skin and labial mucosa	yes	no	**33**	**38**	**43**	**48**
"localized", no detailed information	yes	no	**34**	**39**	**44**	**49**
vermilion only		yes	**50**	**55**	**60**	**65**
superficial extension onto:						
skin		yes	**51**	**56**	**61**	**66**
labial mucosa		yes	**52**	**57**	**62**	**67**
skin and labial mucosa		yes	**53**	**58**	**63**	**68**
no detailed information of above		yes	**54**	**59**	**64**	**69**

LIMITED DIRECT EXTENSION

both lips involved by contiguous growth		no	**70**	**71**	**72**	**74**
extension into musculature (including both lips)		no	**75**	**76**	**77**	**79**
both lips involved by contiguous growth		yes	**80**	**81**	**82**	**84**
extension into musculature (including both lips)		yes	**85**	**86**	**87**	**89**

FURTHER DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
gingiva	**90**	**–0**
maxilla	**91**	**–1**
mandible	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submental; submaxillary, including single mandibular facial node; upper deep jugular chain; parotid group, including preauricular; "upper cervical" NOS

NOTE: In general, at least one lip will be involved at diagnosis.

Loss of mobility or function in the affected part is clinical evidence that musculature is involved and is coded 75–79 or 85–89 in the absence of additional information.

"Neck" or "neck mass' is to be coded as Distant Involvement.

When both lips are involved and origin unknown (409), code Field O by using the appropriate NON-SPECIFIC CODE.

* See "NOTE" on reverse side for anatomic limits of lip (commissure).

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submental.
2 submaxillary, including single mandibular facial node.
3 upper deep jugular chain.
4 parotid group including preauricular.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional node (takes precedence over 1, 2, 3, 4, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 4, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

NOTE: Commissure of the lip is the point of union of upper and lower lips (corner of mouth).

FIELD O—EXTENT OF DISEASE
Columns 34–35

BASE OF TONGUE*
410–411

CARCINOMA IN SITU — Carcinoma in situ 0

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined to one side	no	no	10	15	25
"localized", no detailed information	no	no	14	19	4–
confined to one side	yes	no	30	35	45
"localized", no detailed information	yes	no	34	39	49
confined to one side		yes	50	55	65
no detailed information of above		yes	54	59	69

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
vallecula only	70	80
tumor *extends* to, but does not involve:		
epiglottis	71	81
floor of mouth	72	82
lateral pharyngeal wall	73	83
more than one (71–73) or (81–83)	74	84
tumor *involves:*		
anterior two-thirds of tongue	75	85
gingiva	76	86
anterior two-thirds of tongue and gingiva	79	89

FURTHER DIRECT EXTENSION		
tumor has crossed the midline (does not apply to midline tumor)	90	–0
tumor involves:		
epiglottis	91	–1
floor of mouth	92	–2
lateral pharyngeal wall (including tonsil)	93	–3
mandible	95	–5
more than one (90–95) or (–0 thru –5)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: *upper deep jugular chain; submaxillary; "upper cervical"* NOS

NOTE: Midline tumor is identified in Field K (410). Do not use codes 90, –0.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of base of tongue.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 submaxillary.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—L, M.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Posterior One-third of Tongue (Base of Tongue) consists of the less mobile portion of the tongue which extends inferiorly from the line of circumvallate papillae to the base of the epiglottis, the pharyngo-epiglottic and glosso-epiglottic folds (which bound the vallecula).

FIELD 0—EXTENT OF DISEASE — ANTERIOR TWO-THIRDS OF TONGUE*
Columns 34–35 — 412–418

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 to 2.9*	*3.0 or more*	*Size not known*
confined to one side with:						
no invasion of muscle	no	no	10	15	20	25
invasion of muscle	no	no	11	16	21	26
"localized", no detailed information	no	no	14	19	24	4–
confined to one side with:						
no invasion of muscle	yes	no	30	35	40	45
invasion of muscle	yes	no	31	36	41	46
"localized", no detailed information	yes	no	34	39	44	49
confined to one side with:						
no invasion of muscle		yes	50	55	60	65
invasion of muscle		yes	51	56	61	66
no detailed information of above		yes	54	59	64	69

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes: no*	*yes*
tumor *extends* to, but does not involve:		
floor of mouth	70	80
base of tongue	71	81
floor of mouth and base of tongue	74	84
tumor *involves:*		
floor of mouth	75	85
base of tongue	76	86
floor of mouth and base of tongue	79	89

FURTHER DIRECT EXTENSION		
tumor has crossed midline (does not apply to midline tumors)	90	–0
tumor extends to or involves:		
tonsillar pillars	91	–1
soft palate	92	–2
gingiva	93	–3
maxilla	95	–5
mandible	96	–6
more than one (91–96) or (–1 thru –6)	98	–8
90 and (91–98), or –0 and (–1 to –8)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submaxillary; upper deep jugular chain; submental; "upper cervical" NOS

NOTE: Primary midline tumors are identified in Field K by subsite as 412, 414, or 416. Do not use codes 90, –0, 99, or –9.

When primary site is the "junction of tongue and floor of mouth," code the primary site as 449 in Field K and use the NON-SPECIFIC CODE.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of anterior two-thirds of tongue.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary.
2 upper deep jugular chain.
3 submental.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural cavity.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Anterior Two-thirds of the Tongue consists of the freely movable portion of the tongue which extends anteriorly from the line of circumvallate papillae to the root of the tongue at the junction of the floor of the mouth. It is composed of four areas:

A. Tip
B. Lateral borders
C. Dorsum
D. Undersurface (non-villous surface)

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 to 3.9*	*4 cm. or more*	*Size not known*
single focus and:						
entirely within benign tumor capsule	no	no	10	15	20	25
substance of parotid gland invaded	no	no	11	16	21	26
confined to substance of parotid gland, but multicentric foci	no	no	12	17	22	27
"localized", no detailed information	no	no	14	19	24	4–
single focus and:						
entirely within benign tumor capsule	yes	no	30	35	40	45
substance of parotid gland invaded	yes	no	31	36	41	46
confined to substance of parotid gland, but multicentric foci	yes	no	32	37	42	47
"localized", no detailed information	yes	no	34	39	44	49
single focus and:						
entirely within benign tumor capsule		yes	50	55	60	65
substance of parotid gland invaded		yes	51	56	61	66
confined to substance of parotid gland, but multicentric foci		yes	52	57	62	67
no detailed information of above		yes	54	59	64	69

LIMITED DIRECT EXTENSION

	Involvement of regional lymph nodes: no	*yes*
penetration of capsule of gland into connective tissue	70	80
involvement of neural sheath	71	81
muscle	72	82
skin	73	83
periosteum of mandible	75	85
pharyngeal mucosa	76	86
more than one (70–76) or (80–86)	79	89

FURTHER DIRECT EXTENSION

ulceration of skin	90	–0
mandible	91	–1
skull	92	–2
external auditory meatus	93	–3
major blood vessels	95	–5
more than one (90–95) or (–0 thru –5)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): parotid gland group

NOTE: Facial paralysis may be due to compression of tumor and not invasion.

The lower-most portion of the parotid lies anteriorly in contact with the postero-superior aspect of the submaxillary gland. Because of this intimate relation, the actual origin of some salivary gland tumors will be coded 429 in Field K. In this event, use NON-SPECIFIC CODE in Field O.

When the tumor originates in a minor salivary gland situated in the mucosa or submucosa of the buccal cavity, the case should be coded to the site of anatomic origin and classified accordingly in Field O.

"Neck" or "neck mass" is to be coded as Distant Involvement.

Reminder: Column 58 (Paired Organ Involvement)

* If primary is not excised, report of roentgenography will be acceptable.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 parotid gland group.
7 ***fixed*** node(s) of the parotid gland group.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 to 3.9*	*4 cm. or more*	*Size not known*
single focus and:						
entirely within benign tumor capsule	no	no	10	15	20	25
substance of submaxillary gland invaded	no	no	11	16	21	26
confined to substance of submaxillary gland, but multicentric foci	no	no	12	17	22	27
"localized", no detailed information	no	no	14	19	24	4–
single focus and:						
entirely within benign tumor capsule	yes	no	30	35	40	45
substance of submaxillary gland invaded	yes	no	31	36	41	46
confined to substance of submaxillary gland, but multicentric foci	yes	no	32	37	42	47
"localized", no detailed information	yes	no	34	39	44	49
single focus and:						
entirely within benign tumor capsule		yes	50	55	60	65
substance of submaxillary gland invaded		yes	51	56	61	66
confined to substance of submaxillary gland, but multicentric foci		yes	52	57	62	67
no detailed information of above		yes	54	59	64	69

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
penetration of capsule of gland into connective tissue	70	80
muscle	71	81
sublingual *gland*	72	82
periosteum of mandible	75	85
more than one (70–75) or (80–85)	79	89
FURTHER DIRECT EXTENSION		
mandible	90	–0
nerves	91	–1
major blood vessels	92	–2
more than one (90–92) or (–0 thru –2)	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): submaxillary

NOTE: The lower-most portion of the parotid lies anteriorly in contact with the postero-superior aspect of the submaxillary gland. Because of this intimate relation, the actual origin of some salivary gland tumors will be coded 429 in Field K. In this event, use NON-SPECIFIC CODE in Field O.

When the tumor originates in a minor salivary gland situated in the mucosa or submucosa of the buccal cavity, the case should be coded to the site of anatomic origin and classified accordingly in Field O.

"Neck" or "neck mass" is to be coded as Distant Involvement.

Reminder: Column 58 (Paired Organ Involvement)

* If primary is not excised, report of roentgenography will be acceptable.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary.
7 ***fixed*** submaxillary node.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

CARCINOMA IN SITU **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined to mucosa	no	no	**10**	**15**	**25**
submucosa is involved	no	no	**11**	**16**	**26**
musculature is involved	no	no	**12**	**17**	**27**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined to mucosa	yes	no	**30**	**35**	**45**
submucosa is involved	yes	no	**31**	**36**	**46**
musculature is involved	yes	no	**32**	**37**	**47**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined to mucosa		yes	**50**	**55**	**65**
submucosa is involved		yes	**51**	**56**	**66**
musculature is involved		yes	**52**	**57**	**67**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION

	Involvement of regional lymph nodes *no*	*yes*
tumor extends to or involves:		
gingiva (alveolar ridge)	**70**	**80**
anterior two-thirds of tongue	**71**	**81**
midline of floor of mouth (anterior to tongue)	**72**	**82**
submaxillary *gland*	**73**	**83**
sublingual *gland*	**75**	**85**
more than one (70–75) or (80–85)	**79**	**89**

FURTHER DIRECT EXTENSION

base of tongue	**90**	**–0**
epiglottis	**91**	**–1**
more than one (90–91) or (–0 thru –1)	**92**	**–2**
lateral pharyngeal wall	**94**	**–4**
mandible	**95**	**–5**
soft tissue or skin	**96**	**–6**
more than one (90–96) or (–0 thru –6)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submental; submaxillary; sublingual; upper deep jugular chain; "upper cervical" NOS

NOTE: "Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of floor of mouth.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submental.
2 submaxillary.
3 sublingual.
4 upper deep jugular chain.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 5, 6, 8 and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 4, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Floor of Mouth consists of a semilunar shaped space over the mylohyoid and hypoglossus muscles, extending from the inner surface of the lower alveolar ridge to the root of the tongue. Its posterior boundary is the base of the anterior pillar of the tonsil. It is divided into two sides by the frenulum of the tongue and contains the ostia of the submaxillary and lingual salivary glands.

CARCINOMA IN SITU **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined to mucosa	no	no	**10**	**15**	**25**
submucosa is involved	no	no	**11**	**16**	**26**
musculature is involved	no	no	**12**	**17**	**27**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined to mucosa	yes	no	**30**	**35**	**45**
submucosa is involved	yes	no	**31**	**36**	**46**
musculature is involved	yes	no	**32**	**37**	**47**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined to mucosa		yes	**50**	**55**	**65**
submucosa is involved		yes	**51**	**56**	**66**
musculature is involved		yes	**52**	**57**	**67**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
extension beyond primary site area, but not involving 71–79 or 81–89	**70**	**80**
mandible	**71**	**81**
floor of mouth	**72**	**82**
buccal mucosa (including retromolar area and labial mucosa)	**73**	**83**
tongue	**75**	**85**
more than one (71–75) or (81–85)	**79**	**89**
FURTHER DIRECT EXTENSION		
skin ulceration due to tumor breakthrough	**90**	**–0**
skull	**91**	**–1**
skin ulceration and invasion of skull	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement of submaxillary, including single mandibular facial node; submental; upper deep jugular chain; "upper cervical" NOS

NOTE: Mucous membrane covering the retromolar trigone is coded 447 in Field K and extent of disease classified as above, but do not use codes 73 or 83.

The periosteum of the mandible is a separate structure and can be stripped from the bone, which is frequently done. If the periosteum is involved, but not the mandible, the code is 70 or 80, whichever is applicable.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of lower gingiva.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary, including single mandibular facial node.
2 submental.
3 upper deep jugular chain.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Lower Gingiva includes the alveolar process of the mandible and its covering mucosa, which extends from the line of attachment of mucosa in the buccal gutter to the line of free mucosa of the floor of the mouth. Posteriorly it extends to the ascending ramus of the mandible.

CARCINOMA IN SITU — **Carcinoma in situ** **0**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined strictly to mucosa	no	no	**10**	**15**	**25**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined strictly to mucosa	yes	no	**30**	**35**	**45**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined strictly to mucosa		yes	**50**	**55**	**65**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
tumor extends to or involves:		
musculature	**70**	**80**
gingiva	**71**	**81**
lip, including commissure	**72**	**82**
tonsillar pillars	**73**	**83**
more than one (70–73) or (80–83)	**79**	**89**

FURTHER DIRECT EXTENSION		
skin ulceration due to tumor breakthrough	**90**	**–0**
base of skull	**91**	**–1**
maxilla	**92**	**–2**
mandible	**93**	**–3**
tongue	**95**	**–5**
more than one (90–95) or (–0 thru –5)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submaxillary, including single mandibular facial node; parotid group, including preauricular; "upper cervical" NOS

NOTE: "Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side of anatomic limits of buccal mucosa.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary, including single mandibular facial node.
2 parotid group, including preauricular.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, 6, or 9.
9 "regional lymph nodes(s), NOS" or cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Buccal Mucosa includes all the mucous membrane lining and inner surface of the cheeks and lips, from the line of contact of the opposing lips to the line of attachment of mucosa of the alveolar ridges (upper and lower) and the pterygomandibular raphe.

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined to mucosa	no	no	10	15	25
submucosa is involved	no	no	11	16	26
musculature is involved	no	no	12	17	27
"localized", no detailed information	no	no	14	19	4–
confined to mucosa	yes	no	30	35	45
submucosa is involved	yes	no	31	36	46
musculature is involved	yes	no	32	37	47
"localized", no detailed information	yes	no	34	39	49
confined to mucosa		yes	50	55	65
submucosa is involved		yes	51	56	66
musculature is involved		yes	52	57	67
no detailed information of above		yes	54	59	69

LIMITED DIRECT EXTENSION

	Involvement of regional lymph nodes: no	*yes*
extension beyond primary site area, but not involving 71–79 or 81–89	70	80
maxilla	71	81
palate (soft palate or hard palate)	72	82
buccal mucosa	73	83
more than one (71–73) or (81–83)	79	89

FURTHER DIRECT EXTENSION

skin ulceration due to tumor breakthrough	90	–0
skull	91	–1
maxillary antrum (sinus)	92	–2
nasal cavity	93	–3
more than one (90–93) or (–0 thru –3)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submaxillary, including single mandibular facial node; upper deep jugular chain; "upper cervical" NOS

NOTE: "Neck" or "neck mass" is to be coded as Distant Iinvolvement.

* See "NOTE" on reverse side for anatomic limits of upper gingiva.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary, including single mandibular facial node.
2 upper deep jugular chain.
5 upper cervical.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Upper gingiva is the covering mucosa of the upper alveolar ridge, extending from the line of attachment of mucosa in the upper gingival buccal gutter to the junction with the hard palate. Its posterior margin is the upper end of the pterygopalatine arch.

CARCINOMA IN SITU — Carcinoma in situ **0–**

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined strictly to mucosa	no	no	**10**	**15**	**25**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined strictly to mucosa	yes	no	**30**	**35**	**45**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined strictly to mucosa		yes	**50**	**55**	**65**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes: no*	*yes*
tumor extends to or involves:		
soft palate	**70**	**80**
gingiva	**71**	**81**
buccal mucosa	**72**	**82**
palatine bone	**73**	**83**
more than one (70–73) or (80–83)	**74**	**84**
tumor has crossed midline	**75**	**85**
more than one (70–74) or (80–84) and 75 or 85	**79**	**89**

FURTHER DIRECT EXTENSION		
tumor erosion through maxillary bone	**90**	**–0**
nasal cavity	**91**	**–1**
maxillary antrum (sinus)	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: retropharyngeal; upper deep jugular chain; submaxillary; "upper cervical" NOS

NOTE: Bone tumors are to be classified under bone.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of hard palate.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 retropharyngeal.
2 upper deep jugular chain.
3 submaxillary.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Hard Palate consists of semilunar area between the upper alveolar ridges and the mucous membrane covering the palatine process of maxillary palatine bones. It extends from the inner surface of the superior alveolar ridge to the posterior edge of the palatine bone.

CARCINOMA IN SITU **Carcinoma in situ 0**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 or more*	*Size not known*
confined strictly to mucosa	no	no	**10**	**15**	**25**
musculature is involved	no	no	**11**	**16**	**26**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined strictly to mucosa	yes	no	**30**	**35**	**45**
musculature is involved	yes	no	**31**	**36**	**46**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined strictly to mucosa		yes	**50**	**55**	**65**
musculature is involved		yes	**51**	**56**	**66**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
tumor extends onto or infiltrates:		
hard palate	**70**	**80**
gingiva	**71**	**81**
buccal mucosa	**72**	**82**
lateral pharyngeal wall (tonsillar pillar or fossa)	**73**	**83**
more than one (70–73) or (80–83)	**74**	**84**
tumor crosses midline	**75**	**85**
more than one (70–74) or (80–84) and 75 or 85	**79**	**89**

FURTHER DIRECT EXTENSION	
tongue	**90** **–0**
base of tongue	**91** **–1**
nasopharynx or nasal cavity	**92** **–2**
bone of the hard palate (palatine bone)	**93** **–3**
maxilla	**95** **–5**
mandible	**96** **–6**
more than one (90–96) or (–0 thru –6)	**99** **–9**

DISTANT INVOLVEMENT	
distant site involvement	**&1** **&6**
distant lymph node involvement	**&2** **&7**
distant site and distant lymph node involvement	**&3** **&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: submaxillary; upper deep jugular chain; "upper cervical" NOS

NOTE: Tumors originating in midline (including uvula) will be identified by use of & as the second digit throughout the entire scheme on this page.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of soft palate.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 submaxillary.
2 upper deep jugular chain.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G secondary mass or satellite nodule in oral cavity.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Soft Palate consists of mucosa covering the oral cavity side of the palatine muscles and extends from the posterior edge of the hard palate to the free border of the soft palate and includes the uvula. Its superior lateral margin is the pterygomandibular raphe. The inferior lateral margin completes the faucial arch (glossopalatine arch) and includes the anterior surface of the anterior tonsillar pillar.

CARCINOMA IN SITU			Carcinoma in situ 0–
PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor is not fixed and is limited to:			
posterior wall	no	no	10
lateral wall	no	no	12
anterior wall	no	no	15
"localized", no detailed information	no	no	4–
tumor is not fixed and is limited to:			
posterior wall	yes	no	30
lateral wall	yes	no	32
anterior wall	yes	no	35
"localized", no detailed information	yes	no	39
tumor is not fixed and is limited to:			
posterior wall		yes	50
lateral wall		yes	52
anterior wall		yes	55
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
tumor is not fixed, but extends from:		
posterior wall into lateral wall	70	80
lateral wall into posterior wall	72	82
anterior wall into lateral wall	75	85
any combination of above, regardless of origin	79	89

FURTHER DIRECT EXTENSION		
tumor is not fixed, but extends from:		
posterior wall into prevertebral fascia	90	–0
posterior wall into neck	91	–1
lateral wall into neck	92	–2
lateral wall into prevertebral fascia	93	–3
lateral wall into base of tongue, pyriform sinus, or soft palate	94	–4
anterior wall into base of tongue	95	–5
anterior wall into larynx	96	–6
anterior wall into pyriform sinus or neck	97	–7
any combination of above, regardless of origin	98	–8
tumor is fixed	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: upper deep jugular chain; posterior cervical; "upper cervical" NOS

NOTE: The walls are approximately 0.3 millimeters thick and because of the infiltrating nature of these tumors, fixation of the tumor may be early.

If the lower part of the lateral wall is involved, there could be extension into the base of tongue or pyriform sinus.

If the upper part of the lateral wall is involved, there could be extension into the soft palate.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of oral mesopharynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 posterior cervical.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
G involvement of posterior and both lateral walls.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definitions for anatomic site will apply:

Posterior Wall:	Extends from free borders of the soft palate to the tip of the epiglottis.
Lateral Wall:	Includes the tonsillar pillars, tonsillar fossa and contents.
Anterior Wall:	Consists of the lingual surface of the epiglottis and the folds of the mucosa which bound the vallecula.

CARCINOMA IN SITU — Carcinoma in situ **0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor is not fixed and is limited to:			
posterior superior wall (vault)	no	no	**10**
lateral wall	no	no	**14**
"localized", no detailed information	no	no	**4–**
tumor is not fixed and is limited to:			
posterior superior wall (vault)	yes	no	**30**
lateral wall	yes	no	**34**
"localized", no detailed information	yes	no	**39**
tumor is not fixed and is limited to:			
posterior superior wall (vault)		yes	**50**
lateral wall		yes	**54**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION

	Involvement of regional lymph nodes	
	no	*yes*
tumor is not fixed, but extends from:		
posterior superior wall (vault) into lateral wall	**70**	**80**
lateral wall into posterior superior wall (vault)	**74**	**84**
lateral wall into middle ear	**75**	**85**

FURTHER DIRECT EXTENSION

tumor is not fixed, but extends from posterior superior wall (vault) into:	nasal cavity or oropharynx	**90**	**–0**
	bone (including skull)	**91**	**–1**
	brain	**92**	**–2**
	pterygopalatine fossa	**93**	**–3**
tumor is not fixed, but extends from lateral wall into:	nasal cavity	**94**	**–4**
	oropharynx	**95**	**–5**
	bone or pterygopalatine fossa	**96**	**–6**
	brain	**97**	**–7**
any combination of above, regardless of origin		**98**	**–8**
tumor is fixed		**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: upper deep jugular chain; retropharyngeal; "upper cervical" NOS

NOTE: In general, since the majority of cases of epidermoid carcinoma of the lateral wall of the nasopharynx have their origin at or near the opening of the eustachian tube, involvement of the eustachian tube is assumed and will be coded 14, 34, or 54.

Fixation of the tumor may be early.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of nasopharynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 retropharyngeal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definitions of anatomic limits will apply:

Posterior Superior Wall (vault): Extends from superior border of choana, inferiorly, to level of free border of soft palate; lateral limit is the groove between lateral wall and base of skull.

Lateral Wall: Extends from base of skull on each side, inferiorly, to level of free border of soft palate.

CARCINOMA IN SITU			Carcinoma in situ 0–
PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor is not fixed and is limited to:			
pyriform sinus	no	no	**10**
post-cricoid area	no	no	**13**
posterior pharyngeal wall	no	no	**16**
"localized", no detailed information	no	no	**4–**
tumor is not fixed and is limited to:			
pyriform sinus	yes	no	**30**
post-cricoid area	yes	no	**33**
posterior pharyngeal wall	yes	no	**36**
"localized", no detailed information	yes	no	**39**
tumor is not fixed and is limited to:			
pyriform sinus		yes	**50**
post-cricoid area		yes	**53**
posterior pharyngeal wall		yes	**56**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
tumor is not fixed, but extends from:		
pyriform sinus into posterior pharyngeal wall	**70**	**80**
pyriform sinus into post-cricoid area	**71**	**81**
post-cricoid area into pyriform sinus	**73**	**83**
post-cricoid area into posterior pharyngeal wall	**75**	**85**
posterior pharyngeal wall into pyriform sinus	**76**	**86**
posterior pharyngeal wall into post-cricoid area	**77**	**87**
any combination of above, regardless of origin	**79**	**89**
FURTHER DIRECT EXTENSION		
tumor is not fixed, but extends from:		
pyriform sinus into larynx	**90**	**–0**
pyriform sinus into soft tissue of the neck	**91**	**–1**
pyriform sinus into prevertebral muscle	**92**	**–2**
post-cricoid area into larynx	**93**	**–3**
post-cricoid area into prevertebral muscle	**95**	**–5**
posterior pharyngeal wall into prevertebral muscle	**96**	**–6**
posterior pharyngeal wall into soft tissue of the neck	**97**	**–7**
any combination of above, regardless of origin	**98**	**–8**
tumor is fixed	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: upper deep jugular chain; retropharyngeal; "upper cervical" NOS

NOTE: Fixation of the tumor may be early.
"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of hypopharynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 retropharyngeal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 5, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definitions of anatomic limits will apply:

Pyriform Sinus:	Bounded superiorly by the pharyngoepiglottic fold, anteriolaterally between the inner surface of the thyroid cartilage and the posterior lateral surface of the arytenoid and cricoid cartilages. Inferiorly, it extends to the upper edge of the esophagus.
Post-Cricoid Area:	Posterior surface of the larynx. It extends from the posterior surface of the arytenoid cartilages and their connecting folds to the inferior surface of the cricoid. The lateral margin is the anterior part of the pyriform sinus.
Posterior Pharyngeal Wall:	Extends from the level of the tip of the epiglottis superiorly, down to the inferior margin of the cricoid cartilage; and laterally to the posterior margins of the pyriform sinus.

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined strictly to mucosa of upper third	no	no	10
confined strictly to mucosa, but extends to middle third	no	no	11
muscularis is involved, but not beyond	no	no	12
"localized", no detailed information	no	no	4–
confined strictly to mucosa of upper third	yes	no	30
confined strictly to mucosa, but extends to middle third	yes	no	31
muscularis is involved, but not beyond	yes	no	32
"localized", no detailed information	yes	no	39
confined strictly to mucosa of upper third		yes	50
confined strictly to mucosa, but extends to middle third		yes	51
muscularis is involved, but not beyond		yes	52
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
adventitia and/or adjacent soft tissue	70	80
major blood vessels	71	81
thyroid	72	82
more than one (70–72) or (80–82)	79	89

FURTHER DIRECT EXTENSION		
trachea	90	–0
carina	91	–1
larynx	92	–2
hypopharynx	93	–3
vertebrae, by direct extension	95	–5
more than one (90–95) or (–0 thru –5)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): nodes immediately adjacent to esophagus ("local nodes"); upper deep jugular chain; superior mediastinal; "upper cervical" NOS

NOTE: The esophagus has no serosa and when adherent to other tissues, the full thickness of the wall has been penetrated and is fixed. This condition will probably be coded in the appropriate 10, 30, or 50 series.

In histopathologically proved carcinoma, laryngeal nerve paralysis will be coded in the & series.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 nodes immediately adjacent to esophagus ("local nodes").
2 upper deep jugular chain.
3 superior mediastinal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: "Synonyms" used for hilar nodes: tracheobronchial, carinal, bronchial, nodes of the pulmonary roots.

CARCINOMA IN SITU	Carcinoma in situ	0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined strictly to mucosa of middle third	no	no	**10**
confined strictly to mucosa, but extends to other section(s)	no	no	**11**
muscularis is involved, but not beyond	no	no	**12**
"localized", no detailed information	no	no	**4–**
confined strictly to mucosa of middle third	yes	no	**30**
confined strictly to mucosa, but extends to other section(s)	yes	no	**31**
muscularis is involved, but not beyond	yes	no	**32**
"localized", no detailed information	yes	no	**39**
confined strictly to mucosa of middle third		yes	**50**
confined strictly to mucosa, but extends to other section(s)		yes	**51**
muscularis is involved, but not beyond		yes	**52**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
adventitia and/or adjacent soft tissue (including diaphragm)	**70**	**80**
major blood vessels	**71**	**81**
trachea	**72**	**82**
carina	**73**	**83**
bronchi	**75**	**85**
more than one (70–75) or (80–85)	**79**	**89**
FURTHER DIRECT EXTENSION		
lung via bronchi	**90**	**–0**
ribs	**91**	**–1**
vertebrae	**92**	**–2**
mediastinal structures, NOS (including pleura)	**95**	**–5**
more than one (90–95) or (–0 thru –5)	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): nodes immediately adjacent to esophagus ("local nodes"); hilar; peribronchial.

"Synonyms" used for hilar nodes: tracheobronchial, carinal, bronchial, nodes of the pulmonary roots.

NOTE: The esophagus has no serosa and when adherent to other tissues, the full thickness of the wall has been penetrated and is fixed. This condition will probably be coded in the appropriate 10, 30, or 50 series.

In histologically proved carcinoma, laryngeal nerve paralysis will be coded in the & series.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 nodes immediately adjacent to esophagus ("local nodes").
2 hilar.
3 peribronchial.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)"

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: "Synonyms" used for hilar nodes: tracheobronchial, carinal, bronchial, nodes of the pulmonary roots.

CARCINOMA IN SITU — Carcinoma in situ 0

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined strictly to mucosa of lower third	no	no	10
confined strictly to mucosa, but extends to middle third	no	no	11
muscularis is involved, but not beyond	no	no	12
"localized", no detailed information	no	no	4–
confined strictly to mucosa of lower third	yes	no	30
confined strictly to mucosa, but extends to middle third	yes	no	31
muscularis is involved, but not beyond	yes	no	32
"localized", no detailed information	yes	no	39
confined strictly to mucosa of lower third		yes	50
confined strictly to mucosa, but extends to middle third		yes	51
muscularis is involved, but not beyond		yes	52
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
adventitia and/or adjacent soft tissue	70	80
stomach	71	81
diaphragm	72	82
major blood vessels	73	83
more than one (70–73) or (80–83)	79	89

FURTHER DIRECT EXTENSION

any direct extension other than (70–79) or (80–89)	90	–0

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): paraesophageal; periesophageal; mediastinal, including diaphragmatic nodes at hiatus; nodes immediately adjacent to the lesser curvature of the stomach.

NOTE: The esophagus has no serosa and when adherent to other tissues, the full thickness of the wall has been penetrated and is fixed. This condition will probably be coded in the appropriate 10, 30, or 50 series.

In histologically proved carcinoma, "diaphragm is fixed" means the phrenic nerve is destroyed and will be coded in the & series.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 paraesophageal or periesophageal.
2 mediastinal, including diaphragmatic nodes at hiatus.
3 nodes immediately adjacent to the lesser curvature of the stomach.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)"

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU **Carcinoma in situ 0**

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 to 3.9*	*4 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	10	15	20	25
muscularis is invaded	no	no	11	16	21	26
serosa involved, but not beyond	no	no	12	17	22	27
diffuse involvement of stomach wall**	no	no	13	18	23	28
"localized", no detailed information	no	no	14	19	24	4–
confined to mucosa and submucosa	yes	no	30	35	40	45
muscularis is invaded	yes	no	31	36	41	46
serosa involved, but not beyond	yes	no	32	37	42	47
diffuse involvement of stomach wall**	yes	no	33	38	43	48
"localized", no detailed information	yes	no	34	39	44	49
confined to mucosa and submucosa	yes	yes	50	55	60	65
muscularis is invaded	yes	yes	51	56	61	66
serosa involved, but not beyond	yes	yes	52	57	62	67
diffuse involvement of stomach wall**	yes	yes	53	58	63	68
no detailed information of above	yes	yes	54	59	64	69

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes*	
no invasion of peritoneum, but direct extension into duodenum	70	80
no invasion of peritoneum, but direct extension into distal esophagus	71	81
no invasion of peritoneum, but direct extension into duodenum and distal esophagus	74	84
secondary area of tumor within stomach (including implant)	75	85
more than one (70–74) or (80–84) and 75 or 85	79	89
involvement of:		
immediately adjacent tissue ONLY	90	–0
spleen and/or diaphragm	91	–1
implants on outer surface of stomach	92	–2
duodenum via serosa (or not stated)	93	–3
transverse colon including both flexures	94	–4
other areas of small intestine	95	–5
omentum (lesser or greater)	96	–6
pancreas	97	–7
left lobe of liver by direct extension	98	–8
more than one (91–98) or (–1 thru –8)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): nodes of the greater omentum; nodes immediately adjacent to the lesser curvature of the stomach; nodes of the hilus of the spleen; gastrointestinal nodes, NOS

NOTE: "Immediately adjacent tissue" will include adipose tissue, connective tissue, etc.

Adherence to neighboring organs or tissues may be inflammatory reaction, but in the absence of additional information, would probably be coded "extension thru muscularis and/or serosa, but not beyond".

* If primary is not excised, gross description at surgery, G.I. series films, or reports of scope examinations will be acceptable.

** Diffuse involvement takes priority over other conditions in the 10–60 series.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 nodes of the greater omentum.
2 nodes immediately adjacent to the lesser curvature of the stomach.
3 nodes of the hilus of the spleen.
5 gastrointestinal nodes, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; presence of "rectal shelf"; malignant cells in pleural or ascitic fluid.
G ovary (Krukenberg tumor); satellite nodules or secondary masses within stomach.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU — **Carcinoma in situ** **0**

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa and:					
limited to the first portion	no	no	**10**	**15**	**25**
limited to the second portion	no	no	**11**	**16**	**26**
limited to the third portion	no	no	**12**	**17**	**27**
limited to the fourth portion	no	no	**13**	**18**	**28**
more than one portion involved or "localized", no detailed information	no	no	**14**	**19**	**4–**
confined to mucosa and submucosa and:					
limited to the first portion	yes	no	**30**	**35**	**45**
limited to the second portion	yes	no	**31**	**36**	**46**
limited to the third portion	yes	no	**32**	**37**	**47**
limited to the fourth portion	yes	no	**33**	**38**	**48**
more than one portion involved or "localized", no detailed information	yes	no	**34**	**39**	**49**
confined to mucosa and submucosa and:					
limited to the first portion		yes	**50**	**55**	**65**
limited to the second portion		yes	**51**	**56**	**66**
limited to the third portion		yes	**52**	**57**	**67**
limited to the fourth portion		yes	**53**	**58**	**68**
more than one portion involved or no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
adjacent tissue, NOS	**70**	**80**
bile ducts, including ampulla of Vater	**71**	**81**
pancreatic duct	**72**	**82**
pancreas	**73**	**83**
adjacent mesentery, including mesenteric fat	**75**	**85**
more than one (70–75) or (80–85)	**79**	**89**
FURTHER DIRECT EXTENSION		
transverse colon	**90**	**–0**
greater omentum (including omentum NOS)	**91**	**–1**
liver	**92**	**–2**
kidney	**93**	**–3**
major blood vessels	**95**	**–5**
more than one (90–95) or (–0 thru –5)	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (*first chain of drainage*): pancreaticoduodenal

NOTE: First portion is the Superior Portion (also called duodenal bulb).
Second portion is the Descending Portion.
Third portion is the Horizontal Portion (also called Transverse Portion).
Fourth portion is the Ascending Portion.

* If primary is not excised, gross description at surgery or G. I. series films will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 pancreaticoduodenal.
7 ***fixed*** pancreaticoduodenal lymph node.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU		
	on any part of an (adenomatous) polyp	01
	specified as sessile, "wall" only, no mention of polyp	02
	not specified as above, carcinoma in situ NOS	0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	10	15	25
muscularis is invaded	no	no	11	16	26
extension thru muscularis and/or serosa, but not beyond	no	no	12	17	27
any of the above, with intraluminal involvement of jejunum and ileum**	no	no	13	18	28
"localized", no detailed information	no	no	14	19	4–
confined to mucosa and submucosa	yes	no	30	35	45
muscularis is invaded	yes	no	31	36	46
extension thru muscularis and/or serosa, but not beyond	no	no	32	37	47
any of the above, with intraluminal involvement of jejunum and ileum**	yes	no	33	38	48
"localized", no detailed information	yes	no	34	39	49
confined to mucosa and submucosa		yes	50	55	65
muscularis is invaded		yes	51	56	66
extension thru muscularis and/or serosa, but not beyond		yes	52	57	67
any of the above, with intraluminal involvement of jejunum and ileum**		yes	53	58	68
no detailed information of above		yes	54	59	69

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:		*Involvement of regional lymph nodes* no	yes
no invasion of peritoneum, but direct extension into	adjacent tissue, NOS	70	80
	ileocecal valve from ileum	71	81
	duodenum from jejunum	72	82
	mesentery, including mesenteric fat	73	83
	more than one (70–73) or (80–83)	79	89
involvement of: other loop of small intestine		90	–0
large intestine, including appendix		91	–1
bladder		92	–2
uterus, ovaries, fallopian tubes		93	–3
abdominal wall		95	–5
retroperitoneum		96	–6
more than one (90–96) or (–0 thru –6)		99	–9
DISTANT INVOLVEMENT			
distant site involvement		&1	&6
distant lymph node involvement		&2	&7
distant site and distant lymph node involvement		&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage):
jejunum, ileum: mesenteric
terminal ileum (ileocecal area): ileocolic; posterior cecal

NOTE: Involvement of the ileocecal valve from an ileum primary may have distant node involvement.

* If primary is not excised, gross description at surgery or G. I. series films will be acceptable.

** This refers to a contiguous growth ONLY.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE FOR THIS SITE (first chain of drainage). NO DISTANT INVOLVEMENT.

1 mesenteric for jejunum and ileum, excluding terminal ileum (ileocecal area).*
2 ileocolic for terminal ileum (ileocecal area) only.*
3 posterior cecal for terminal ileum (ileocecal area) only.*
6 more than one of the above categories—2, 3 for terminal ileum (ileocecal area only).
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesentery; malignant cells in pleural fluid.
G extensive involvement of contiguous structures or tissues, including blood vessels, nerve trunks, perineural lymphatics, skeletal muscles.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

* Mesenteric lymph node is to be considered a distant node for terminal ileum (ileocecal area).

Ileocolic lymph node is to be considered a distant node for jejunum and ileum, excluding terminal ileum (ileocecal area).

Posterior cecal lymph node is to be considered a distant node for jejunum and ileum, excluding terminal ileum (ileocecal area).

FIELD 0—EXTENT OF DISEASE
Columns 34–35

ASCENDING COLON 530
CECUM 534

CARCINOMA IN SITU		
on any part of an (adenomatous) polyp		01
specified as sessile, "wall" only, no mention of polyp		02
not specified as above, carcinoma in situ NOS		0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	10	15	25
muscularis is invaded	no	no	11	16	26
extension thru muscularis and/or serosa, but not beyond	no	no	12	17	27
any of the above, with intraluminal extension to other section(s)	no	no	13	18	28
"localized", no detailed information	no	no	14	19	4–
confined to mucosa and submucosa	yes	no	30	35	45
muscularis is invaded	yes	no	31	36	46
extension thru muscularis and/or serosa, but not beyond	yes	no	32	37	47
any of the above, with intraluminal extension of other section(s)	yes	no	33	38	48
"localized", no detailed information	yes	no	34	39	49
confined to mucosa and submucosa		yes	50	55	65
muscularis is invaded		yes	51	56	66
extension thru muscularis and/or serosa, but not beyond		yes	52	57	67
any of the above, with intraluminal extension to other section(s)		yes	53	58	68
no detailed information of above		yes	54	59	69

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes: no*	*yes*
no invasion of peritoneum, but direct extension into appendix from cecum primary	70	80
no invasion of peritoneum, but direct extension into adjacent tissues, NOS	71	81
no invasion of peritoneum, but direct extension into mesentery, including mesenteric fat	72	82
no invasion of peritoneum, but direct extension into more than one of above	74	84
implants inside the large intestine	75	85
more than one (70–74) or (80–84) and 75 or 85	79	89
involvement of: small intestine	90	–0
involvement of: greater omentum	91	–1
involvement of: liver (by direct extension)	92	–2
involvement of: uterus	93	–3
involvement of: ovary and/or fallopian tube	95	–5
involvement of: more than one (90–95) or (–1 thru –5)	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage). 530: right colic; middle colic; superior mesenteric. 534: ileocolic (cecal)

NOTE: Adherence to neighboring organs or tissues may be inflammatory reaction, but, in the absence of additional information, would probably be coded "extension thru muscularis and/or serosa, but not beyond".

Intraluminal extension into ileum from the cecum is to be coded 90 or –0 in the absence of additional involvement. This does not include ileocecal tumors, 536.

* If primary is not excised, gross description at surgery, G. I. series films, or report of scope examinations will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 right colic.
2 middle colic.
3 superior mesenteric.
4 ileocolic (cecal)—only for subsite 534.
6 more than one of above categories—1, 2, 3, 4.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
G extensive involvement of contiguous structures or tissues, including blood vessels, nerve trunks, perineural lymphatics, skeletal muscles, right kidney or ureter.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU	on any part of an (adenomatous) polyp	01
	specified as sessile, "wall" only, no mention of polyp	02
	not specified as above, carcinoma in situ NOS	0–

PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	**Size of primary tumor (Path. Dept. Statement *)** *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	**10**	**15**	**25**
muscularis is invaded	no	no	**11**	**16**	**26**
extension thru muscularis and/or serosa, but not beyond	no	no	**12**	**17**	**27**
any of above, with intraluminal extension to other section(s)	no	no	**13**	**18**	**28**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined to mucosa and submucosa	yes	no	**30**	**35**	**45**
muscularis is invaded	yes	no	**31**	**36**	**46**
extension thru muscularis and/or serosa, but not beyond	yes	no	**32**	**37**	**47**
any of above, with intraluminal extension to other section(s)	yes	no	**33**	**38**	**48**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined to mucosa and submucosa		yes	**50**	**55**	**65**
muscularis is invaded		yes	**51**	**56**	**66**
extension thru muscularis and/or serosa, but not beyond		yes	**52**	**57**	**67**
any of above, with intraluminal extension to other section(s)		yes	**53**	**58**	**68**
no detailed information of above		yes	**54**	**59**	**69**

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes: no*	*yes*
no invasion of peritoneum, but direct extension into: adjacent tissues, NOS	**70**	**80**
no invasion of peritoneum, but direct extension into: mesentery, including mesenteric fat	**71**	**81**
no invasion of peritoneum, but direct extension into: greater omentum	**72**	**82**
no invasion of peritoneum, but direct extension into: more than one of above	**74**	**84**
implants inside the large intestine	**75**	**85**
more than one (70–74) or (80–84) and 75 or 85	**79**	**89**
involvement of:		
spleen	**90**	**–0**
stomach	**91**	**–1**
pancreas	**92**	**–2**
kidney(s)	**93**	**–3**
liver (by direct extension)	**95**	**–5**
small intestine	**96**	**–6**
more than one (90–96) or (–0 thru –6)	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): right and middle colic for hepatic flexure; middle colic for transverse colon; left colic for splenic flexure.

Right colic lymph node is to be considered a distant node for splenic flexure and transverse colon; middle colic lymph node is to be considered a distant node for splenic flexure; left colic lymph node is to be considered a distant node for hepatic flexure and transverse colon.

NOTE: Adherence to neighboring organs or tissues may be inflammatory reaction, but, in the absence of additional information, would probably be coded "extension thru muscularis and/or serosa, but not beyond".

Intraluminal extension to ascending colon from hepatic flexure or extension to descending colon from splenic flexure may have distant node involvement.

* If primary is not excised, gross description at surgery, G. I. series films, or reports of scope examinations will be acceptable.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 right colic for hepatic flexure only.*
2 middle colic for hepatic flexure (use 3 when transverse colon is primary site).*
3 middle colic for transverse colon (use 2 when hepatic flexure is primary site).*
4 left colic for splenic flexure only.*
6 more than one of the above categories—1, 2 for hepatic flexure primary only.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
G extensive involvement of contiguous structures or tissues, including blood vessels, nerve trunks, perineural lymphatics, skeletal muscles.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

* Right colic lymph node is to be considered a distant node for splenic flexure and transverse colon.
Middle colic lymph node is to be considered a distant node for splenic flexure.
Left colic lymph node is to be considered a distant node for hepatic flexure and transverse colon.

CARCINOMA IN SITU	on any part of an (adenomatous) polyp	01
	specified as sessile, "wall" only, no mention of polyp	02
	not specified as above, carcinoma in situ NOS	0–

PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	**Size of primary tumor (Path. Dept. Statement *)** *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	10	15	25
muscularis is invaded	no	no	11	16	26
extension thru muscularis and/or serosa, but not beyond	no	no	12	17	27
any of above, with intraluminal extension to other section(s)	no	no	13	18	28
"localized", no detailed information	no	no	14	19	4–
confined to mucosa and submucosa	yes	no	30	35	45
muscularis is invaded	yes	no	31	36	46
extension thru muscularis and/or serosa, but not beyond	yes	no	32	37	47
any of above, with intraluminal extension to other section(s)	yes	no	33	38	48
"localized", no detailed information	yes	no	34	39	49
confined to mucosa and submucosa		yes	50	55	65
muscularis is invaded		yes	51	56	66
extension thru muscularis and/or serosa, but not beyond		yes	52	57	67
any of above, with intraluminal extension to other section(s)		yes	53	58	68
no detailed information of above		yes	54	59	69

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes* — *no*	*yes*
no invasion of peritoneum, but direct extension into adjacent tissues, NOS	70	80
no invasion of peritoneum, but direct extension into mesentery, including mesenteric fat	71	81
no invasion of peritoneum, but direct extension into more than one of the above	74	84
implants inside the large intestine	75	85
more than one (70–74) or (80–84) and 75 or 85	79	89
involvement of:		
spleen	90	–0
small intestine	91	–1
uterus	92	–2
ovary and/or fallopian tube	93	–3
more than one (90–93) or (–0 thru –3)	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): left colic; inferior mesenteric

NOTE: Adherence to neighboring organs or tissues may be inflammatory reaction, but, in the absence of additional information, would probably be coded "extension thru mucularis and/or serosa, but not beyond".

Intraluminal extension to splenic flexure from descending colon or to rectosigmoid from sigmoid colon may have distant node involvement.

* If primary is not excised, gross description at surgery, G. I. series films, or reports of scope examinations will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 left colic.
3 inferior mesenteric.
6 more than one of the above categories—1, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
G extensive involvement of contiguous structures or tissues, including blood vessels, nerve trunks, perineural lymphatics, skeletal muscles, left kidney or left ureter.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU			Carcinoma in situ		0–
PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** ***Primary Tumor Description***	***Local Vessel Invasion***	***Regional Lymph Nodes***	**Size of primary tumor (Path. Dept. Statement *)** *Less than 1 cm.*	*1 cm. or more*	*Size not known*
incidental finding of malignancy in hemorrhoid and no other involvement	–	–	**10**	**10**	**10**
confined to anal mucosa and submucosa	no	no	**11**	**15**	**25**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined to anal mucosa and submucosa	yes	no	**31**	**35**	**45**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined to anal mucosa and submucosa		yes	**51**	**55**	**65**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
rectal mucosa or submucosa	**70**	**80**
perianal skin	**71**	**81**
muscles	**72**	**82**
ischiorectal fat	**73**	**83**
more than one (70–73) or (80–83)	**79**	**89**

FURTHER DIRECT EXTENSION		
prostate	**90**	**–0**
perineum and/or vulva	**91**	**–1**
bladder	**92**	**–2**
vagina and/or cervix	**93**	**–3**
broad ligaments and/or uterus	**95**	**–5**
urethra	**96**	**–6**
more than one (90–96) or (–0 thru –6)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage); anorectal; local nodes adjacent to rectum (perirectal); inguinal

NOTE: Malignant melanoma of anus should be classified according to the scheme for "Malignant Melanoma of the Skin" and coded 542 in Field K.

* If primary is not excised, gross description at surgery, G. I. series films, or reports of scope examinations will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 anorectal.
2 local nodes adjacent to rectum (perirectal).
3 inguinal.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU		
on any part of an (adenomatous) polyp		01
specified as sessile, "wall" only, no mention of polyp		02
not specified as above, carcinoma in situ NOS		0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Path. Dept. Statement *) *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	10	15	25
muscularis is invaded	no	no	11	16	26
extends thru muscularis and/or serosa, but not beyond	no	no	12	17	27
any of above, with intraluminal extension to other section(s)	no	no	13	18	28
"localized", no detailed information	no	no	14	19	4–
confined to mucosa and submucosa	yes	no	30	35	45
muscularis is invaded	yes	no	31	36	46
extends thru muscularis and/or serosa, but not beyond	yes	no	32	37	47
any of above, with intraluminal extension to other section(s)	yes	no	33	38	48
"localized", no detailed information	yes	no	34	39	49
confined to mucosa and submucosa		yes	50	55	65
muscularis is invaded		yes	51	56	66
extends thru muscularis and/or serosa, but not beyond		yes	52	57	67
any of above, with intraluminal extension to other section(s)		yes	53	58	68
no detailed information of above		yes	54	59	69

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	 *yes*
immediately adjacent tissue, including perirectal fat	70	80
deep infiltration of surrounding tissues	71	81
infiltration of surrounding tissues, NOS	79	89
FURTHER DIRECT EXTENSION		
cervix	90	–0
uterus	91	–1
bladder	92	–2
prostate and/or ductus deferens or seminal vesicle	93	–3
vagina	95	–5
urethra	96	–6
skeletal muscles	97	–7
bones of pelvis	98	–8
more than one (90–98) or (–0 thru –8)	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): perirectal (local nodes immediately adjacent to rectum); sigmoid mesenteric nodes; left colic nodes

NOTE: In general, adenocarcinoma will be of rectal origin; epidermoid carcinoma will be of anal origin.

Intraluminal extension from rectum to anus may have distant node involvement.

* If primary is not excised, gross description at surgery, G. I. series films, or reports of scope examinations will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 perirectal ("local nodes" adjacent to rectum).
2 sigmoid mesenteric nodes.
3 left colic nodes.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
G involvement of blood vessels, nerve trunks, perineural lymphatics, or free peritoneal cavity (cul-de-sac).
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU	
on any part of an (adenomatous) polyp	**01**
specified as sessile, "wall" only, no mention of polyp	**02**
not specified as above, carcinoma in situ NOS	**0–**

PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	**Size of primary tumor (Path. Dept. Statement *)** *2 cm. or less*	*2.1 cm. or more*	*Size not known*
confined to mucosa and submucosa	no	no	**10**	**15**	**25**
muscularis is invaded	no	no	**11**	**16**	**26**
extension thru muscularis and/or serosa, but not beyond	no	no	**12**	**17**	**27**
any of above, with intraluminal extension to other section(s)	no	no	**13**	**18**	**28**
"localized", no detailed information	no	no	**14**	**19**	**4–**
confined to mucosa and submucosa	yes	no	**30**	**35**	**45**
muscularis is invaded	yes	no	**31**	**36**	**46**
extension thru muscularis and/or serosa, but not beyond	yes	no	**32**	**37**	**47**
any of above, with intraluminal extension to other section(s)	yes	no	**33**	**38**	**48**
"localized", no detailed information	yes	no	**34**	**39**	**49**
confined to mucosa and submucosa		yes	**50**	**55**	**65**
muscularis is invaded		yes	**51**	**56**	**66**
extension thru muscularis and/or serosa, but not beyond		yes	**52**	**57**	**67**
any of above, with intraluminal extension to other section(s)		yes	**53**	**58**	**68**
no detailed information of above		yes	**54**	**59**	**69**

TUMOR HAS EXTENDED TO, INVADED OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes: no*	*yes*
no invasion of peritoneum, but direct extension into perirectal fat	**70**	**80**
no invasion of peritoneum, but direct extension into mesentery, including its nerves, lymphatics	**71**	**81**
no invasion of peritoneum, but direct extension into more than one (70–71) or (80–81)	**79**	**89**
involvement of: intestines (other than intraluminal)	**90**	**–0**
involvement of: bladder	**91**	**–1**
involvement of: uterus	**92**	**–2**
involvement of: ovary and/or fallopian tubes	**93**	**–3**
involvement of: prostate	**95**	**–5**
involvement of: more than one (90–95) or (–0 thru –5)	**99**	**–9**
DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): perirectal ("local nodes" immediately adjacent to the rectum); sigmoid mesenteric nodes

NOTE: Intraluminal extension from rectosigmoid to sigmoid or extension from rectosigmoid to rectum may have distant node involvement.

* If primary is not excised, gross description at surgery, G. I. series films, or reports of scope examinations will be acceptable.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 Perirectal ("local nodes" immediately adjacent to the rectum).
2 sigmoid mesenteric.
6 more than one of the above categories—1, 2.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesentery; malignant cells in pleural or ascitic fluid.
G seeding of neighboring organs or tissues in the peritoneal cavity and/or involvement of the free peritoneal cavity (cul-de-sac).
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU			Carcinoma in situ 0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to mucosa and submucosa	no	no	**10**
muscularis is invaded	no	no	**11**
extension through muscularis and/or serosa, but not beyond	no	no	**12**
"localized", no detailed information	no	no	**4–**
confined to mucosa and submucosa	yes	*no*	**30**
muscularis is invaded	yes	no	**31**
extension through muscularis and/or serosa, but not beyond	yes	no	**32**
"localized", no detailed information	yes	no	**39**
confined to mucosa and submucosa		yes	**50**
muscularis is invaded		yes	**51**
extension through muscularis and/or serosa, but not beyond	yes	yes	**52**
no detailed information of above		yes	**59**

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes*	
	no	*yes*
tumor extension into:		
liver	**70**	**80**
bile ducts	**71**	**81**
liver and bile ducts	**74**	**84**
bile ducts, further to pancreas	**75**	**85**
(70 & 75) or (80 & 85)	**79**	**89**
involvement of:		
small intestine	**90**	**–0**
large intestine	**91**	**–1**
stomach	**92**	**–2**
pancreas (other than 75 or 85)	**93**	**–3**
greater omentum	**95**	**–5**
more than one (90–95) or (–0 thru –5)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): cystic nodes; nodes along the portal vein *(periportal)*; *nodes along head of pancreas*

NOTE: The statement "gallbladder is replaced by tumor" indicates there is extension into the liver and is to be coded 70 or 80 in the absence of additional data regarding further involvement.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 cystic node.
2 nodes along the portal vein (periportal).
3 nodes along head of pancreas.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)" or cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G seeding of gallbladder, neighboring organs (other than liver), peritoneum, portal vein, or hepatic artery.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor confined to bile ducts	no	no	**10**
"localized", no detailed information	no	no	**4–**
tumor confined to bile ducts	yes	no	**30**
"localized", no detailed information	yes	no	**39**
tumor confined to bile ducts		yes	**50**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
involvement of:		
duodenum	**70**	**80**
gallbladder	**71**	**81**
pancreas	**72**	**82**
liver	**73**	**83**
more than one (70–73) or (80–83)	**79**	**89**

FURTHER DIRECT EXTENSION

any direct extension greater than (70–79) or 80–89)	**90**	**–0**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): cystic node; nodes along portal vein (periportal); pancreaticoduodenal

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 cystic node.
2 nodes along portal vein (periportal).
3 pancreaticoduodenal.
6 more than one of the above categories—1, 2, 3.
7 and ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)" or "gastrointestinal lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
single lesion, confined to one lobe	no	no	**10**
satellite nodules confined to lobe of primary lesion	no	no	**15**
"localized to one lobe", no detailed information	no	no	**4–**
single lesion, confined to one lobe	yes	no	**30**
satellite nodules confined to lobe of primary lesion	yes	no	**35**
"localized to one lobe", no detailed information	yes	no	**39**
single lesion, confined to one lobe		yes	**50**
satellite nodules confined to lobe of primary lesion		yes	**55**
one lobe involved, no detailed information		yes	**59**

TUMOR HAS EXTENDED TO OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes*	
	no	*yes*
involvement of:		
two lobes by contiguous growth	**70**	**80**
gallbladder from right lobe (when right lobe is primary site)	**71**	**81**
satellite nodules of liver*	**75**	**85**
more than one (70–75) or (80–85)	**79**	**89**

FURTHER DIRECT EXTENSION

major blood vessels	**90**	**–0**
extrahepatic duct(s)	**91**	**–1**
diaphragm	**92**	**–2**
pleura	**93**	**–3**
more than one (90–93) or (–0 thru –3)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): nodes of the hepatic pedicle; nodes of the inferior vena cava; nodes of the hepatic artery; coronary chain nodes; nodes of the renal artery; pericardial nodes; juxtaphrenic nodes of the posterior mediastinum

NOTE: Jaundice per se does not mean extension of disease beyond one lobe of liver.

* Include surface nodules as well as parenchymal nodules.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE FOR THIS SITE (first chain of drainage). NO DISTANT INVOLVEMENT.

1 nodes of the hepatic pedicle.
nodes of the inferior vena cava.
2 nodes of the hepatic artery.
3 coronary chain nodes.
4 nodes of the renal artery.
5 pericardial nodes.
juxtaphrenic nodes of the posterior mediastinum.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph nodes (takes precedence over 1, 2, 3, 4, 5, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; surface implants on the intestinal tract, peritoneum, or mesenteries; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to head of pancreas, WITHOUT obstruction of bile duct(s)	no	no	**10**
confined to head of pancreas, WITH obstruction of bile duct(s)	no	no	**11**
body of pancreas is involved (with or without bile duct obstruction)	no	no	**12**
"localized", no detailed information	no	no	**4–**
confined to head of pancreas, WITHOUT obstruction of bile duct(s)	yes	no	**30**
confined to head of pancreas, WITH obstruction of bile duct(s)	yes	no	**31**
body of pancreas is involved (with or without bile duct obstruction)	yes	no	**32**
"localized", no detailed information	yes	no	**39**
confined to head of pancreas, WITHOUT obstruction of bile duct(s)		yes	**50**
confined to head of pancreas, WITH obstruction of bile duct(s)		yes	**51**
body of pancreas is involved (with or without bile duct obstruction)		yes	**52**
no detailed information of above		yes	**59**

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes* *no*	*yes*
tumor extension into:		
bile duct(s)	**70**	**80**
doudenum	**71**	**81**
area of stomach adjacent to pancreas	**72**	**82**
more than one (70–72) or (80-82)	**79**	**89**
involvement of:		
liver (by direct extension)	**90**	**–0**
transverse colon	**91**	**–1**
omentum	**92**	**–2**
gallbladder	**93**	**–3**
body of stomach	**95–**	**–5–**
more than one (90–95) or (–0 thru –5)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): pancreaticoduodenal; celiac; upper retroperitoneal

NOTE: Bile duct obstruction in the 10 thru 50 series means the ducts are *obstructed* by tumor, but there is no invasion of tumor into the bile duct.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 pancreaticoduodenal.
2 celiac.
3 upper retroperitoneal.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G involvement of contiguous structures or tissues including blood vessels, nerve trunks, perineural lymphatics, ligaments, kidneys, adrenals, small intestine; tumor is fixed.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to body and/or tail	no	no	**10**
head of pancreas is involved	no	no	**11**
"localized", no detailed information	no	no	**4–**
confined to body and/or tail	yes	no	**30**
head of pancreas is involved	yes	no	**31**
"localized", no detailed information	yes	no	**39**
confined to body and/or tail		yes	**50**
head of pancreas is involved		yes	**51**
no detailed information of above		yes	**59**

TUMOR HAS EXTENDED TO, INVADED OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes*	
	no	*yes*
direct extension into:		
kidney	**70**	**80**
spleen	**71**	**81**
left suprarenal gland	**72**	**82**
retroperitoneal soft tissue (space)	**73**	**83**
more than one (70–73) or (80–83)	**79**	**89**
involvement of		
stomach	**90**	**–0**
adjacent mesenteries, including mesenteric fat	**91**	**–1**
liver (by direct extension)	**92**	**–2**
gallbladder	**93**	**–3**
small intestine	**95**	**–5**
more than one (90–95) or (–0 thru –5)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): upper retroperitoneal

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper retroperitoneal.
7 ***fixed*** upper retroperitoneal lymph node(s).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G involvement of contiguous structures or tissues including blood vessels, nerve trunks, perineural lymphatics.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU **Carcinoma in situ 0**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor confined to:			
laryngeal surface of epiglottis	no	no	10
an aryepiglottic fold	no	no	11
an arytenoid (including laryngeal cartilage)	no	no	12
a ventricular cavity	no	no	13
a ventricular band	no	no	15
more than one (10–15), ipsilateral	no	no	16
"localized", no detailed information	no	no	4–
tumor confined to:			
laryngeal surface of epiglottis	yes	no	30
an aryepiglottic fold	yes	no	31
an arytenoid (including laryngeal cartilage)	yes	no	32
a ventricular cavity	yes	no	33
a ventricular band	yes	no	35
more than one (30–35), ipsilateral	yes	no	36
"localized", no detailed information	yes	no	39
tumor confined to:			
laryngeal surface of epiglottis		yes	50
an aryepiglottic fold		yes	51
an arytenoid (including laryngeal cartilage)		yes	52
a ventricular cavity		yes	53
a ventricular band		yes	55
more than one (50–55), ipsilateral		yes	56
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes: no*	*yes*
tumor involving epiglottis and extending bilaterally to:		
ventricular bands	70	80
ventricular cavities	71	81
ventricular bands and cavities	74	84
tumor extends onto cord(s)	75	85
more than one (70–74) or (80–84) and 75 or 85	79	89

FURTHER DIRECT EXTENSION		
thyroid cartilage	90	–0
pyriform sinus	91	–1
postcricoid region	92	–2
vallecula	93	–3
base of tongue	95	–5
more than one (90–95) or (–0 thru –5)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: upper deep jugular chain; prelaryngeal; pretracheal; "upper cervical" NOS

NOTE: "Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of supraglottic larynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 prelaryngeal.
3 pretracheal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8 and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definitions for anatomic site will apply:

Supraglottic: posterior surface of the epiglottis, including the tip of the epiglottis and aryepiglottic fold (marginal zone)
arytenoid (right and left)
ventricular bands (false cords, right and left)
ventricular cavities (right and left)

CARCINOMA IN SITU			
		Carcinoma in situ	0

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
normal motility of cords and:			
tumor involves one cord	no	no	10
tumor involves both cords	no	no	11
"localized", no detailed information	no	no	4–
normal motility of cords and:			
tumor involves one cord	yes	no	30
tumor involves both cords	yes	no	31
"localized", no detailed information	yes	no	39
normal motility of cords and:			
tumor involves one cord		yes	50
tumor involves both cords		yes	51
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
fixation of cord(s) and:		
tumor involves one cord	70	80
tumor involves both cords	71	81
tumor involves one or both cords with:		
extension to subglottic region	72	82
extension to supraglottic region	73	83
extension to subglottic and supraglottic regions	74	84
no fixation of cord(s) and:		
extension to subglottic region	75	85
extension to supraglottic region	76	86
extension to subglottic and supraglottic regions	79	89

FURTHER DIRECT EXTENSION		
beyond glottis to involve:		
skin	90	–0
pyriform sinus	91	–1
postcricoid region	92	–2
more than one (90–92) or (–0 thru –2)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: upper deep jugular chain; prelaryngeal; pretracheal; "upper cervical" NOS

NOTE: Any loss of motility is to be considered fixation of cord—i.e., "sluggish", partially fixed, etc.

"Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of glottic larynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain.
2 prelaryngeal.
3 pretracheal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definition for anatomic site will apply:

Glottic: true vocal cords (right and left),
anterior glottic commissure.

CARCINOMA IN SITU			Carcinoma in situ 0–
PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
exclusive of undersurface of cord: tumor is limited to one side of subglottic region	no	no	**10**
"localized", no detailed information	no	no	**4–**
exclusive of undersurface of cord: tumor is limited to one side of subglottic region	yes	no	**30**
"localized", no detailed information	yes	no	**39**
exclusive of undersurface of cord: tumor is limited to one side of subglottic region		yes	**50**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	 *yes*
exclusive of undersurface of cord: tumor extends to both sides of subglottic region	**70**	**80**
tumor extends onto cords	**71**	**81**
more than one (70–71) or (80–81)	**79**	**89**

FURTHER DIRECT EXTENSION		
trachea	**90**	**–0**
skin	**91**	**–1**
postcricoid region	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): ipsilateral, bilateral, or contralateral involvement: pretracheal; prelaryngeal; "lower cervical" NOS

NOTE: "Neck" or "neck mass" is to be coded as Distant Involvement.

* See "NOTE" on reverse side for anatomic limits of subglottic larynx.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

2 prelaryngeal.
3 pretracheal.
4 lower cervical, NOS.
6 more than one of the above categories—2, 3, 4.
7 any ***fixed*** regional lymph node (takes precedence over 2, 3, 4, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 2, 3, 4, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)"

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: According to the American Joint Committee for Cancer Staging, the following definitions for anatomic site will apply:

Subglottic: right and left wall of the subglottis, exclusive of undersurface of cord.

CARCINOMA IN SITU **Carcinoma in situ 0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
single tumor within one lobe	no	no	10
multicentric within one lobe	no	no	11
more than one lobe involved with contiguous growth	no	no	12
multicentric within one lung	no	no	13
"localized", no detailed information	no	no	4–
single tumor within one lobe	yes	no	30
multicentric within one lobe	yes	no	31
more than one lobe involved with contiguous growth	yes	no	32
multicentric within one lung	yes	no	33
"localized", no detailed information	yes	no	39
single tumor within one lobe		yes	50
multicentric within one lobe		yes	51
more than one lobe involved with contiguous growth		yes	52
multicentric within one lung		yes	53
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* no	yes
mediastinal or hilar extension, NOS	70	80
main bronchus	71	81
carina	72	82
trachea	73	83
esophagus	75	85
parietal pericardium or pericardium unspecified	76	86
mediastinal blood vessels or nerves	77	87
more than one (70–77) or (80–87)	79	89

FURTHER DIRECT EXTENSION	
visceral pleura (including pleura NOS)	–0
parietal pleura	–1
adjacent rib	–2
chest wall	–3
visceral pericardium	–5
heart	–6
mediastinum	–7
diaphragm	–8
more than one (–0 through –8)	–9

DISTANT INVOLVEMENT	
distant site involvement	&6
distant lymph node involvement	&7
distant site and distant lymph node involvement	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): hilar; mediastinal. "Synonyms" used for hilar nodes: tracheobronchial, carinal, bronchial, nodes of the pulmonary roots.

NOTE: When "hilar mass" or "mediastinal mass" is only description, code 70 or 80. This is usually when it is not clear whether the mass is extension from the lung or matted nodes. Codes 97 and –7 should be used when extension of the primary is specified.

Primary tumor in Main Stem Bronchus will be coded 623 in Field K; 71 or 81 will not be used in coding Field O. Use 4– if limited to Main Stem Bronchus.

Reminder: Column 58 (Paired Organ Involvement).

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 hilar.
2 mediastinal.
6 more than one of the above categories—1, 2.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; malignant cells in pleural fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes 1, 2.
K contralateral involvement of regional lymph nodes 1, 2.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: "Synonyms" used for hilar nodes: tracheobronchial, carinal, bronchial, nodes of the pulmonary roots.

Recurrent laryngeal nerve paralysis may or may not be indicative of tumor involvement and resultant hoarseness of patient. The larynx may be displaced by expansion of the tumor.

CARCINOMA IN SITU		Carcinoma in situ 0–
PAGET'S DISEASE ONLY (no mention of underlying tumor)	Paget's disease confined to nipple	10
	Paget's disease extended beyond nipple	11
	Paget's disease, extent not recorded	12

	*Primary Tumor Size in cm. (Path. Dept. Statement *)*	*No Involvment of Regional Lymph Nodes, but Local Vessel Invasion* no	yes	*Involvement of Regional Lymph Nodes*
PRIMARY TUMOR	Size unknown	20	30	50
NO DIRECT EXTENSION	1.0 or less	21	31	51
NO DISTANT INVOLVEMENT	1.1–2.0	22	32	52
	2.1–3.0	23	33	53
	3.1–4.0	24	34	54
	4.1–5.0	25	35	55
	5.1–6.0	26	36	56
	6.1–7.0	27	37	57
	7.1–8.0	28	38	58
	8.1 or more	29	39	59

SKIN ATTACHMENT. (incomplete fixation)	*Primary Tumor Size in cm. (Path. Dept. Statement *)*	*Involvement of Regional Lymph Nodes* no	yes
	Size unknown	60	80
	1.0 or less	61	81
	1.1–2.0	62	
	2.1–3.0	63	82
	3.1–4.0	64	
	4.1–5.0	65	83
	5.1–6.0	66	
	6.1–7.0	67	84
	7.1–8.0	68	
	8.1 or more	69	

MUSCLE AND/OR CHEST WALL ATTACHMENT (incomplete fixation)	*Primary Tumor Size in cm. (Path. Dept. Statement *)*	*No Involvement of Regional Lymph Nodes, but Attachment to* Pectoral Muscle	Chest Wall	*Involvement of Regional Lymph Nodes*
	Size unknown	70	75	85
	2.0 or less	71	76	86
	2.1–4.0	72	77	87
	4.1–6.0	73	78	88
	6.1 or more	74	79	89

FURTHER DIRECT EXTENSION	*Involvement of regional lymph nodes* no	yes
Complete fixation of skin, skin infiltration, skin ulceration, skin edema, or peau d'orange	90	–0
Chest wall infiltration (including complete fixation)	91	–1
Pectoral muscle infiltration (including fixation to muscle without infiltration)	92	–2
More than one (90–92) or (–0 thru –2)	94	–4
Satellite nodules of skin of breast	97	–7
97 and 90–94, or –7 and any (–0 thru –4)	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): axillary, internal mammary (parasternal). Ipsilateral only; bilateral and contralateral involvement of these nodes is classified as distant node involvement.

NOTE: Use of 078 in Field M will serve to identify "inflammatory carcinoma".

* If primary is not excised, use clinical statement.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.
Ipsilateral and not fixed:

1 axillary, first level (axillary area adjacent to tail of breast)—low axillary.
2 axillary, second level (axillary area beneath the pectoralis minor)—mid axillary.
3 axillary, third level (apex of the axilla)—high axillary.
4 more than one of the above categories—1, 2, 3.
5 axillary NOS.
6 any ***fixed*** axillary node or involvement of axillary tissue surrounding node.
7 any internal mammary (parasternal) node. This has priority over 1, 2, 3, 4, 5.
8 both categories 6 and 7.
9 "regional lymph node(s)" NOS.

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G ovary (may be bilateral).
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J involvement of regional nodes (1–6 above), bilateral.
K involvement of regional nodes (1–6 above), contralateral ONLY.
L supraclavicular lymph node(s) ONLY. Include bilateral and/or contralateral.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: Reminder: Column 58 (Paired Organ Involvement).
Column 59 (Assessment of Regional Nodes).

CARCINOMA IN SITU — Carcinoma in situ **0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
minimal stromal invasion, "micro-invasion" (preclinical)	no	no	**10**
tumor confined strictly to cervix	no	no	**12**
"localized", no detailed information	no	no	**4–**
minimal stromal invasion, "micro-invasion" (preclinical)	yes	no	**30**
tumor confined strictly to cervix	yes	no	**32**
"localized", no detailed information	yes	no	**39**
minimal stromal invasion, "micro-invasion" (preclinical)		yes	**50**
tumor confined strictly to cervix		yes	**52**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
body of uterus *without* infiltration of parametrium	**70**	**80**
upper two-thirds of vaginal wall * *without* infiltration of parametrium	**71**	**81**
both of above (70–71) and (80-81)	**74**	**84**
parametrium only	**75**	**85**
body of uterus *with* infiltration of parametrium	**77**	**87**
upper two-thirds of vaginal wall * *with* infiltration of parametrium	**78**	**88**
both of above (77–78) and (87–88)	**79**	**89**

FURTHER DIRECT EXTENSION

extension into cul-de-sac, but *not* beyond	**90**	**–0**
pelvic wall	**91**	**–1**
uterosacral ligaments	**92**	**–2**
bladder and/or ureter	**93**	**–3**
rectum	**95**	**–5**
lower one-third of vagina	**96**	**–6**
vulva	**97**	**–7**
more than one (91–97) or (–1 thru –7)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): common iliac; internal iliac (hypogastric); external iliac; obturator; parametrial

NOTE: For non-surgical cases, code "clinically palpable nodes" as 5&.

"Attachment to pelvic wall" is to be coded 91 or –1.

When pathology report states "carcinoma in situ with micro-invasion", code as 10.

Fornices are considered a part of the upper two-thirds of the vagina.

Endo-cervix is considered part of the cervix uteri.

* Including "vaginal wall" NOS.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 common iliac.
2 internal iliac (hypogastric).
3 external iliac.
4 obturator.
5 parametrial
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 5, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; nodularity or implants on vaginal wall; any peritoneal involvement; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU — pre-invasive; carcinoma in situ — 0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Pathologic grade classification *I*	*II*	*III–IV*	*Not specified*
confined to endometrium only	no	no	10	15	20	25
halfway or less thru myometrium*	no	no	11	16	21	26
more than halfway thru myometrium	no	no	12	17	22	27
tumor penetrated to serosa	no	no	13	18	23	28
"localized", no detailed information	no	no	14	19	24	4–
confined to endometrium only	yes	no	30	35	40	45
halfway or less thru myometrium*	yes	no	31	36	41	46
more than halfway thru myometrium	yes	no	32	37	42	47
tumor penetrated to serosa	yes	no	33	38	43	48
"localized", no detailed information	yes	no	34	39	44	49
confined to endometrium only		yes	50	55	60	65
halfway or less thru myometrium *		yes	51	56	61	66
more than halfway thru myometrium		yes	52	57	62	67
tumor penetrated to serosa		yes	53	58	63	68
no detailed information of above		yes	54	59	64	69

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
involvement of:		
cervix	70	80
into parametria, but not beyond	71	81
more than one (70–71) or (80–81)	79	89

FURTHER DIRECT EXTENSION		
adjacent organs in pelvic cavity	90	–0
adjacent organs in abdominal cavity	91	–1
vagina	92	–2
vulva	93	–3
bladder	95	–5
rectum	96	–6
more than one (90–96) or (–0 thru –6)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): common iliac; internal iliac (hypogastric); external iliac; obturator

NOTE: The serosa of the uterus is a one-celled layer.

Enlargement of the uterus does not necessarily mean the serosa has been involved.

Female trophoblastic tumors are to be classified in Field O by use of the NON-SPECIFIC CODE.

* Including "involvement of myometrium" NOS.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 common iliac.
2 internal iliac (hypogastric).
3 external iliac.
4 obturator.
6 more than one of the above categories—1, 2, 3, 4.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 6, 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; implants in the pelvic cavity; implants on vagina, vulva, or cervix; malignant cells in pleural or ascitic fluid.
G "uterus is fixed"; involvement of the cul-de-sac.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined strictly to ovarian tissue	no	no	**10**
"localized" to ovarian tissue	no	no	**4–**
confined strictly to ovarian tissue	yes	no	**30**
"localized" to ovarian tissue	yes	no	**39**
confined strictly to ovarian tissue		yes	**50**
no detailed information of above		yes	**59**

TUMOR HAS EXTENDED TO OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes*	
	no	*yes*
local invasion of peritoneum and/or fallopian tube by extension	**70**	**80**
implants on ovary of primary site	**71**	**81**
implants on peritoneum in area immediately adjacent to ovary of primary site	**72**	**82**
more than one (70–72) or (80–82)	**79**	**89**

FURTHER DIRECT EXTENSION

any adjacent extension other than 70 or 80	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): internal iliac (hypogastric); inguinal; external iliac; common iliac, including uterosacral lymph nodes; obturator

NOTE: Ascites should **not** be considered when determining classification of extent of disease unless malignant cells are present.

When specific description such as left ovary, both ovaries, etc. is given, code 10, 30, or 50. If such terms as "ovarian carcinoma" are the only description, use code 4–, 39, or 59.

Reminder: Column 58 (Paired Organ Involvement)

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 internal iliac (hypogastric).
2 inguinal.
3 external iliac.
4 common iliac (including uterosacral lymph nodes).
5 obturator.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 5, 6, 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F malignant cells in pleural or ascitic fluid.
G involvement of cul-de-sac; secondary masses; extensive seeding of neighboring organs or tissues in the peritoneal cavity beyond the immediately adjacent site area.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes—1, 2, 3, 4, 5, 6, 7, 9.
K contralateral involvement of regional lymph nodes—1, 2, 3, 4, 5, 6, 7, 9.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to fallopian tube(s)	no	no	10
"localized", no detailed information	no	no	4–
confined to fallopian tube(s)	yes	no	30
"localized", no detailed information	yes	no	39
confined to fallopian tube(s)		yes	50
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
ovary on side of primary site	70	80
endometrium on side of primary site**	71	81
ovary and endometrium on side of primary site**	79	89

DE

FURTHER DIRECT EXTENSION		
any adjacent extension other than (70–79) or (80–89)	99	–9

DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): internal iliac (hypogastric); inguinal; external iliac; common iliac; obturator

Reminder: Column 58 (paired organ involvement).

* When broad ligament (part of site 751) is the primary site, code Field O by using the appropriate NON-SPECIFIC CODE.

** Including Uterus NOS.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 internal iliac (hypogastric).
2 inguinal.
3 external iliac.
4 common iliac.
5 obturator.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 5, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; extensive seeding of neighboring organs or tissues in the peritoneal cavity; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G secondary masses; involvement of cul-de-sac.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes—1, 2, 3, 4, 5, 6, 7, 9.
K contralateral involvement of regional lymph nodes—1, 2, 3, 4, 5, 6, 7, 9.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

* When broad ligament (part of site 751) is the primary site, code Field O by using the appropriate NON-SPECIFIC CODE.

FIELD O—EXTENT OF DISEASE
Columns 34–35

VULVA*
760

CARCINOMA IN SITU — **Pre-invasive; carcinoma in situ** — **0**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined strictly to mucosa and submucosa	no	no	**10**
muscularis is invaded	no	no	**11**
"localized", no detailed information	no	no	**4–**
confined strictly to mucosa and submucosa	yes	no	**30**
muscularis is invaded	yes	no	**31**
"localized", no detailed information	yes	no	**39**
confined strictly to mucosa and submucosa		yes	**50**
muscularis is invaded		yes	**51**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
involvement of:		
vaginal wall	**70**	**80**
urethral orifice	**71**	**81**
perianal skin or perineum	**72**	**82**
more than one (70–72) or (80–82)	**79**	**89**

FURTHER DIRECT EXTENSION

perineal body	**90**	**–0**
anus	**91**	**–1**
rectal mucosa	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): superficial inguinal (superficial femoral); deep inguinal

NOTE: Malignant melanoma of the vulva should be classified in Field O according to the scheme for "Malignant Melanoma of the Skin" and coded 760 in Field K.

* "Vestibule" or "vestibule of the vagina" is coded 760 in Field K and extent of disease classified using the scheme on this page.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 superficial inguinal (superficial femoral).
2 deep inguinal.
6 more than one of the above categories—1, 2.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

CARCINOMA IN SITU	Pre-invasive; carcinoma in situ	0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to mucosa and submucosa and:			
does not involve more than one-third of the vagina	no	no	**10**
involves more than one-third of the vagina	no	no	**11**
"localized", no detailed information	no	no	**4–**
confined to mucosa and submucosa and:			
does not involve more than one-third of the vagina	yes	no	**30**
involves more than one-third of the vagina	yes	no	**31**
"localized", no detailed information	yes	no	**39**
confined to mucosa and submucosa and:			
does not involve more than one-third of the vagina		yes	**50**
involves more than one-third of the vagina		yes	**51**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes: no*	*yes*
cervix	**70**	**80**
vulva	**71**	**81**
musculature of vagina	**72**	**82**
more than one (70–72) or (80–82)	**74**	**84**
adjacent stroma, NOS	**77**	**87**
more than one (70–74) or (80–84) and 77 or 87	**79**	**89**

FURTHER DIRECT EXTENSION		
paracystium or rectovaginal septum	**90**	**–0**
rectum	**91**	**–1**
bladder	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): external iliac; internal iliac (hypogastric); common iliac

NOTE: "Vestibule" or "vestibule of the vagina" is coded 760 in Field K and extent of disease classified with use of the scheme for vulva.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 external iliac.
2 internal iliac (hypogastric).
3 common iliac.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G fixation of pelvic wall.
H more than one of the above categories—A, B, C, D, E, F, G.
& distant site other than A–G; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

CARCINOMA IN SITU — Carcinoma in situ **0–**

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
confined to prostate and:			
one lobe involved	no	no	**10**
more than one lobe involved	no	no	**11**
prostatic urethra involved	no	no	**12**
"localized", no detailed information	no	no	**4–**
confined to prostate and:			
one lobe involved	yes	no	**30**
more than one lobe involved	yes	no	**31**
prostatic urethra involved	yes	no	**32**
"localized", no detailed information	yes	no	**39**
confined to prostate and:			
one lobe involved		yes	**50**
more than one lobe involved		yes	**51**
prostatic urethra involved		yes	**52**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes*	
	no	*yes*
extension into capsule, but not through capsule	**70–**	**80**
extension through capsule:		
but not beyond*	**71**	**81**
into seminal vesicle(s)	**72**	**82**
into immediately adjacent tissue	**73**	**83**
more than one (71–73) or (81–83)	**79**	**89**

FURTHER DIRECT EXTENSION		
bladder	**90**	**–0**
rectum	**91**	**–1**
skeletal muscles	**92**	**–2**
adjacent bone (including pelvic wall)	**93**	**–3**
more than one (90–93) or (–0 thru –3)	**94**	**–4**
tumor is fixed	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): external iliac; internal iliac (hypogastric); sacral

NOTE: Perineural sheath involvement, "nerve" involvement, perineural lymphatic involvement—all will be coded in the 30 series.

When tumor is thru the capsule, but extent not stated: In the absence of additional information, use NON-SPECIFIC CODE 8–.

Prostatic capsule: The outer capsular layer is made up of connective and elastic tissue, muscle, and an abundant network of nerves.

* Including adherence of organ with no mention of extension beyond capsule.

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 external iliac.
2 internal iliac (hypogastric).
3 sacral.
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *2.0 or less*	*2.1 or more*	*Size not known*
no surface implants and confined strictly by the tunica albuginea	no	no	**10**	**15**	**25**
surface implants of tunica albuginea	no	no	**11**	**16**	**26**
invasion of tunica vaginalis propria	no	no	**12**	**17**	**27**
"localized", no detailed information	no	no	**14**	**19**	**4–**
no surface implants and confined strictly by the tunica albuginea	yes	no	**30**	**35**	**45**
surface implants of tunica albuginea	yes	no	**31**	**36**	**46**
invasion of tunica vaginalis propria	yes	no	**32**	**37**	**47**
"localized", no detailed information	yes	no	**34**	**39**	**49**
no surface implants and confined strictly by the tunica albuginea		yes	**50**	**55**	**65**
surface implants of tunica albuginea		yes	**51**	**56**	**66**
invasion of tunica vaginalis propria		yes	**52**	**57**	**67**
no detailed information of above		yes	**54**	**59**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes: no*	*yes*
ipsilateral scrotal wall without ulceration	**70**	**80**
epididymis	**71**	**81**
spermatic cord	**72**	**82**
more than one (70–72) or (80–82)	**79**	**89**

FURTHER DIRECT EXTENSION		
ulceration of scrotum	**90**	**–0**
invasion of contralateral scrotum	**91**	**–1**
invasion of base of penis	**92**	**–2**
more than one (90–92) or (–0 thru –2)	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): abdominal aortic nodes below level of renal arteries (lower retroperitoneal); external iliac; nodes in the region of the left renal vein; nodes in the region of the inferior mesenteric artery

NOTE: High obstruction of one or both ureters means lymph nodes are involved.

Reminder: Column 58 (Paired Organ Involvement)

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 abdominal aortic nodes below level of renal arteries (lower retroperitoneal).
2 external iliac.
3 nodes in the region of the left renal vein.
4 nodes in the region of the inferior mesenteric artery.
6 more than one of the above categories—1, 2, 3, 4.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes—1, 2, 3, 4, 6, 7, 9.
K contralateral involvement of regional lymph nodes—1, 2, 3, 4, 6, 7, 9.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: High obstruction of one or both ureters means lymph nodes 3 and 4 are involved.

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor is confined strictly to skin of penis and:			
less than 1 cm.	no	no	10
1 cm. or more	no	no	11
"localized", no detailed information	no	no	4–
tumor is confined strictly to skin of penis and:			
less than 1 cm.	yes	no	30
1 cm. or more	yes	no	31
"localized", no detailed information	yes	no	39
tumor is confined strictly to skin of penis and:			
less than 1 cm.		yes	50
1 cm. or more		yes	51
no detailed information of above		yes	59

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:

	Involvement of regional lymph nodes	
	no	*yes*
corpora cavernosa	70	80
urethra	71	81
corpora cavernosa and urethra	74	84
satellite nodules on prepuce and glans	77	87
more than one (70–74) or (80–84) and 77 or 87	79	89

FURTHER DIRECT EXTENSION

skin of abdomen	90	–0
skin of scrotum	91	–1
skin of perineum	92	–2
more than one (90–92) or (–0 thru –2)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): inguinal

NOTE: Malignant melanoma is to be classified in Field O under "Malignant Melanoma of the Skin" and coded 790 in Field K.

Skin of penis is to be classified by use of the scheme on this page.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 inguinal.
7 ***fixed*** inguinal node.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Code
confined to kidney cortex	no	no	10
confined to medulla	no	no	11
involves cortex and medulla	no	no	12
involves medulla and renal pelvis	no	no	13
involves cortex, medulla, and renal pelvis	no	no	15
"localized", no detailed information	no	no	4–
confined to kidney cortex	yes	no	30
confined to medulla	yes	no	31
involves cortex and medulla	yes	no	32
involves medulla and renal pelvis	yes	no	33
involves cortex, medulla, and renal pelvis	yes	no	35
"localized", no detailed information	yes	no	39
confined to kidney cortex		yes	50
confined to medulla		yes	51
involves cortex and medulla		yes	52
involves medulla and renal pelvis		yes	53
involves cortex, medulla, and renal pelvis		yes	55
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION

	Involvement of regional lymph nodes	
	no	*yes*
extrarenal portion of renal vein	70	80
perirenal tissue (fat)	71	81
perirenal veins	72	82
adrenal, ipsilateral	73	83
ureter (may be implant)	77	87
more than one (70–77) or 80–87)	79	89

FURTHER DIRECT EXTENSION

posterior peritoneum	90	–0
adjacent organ(s)	91	–1
diaphragm	92	–2
ribs	93	–3
aorta (renal artery)	95	–5
vena cava	96	–6
hilar blood vessels, NOS	97	–7
more than one (90–97) or (–0 thru –7)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): lateroaortic; hilar (small nodes at the renal pelvis). Ipsilateral only.

NOTE: Subcapsular nodules are to be coded in the 10-50 series when tumor is considered a single primary.

The terms "pelvis" or "pelvic" used in discussion of a kidney tumor always mean *renal pelvis.*

Opposite kidney involvement is considered a distant organ.

Renal vein within Kidney Parenchyma is to be coded in the 30 series in the absence of additional information.

In general, unless specifically stated to the contrary by the pathologist, an adenocarcinoma (hypernephroma, renal cell, clear cell) is considered primary in the renal parenchyma.

Reminder: Column 58 (Paired Organ Involvement)

0 **DOES NOT APPLY. No regional lymph node involvement or distant involvement.**

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 lateroaortic.
2 hilar (small nodes at the renal pelvis).
6 more than one of the above categories—1, 2.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural and ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes—1, 2, 6, 7, 9.
K contralateral involvement of regional lymph nodes—1, 2, 6, 7, 9.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M "retroperitoneal lymph node(s)".
P more than one of the above categories—J, K, L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R **DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT.** Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z **NOT SUBMITTED. Also, no information.**

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Pathologic grade classification *I*	*II*	*III–IV*	*Not specified*
single papilloma, no infiltration	no	no	10	15	20	25
multiple papillary or sessile tumor, no infiltration	no	no	11	16	21	26
multiple or single tumor, confined to mucosa and submucosa	no	no	12	17	22	27
"localized", no detailed information	no	no	14	19	24	4–
multiple or single tumor, confined to mucosa and submucosa	yes	no	32	37	42	47
"localized", no detailed information	yes	no	34	39	44	49
single papilloma, no infiltration		yes	50	55	60	65
multiple papillary or sessile tumor, no infiltration		yes	51	56	61	66
multiple or single tumor, confined to mucosa and submucosa		yes	52	57	62	67
no detailed information of above		yes	54	59	64	69

TUMOR HAS EXTENDED TO, INVADED, OR INFILTRATED THE FOLLOWING:	*Involvement of regional lymph nodes* *no*	*yes*
invasion of muscularis	70	80
extension to connective tissue	71	81
tumor implants distal in ureter	72	82
extension into ureter from renal pelvis primary	73	83
medulla is involved	75	85
kidney cortex and medulla are involved	76	86
only kidney cortex is involved	77	87
involvement of kidney, NOS	78	88
more than one (70–78) or (80–88)	79	89

FURTHER DIRECT EXTENSION

spleen	90	–0
pancreas	91	–1
liver	92	–2
descending colon	93	–3
bladder	95	–5
more than one (90–95) or (–0 thru –5)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): renal hilar for renal pelvis tumors ONLY; periureteral for ureter tumors ONLY

NOTE: Hilum is part of the renal pelvis.

In general, unless specifically stated to the contrary by the pathologist, a transitional cell carcinoma is considered primary in the renal pelvis.

Reminder: Column 58 (Paired Organ Involvement)

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 renal hilar for renal pelvis tumors.
2 periureteral for ureteral tumors.
7 ***fixed*** renal hilar node(s) for renal pelvis tumors; ***fixed*** periureteral node(s) for ureteral tumors.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
G implants in bladder; extension of tumor into bladder via ureter from renal pelvis primary.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

J bilateral involvement of regional lymph nodes—1, 2, 7, 9.
K contralateral involvement of regional lymph nodes—1, 2, 7, 9.
L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
P more than one of the above categories—J, K, L.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

CARCINOMA IN SITU Pre-invasive; carcinoma in situ, either papillary or sessile 0–

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	Pathologic grade classification *I*	*II*	*III–IV*	*Not specified*
single papilloma, no infiltration	no	no	10	15	20	25
multiple papillary or sessile tumor, no infiltration	no	no	11	16	21	26
multiple or single tumor, confined to mucosa and submucosa	no	no	12	17	22	27
"localized", no detailed information	no	no	14	19	24	4–
multiple or single tumor, confined to mucosa and submucosa	yes	no	32	37	42	47
"localized", no detailed information	yes	no	34	39	44	49
single papilloma, no infiltration		yes	50	55	60	65
multiple papillary or sessile tumor no infiltration		yes	51	56	61	66
multiple or single tumor, confined to mucosa and submucosa		yes	52	57	62	67
no detailed information of above		yes	54	59	64	69

INVASION WITHIN BLADDER

superficial invasion of muscle	no	70	71	72	73
deep infiltration of muscle	no	74	75	76	77
involvement of muscle, NOS	no	78	78	79	7&
superficial invasion of muscle	yes	80	81	82	83
deep infiltration of muscle	yes	84	85	86	87
involvement of muscle, NOS	yes	88	88	89	8&

FURTHER DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
surrounding connective tissue (including perivesical fat)	90	–0
prostate gland or parametria	91	–1
ureter	92	–2
other adjacent tissue or organ (including urethra NOS)	93	–3
more than one (90–93) or (–0 thru –3)	94	–4
bladder is fixed	95	–5
tumor extension is fixed, but bladder movable	96	–6
tumor is fixed, NOS	97	–7
more than one (90–97) or (–0 thru –7)	99	–9

DISTANT INVOLVEMENT

distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): perivesical; external iliac; internal iliac (hypogastric)

NOTE: "Superficial invasion" is less than one-half way thru muscular coat.
"Deep infiltration" is one-half way or more thru muscular coat.
"lamina propria" is the middle layer of the muscular coat.

Satellite nodules within the bladder are not to be considered second primary or multiple tumors. This condition is due to vessel invasion within the bladder.

Reminder: Column 60 (Multiplicity). Use greatest extent of disease and highest pathologic grade (even if different lesions) to derive a single composite code for multiple tumors of the first episode.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 perivesical.
2 external iliac.
3 internal iliac (hypogastric).
6 more than one of the above categories—1, 2, 3.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 6, and 9).
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

IN SITU	So-called "superficial melanoma"; in situ	0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	Size of primary tumor (Clinical—in cm.) *Less than 1.0*	*1.0 to 1.9*	*2.0 or more*	*Size not known*
malignant melanotic freckle	no	no	**10**	**15**	**20**	**25**
single lesion, with invasion of:						
upper one-fourth of dermis	no	no	**11**	**16**	**21**	**26**
more than one-fourth of dermis, but confined to dermis	no	no	**12**	**17**	**22**	**27**
confined to dermis, NOS	no	no	**13**	**18**	**23**	**28**
"localized", no detailed information	no	no	**14**	**19**	**24**	**4–**
single lesion, with invasion of:						
upper one-fourth of dermis	yes	no	**31**	**36**	**41**	**46**
more than one-fourth of dermis, but confined to dermis	yes	no	**32**	**37**	**42**	**47**
confined to dermis, NOS	yes	no	**33**	**38**	**43**	**48**
"localized", no detailed information	yes	no	**34**	**39**	**44**	**49**
malignant melanotic freckle		yes	**50**	**55**	**60**	**65**
single lesion, with invasion of:						
upper one-fourth of dermis		yes	**51**	**56**	**61**	**66**
more than one-fourth of dermis, but confined to dermis		yes	**52**	**57**	**62**	**67**
confined to dermis, NOS		yes	**53**	**58**	**63**	**68**
no detailed information of above		yes	**54**	**59**	**64**	**69**

PRIMARY TUMOR HAS PROGRESSED TO INCLUDE:	*Involvement of regional lymph nodes* *no*	*yes*
invasion into subcutaneous tissue (thru entire dermis)	**70**	**80**
ulceration is present	**71**	**81**
more than one (70–71) or (80–81)	**74**	**84**
satellite skin nodule(s) not more than 1 cm. from primary tumor	**75**	**85**
satellite skin nodule(s) 1.1–4.0 cm. from primary tumor	**76**	**86**
(70–74) or (80–84) and (75, 76) or (85, 86)	**79**	**89**

A SKIN METASTASIS MORE THAN 4 CMS. BEYOND MARGIN OF PRIMARY TUMOR BUT CONFINED TO PRIMARY SITE AREA (FIELD K)	**90**	**–0**

DISTANT INVOLVEMENT		
distant site involvement (including skin)*	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): See "Lymph Nodes of Skin" or the reverse side.

NOTE: Malignant melanoma of the vulva, anus, penis are also coded by the scheme on this page.

Metastatic malignant melanoma without a pathologically proved primary lesion:
No regional lymph node involvement 4&
With regional lymph node involvement 6&
Skin metastases in site area 9&.
Distant site or node involvement &&

Examples:
(a) regressing primary lesion with malignant melanoma metastasis.
(b) mole in history, disappeared or scratched off—now area has pathologic evidence of loss of melanin or other indications of the lesion in history.
(c) mole in history excised, no or unknown pathologic diagnosis—now metastic melanoma.

Reminder: Column 60 (Multiplicity).

* If there is a metastatic skin lesion beyond the primary site area (Field K) code as distant.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 first chain of nodes in area of tumor.*
5 upper cervical (for head and neck tumors only).
6 more than one of the above categories—1, 5.
7 any ***fixed*** lymph node in the first chain of regional lymph nodes in area of tumor.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.**
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

LYMPH NODES OF THE SKIN

* preauricular for:
- forehead
- temporal region
- malar region
- lateral half of eyelids
- outer canthus
- anterior half of ear

submaxillary for:
- midline of forehead
- medial half of eyelids
- inner canthus
- nose
- lips
- cheeks

upper deep jugular chain for:
- posterior half of ear

posterior cervical for:
- scapula, above transverse line

cervical for:
- parietal scalp
- occipital scalp

supraclavicular for:
- posterior chest wall

axillary for:
- arm
- anterior chest wall
- scapula, below transverse line

epitrochlear for:
- hand
- forearm

inguinal for:
- lumber region
- anterior abdominal wall
- lower extremities (excluding heel)

popliteal for:
- heel

** Not to be used for posterior chest wall.

CARCINOMA IN SITU — Carcinoma in situ 0–

PRIMARY TUMOR NO DIRECT EXTENSION NO DISTANT INVOLVEMENT *Primary Tumor Description*	*Vessel Invasion Local*	*Regional Lymph Nodes*	Size of primary tumor (Clinical Statement) *Less than 1 cm.*	*1.0 to 1.9*	*2 cm. or more*	*Size not known*
single, freely movable lesion	no	no	**10**	**15**	**20**	**25**
"localized," no detailed information	no	no	**14**	**19**	**24**	**4–**
single, freely movable lesion	yes	no	**30**	**35**	**40**	**45**
"localized," no detailed information	yes	no	**34**	**39**	**44**	**49**
single, freely movable lesion		yes	**50**	**55**	**60**	**65**
no detailed information of above		yes	**54**	**59**	**64**	**69**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
tumor involves subcutaneous tissue, regardless of size	**70**	**80**

FURTHER DIRECT EXTENSION

tumor is fixed to:		
underlying muscle	**90**	**–0**
cartilage	**91**	**–1**
more than one (90–91) or (–0 thru –1)	**94**	**–4**
bone	**99**	**–9**

DISTANT INVOLVEMENT

distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage):

preauricular for:
- forehead
- temporal region
- malar region
- lateral half of eyelids
- outer canthus
- anterior half of ear

submaxillary for:
- midline of forehead
- medial half of eyelids
- inner canthus
- nose
- lips
- cheeks

upper deep jugular chain for:
- posterior half of ear

posterior cervical for:
- scapula, above transverse line

cervical for:
- parietal scalp
- occipital scalp

supraclavicular for:
- posterior chest wall

axillary for:
- arm
- anterior chest wall
- scapula, below transverse line

epitrochlear for:
- hand
- forearm

inguinal for:
- lumbar region
- anterior abdominal wall
- lower extremities (excluding heel)

popliteal for:
- heel

NOTE: Anal canal, anal mucosa, penis, vulva are **not** included in this site for Field K or Field O. These are specific sites.

Perianal skin as primary site is to be coded 541 in Field K and extent of disease coded by use of the NON-SPECIFIC CODE.

If multiple simultaneous skin cancers at first episode, classify greatest involvement of a single lesion.

Skin of ear with involvement of the auricular cartilage and no other involvement should be coded 4–.

Reminder: Field Z (Multiplicity).

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 first chain of nodes in area of tumor.*
5 upper cervical (for head and neck tumors only).
6 more than one of the above categories—1, 5.
7 any ***fixed*** lymph node in the first chain of regional lymph nodes in area of tumor.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.**
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

LYMPH NODES OF THE SKIN

* preauricular for:
- forehead
- temporal region
- malar region
- lateral half of eyelids
- outer canthus
- anterior half of ear

submaxillary for:
- midline of forehead
- medial half of eyelids
- inner canthus
- nose
- lips
- cheeks

upper deep jugular chain for:
- posterior half of ear

posterior cervical for:
- scapula, above transverse line

cervical for:
- parietal scalp
- occipital scalp

supraclavicular for:
- posterior chest wall

axillary for:
- arm
- anterior chest wall
- scapula, below transverse line

epitrochlear for:
- hand
- forearm

inguinal for:
- lumbar region
- anterior abdominal wall
- lower extremities (excluding heel)

popliteal for:
- heel

** Not to be used for posterior chest wall.

CARCINOMA IN SITU			Carcinoma in situ 0–
PRIMARY TUMOR **NO DIRECT EXTENSION** **NO DISTANT INVOLVEMENT** *Primary Tumor Description*	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor with or without capsule:			
single tumor within one lobe	no	no	10
multicentric within one lobe	no	no	11
isthmus is involved	no	no	12
crosses midline, but other lobe *not* involved	no	no	13
both lobes involved with contiguous growth	no	no	15
multicentric within thyroid gland	no	no	16
involvement of capsule of gland	no	no	17
"localized", no detailed information	no	no	4–
tumor with or without capsule:			
single tumor within one lobe	yes*	no	30
multicentric within one lobe	yes*	no	31
isthmus is involved	yes*	no	32
crosses midline, but other lobe *not* involved	yes*	no	33
both lobes involved with contiguous growth	yes*	no	35
multicentric within thyroid gland	yes*	no	36
involvement of capsule of gland	yes*	no	37
"localized", no detailed information	yes*	no	39
tumor with or without capsule:			
single tumor within one lobe		yes	50
multicentric within one lobe		yes	51
isthmus is involved		yes	52
crosses midline, but other lobe *not* involved		yes	53
both lobes involved with contiguous growth		yes	55
multicentric within thyroid gland		yes	56
involvement of capsule of gland		yes	57
no detailed information of above		yes	59

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	 *yes*
thru capsule of gland, but not beyond	70	80
tumor outside capsule of gland into:		
connective tissue	71	81
adjacent muscles (strap muscles)**	72	82
recurrent laryngeal nerve	73	83
more than one (71–73) or (81–83)	79	89
FURTHER DIRECT EXTENSION		
esophagus	90	–0
trachea	91	–1
larynx, including thyroid cartilage and cricoid cartilage	92	–2
blood vessels	93	–3
skeletal muscles	95	–5
bone	96	–6
more than one (90–96) or (–0 thru –6)	97	–7
tumor is fixed	99	–9
DISTANT INVOLVEMENT		
distant site involvement	&1	&6
distant lymph node involvement	&2	&7
distant site and distant lymph node involvement	&3	&8

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): upper deep jugular chain, including single subdigastric node; pretracheal and/or paratracheal; submental and/or submaxillary; retropharyngeal chain; "upper cervical" NOS

* Exclude encapsulated follicular carcinomas with capsular vessel invasion. These should be classified as 10.

** Strap muscles: sternothyroid, omohyoid, sternocleidomastoid

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 upper deep jugular chain including single subdigastric node.
2 pretracheal and/or paratracheal.
3 submental and/or submaxillary.
4 retropharyngeal.
5 upper cervical, NOS.
6 more than one of the above categories—1, 2, 3, 4, 5.
7 any ***fixed*** regional lymph node (takes precedence over 1, 2, 3, 4, 5, 6, 8, and 9).
8 bilateral or contralateral involvement of regional lymph nodes 1, 2, 3, 4, 5, 6, or 9.
9 "regional lymph node(s)" or "cervical lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
M lower cervical, NOS.
P more than one of the above categories—L, M.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

NOTE: Recurrent laryngeal nerve paralysis may or may not be indicative of tumor involvement and resultant hoarseness of patient. The larynx may be displaced by expansion of the tumor.

PRIMARY TUMOR
NO DIRECT EXTENSION
NO DISTANT INVOLVEMENT

Primary Tumor Description	*Local Vessel Invasion*	*Regional Lymph Nodes*	*Code*
tumor within bone, no break in periosteum, and:			
normal configuration of that bone	no	no	**10**
abnormal configuration of that bone	no	no	**11**
"localized", no detailed information	no	no	**4–**
tumor within bone, no break in periosteum, and:			
normal configuration of that bone	yes	no	**30**
abnormal configuration of that bone	yes	no	**31**
"localized", no detailed information	yes	no	**39**
tumor within bone, no break in periosteum, and:			
normal configuration of that bone		yes	**50**
abnormal configuration of that bone		yes	**51**
no detailed information of above		yes	**59**

LIMITED DIRECT EXTENSION	*Involvement of regional lymph nodes* *no*	*yes*
tumor has broken through periosteum:		
but not beyond	**70**	**80**
with extension to surrounding tissue (including skeletal muscle)	**79**	**89**

FURTHER DIRECT EXTENSION		
ulceration of skin	**90**	**–0**
adjacent bone is involved	**91**	**–1**
ulceration of skin and adjacent bone involvement	**99**	**–9**

DISTANT INVOLVEMENT		
distant site involvement	**&1**	**&6**
distant lymph node involvement	**&2**	**&7**
distant site and distant lymph node involvement	**&3**	**&8**

REGIONAL LYMPH NODES FOR THIS SITE (first chain of drainage): first chain of nodes in area of tumor

NOTE: Because of the frequency of lymph node inflammation in bone tumors, only histology should be relied upon when indicating lymph node involvement in 50, 80, —0 series.

The radiologist will usually state whether or not configuration of the bone is normal.

0 DOES NOT APPLY. No regional lymph node involvement or distant involvement.

REGIONAL LYMPH NODE INVOLVEMENT (first chain of drainage). NO DISTANT INVOLVEMENT.

1 first chain of nodes in area of tumor.
7 any ***fixed*** node in first chain of nodes in area of tumor.
9 "regional lymph node(s)".

DISTANT SITE INVOLVEMENT, BUT NO DISTANT LYMPH NODE INVOLVEMENT.

A solitary metastasis in lung tissue.
B lung, other than A; lung NOS.
C liver.
D bone, other than adjacent bone.
E brain.
F implants on pleura; implants in thoracic cavity, NOS; implants on peritoneum; malignant cells in pleural or ascitic fluid.
H more than one of the above categories—A, B, C, D, E, F.
& distant site other than A–F; "distant site" NOS.

DISTANT LYMPH NODE INVOLVEMENT, BUT NO DISTANT SITE INVOLVEMENT.

L supraclavicular lymph node(s) ONLY. This will include fixed or not fixed.
Q "lymph nodes" NOS (assume to be distant unless specified as regional).
– distant lymph node(s), NOS.

R DISTANT SITE AND DISTANT LYMPH NODE INVOLVEMENT. Also includes generalized NOS; distant metastases, NOS; carcinomatosis NOS; sarcomatosis NOS.

Z NOT SUBMITTED. Also, no information.

FIELD 0—EXTENT OF DISEASE
Columns 34–35

LYMPHOMA
000–021

No lymphadenopathy, no evidence of disseminated disease, but clinical diagnosis of lymphoma 0–

LYMPH NODE INVOLVEMENT	*Asymptomatic **	*Symptomatic ***	*Unknown*
involvement above diaphragm only:			
one node	10	20	30
one chain of nodes	11	21	31
two contiguous chains	12	22	32
two or more non-contiguous chains	14	24	34
involvement below diaphragm only:			
one node	15	25	35
one chain of nodes	16	26	36
two contiguous chains	17	27	37
two or more non-contiguous chains	19	29	39
involvement of nodes above and below diaphragm with no visceral or osseus involvement	40	50	60

DISSEMINATED DISEASE	*Involvement of lymph nodes*			
	Above Diaphragm	*Below Diaphragm*	*Above & Below Diaphragm*	*No Node Involvement*
involvement of:				
bone marrow	70	80	90	&0
lung and/or pleura	71	81	91	&1
liver	72	82	92	&2
bone	73	83	93	&3
skin	74	84	94	&4
kidneys	75	85	95	&5
G.I. tract	76	86	96	&6
spleen	77	87	97	&7
other and unspecified (including masses NOS)	78	88	98	&8
more than one (70–78, 80–88, 90–98, &0–&8)	79	89	99	&9

LYMPH NODES: above diaphram: cervical, axillary, mediastinal
below diaphragm: inguinal, abdominal (including retroperitoneal)

NOTE: See Column 36 code on reverse side for nodes not specified above.

Use the NON-SPECIFIC CODE when the only statement regarding extent of disease is "localized", "regional", "distant", or "generalized", or when identification of palpable node(s) is not provided.

* When the only sign of disease is the enlargement of lymph nodes, codes 10–19 or 40 will be used.

** Refer to 1–9 in the column 36 code on reverse side. Use these symptoms to determine coding of 20–29 and 50 in columns 34–35.

0 **DOES NOT APPLY.** Also used with codes 10–19 and 40 in columns 34–35.

SIGNS AND SYMPTOMS—To be used with codes 0–, 20–29 and 50 in columns 34–35

1 dysphagia, anorexia, nausea and vomiting, loss of weight.
2 hemoptysis, hemotemesis, melena, hemorrhage, hematuria, petechia.
3 skin nodules, itching.
4 chills, fever, intermittent fever.
5 blood changes, progressive anemia, pallor.
6 splenomegaly, hepatomegaly.
7 sore throat, enlarged tonsils, lower respiratory disturbances.
8 signs or symptoms other than the above categories—1, 2, 3, 4, 5, 6, 7.
9 more than one of the above categories—1, 2, 3, 4, 5, 6, 7, 8.

LYMPH NODE INVOLVEMENT—To be used with codes 70–99 in columns 34–35

Above Diaphragm (70–79)

A cervical.
D axillary.
G mediastinal.
K cervical, axillary.
N cervical, mediastinal.
R axillary, mediastinal.
U cervical, axillary, mediastinal.
Y other than above categories.
& any fixed lymph node.

Below Diaphragm (80–89)

A abdominal.*
D inguinal.
X abdominal, inguinal.
Y other than above categories.
& any fixed lymph node.

Above and Below Diaphragm (90–99)

A cervical, abdominal.
B cervical, inguinal.
C cervical, abdominal, inguinal.
D axillary, abdominal.
E axillary, inguinal.
F axillary, abdominal, inguinal.
G mediastinal, abdominal.
H mediastinal, inguinal.
J mediastinal, abdominal, inguinal.
K cervical, axillary, abdominal.
L cervical, axillary, inguinal.
M cervical, axillary, abdominal, inguinal.
N cervical, mediastinal, abdominal.
P cervical, mediastinal, inguinal.
Q cervical, mediastinal, abdominal, inguinal.
R axillary, mediastinal, abdominal.
S axillary, mediastinal, inguinal.
T axillary, mediastinal, abdominal, inguinal.
U cervical, axillary, mediastinal, abdominal.
V cervical, axillary, mediastinal, inguinal.
W cervical, axillary, mediastinal, abdominal, inguinal.
Y other than above categories.
& any fixed lymph node.

Z **NOT SUBMITTED. Also, no information.** Also used with Codes 30–39, 60, and &0–&9 in columns 34–35.

* Abdominal includes retroperitoneal.

1967 ERG Code | Instructions for analytic cases

General:

Clinical experience consistently reports longer survival in patients receiving only supportive care than in those receiving no treatment at all. ERG's past data, based solely upon definitive treatment information, could not have separated these two groups of patients since both of them would have been classified only as "no treatment". In this 1967 Code, an attempt is made in Field P to subdivide those receiving no definitive therapy into several sub-groups in order to study possible differences in survival. The code in Field P will also identify those cases who eventually received definitive therapy, but not until after a prior course of non-definitive treatment.

In this first venture into the collection of information concerning symptomatic and supportive therapy, the data are being collected *only* if such treatment is given *before* the first definitive treatment. Supportive therapy received during the same hospitalization as any type of definitive therapy is *excluded.*

A further limitation is shown clearly by the code. The emphasis is upon "bypass surgery". Other supportive therapy is identified separately only in the absence of bypass surgery.

Supportive Treatment:

The phrase "supportive treatment", as used here, refers to all *non-definitive* therapy directed at alleviation of the patient's subjective symptoms and relief from the mechanical effects of the cancer. Usually there is no expectation of reducing the size of the tumor or of delaying the spread of the disease. In effect, it is treatment of the patient and not of the cancer. Its object is to help the patient live longer or more comfortably with his cancer, or to help prepare the patient for definitive therapy.

It should be emphasized that in the ERG system "palliative" is not the same as "non-definitive". Some treatment normally termed palliative (not curative) is coded definitive therapy, as defined on pages DEF–1 to DEF–4, since tumor tissue is removed or destroyed. Surgery or X-ray to a metastatic lesion because of pain may be described as palliative, but constitutes cancer-directed (definitive) therapy according to the ERG definitions. Partial removal of a tumor may also be stated to be palliative, but is coded in Field Q as definitive therapy. A course of definitive radiation or chemotherapy which is "incomplete" must be coded as definitive therapy even if the desired dosage was not achieved. In other words, do not code in Field P any therapy which can be coded in Field Q.

SUPPORTIVE TREATMENT BEFORE DEFINITIVE THERAPY
(Column 37)

1967 ERG Code	Instructions for analytic cases

***Supportive Treatment* (Continued):**

Code:

0	No non-definitive therapy before first definitive therapy
1	Bypass surgery only
2	Bypass surgery and any of the treatments coded 3–7
	No bypass surgery, but
3	surgical procedures only to remove fluid and/or relieve pressure
4	poudrage
5	blood transfusion
6	antibiotics or other non-definitive systemic therapy
7	any combination of codes 3–6
	None of the above, but
8	neurosurgical procedures for the relief of pain
9	Only non-definitive therapy not described above
–	Information not submitted

Note: Code numbers 1–2 take priority over all other codes. Codes 3–7 take precedence over codes 8–9. Code number 8 takes priority over code 9.

Definitions of the categories above will be found on pages P–3 and P–4.

Bypass Surgery (Codes 1 and 2):

"Bypass surgery" is literally that—a surgical procedure that shunts or diverts a passage around the tumor or obstruction associated with the tumor. No cancer is removed, except very incidentally in some cases; often no tissue of any kind is removed. Most bypass procedures are performed to relieve obstructions of the respiratory, gastrointestinal, or urinary systems and are usually called "–ostomies". Examples: colostomy, tracheostomy tube, permanent gastrostomy tube, suprapubic cystostomy, permanent catheter, cholecystojejunostomy, permanent nephrostomy tube, ureterointestinal anastomosis, intestinal anastomoses without removal of tumor tissue, etc. Occasionally bypass procedures are used in treating brain tumors. Examples include the permanent catheter, ventriculocisternostomy.

When "–ostomies" are done as a part of a cancer-removing operation, they are not coded as bypass surgery. A colostomy is a necessary part of an abdominoperineal resection for cancer of the rectum and would not be coded as bypass surgery. In contrast, a cecostomy, performed several weeks in advance of an abdominoperineal resection in order to relieve obstruction before attempting the major surgery, would be coded as bypass surgery. Ureterostomy for bladder, prostate, and other urinary system obstructions would be acceptable as bypass surgery, but not a ureterosigmoidostomy which is part of an exenteration.

Incidentally, none of the bypass procedures necessarily reflects the precise primary site of the tumor.

Surgical procedures only to remove fluid, and/or relieve pressure (Code 3):

Although decompression is often one of the results of bypass surgery, the major objective is to achieve a clear passage and not just to remove the contents accumulating behind the obstruction. There are, however, common surgical procedures whose primary purpose is at least temporary control of pressure by removal of excess fluid. In most cases such procedures are applied at sites where the excess fluid is not the result of an obstruction; but there are instances of obstruction where the fluid is removed and a bypass not attempted (e.g., some brain tumors). Code 3 also includes procedures in which the removal of fluid or fluid tissue is not primarily to control pressure, but to relieve other symptoms.

Included are: paracentesis, thoracentesis, phlebotomy, cranial decompression, and splenectomy (when not considered definitive therapy). The presence or absence of malignant cells in the fluid does not affect the coding of Field P.

This type of treatment is not coded if it is part of a course of definitive therapy.

1967 ERG Code | Instructions for analytic cases

Poudrage (Code 4):

Poudrage is the powdering of a surface (usually the pleura) with talc or other irritating substance to induce adhesions. It may be an adjunct to definitive surgery; if so, it is not coded here.

General remarks concerning Codes 1–4:

The surgical attack upon a specific cancer may on occasion be performed in several stages. At one of these stages cancer tissue is removed or destroyed. The treatment is considered definitive after this particular stage has been attempted, but not until then. If any of the earlier non-definitive stages is performed during a separate hospitalization from that first definitive procedure, the "preliminary" stage of treatment is considered a course of non-definitive therapy and may be coded in Field P. If, however, the various preliminary or non-definitive stages are performed during the same hospitalization as the definitive procedure, all of the therapy is considered one course of definitive treatment and no part of it is coded in Field P.

Blood Transfusion (Code 5):

Code 5 includes transfusion or series of transfusions of any blood component *before* hospitalization for the first course of definitive therapy. In other words, administration of platelets would be coded here as well as a transfusion of whole blood.

Antibiotics or other non-definitive systemic therapy (Code 6):

One important use for code 6 will be the description of supportive therapy for leukemia *before* definitive chemotherapy is given. In this connection, note that some antibiotics such as Actinomycin D are given as definitive therapy and not only to control infection, etc. If the specific antibiotic is classified as definitive (see Appendix 1) do not code its use in Field P.

Neurosurgical procedures for the relief of pain (Code 8):

Measures to control pain are coded only in the absence of the specified supportive measures coded 1–7, and then only if during a hospitalization earlier than the definitive therapy.

Definition of Definitive Treatment:

For the End Results Program the concept of "definitive treatment" is limited to procedures directed toward cancer tissue whether of the primary site or of metastases. If a specific therapy normally affects, controls, changes, removes, or destroys cancer tissue, it is classified as "definitive treatment" even if it cannot be considered "curative" for a particular patient in view of the extent of disease, incompleteness of treatment, lack of apparent response, size of dose, operative mortality, or other criterion.

By "cancer tissue" is meant proliferating malignant cells or an area of active production of malignant cells. In some instances, such as in leukemia, "malignant" cells are commonly found in tissues (peripheral blood, for example) in which they did not originate and in which they do not apparently reproduce. It should be emphasized that a procedure removing "malignant" cells but not attacking a site of proliferation of such cells is not to be considered cancer treatment for the purposes of this program. Such a procedure is more properly classified as symptomatic or supportive therapy. Paracentesis, phlebotomy (for polycythemia vera), and occasionally splenectomy represent procedures that may remove fluids or tissues which contain "malignant" but non-proliferating cells. The spleen, however, is often the site of active production of white cells. Thus, paracentesis and phlebotomy should probably be coded as "No Definitive Treatment" in all cases, but a splenectomy may or may not be coded as definitive treatment according to the best evaluation of the role of the spleen in the disease process of the patient being treated.

The definition includes only "cancer-directed" or definitive therapy and excludes therapy which treats the patient but has no effect on malignant tissue. Treatment solely for the relief of symptoms is therefore excluded. As an example, morphine or other therapy administered *only* for the relief of pain is not considered definitive treatment for this program. In addition, procedures which enable the patient to live longer but do not affect the cancer are not considered definitive treatment. For example, blood transfusions extend the life of the leukemia patient but are not considered treatment directed at neoplastic tissue.

***Definition of Definitive Treatment* (continued):**

The terms "curative" and "palliative" are not germane to the concept of definitive treatment in this program. Nevertheless, some discussion of these terms is necessary since the definition of treatment includes all "curative" therapy but not all "palliative" therapy. The term "palliative" is normally used in two senses; (a) as meaning non-curative, and (b) as meaning the alleviation of symptoms. Some doctors call a procedure which destroys tumor tissue "palliative" if the patient is not completely cured. The same doctors may use the same word to describe a procedure used to relieve pain without any possibility of attacking tumor tissue. Thus, some of the treatments termed palliative fall within the definition of cancer-directed treatment and some are excluded as treating the patient but not the cancer.

It is recognized that in some cases a lay person cannot determine from the medical record whether the treatment falls within the definition since it is not clear whether the treatment was given to attack or control the cancer or only as symptomatic or supportive therapy. Knowledge of dose levels, for example, might be necessary to determine whether in a particular case the hormonal therapy was cancer-directed or supportive. It is important, therefore, that a doctor interpret the medical record in problem cases and aid the registry staff in classifying the treatment received by the patient.

Most patients receive cancer-directed therapy after diagnosis. However, in some instances the diagnosis and the first cancer-directed treatment occur approximately at the same time. For example, an operation yields a surgical specimen from which a diagnosis of cancer is made during or after the operation. In such a case the surgery is properly classified as "treatment" in the End Results Program. There is, on the other hand, a group of patients whose treatment is excluded because it takes place considerably *before* even a presumptive clinical diagnosis of cancer. Such treatment is not classified as cancer-directed even if it might have had an effect on cancerous tissue. Thus, the radiation to a uterine fibroid which is not diagnosed as malignant until several months after the radiation is not considered cancer treatment in this program.

The definition of treatment excludes procedures which are entirely diagnostic and not considered as definitive cancer therapy. This means that any incisional biopsy is not considered treatment any more than is diagnostic X-ray, exploratory surgery, or blood smear. The only time a diagnostic procedure is classified as definitive treatment is when the procedure completely extirpates the tumor. Most excisional skin biopsies fall into this category and are coded as surgery.

***Definition of Definitive Treatment* (continued):**

In summary of the above discussion, the following is the definition of tumor-directed treatment in the End Results Program:

Definitive treatment is restricted to any and all procedures or therapies administered during or after the first clinical diagnosis of cancer, which usually modify, control, remove, or destroy proliferating cancer tissue whether primary or metastatic—regardless of response in a particular patient.

Definitive treatment does not include procedures or therapies which are purely diganostic, symptomatic, or supportive.

Any therapy which is not considered cancer-directed or which does not fall within the definition above is to be classified as "No Definitive Treatment" in Fields Q and R.

It is understood, of course, that it is the treatment actually received by the patient that is coded—not the plan of treatment.

Excluded from Definition of Definitive Treatment—Examples:

The following are examples of diagnostic procedures which do not constitute definitive treatment:

Biopsy, if only part of the tumor is removed

D & C for uterine cancer (dilatation and curettage)

Exploratory Surgery

Diagnostic X-ray

Exfoliative Cytology

The following are examples of supportive or symptomatic therapy which do not constitute definitive treatment:

Catheterization

Plastic Surgery (Reconstructive Surgery)

Surgery which only short-circuits the neoplasm without removing tissue—e.g., colostomy or anastomosis (such as uretero-intestinal transplantation) qualified as not removing tumor tissue.

Chordotomy for cancer of the spinal cord—even if some tumor tissue is removed.

Vasectomy ONLY (no removal of tumor tissue) for tumors of bladder, prostate, testis.

Removal of Fluid—e.g., Paracentesis, Thoracentesis

Blood Transfusions—whether for leukemia or for any other reason.

General Description of Definitive Treatment Code:

The definitive treatment section of the ERG Punchcard is, for analytic cases, divided into two fields, Q and R, which respectively describe the patient's first definitive treatment for this cancer and the treatment subsequent to the first course. For non-analytic cases the definitive treatment section of the punchcard has three fields, P(NA), Q, and R, which respectively represent the definitive treatment prior to admission to the registry system, the first course of treatment after admission, and the subsequent treatment. (Except as covered on page DEF–5 and in the specific instructions for Field P(NA) for non-analytic cases, Field P(NA) will be ignored in this Manual. For the analytic cases, the punchcard columns assigned to Field P(NA) are used for other purposes.)

In general, each of the treatment fields is composed of three punchcard columns each with a different code since each column refers to different types or combinations of therapy. For convenience, the three columns will be referred to as "**a**", "**b**", and "**c**".

Column ***a***, the first column in each field (columns 38 and 41) always identifies the administration of surgery, beam radiation, other radiation, or any combination of these three types of treatment.

Column ***b*** in each field (columns 39 and 42) identifies primarily the use of chemotherapy or treatment for hormonal effect.

The third column ***c***, (columns 40 and 43) designates the specific type of treatment for hormonal effect. Column ***c*** is thus a detailed expansion of one of the elements of column ***b***.

Definitive Treatment Code:*

Column ***a*** (Cols. 38, 41, 35**) Surgery or radiation to cancer tissue

1 Surgery
2 Radiation—beam therapy
3 (1+2) Surgery and beam radiation
4 Radiation—other
5 (1+4) Surgery and other radiation
6 (2+4) Beam radiation and other radiation
7 (1+2+4) Surgery and beam radiation and other radiation
9 Not specified, not recorded, or information unknown
0 None of the above

Column ***b*** (Cols. 39, 42, 36**) Treatment other than surgery or radiation

1 Chemotherapy
2 Hormonal treatment
3 (1+2) Chemotherapy and hormonal treatment
4 Other cancer-directed therapy
5 (1+4) Chemotherapy and other therapy
6 (2+4) Hormonal treatment and other therapy
7 (1+2+4) Chemotherapy and hormonal treatment and other therapy
9 Not specified, not recorded, or information unknown
0 None of the above

Column ***c*** (Cols. 40, 43, 37**) Type of hormonal treatment

1 Hormones, anti-hormones, steroids
2 Endocrine surgery when cancer originates at another site
3 (1+2) Hormones and endocrine surgery
4 Endocrine radiation when cancer originates at another site
5 (1+4) Hormones and endocrine radiation
6 (2+4) Endocrine surgery and endocrine radiation
7 (1+2+4) Hormones and endocrine surgery and endocrine radiation
0 None of the above

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* Note that code 8 in each column is reserved for use by ERS. Also note the discussion of the code items in the pages following.

** Non-analytic cases only. Field P(NA), TUMOR TREATMENT PRIOR TO ADMISSION, is assigned columns 35–37.

Discussion of Items in Definitive Treatment Code*

SURGERY (For removal of cancer tissue)—Code **1** in column **a**:

This category is restricted to surgery which removes cancer tissue. Included are, for example:

Hysterectomy for uterine cancer
Mastectomy for breast cancer
TUR (transurethral resection) *with removal of cancer tissue* for bladder and prostate neoplasms.
Local excision *with removal of cancer tissue* (including excisional biopsy)
Dessication and curettage for bladder and skin neoplasms
Fulguration for bladder and skin neoplasms
Electrocautery
Photocoagulation
Cryosurgery
Chemosurgery
Conization of carcinoma in situ of the cervix
Surgery removing metastatic malignant tissue

Note that wire brush surgery or dermoplaning is not coded as surgery but as "other cancer-directed therapy".

Surgery for removal of cancer tissue has a different code than surgery with hormonal effect. However, often a surgical procedure will fit both categories and can be given both codes. For example, a bilateral oophorectomy as treatment for breast cancer would be coded 022 if the ovaries were free of cancer, but coded 122 if either ovary contained metastatic cancer tissue.

See below under ENDOCRINE SURGERY for the specific rules since there are some instances in which only the removal of cancer tissue is coded. This is usually where the primary cancer is in an endocrine gland so that the site code (Field K) already indicates hormonal implications. In general, the removal of cancer tissue whether primary or secondary is *always* coded; the endocrine surgery may not always be coded.

***Discussion of Items in Definitive Treatment Code* (continued):**

RADIATION—BEAM THERAPY (to cancer tissue)—Code **2** in column **a**:

In this category is included all teletherapy regardless of the source of radiation. Included, for example, is treatment via:

X-ray	Linear Accelerator	Betatron
Cobalt Bomb	Neutron Beam	Spray Radiation

Also included in this category is Radiation NOS—Radiation not specified as to source or method of administration. Such cases should be very rare and usually in reference to therapy administered at an institution which is not the reporting institution.

Radiation for hormonal effect is coded differently than radiation to tumor tissue. Occasionally the radiotherapy can have both purposes and both codes may be indicated. See below under ENDOCRINE RADIATION for specific rules. In a parallel to the coding of endocrine surgery, endocrine radiation may not always be coded, but radiation to affect cancer tissue is always coded.

RADIATION—OTHER (to cancer tissue)—Code **4** in column **a**:

In this category is included all radiation therapy other than beam therapy. Included, for example, is treatment via:

Internal use of radioactive isotopes whether given orally, intracavitarily, interstitially, or by intravenous injection.

All implants, molds, seeds, needles, applicators of radioactive material—such as radium, radon, radioactive gold, etc.

(In Appendix I are references to the therapeutic use of radioactive phosphorus, cobalt, iodine, and gold, as well as to radon and radium. The information in the Appendix summarizes the various cancer sites for which such usage has been attempted in the past as well as information concerning dosage and route of administration.)

The types of radiotherapy included in this code category may on occasion be given for hormonal effect. See section on ENDOCRINE RADIATION for the coding rules.

CHEMOTHERAPY—Code **1** in column **b**; code **0** in column **c**:

In this category is included any chemical which is administered to attack or treat cancer tissue and which is not considered to achieve its effect through change of the hormone balance. Appendix I should be of help in making this classification since it lists separately Endocrine Agents from Oncolytic Agents.

Perfusion is a recently developed technique of administration of chemotherapeutic agents. It should be noted that although a surgeon may be a key person in perfusion therapy, such therapy is not to be coded as surgery or as surgery plus chemotherapy, but just as chemotherapy (010).

***Discussion of Items in Definitive Treatment Code* (continued):**

HORMONAL TREATMENT—Code **2** in column **b**; codes **1–7** in column **c**:

This group of code categories indicates the use of any type of therapy which exercises its effect on cancer tissue via change of the hormone balance of the patient. Thus, included here are the administration of hormones, anti-hormones, or steroids, surgery for hormonal effect on cancer tissue, and radiation for hormonal effect on cancer tissue. These specific types of hormonal treatment are further specified in column **c**. Any treatment or combination of treatments coded 2, 3, 6, or 7 in column **b** should have a specific code in column **c** also; i.e., any code number from 1 through 7, but not 0.

HORMONES, ANTI-HORMONES, STEROIDS—Code **2** in column **b**; code **1** in column **c**:

This category literally includes the agents specified in its title. Primarily it concerns agents which are hormones, have hormonal properties, or which alter the natural production of hormones by the patient.

The list of various types of endocrine agents in Appendix I should be of help to the abstractor.

It should, however, be mentioned that it is only if such agents are given to affect cancer tissue that they are coded in this category. The administration of hormones to replace natural hormones no longer being produced at a normal physiologic level by the patient is usually not considered cancer therapy. If, after removal of the ovaries, female sex hormones are routinely taken by the patient, such added hormones would be considered as treatment of the patient not of the cancer. It may take a doctor's knowledge of dosage levels for the type of compound being administered to code Hormonal Treatment properly.

Ideas change over time. It is appropriate to quote here a statement (April 1963) of the Medical and Technical Advisory Committee in regard to the administration of thyroid extract or dessicated thyroid as tumor-directed therapy: "Within the last one or two years, it has been discovered that the administration of dessicated thyroid to patients who have had total thyroidectomies for carcinoma has a beneficial effect upon any remaining neoplasia. Previously, thyroid extract was given only as substitution or replacement therapy. Thus, previously it would not have been coded as definitive treatment; now it should be coded as hormonal treatment for cancer of the thyroid".

***Discussion of Items in Definitive Treatment Code* (continued):**

ENDOCRINE SURGERY (when cancer originates at another site)—Code **2** in column **b**; code **2** in column **c**:

Endocrine glands may be grouped into those which are single (pituitary, thyroid) and those which are paired (adrenals, ovaries, testes). Removal of the entire gland (if single) or of *both* glands (if paired) is the definition of endocrine surgery here. This will also include the case where the second or remaining gland is removed, the first having been removed or functionally destroyed in the past. Therefore, the partial removal of a single gland or the failure to remove one of a pair of glands will *not* be considered endocrine surgery.

This definition will apply regardless of the reason, purpose, or intent of the treatment.

Endocrine surgery, so defined, will *not* be coded when the cancer is primary in the gland (or pair) removed. The case will be coded as 100, surgery for removal of cancer tissue. This statement holds even if both of a pair of endocrine glands are removed although cancer is present in only one of them. . . . As an example of the typical case, a primary cancer of the thyroid treated by surgical removal of the thyroid is to be coded 100.

Endocrine surgery will be coded only when the cancer is primary *at another site.* Removal of both ovaries as treatment for breast cancer is coded 022. Hypophysectomy (removal of the pituitary) as treatment for thyroid cancer is coded 022.

If the endocrine surgery removes metastatic cancer tissue, the code will be 122 if the primary is at another site. If, however, the primary is in one of a pair with the second of the pair containing malignant tissue considered to be metastatic from the first gland, the code would be 100.

Code 122 will also be the proper code in other situations. For example, if the first treatment for a breast cancer patient was a mastectomy, followed a short time later by a bilateral oophorectomy, the treatment would be coded 122—removal of cancer tissue as well as endocrine surgery.

The "incidental" removal of *both* uninvolved ovaries as well as the uterus from a patient with cancer of the uterus will be coded 122. If the patient had been left with one ovary, the code would be 100.

The coding clerks should be aware of the fact that an ovary may be removed for other reasons than hormonal therapy even when the primary cancer is at another site. For example, a Krukenberg tumor may cause removal of a cancerous ovary assumed to be metastatic from a primary cancer in the gastrointestinal tract. Such surgery would be coded 100 except for the rare case in which both ovaries were removed.

***Discussion of Items in Definitive Treatment Code* (continued):**

ENDOCRINE RADIATION (when cancer originates at another site)—Code **2** in column **b**; code **4** in column **c**:

Endocrine Radiation includes radiation of any type specifically focused on or directed toward an endocrine organ in order to affect cancer tissue by altering the hormonal balance. Radiation of an endocrine gland solely to treat cancer tissue is not considered Endocrine Radiation.

The specific rules concerning single or paired endocrine glands are the same as in endocrine surgery. The rules are identical also concerning when endocrine radiation is to be coded. Endocrine radiation is not coded if the cancer is primary in the glands radiated; such radiation is coded only as radiation to destroy cancer tissue (200, 400, or 600). If the cancer originates at another site, endocrine radiation is coded 024. If there is metastatic cancer present in the endocrine glands being irradiated, the code will identify both radiation to destroy cancer tissue and endocrine radiation—224, 424, or 624 according to the source and method of radiation.

In the absence of further information, any radiation to an endocrine gland which is not the primary site of the cancer is considered to be hormonal treatment rather than direct radiation to cancer tissue. If the other definitional qualifications are satisfied (i.e., treatment of both paired glands) it will be coded as endocrine radiation. If, however, such radiation is incidental to focus on cancer tissue at another site in the same field, the radiation will not be defined or coded as endocrine radiation.

OTHER CANCER-DIRECTED THERAPY—Code **4** in column **b**; code **0** in column **c**:

This category includes any and all cancer-directed therapy that it is not entirely appropriate to assign to the other specific treatment codes. Here is a code to use for any such therapy until there is a specific ruling from the Medical and Technical Advisory Committee. For example, an experimental or newly developed method of treatment differing greatly from commonly accepted types of cancer therapy can be coded here.

At present, this code is used for the following but is not restricted to them:

dermoplaning or wire brush surgery (multiple skin cancer)
hyperbaric oxygen (as adjunct to other definitive treatment)
vaccine therapy
virus therapy

***Discussion of Items in Definitive Treatment Code* (continued):**

NO DEFINITIVE TREATMENT—Code **000**—code **0** in each of columns **a**, **b**, and **c**:

In previous editions, the ERG code attempted to subdivide the "no treatment" group of patients by special punches in columns **a** and **b**. The items requested concerned specific reasons for no definitive treatment including the fact of patient refusal. However, the data obtained were so incomplete as to be worthless. Those codes have been dropped from the 1967 code.

Instead, a different type of subdivision of the "untreated" is being initiated for analytic cases, but in a different code field. For patients receiving no definitive therapy, Field P will identify any non-definitive therapy.

"No definitive treatment" includes the absence of information in the medical record. For analytic cases, lack of information should be coded 0 rather than 9 (unknown); Code 9 has more utility in reference to the previously treated patient with an incomplete medical record.

DOUBLE BLIND CLINICAL TRIALS:

Some of the reporting institutions participate in the conduct of double blind clinical trials of cancer therapy. Whether or not the trials involve adjuvant usage with radiation or surgery, it is likely that until the end of the clinical trial it will be unknown whether a specific drug or a placebo was administered to a particular patient. While the surgery or radiation should be detectable from the record, the coding of column **b** is often impossible. In cases where the trial is between two chemotherapeutic agents or two different hormones, an appropriate code can be found. However, if the trial is between a chemotherapeutic agent and a hormone, or if there is any use of a placebo, one can only code column **b** as 9 (unknown) until the information becomes available. It should be emphasized that registry personnel may have to make a special effort to acquire information at the end of the clinical trial; it might not otherwise be entered into the patient's record.

General:

Field Q contains basic information for most of the studies of cancer therapy planned by the End Results Group. The title "Definitive Treatment—First Course" seems to represent a simple clean clear concept. However, because of frequent lack of precision in medical records, varying capacity and training of lay abstractors, and differing degrees of remoteness from the primary record source, it is not easy to assure similar and comparable classification and coding of this treatment concept. The discussion here is intended to provide guidelines for coding of highly detailed first-hand information as well as indefinite third-hand data.

In the past, "operational definitions" were supplied primarily for central registry coding personnel who were usually working from an abstract rather than the patient's complete medical record. They could not be expected to have an intimate knowledge of the treatment policies of specific doctors or hospital departments. It was thought, however, that personnel in the individual hospital registries would not need such operational definitions since they had the complete medical record and also access to the doctors concerned with the treatment of the cancer patients. Therefore, it was assumed that they could readily apply a more precise definition than central registry personnel and easily distinguish between the first and second course of definitive therapy. Actually neither the availability of the patient's chart nor the supposed ease of gathering more complete information from interested clinicians eliminated the coding problems. The coders were still tempted to "read into" the medical record the clinical judgments and detailed information which had been omitted—and which the coders were not usually qualified even to infer.

Definition of First Course:

Field Q was originally intended to describe the first planned attack upon the cancer, but not to include any treatment given because this first prescribed therapy had failed. If the intended treatment policy consisted of a combination of different modes of therapy, all were to be coded in Field Q. If a statement describing such a planned course of treatment is found in the patient's medical record, it can usually be used as the basis for coding the first course of definitive treatment. There is generally a recognizable period of time before additional or subsequent treatment is necessary.

***Definition of First Course* (continued):**

However, such a statement is not common. From the record it may be almost impossible to detect whether a second type of treatment was originally intended, was later attempted to supplement the first course, or was a new attack upon the cancer process after failure of the first course.

The following rules are, therefore, suggested in the *absence* of precise information in the patient's record. Because of a different time span, it is convenient to separate the coding rules for leukemias from those for other malignancies.

RULES FOR ALL MALIGNANCIES EXCEPT LEUKEMIAS

1. The general rule is that all definitive treatment received by the patient within the ***first four months*** may be coded as first course of therapy.
   a) The four-month period begins when definitive treatment begins—on the date coded in Field I.
   b) All definitive treatment *initiated* during that four-month period may be included. It does not matter if the different modes of therapy are given simultaneously or in sequence.
   c) Intent to cure, control, or palliate does not affect the definition or the coding of definitive therapy; neither does the success or failure of the therapy. However, when failure is indicated it does suggest that all *further* definitive treatment be coded as subsequent therapy.
   d) It does not matter whether all or part of the treatment(s) were received at a reporting institution. The code pertains to the *patient*, not to the institution.
2. For bladder and skin malignancies which are multifocal at the first episode (coded 4–7 in Field Z), the four-month period begins with the date coded in Field I—the date when definitive therapy was directed at any one of the neoplastic areas. If treatment to any of the other cancerous areas is delayed until after the four-month period, such treatment will be coded in Field R as subsequent therapy. In Field Q will be coded all definitive therapy to any or all of the multifocal areas which is *initiated* during the four months beginning with the date in Field I.
3. Since the definition of extent of disease in Field O is related to the definitive treatment coded in Field Q, a summary may be useful here. Field O is defined as the extent of disease at the initiation of tumor-directed therapy as appraised at the first hospital discharge after surgery or at the end of the first series of other treatments.

***Definition of First Course* (continued):**

This definition permits a reassessment of the originally known extent of disease to take cognizance of any manifestations of the disease discovered during the first series of treatments. (See Field O instructions for examples.) Any new information may, of course, be reflected by changes in the prescribed definitive therapy. However, as the definition emphasizes, the code in Field O may not reflect all the knowledge about the extent of disease available by the end of the four-month period—and it should not, since that code is intended to present the extent at the time treatment was determined and not the progress of the disease. The changes in treatment, if any, will be covered by the normal coding of Field Q.

RULES FOR THE CODING OF LEUKEMIAS

1. The rules are essentially the same as for other malignancies except that the basic time period is ***two months*** after the date coded in Field I.
2. When precise information permits, the first course of definitive treatment is to be related to the first "remission" as follows—even in violation of the two-month rule:
   a) If a remission (complete or partial) is achieved during the first chemotherapeutic attack upon the leukemic process, include as first course of treatment
      (1) all definitive therapy considered as "remission inducing" for the first remission, and
      (2) all definitive therapy considered as "remission maintaining" for the first remission.
   b) Consider as subsequent therapy (Field R) all treatment received by the patient after the end ("lapse") of the first remission.
   c) If no remission is attained during the first course of chemotherapy (including combination therapy), use the two-month rule. This rule would apply, therefore, if remission were attained during a later course of therapy or were never achieved. Field Q would cover all definitive therapy initiated within two months after the date in Field I. All later therapy would be summarized in Field R.

Specific:

The code for Field Q will be found on page DEF–5.

Class 1 cases should have the date of first definitive treatment (Field I) associated with the treatment coded in Field Q.

Class 8 cases will be coded 990 in Field Q.

Class 9 cases will be coded 000 in Field Q.

The coding of Class 5 and Class 6 cases is not outlined in this Manual. However, for the sake of completeness it should be mentioned that for such cases Field Q refers to the first definitive therapy received *after the patient was admitted to the registry system* unless coded 9 in Field YY.

1967 ERG Code — Instructions for analytic cases

Definition:

Field R is a *summary* of all definitive treatment initiated *after* the end of the course of definitive treatment coded in Field Q. The end of the first course of definitive therapy was not a factor in the coding of Field Q, but does occasionally become important in the coding of Field R. Sometimes the patient continues to receive definitive therapy such as chemotherapy or hormones for many months—possibly on an out-patient basis. When the first course of treatment continues in this manner, the therapy received after a specific time is considered as "subsequent treatment" and coded in Field R in addition to any other later definitive therapy.

a) For leukemias not achieving remission, the time period is **two months**. In other words, any treatment received more than two months after the date in Field I is subsequent therapy—even if also coded in Field Q.

b) For leukemias achieving remission, Field R contains a summary of all definitive treatment received after lapse of the first remission.

c) For all malignancies except leukemias, the time period is **four months**. And chemotherapy or hormone therapy continuing more than four months after the date in Field I will be included in the Field R summary even if also coded in Field Q.

All subsequent tumor-directed therapy is included in Field R—even if received outside the registry system and known only because of follow-up procedures. Moreover, Field R is in itself a follow-up item. For many cases the code in this field will change from year to year since the most recent treatment will be included.

Since Field R is a summary, the number of courses of subsequent therapy is not relevant to the coding; neither is the effectiveness of therapy.

Specific:

The code for Field R will be found on page DEF–5.

For Class 1 cases with no definitive treatment coded in Field Q, there should also be no definitive treatment coded in Field R. In other words, if code 000 in Field Q, then code 000 in Field R also.

For Class 5 and Class 6 punchcards, Field R is a summary of all definitive therapy received after the course of treatment coded in Field Q.

All Class 8 cases should be coded 990 in Field R.

All Class 9 cases should be coded 000 in Field R.

For all punchcards coded 1–7 in Field Z ("summary punchcards"), Field R contains a summary of definitive therapy (to any or all cancerous areas) received after that coded in Field Q was initiated. This may include first treatment to some of the neoplastic areas which was begun more than four months after first treatment to another area in the same site.

1967 ERG Code — Instructions for all cases

General:

This is a four-digit code, with the first two digits coding the month and the last two digits coding the year of the latest follow-up information—or the date of death. Note that this date is the date pertaining to the information and not the date follow-up inquiry was forwarded or the date the follow-up report was received.

It should be emphasized that the date of last follow-up information should be punched *regardless of the length of time lapsed* between that date and the submission of the deck of punchcards. Even an "up-to-date" punchcard from a Central Registry will often reflect information eighteen months earlier than the date of submission of the punchcard. However, many cards will contain information that is very recent. For some patients there may be no time lapse at all since follow-up information may be received just before the punchcard is prepared.

An entry must appear in this field on each punchcard. If there is no new follow-up information, the entry in Field S will be the same as that on the last punchcard previously submitted for this patient. For the patient for whom no follow-up information was *ever* received, repeat in Field S the date punched in Field I.

This field pertains to the patient not to the cancer. Thus, for a patient with more than one malignancy, all punchcards for that patient should have the same entry in Field S.

Specific:

In columns 44 and 45 code the ***month*** of follow-up or death (01–12) using 99 for unknown month. For example, April is coded 04.

In columns 46 and 47 code the last two digits of the ***year*** of follow-up or death. For example, 1959 would be coded 59. There should be *no* use of 99 in these two columns.

Class 8 and Class 9 cases will indicate in Field S the date of death.

General:

This field summarizes the best *available information* concerning the vital status and the cancer status of the patient as of the date coded in Field S.

For a living patient with history of more than one cancer, the code actually describes the patient rather than any one specific cancer. However, for the dead patient with history of more than one cancer, the code pertains to *this* cancer.

Thus, for the completed case, this field provides a final statement of whether the cancer-specific treatment had been successful. Naturally, therefore, where detailed information from the autopsy is available, it will be utilized in coding Field T.

There must be an entry in this field on every punchcard. If there is no new follow-up information, the code in Field T will be the same as on the last punchcard previously submitted for this patient. If no follow-up information is *ever* received, the patient's status at first discharge from the hospital should be coded in Field T.

Specific:

1 Alive at Last Contact—No Evidence of Cancer
2 Alive at Last Contact—With Any Cancer
3 Alive at Last Contact—Cancer Status Unknown

4 Dead—No Evidence of Cancer at Death
5 Dead—*This* Cancer Present at Death (even if other cancer also present)
6 Dead—No Evidence of This Cancer, but *Another* Cancer Present at Death
7 Dead—Cancer Present at Death, but whether it was This Cancer or Another cannot be established
8 Dead—Indeterminate whether Cancer was Present at Death

For all cases use the best available information. Of course, Class 8 and Class 9 cases must be coded 5 in Field T.

It should be emphasized that death certificates are often in error. If the official death certificate does not indicate the presence of cancer although the registry records demonstrate that the patient had cancer at death, the punchcard is to be coded 5, 6, or 7 in accordance with the registry information. Conversely, a death certificate may indicate cancer but receive no support from registry records. Selection of the best code may depend upon how long before death the last follow-up information was obtained, whether it was based upon a medical examination, whether the death occurred in a registry hospital, and whether the autopsy findings were available to the registry staff. *If the best available information is coded in Field T, there may be no correspondence between the entries in Field T and Field V, Cause of Death.*

1967 ERG Code Instructions for all cases

General:

This is a four digit field which measures survival time from diagnosis in terms of completed years and completed months "left over". The entry in Field U represents the period of time between the date of diagnosis (Field H) and the date of the latest follow-up information (Field S).

Specific:

Columns 49 and 50, the first two digits of Field U, identify the number of **completed years** of survival. A code of 99 would indicate that the amount of survival time was completely unknown and unable to be estimated—an extremely rare situation for a case in the "analytic deck". However, if a code of 99 appears in columns 49 and 50, there should also be a code of 99 in columns 51 and 52.

Columns 51 and 52, the last two digits of Field U, represent the number of **completed months** "left over". Permissible codes are 00–11 and 99. Code 99 represents an unknown number of months survival beyond a precisely known or estimated number of years.

For all "analytic deck" punchcards, the entry in Field U should be consistent with a subtraction of Field H from Field S. "Consistent" here means that a discrepancy of one month is permitted.

If survival time since diagnosis is less than one full month, the code in Field U is 0000.

If one or both of the basic dates of Field H or S are incomplete, coded with a 99 in the month portion of the field, the entry in Field U will be estimated. However, only the years of survival will be estimated; the additional months of survival will be coded as unknown (99). The estimation methods differ slightly according to which date is incomplete:

1. *Diagnosis Date Incomplete; Follow-up Date Complete:*

   Here all is known except the month of diagnosis. In the absence of other information, the month is assumed to be July, Code 07. Estimate the completed years of survival by substituting 07 for 99 in columns 17–18. Enter the estimate in columns 49–50. Enter a 99 in columns 51–52.

   The estimated month is used only for calculations. It is *not* entered on the punchcard instead of the 99 in columns 17–18.

2. *Diagnosis Date Complete; Follow-up Date Incomplete:*

   In this situation the missing item is the month of follow-up. The method of estimation will depend upon the registry follow-up practices and the circumstances of the particular case. Some registries have a different estimation procedure for cases known to be dead with unknown date of death than for cases alive at last information with vague, unrecorded or unknown date. *Please state in the*

***Specific* (continued):**

transmittal letter accompanying the punchcard shipment exactly what is *the usual estimation policy* for this type of case and whether it differs for living or dead cases.

With this type of incomplete information, approximation of survival time involves first obtaining an estimate of the month of follow-up and then using the estimated month in the calculation of completed years of survival. The calculated years of survival are punched in columns 49–50. The months "left over" are not estimated and a 99 is punched in columns 51–52. Incidentally, the estimated month of follow-up is not punched in columns 44–45 which remain coded 99; the estimated month is used only in the calculations.

There are listed here several estimating procedures (for living cases) with indication of the follow-up practice upon which they are based. This is by no means a complete list of ways to estimate the month of followup; it is only illustrative. Your method may not be mentioned.

(a) If follow-up information is obtained only at the time of the "anniversary date" or "basic date", the usual follow-up month for the patient could be used as the estimated month. If, however, the estimation is done on a mass basis as in a system in which all survival time is calculated by an electronic computer, the closest approximation to the anniversary date on the Uniform Punchcard is the date of first definitive treatment (or the date of admission for "old" cases). Therefore, use the entry in columns 21–22 as the estimated month of follow-up.

(b) If additional follow-up sources are used when the normal follow-up procedure is unproductive, the estimation process will be pertinent to the source which yielded the latest information. For example, city directories and telephone street guide directories are used in some registries as a final reference. If a person is listed in one directory but not in the next edition, one can determine the date the earlier directory was prepared (in May for for example) and use that month as the estimate. One state registry, however, using city directories from all over the state does not attempt to discover when each particular directory is prepared, but uses July 1 as a likely mid-year average of all of them—thus, using July as the estimated month in all directory-search cases.

3. *Both Diagnosis and Follow-up Dates are Incomplete:*

For each date the year is known, but the month is unknown. Subtract the year in Field H from the Year in Field S and place the answer in columns 49–50, Punch 99 in columns 51–52.

There must be a punch in each of the columns of this field. If the number of years or months is less than ten, use the zero rather than leaving a column blank. For example, survival time of 7 years and 3 months is coded in Field U as 0703.

For patients having more than one punchcard, Field U is computed separately for each punchcard.

General:

Field V indicates the ICD code for the primary or underlying cause of death *as found on the official death certificate.* Even when the death certificate is believed to be in error, the entry on the death certificate is to be used. Special studies will be undertaken concerning the differences between cause of death as determined from the death certificate and the cause of death according to the best available information. It is possible that as a result of such studies there may be a future change in the definition of this field.

The *International Statistical Classification of Diseases, Injuries, and Causes of Death* published by the World Health Organization is the code for this field. (Abbreviated as ICD) The ICD is revised every ten years; the next revision (the Eighth) is due to take effect in 1968. Since it is very difficult to convert one code to another, the ERG system has been modified so that Field XX (Column 77) will indicate the number of the ICD revision being used. It will not be necessary to change the codes based upon the Seventh Revision; just punch a 7 in column 77.

It is not necessary that the registry see or have in its possession a copy of the death certificate provided that it has information as to the official code for the cause of death. The Vital Statistics Office of some State Health Departments prepares a monthly tabulation by name of deceased which lists the code for cause of death as well as other information about the deceased.

If such official coding is not available to your registry, it is suggested that you follow the same coding rules as the Vital Statistics Office of your State Health Department. Each Vital Statistics Office has a coding procedure to determine which of several diseases mentioned on the death certificate is the primary cause of death. In general, the rules are those of the National Office of Vital Statistics of the U.S. Department of Health, Education and Welfare. The End Results Section will obtain copies of such rules for your registry if you cannot obtain coding assistance from your State Health Department.

Specific:

In Field V the complete four-digit ICD code is used, not three digits as in Field K. Where the ICD does not use the fourth or decimal digit, ERG uses (–) as code for the fourth digit.

For violent or accidental deaths, the E series of ICD is to be used instead of the N series—although the letter is not coded. For example, a death due to suicide by overdose of drugs is assigned ICD category E970 (Seventh Revision) or E950 (Eighth Revision). The ERG codes are 970– and 950–, respectively.

Code these specific situations as follows:	ICD Revision	
	Seventh	Eighth
Patient alive at last contact	0000	6600
Death Certificate available, cause of death unknown	7955	7969
Death Certificate not available	7777	6677
Information not being submitted	6666	6666

General:

This field records the fact that an autopsy was performed and whether the detailed findings were available to the registry personnel. There is no implication that the findings were used in any of the other punchcard fields although it is likely that they may have been used in determining the codes for Fields M, N, or T.

Specific:

0 Alive, does not apply

1 Autopsy performed and information available
2 Autopsy performed, information not available

3 Dead, autopsy known not to have been performed
9 Dead, unknown whether autopsy was performed

1967 ERG Code Instructions for analytic cases

General:

There is need for information just describing the types of involvement that occur when cancer is found in one or both of a set of paired organs. This column is intended to provide such a description without any judgment whether the "second" tumor is a metastasis or a new primary.

In case the reporting registry shall consider right and left tumors as independent primaries and make separate punchcards for each, it is expected that each punchcard shall carry the same code (4–7) in Field X.

This field is a follow-up item for cases coded 1–3.

There are a number of sites for which this code can be useful. In the following list, the sites in **bold** type are those for which Field X coding is also currently requested as a supplement to Field O: **parotid gland, submaxillary gland, tonsil,** eustachian tube, middle ear, maxillary sinus, frontal sinus, pleura, **bronchus, lung, breast, ovary, fallopian tube, testis,** seminal vesicle, **kidney parenchyma, renal pelvis, ureter,** eye, adrenal gland, parathyroid gland, carotid body. It should be noted that lateralization of bone, skin, and soft tissue tumors to different sides of the body or different extremities will not be considered as organ pairs. In addition, right and left colon are not separate organs.

Specific:

0 Not a paired organ, therefore not applicable

1 Right organ involvement only
2 Left organ involvement only
3 Only one organ involved, right or left unspecified
4 Both organs involved simultaneously

5 Left organ involved after previous involvement of right organ
6 Right organ involved after previous involvement of left organ
7 Both organs involved at different time, but unknown which one was first

9 Paired organ, but no information concerning lateral involvement

– Not being submitted

1967 ERG Code	Instructions for analytic cases

General:

In Field O, Extent of Disease, the pathologist's report supersedes the clinician's assessment of regional lymph node involvement if the pathologist makes a definite statement. Since the use of the microscope may be required to distinguish between neoplasia and inflammation or infection, this rule is quite justifiable, However, the clinician's appraisal of the lymph nodes is useful information in itself. Field Y preserves both opinions.

The data in Field Y make possible a closer approximation to the purely clinical TNM rating than does use of Field O alone. In addition, such data permit identification of the cases with palpable regional lymph nodes which were pathologically negative for cancer—a group of patients with considerable study interest.

Specific:

Regional Lymph Node Involvement as Assessed by:

	Pathologist	*Clinician*
0	unknown	unknown
1		not palpable*
2		palpable
3	negative	unknown
4		not palpable
5		palpable
6	positive	unknown
7		not palpable
8		palpable
–	not submitted	

* includes cases clinically localized for which no node specimens were examined.

Field Y is intended as a supplement to Field O for cancers** of Head and Neck, Breast, Skin, and Melanoma of Skin.

** except lymphomas.

1967 ERG Code — Instructions for analytic cases

General:

The phrase "multiple within primary site" means that at some time there were *multiple areas of tumor tissue* of a permissible histology within the organ or sub-organ covered by the site code number. However, in Field Z there is a distinction made between simultaneous multiple tumorous areas at "first episode" and those which occur in the same organ later in life. The emphasis is upon those present at first episode (defined on page Z–3).

There are several common terms or synonyms for concurrent multiple areas of neoplasia in the same organ—"multicentric", "multifocal", "multiple foci of . . . .", etc. If the condition is present, the fact is plainly stated in the patient's record and need not be inferred. If not specified in such a manner, the tumor should be coded as "single focus".

Often the simultaneous presence of multiple areas of tumor tissue within the same primary site creates a problem in deciding whether there are two independent cancers or several manifestations of the same general cancer process. A similar problem arises in determining whether a later appearance of tumor tissue is a recurrence or a new primary. This is important in regard to the preparation of punchcards since the basic ERG rule is that there shall be a separate punchcard for each independent cancer.

Field Z is an attempt to identify cases of multiplicity within certain specified sites by creating a single "summary card".

Authorized Sites:

At the present time the detailed codes of Field Z are requested for only the following authorized sites:

Urinary Bladder: Site codes 810–819; all papillomas, papillary carcinomas, transitional cell carcinomas, epidermoid carcinomas, and "carcinoma NOS".

Skin Melanomas: Site codes 900–909; all malignant melanomas of skin.

Skin, "Other": Site codes 910–919; all malignant basal cell, baso-squamous, and squamous neoplasms, also "carcinoma NOS".

Note that tumors with different histology than those mentioned are not covered and should be represented by separate punchcards like primary cancers of a different site. For example: Adenocarcinoma, syringocarcinoma, lymphosarcoma of skin should be represented by punchcards separate from the one mentioning a squamous cell carcinoma. Similarly, a sarcoma of the bladder should not be represented on the same

1967 ERG Code | Instructions for analytic cases

***Authorized Sites* (continued):**

punchcard as the papillomas and transitional cell carcinomas. As a rough guide, Field Z usage is restricted for the presently authorized sites to histology codes with the first two digits ranging from 11 to 19. It should also be noted that *within the bladder,* at least, it becomes unnecessary to distinguish between a recurrence or a new primary.

At a later time, usage of Field Z may be extended to a few other sites such as the colon and possibly some of the paired organs. However, those situations are more complicated and some pilot studies may be necessary before adequate rules can be devised.

Code:

Single focus at first episode*

0 and no other tumor develops later within the same organ (same major site—same two digit primary site code number).

1 and at later time other tumors appear—*all* within same sub-site as original tumor.

2 and at later time other tumors appear in same organ, at least one of which originates in a different sub-site than original tumor.

3 and at later time other tumors appear in same organ, but their precise location is not specified.

Multiple within same sub-site code number at first episode*

4 and no other tumor develops later within the same organ (same major site—same two digit primary site code number).

5 and at later time other tumors appear—*all* within same sub-site as original tumors.

6 and a later time other tumors appear in same organ, at least one of which originates in a different sub-site than the original tumors.

7 and at later time other tumors appear in same organ, but their precise location is not specified.

9 Code not authorized for this site at time of coding.

– Information not submitted or unknown.

* Substitute "at diagnosis" for "at first episode" if patient never received definitive treatment (000 in Field K).

1967 ERG Code | Instructions for analytic cases

***Code* (continued):**

For the sub-site codes 818, 908, 918 (which indicate presence of tumorous areas originally at more than one sub-site), use codes 4 and 5 to show whether or not additional tumors appear anywhere in the major site.

For "unknown sub-site" codes 819, 909, 919, if also multicentric originally, use codes 4 and 5 to indicate later appearance of additional tumors anywhere within the major site.

For the unknown subsites, if originally single focus or if no mention of multiplicity, use codes 0 and 3 to show absence or presence of later tumors anywhere within the major site.

"First Episode":

The "first episode" includes all tumors or tumorous areas present at the time of first definitive treatment of any of them. This term thus refers to the clinical condition of the patient at the date coded in Field I, not Field H. (Of course, for the untreated case the date in both fields is the date of diagnosis.)

If, as occasionally happens in skin cancer, one lesion is treated by one doctor and later a lesion in a different skin area is treated by another doctor—and there is no statement whether both were present originally—use **one month** as an operational rule. In other words, when lacking explicit information assume that the second lesion was present at the time the first one was treated provided the second lesion is diagnosed or treated within a month after the date in Field I.

"Summary Cards":

There are two types of multiplicity covered by the code in Field Z—originally multicentric and multiple over time. For either or both of these conditions a "summary card" is created—a single punchcard representing more than one malignant area within the same general primary site. A "summary card" must have a code 1–7 in Column 60.

For authorized sites, code 0 in Field Z identifies a punchcard representing only one area of cancer.

Codes 4–7 are summary card cases from the beginning. Those coded 1–3 became summary card cases when follow-up information revealed the presence of new tumor tissue in the same organ.

1967 ERG Code | Instructions for analytic cases

The Coding in Other Fields for "Summary Cards":

For the punchcards coded 1–7 in Field Z, there are some modifications in the coding rules for other punchcard fields. The following is a short survey of such changes:

Field	*Comment*
G	Based on first lesion treated definitively.
H	Based on first lesion diagnosed.
I	Based upon first lesion treated definitively.
K	Based upon location of lesions present at first episode.
L	Summary Card treated as single tumor in sequence code.
M	Based upon lesions of first episode. Does not change if later lesions show different histology. There are special rules and special code numbers provided for mixtures of tumors, but only certain histologic types are acceptable on summary punchcards. For sites 810–819 these are transitional cell tumors, squamous cell tumors, and "carcinoma" NOS. For sites 910–919 any basal, baso-squamous, and squamous malignancies are acceptable as well as "carcinoma NOS". For sites 900–909 all lesions must be melanomas; no unknown histology permitted.
N	Refers to histologic confirmation of any one of the lesions during patient's complete medical record. Lowest number takes priority. If code 8 is entered, it means that none of the lesions could have been assigned a lower number.
O	Based upon lesions of first episode and extent of disease information available at end of first series of treatments.
P	Based upon lesions of first episode or earlier.
Q	Any definitive therapy to any or all of the lesions present at first episode which is initiated during the four months beginning with the date in Field I.
R	Includes, in addition to its usual definition, the following: a) Any definitive therapy to any lesion(s) appearing after the first episode. b) Definitive treatment to any first episode lesion which was initiated or continued after the four-month time period. (See pages Q–2 and R–1.)
X	Should be coded 0 (zero) for all presently authorized sites.
Y	Same definitions as in Field O.

1967 ERG Code | Instructions for all cases

General:

In coding the Cause of Death, the complete ICD code is used in Field V. However, every ten years there is a revision of the ICD code. A new revision, the Eighth Revision, takes effect in 1968 in the Vital Statistics offices throughout the country. All previous causes of death will have been on the basis of the Seventh Revision. It does not seem reasonable to require all registries to convert all coding in Field V to a common base. Therefore, Field XX will be used to identify which ICD revision is used on a particular punchcard.

Since there are great differences between the Seventh and Eighth ICD Revisions, it can be a very laborious matter to convert either code to the other—if, in fact, it is completely possible. Therefore, it is suggested that the registries use Field XX without attempting any conversion.

The code in Field XX also provides for identification of any past ICD revisions if they are still on the punchcards.

Code:

5 6 7 8	Code the number of the ICD Revision which is used in columns 53–56 (Field V) of this punchcard.

Note that the following ERG codes used in Field V to supplement ICD are considered part of the Seventh or Eighth Revisions for the coding of Field XX:

Seventh Revision: 0000, 7955, 7777, 6666
Eighth Revision: 6600, 7969, 6677, 6666

1967 ERG Code — Instructions for all cases

General:

Class I cases (Field G) must be entirely coded in detail according to the 1967 code. Class 2 cases are old analytic cases which are not able to be classified as Class 1. However, without identification of which specific fields have been reviewed and which have been mechanically converted from an earlier punchcard, it is difficult to utilize Class 2 cases in many analyses. Field YY is primarily intended to remedy this lack, although it may be used for other purposes as well.

Specific Code:

It is assumed in the code below that since Field O (Extent of Disease) is site-specific, a review of the patient's record in order to code Field O presumes a review also of Field K (Primary Site).

0. All coding in Fields I, K, and O is a mechanical conversion from old codes without review of the patient's record.

1. Field I (Date of First Definitive Therapy) based upon record review*, but not Fields K or O.

2. Field K (Primary Site) based upon record review**, but not Fields I or O.

3. Both Fields I and K based upon record review, but not Field O.

4. Field O (Extent of Disease) based upon record review, but not Field I. (Assumes Field K reviewed.)

5. All three Fields (I, K, O) based upon record review. Case may properly be coded as Class 1 if it is an analytic case.

6. A new Class 1 case—no old punchcard to be reviewed.

7. Completely reviewed and coded according to 1967 code; a Class 1 case (Field G).

9. A non-analytic case coded the same as an analytic case in Fields I, K, O, and Q.

– Not applicable; a normal non-analytic case.

* Include as reviewed any instances where the local punchcard provides the date of first definitive therapy.

** If desired, may include as reviewed all sites for which the 1967 ERG code is identical to the previous code in Field K with no changes or additions to the sub-site codes.

General:

Enter here the last two digits of the year this punchcard deck is submitted to ERS.

1967 ERG Code — Instructions for non-analytic cases

If the non-analytic punchcards are requested by the Project Officer, use only the first digit of the Field O code in Field O(NA) for reviewed cases. This is the column 34 component of the code for analytic cases. For old unreviewed punchcards, convert to the first digit of the Non-Specific Code. (Consider "post treated" cases as "unstaged or no information".)

At present, punchcards for non-analytic cases are routinely requested only from population-based registries. A special supplement will be produced on the coding of non-analytic cases if there is need.

For advice concerning a compatible coding of non-analytic cases on the registry's own punchcards, please contact the Project Officer. (Code 9 in Field YY then becomes useful.)

1967 ERG Code — Instructions for non-analytic cases

General:

This field is of importance if the patient has received at least one course of tumor-directed treatment before being admitted to a hospital or clinic within the local registry system. A *summary* of such prior definitive treatment is entered here, classified by the same code used for Fields Q and R.

Completeness of treatment, effectiveness of treatment, the number of recurrences, the number of courses of therapy—none of these factors affect the coding of the previous treatment that is summarized in Field P(NA).

Obviously, a patient who has had no definitive therapy or whose first definitive treatment was received at a registry hospital has no prior treatment to be coded. Therefore, this field is not used for analytic cases and these punchcard columns are used to classify other information.

Specific:

If Class of Case is 1 or 2, see Fields O and P.

The code for Field P(NA) will be found on page DEF–5.

Class 5 cases should usually have a code other than 000 in Field P(NA). In fact, it is only for Class 5 cases that this field has real meaning.

All Class 6 and Class 8 cases will be coded 990 in Field P(NA).

All Class 9 cases will be coded 000 in Field P(NA).

On "summary punchcards" which are Class 5 reports, in Field P(NA) is coded a summary of *all* therapy received for any of the lesions *before* the first definitive treatment at a registry institution.

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