Revised Coding Instructions

This document contains revised coding instructions for the following data items.

- Tumor Size – Clinical
- Tumor Size – Pathologic
- Tumor Size – Summary
- Mets at Dx – Bone
- Mets at Dx – Brain
- Mets at Dx – Liver
- Mets at Dx – Lung
- Mets at Dx – Distant Lymph Node(s)
- Mets at Dx – Other

The revised coding instructions are applicable to cases diagnosed in 2016 and 2017.

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Tumor Size - Clinical

Item Length: 3
NAACCR Item #:752
NAACCR Name: Tumor Size Clinical

Updated coding instructions: required for 2017 and can be used for 2016

Description

This data item records the size of a solid primary tumor **before any treatment** (surgical resection or initiation of any treatment including neoadjuvant)

Rationale

Clinical tumor size (pre-treatment size) is essential for treatment decision making and prognosis determination for many types of cancer.

Code	Description
000	No mass/tumor found
001	1 mm or described as **less than** 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given

998	Alternate descriptions of tumor size for specific sites
	
	Familial/multiple polyposis
	    Rectosigmoid and rectum (C19.9, C20.9)
	    Colon (C18.0, C18.2-C18.9)
	
	If no size is documented
	Circumferential
	    Esophagus (C15.0-C15.5, C15.8-C15.9)
	
	Diffuse; widespread: three-fourths or more; linitis plastica
	    Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9)
	
	Diffuse, entire lung or NOS
	    Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9)
	
	Diffuse
	    Breast (C50.0-C50.6, C50.8-C50.9)

Code	Description
999	Unknown; size not stated
	Not documented in patient record
	Size of tumor cannot be assessed
	The only measurement(s) describes pieces or chips
	Not applicable (See #12 below)

Coding Instructions

Note: Record tumor size only in millimeters (mm). Convert to millimeters from centimeters when size of tumor is measured in centimeters. Often measurements are given in centimeters and must be converted to millimeters, such as 2 cm, which is 20 mm

1.   Record size in specified order using

     a. The largest measurement of the primary tumor from physical exam, imaging, or other diagnostic procedures **before any form of treatment. See Coding Instructions 7-9 below.**

     b. The largest size from all information available within four months of the date of diagnosis, in the absence of disease progression when no treatment is administered.

     c. Record the size of the primary tumor, including contiguous tumor tissue extension, at the time of diagnosis.

2.   Tumor size is the **largest dimension** of the tumor, **not the depth or thickness** of the tumor.

3.   **Code the largest size of the primary tumor before neoadjuvant treatment.** Use code 999 if size is unknown.

     a.   Tumor size noted in a resection operative report is a clinical tumor size, and not a pathologic tumor size.

     b.   Check the Clinical History/Clinical Impression/Clinical Information section of the pathology report for information on the clinical size of the tumor.

4.   *Example:* Patient has a 2.2 cm (22 mm) mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 2.8 cm (28 mm). Record clinical tumor size as 022 (22 mm) since the pathologic resection is after the neoadjuvant therapy.**Record 'less than' OR 'greater than' tumor size**

     a.   Record the tumor size as **one mm less than stated** when tumor size is reported as "less than x mm or less than x cm".

          i.   For example, if size is < 10 mm, code size as 009

          ii.   Often measurements are given in centimeters and must be converted to millimeters, such as < 1 cm (<10 mm), which is coded as 009, or < 2 cm (<20 mm), which is coded as 019

          iii.   Code 001 when stated as less than 1 mm.

    b. Record the tumor size as **one mm more than stated when** tumor size is reported as "more than x mm" or "more than x cm"

        i. For example, if size is > 10 mm, code size as 011

        ii. Often measurements are given in centimeters and must be converted to millimeters such as: > 1 cm (> 10 mm), code as 011; or > 2 cm (> 20 mm), code as 021

        iii. Code 989 when described as anything greater than 989 mm (98.9 cm)

5. Record "between" tumor sizes as the midpoint between the two measurements when tumor size is reported to be between two sizes; i.e., add the two sizes together and divide by two.

    Example: Tumor size is "between 2 and 3 cm." Code size as 025 since 2 + 3 = 5 divided by 2 = 2.5 cm (25mm).

6. **Round decimals:** Round the tumor size when it is described in fractions (decimals) of millimeters as follows

    Note 1: Record tumor size as 001 (do not round down to 000) when the largest dimension of a tumor is less than 1 millimeter (greater than 0 mm and less than 1 mm).

    Note 2: Code 001 when tumor size is 1mm

    a. When tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter.

    Examples

    Breast cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.

    2.3 millimeter cancer in a polyp. Round down to 2 mm and code as 002.

    Focus of cancer described as 1.4 mm in size. Round down to 1 mm and code as 001.

    5.2 cm breast cancer.   Convert to millimeters (52 mm) and do not round; code as 052 millimeters.

    2.5 cm rectal cancer. *Do not round, record as 025 millimeters.*

    b. Do not round tumor size expressed in centimeters to the nearest whole centimeter; rather, convert the measurement to millimeters by moving the decimal point one space to the right

7. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, but over a physical exam.

8. **Tumor size discrepancies among imaging and radiographic reports**: Record the largest size in the record- regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies the imaging that is most accurate.

9. Record size from an incisional biopsy. Use the clinical guidelines for TNM to determine if the biopsy was done during the clinical timeframe. Use the source that gives you the best size and take the largest size.

    Note: An incisional biopsy that removed the whole tumor is actually an excisional biopsy. Record tumor size in Tumor Size – Pathologic.

10. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.** However, when the tumor is described as a "cystic mass or polypoid mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts or polyps are part of the tumor itself.

11. **Multifocal/multicentric tumors:** Code the size of the largest invasive tumor, or the largest in situ tumor if all tumors are in situ, when the tumor is multi-focal or when multiple tumors are reported as a single primary.

12. **Assign tumor size code 999 when size is unknown or not applicable**.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris
    Unknown primary site

13. Document the information in the appropriate text field of the abstract to support the clinical tumor size as coded.

Tumor Size - Pathologic

Item Length: 3
NAACCR Item #:754
NAACCR Name: Tumor Size Pathologic

Updated coding instructions: required for 2017 and can be used for 2016

Description

This data item records the size of a solid primary tumor that has been resected.

Rationale

Pathologic tumor size is an important prognostic indicator and valuable for clinical practice and research on surgically treated patients for most cancers.

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites Familial/multiple polyposis Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) If no size is documented Circumferential Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated

Code	Description
	Not documented in patient record
	Size of tumor cannot be assessed
	No excisional biopsy or tumor resection done (See #1 below)
	The only measurement(s) describes pieces or chips (See #14 below)
	Not applicable (See #16 below.)

Coding Instructions

Note: Record tumor size only in millimeters (mm). Convert to millimeters from centimeters when size of tumor is measured in centimeters (cm). Often measurements are given in centimeters and must be converted to millimeters, such as < 1 cm, code as 009; or < 2 cm, code as 019.

Record size

1. Code pathologic tumor size to 999 for unknown when there is no excisional biopsy or tumor resection.

2. **Record the size of the invasive component, if given**

   a) Record the size of the invasive component, even if it is smaller, when both an in situ and an invasive component are present and the invasive component is measured.

   Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (1.4 cm or 14 mm).

   b) Record the size of the entire tumor from the surgical report or pathology report when the size of the invasive component is not given

   Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (2.3 cm or 23 mm).

   Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (1.9 cm = 19 mm).

   c) Record the size of the primary tumor, including contiguous tumor tissue extension

3. Code the largest size of the primary tumor measured on the surgical resection specimen when **surgery is administered as part of the first definitive treatment.**

   Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy.

   a. Code the size from the synoptic report (also known as CAP protocol or pathology report checklist) when there is a discrepancy among tumor size measurements in the various sections of the pathology report.

   b. Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available.

   Example 1: Chest x-ray shows 3.5 cm mass. The pathology report from the lobectomy states RUL lung mass: 2.8 cm adenocarcinoma. Record pathologic tumor size as 028 (28 mm).

Example 2: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record pathologic tumor size as 032 (32 mm).

4. Tumor size is the **largest dimension** of the tumor, **not the depth or thickness of the tumor**

5. Include pathologic information obtained **through completion of definitive surgery** when the surgery is part of the first course of treatment

6. Information on size from **imaging/radiographic techniques cannot be used** to code Tumor Size - Pathologic

7. **Record 'less than' OR 'greater than' tumor size**

   a. Record the tumor size as one mm less than stated when tumor size is reported as "less than x mm" or "less than x cm".

      Example: size is < 10 mm code size as 009.

      i. Often measurements are given in centimeters and must be converted to millimeters, such as < 1 cm, code as 009; or < 2 cm, code as 019.

      ii. Code 001 when stated as less than 1 mm.

   b. Record the tumor size as one mm more than stated when tumor size is reported as "more than x mm" or "more than x cm",

      i. For example, if size is > 10 mm, code size as 011.

      ii. Often measurements are given in centimeters and must be converted to millimeters, such as > 1 cm, code as 011; or > 2 cm, code as 021.

   c. Code 989 when tumor size is greater than 989 mm (98.9 cm).

8. Record "between" tumor sizes as the midpoint between the two measurements when tumor size is reported to be between two sizes; i.e., add the two sizes together and divide by two.

   Example: "between 2 and 3 cm." Code size as 025 since 2 + 3 =5 divided by 2 = 2.5 (or 025 mm).

9. **Round decimals:** Round the tumor size only if it is described in fractions of millimeters.

   Note 1: Record tumor size as 001 (do not round down to 000) when the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm).

   Note 2: Code 001 when tumor size is 1mm

   a. When tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter.

   Examples

   Breast cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.

   2.3 millimeter cancer in a polyp. Round down to 2 mm and code 002.

   Focus of cancer described as 1.4 mm in size. Round down to 1 mm and code as 001.

   5.2 cm breast cancer. Convert to millimeters and code 052.

2.5 cm rectal cancer. *Do not round, record as 025 millimeters.*

    b.   Do not round tumor size expressed in centimeters to the nearest whole centimeter; rather, convert the measurement to millimeters by moving the decimal point one space to the right

10. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.** However, when the tumor is described as a "cystic mass" or "polypoid mass" and only the size of the entire mass is given, code the size of the entire mass, since the cysts or polyps are part of the tumor itself.

11. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor**

    Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

12. **Record the size as stated for purely in situ lesions**

13. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.

14. Record tumor size as 999 when the only measurement describes pieces or chips. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. **However, when the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.**

15. **Multifocal/multicentric tumors:** Code the size of the largest invasive tumor, or the largest in situ tumor if all tumors are in situ, when the tumor is multi-focal or when multiple tumors are reported as a single primary.

16. **Assign tumor size code 999 when size is unknown or not applicable**.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris
    Unknown primary site

17. Document the information to support coded pathologic tumor size in the appropriate text field of the abstract.

Tumor Size - Summary

Item Length: 3
NAACCR Item #: 756
NAACCR Name: Tumor Size Summary

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Instructions for Coding

Note: All measurements should be in millimeters (mm).

Record size in specified order:

1. Size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.**

    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; find needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See Coding Rules below).

4. If 1, 2, and 3 do not apply, record the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Instructions

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.

2. **Recording less than/greater than Tumor Size:**

   a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example, if size is <10 mm, code size as 009. Often these are given in cm such as < 1 cm which is coded as 009, < 2 cm is coded as 019, < 3 cm is coded as 029, < 4 cm is coded as 039, < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.

   b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if size is >10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011, > 2 cm is coded as 021, > 3 cm is coded as 031, > 4 cm is coded as 041, > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.

   c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).

3. **Rounding:** Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Examples:

   Breast cancer described as 6.5 millimeters in size. *Round up* Tumor Size *as 007.*

   Cancer in polyp described as 2.3 millimeters in size. *Round down* Tumor Size *as 002.*

   Focus of cancer described as 1.4 mm in size. *Round down* Tumor Size *as 001.*

   5.2 mm breast cancer. *Round down* Tumor Size *to 5 mm and code as 005.*

4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report; it should be taken as lower priority, but over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis.** However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

7. **Record the size of the invasive component, if given.**

    a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

    Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm)

    b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

    Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

    Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

8. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**

    Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. **Record the size as stated for purely in situ lesions.**

10. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.

11. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. **Multifocal/multicentric tumors:** If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris
    Unknown primary site

14. **Document the information to support coded tumor size in the appropriate text data item of the abstract**

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8 cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	Alternate descriptions of tumor size for specific sites Familial/multiple polyposis Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) If no size is documented Circumferential Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed No excisional biopsy or tumor resection done The only measurement(s) describes pieces or chips Not applicable

Mets at Dx – Bone

Item Length: 1
NAACCR Item #:1112
NAACCR Name: Mets at Dx–Bone

Updated coding instructions: required for 2017 and can be used for 2016

Description

This field identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site Not documented in patient record

Coding Instructions

1. **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. Do *not* code bone marrow involvement in this field.

   Note: See **code 1** in "Mets at Dx-Other" for bone marrow involvement.

   a. Bone involvement may be single or multiple

   b. Information about bone involvement may be clinical or pathologic

   c. Code this field for bone metastases even if the patient had neoadjuvant (preoperative)systemic therapy

   d. Code this field for all solid tumors, Kaposi Sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      i.   Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

Use of codes: Assign the code that best describes whether the case has bone metastases at diagnosis.

a. Use **code 0** when the medical record

   i. Indicates that there are no distant (discontinuous) metastases at all
   ii. Includes a clinical or pathologic statement that there are no bone metastases
   iii. Includes imaging reports that are negative for bone metastases
   iv. Indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site

   Example: **Use code 0** when the patient has metastasis to lung and liver but not bone

b. Use **code 1** when the medical record

   i. Indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site
   ii. Indicates that bone is the primary site and there are metastases in a different bone or bones
      a) Do ***not*** assign code 1 for a bone primary with multifocal bone involvement of the same bone.
   iii. Indicates that the patient is diagnosed with an unknown primary (C80.9) and bone is mentioned as a distant metastatic site

c. Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use **code 9** when it cannot be determined whether the patient specifically has bone metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

Mets at Dx – Brain

Item Length: 1
NAACCR Item #: 1113
NAACCR Name: Mets at Dx-Brain

Updated coding instructions: required for 2017 and can be used for 2016

Description

This field identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is involved metastatic site Not documented in patient record

Coding Instructions

1. **Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. Do *not* code involvement of spinal cord or other parts of the central nervous system in this field.

   Note: See **code 1** in "Mets at Dx-Other" for mets to spinal cord or other parts of the central nervous system.

   a. Brain involvement may be single or multiple

   b. Information about brain involvement may be clinical or pathologic

   c. Code this field whether or not the patient had neoadjuvant (preoperative)systemic therapy

   d. Code this field for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      i. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. **Use of codes.**   Assign the code that best describes whether the case has brain metastases at diagnosis.

a. Use **code 0** when the medical record

    i. Indicates that there are no distant (discontinuous) metastases at all

    ii. Includes a clinical or pathologic statement that there are no brain metastases

    iii. Includes imaging reports that are negative for brain metastases

    iv. Indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site

    Example: **Use code 0** when the patient has metastasis to lung and liver but not brain

b. Use **code 1** when the medical record

    i. Indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site.

    ii. Indicates that the patient is diagnosed with an unknown primary (C809) and brain is mentioned as a distant metastatic site

c. Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use **code 9** when it cannot be determined whether the patient specifically has brain metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

Mets at Dx – Liver

Item Length: 1
NAACCR Item #: 1115
NAACCR Name: Mets at Dx-Liver

Updated coding instructions: required for 2017 and can be used for 2016

Description

This field identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no liver metastases
1	Yes; distant liver metastases
8	Not applicable
9	Unknown whether liver is involved metastatic site Not documented in patient record

Coding Instructions

1. **Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis.

   a. Liver involvement may be single or multiple

   b. Information about liver involvement may be clinical or pathologic

   c. Code this field whether or not the patient had neoadjuvant (preoperative) systemic therapy

   d. Code this field for all solid tumors, Kaposi Sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      i. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. **Use of codes:** Assign the code that best describes whether the case has liver metastases at diagnosis.

   a. Use **code 0** when the medical record

      i. Indicates that there are no distant (discontinuous) metastases at all

    ii.   Includes a clinical or pathologic statement that there are no liver metastases

    iii. Includes imaging reports that are negative for liver metastases

    iv. Indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site

    Example: **Use code 0** when the patient has metastasis to lung and brain but not liver

b. Use **code 1** when the medical record

    i.   Indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site

    ii. Indicates that the patient is diagnosed with an unknown primary (C80.9) and liver is mentioned as a distant metastatic site

c. Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use **code 9** when it cannot be determined whether the patient specifically has liver metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

Mets at Dx – Lung

Item Length: 1
NAACCR Item #: 1116
NAACCR Name: Mets at Dx-Lung

Updated coding instructions: required for 2017 and can be used for 2016

Description

This field identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is involved metastatic site Not documented in patient record

Coding Instructions

1. **Code information about lung metastases only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. Do *not* code pleural or pleural fluid involvement in this field.

   Note: See **code 1** in "Mets at Dx-Other" for pleural nodules, malignant pleural or pericardial effusion

   a. Lung involvement may be single or multiple

   b. Information about lung involvement may be clinical or pathologic

   c. Code this field whether or not the patient had neoadjuvant (preoperative)systemic therapy unless determined to be disease progression

   d. This field should be coded for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

      i. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. **Use of codes:** Assign the code that best describes whether the case has lung metastases at diagnosis.

a. Use **code 0** when the medical record

   i. Indicates that there are no distant (discontinuous) metastases at all
   ii. Includes a clinical or pathologic statement that there are no lung metastases
   iii. Includes imaging reports that are negative for lung metastases
   iv. Indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site

   Note: A single tumor in each lung is two primaries, unless proven to be metastatic (see MPH/H rules for Lung)

   Example: **Use code 0** when the patient has metastasis to liver and brain but not lung

b. Use **code 1** when the medical record

   i. Indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site
   ii. Indicates that lung is the primary site and there are metastases in the contralateral lung
   iii. Indicates that the patient is diagnosed with an unknown primary (C809) and lung is mentioned as a distant metastatic site

   Note: Do *not* assign **code 1** for a lung primary with multifocal involvement of the same lung

c. Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use **code 9** when it cannot be determined whether the patient specifically has lung metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

Mets at Dx – Distant Lymph Node(s)

<div align="right">

Item Length: 1
NAACCR Item #: 1114
NAACCR Name: Mets at Dx-Distant LN

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Updated coding instructions: required for 2017 and can be used for 2016

Description

This field identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Dx-Metastatic Sites fields provide information on specific metastatic sites for data analysis.

Code	Description
0	None; no distant lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are involved metastatic site
	Not documented in patient record

Coding Instructions

Note 1: Use AJCC TNM to determine regional versus distant lymph nodes

Note 2: Assign **code 0** (None) for unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes

Note 3: Placental lymph node involvement for placental primaries is classified as distant lymph node involvement (M1) and recorded in this field

1. **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.

   a. Distant lymph node involvement may be single or multiple

   b. Information about distant lymph node involvement may be clinical or pathologic

   c. Code this field whether or not the patient had neoadjuvant (preoperative)systemic therapy

   d. Do *not* code this field for regional lymph node involvement.

   e. Code this field for all solid tumors, Kaposi sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

Note: **Code 0** for all lymphomas. Lymph node involvement is recorded in stage group and is based on involvement above and below the diaphragm. The distinction between regional and distant lymph nodes is not relevant.

    i.   Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. **Use of codes:** Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.

    a.   Use **code 0** when the medical record

        i.   Indicates that there are no distant (discontinuous) metastases at all
        ii.   Includes a clinical or pathologic statement that there are no distant lymph node metastases
        iii.   Includes imaging reports that are negative for distant lymph node metastases
        iv.   Indicates lymph nodes are involved, but there is no indication whether they are regional or distant
        v.   Indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site

    Example: **Use code 0** when the patient has metastasis to lung and liver but not distant lymph node(s)

    b.   Use **code 1** when the medical record

        i.   Indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site

    c.   Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

    d.   Use **code 9** when it cannot be determined whether the patient specifically has distant lymph node metastases. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

Mets at Dx – Other

Item Length: 1
NAACCR Item #: 1117
NAACCR Name: Mets at Dx-Other

Updated coding instructions: required for 2017 and can be used for 2016

Description

The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis. This field identifies any type of distant involvement not captured in the **Mets at Dx – Bone, Mets at Dx– Brain, Mets at Dx – Liver, Mets at Dx – Lung, and Mets at Dx – Distant Lymph Nodes fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis.** Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Code	Description
0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes ***Note***: includes bone marrow involvement for lymphomas
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site or generalized metastases Not documented in patient record

Coding Instructions

1. **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This field should not be coded for bone, brain, liver, lung, or distant lymph node metastases.

    a.   Other involvement may be single or multiple

    b.   Information about other involvement may be clinical or pathologic

    c.   Code this field whether or not the patient had any preoperative (neoadjuvant) systemic therapy

    d.   Code this field for all solid tumors, Kaposi Sarcoma, Lymphomas, Unknown Primary Site, and Other and Ill-Defined Primary Sites

    i. Code this field for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738, 9811-9818, 9823, 9827, 9837) (All sites)

2. **Use of codes:** Assign the code that best describes whether the case has other metastases at diagnosis.

    a. Use **code 0** when the medical record

       i. Indicates that there are no distant (discontinuous) metastases at all
       ii. Includes a clinical or pathologic statement that there are no other metastases
       iii. Includes imaging reports that are negative for other metastases
       iv. Indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved

       Example: **Use code 0** when the patient has metastasis to lung and liver only

    b. Use **code 1** when the medical record indicates

       i. distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung or distant lymph node(s)
         a) Includes, but not limited to, the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin

       ii. Lymphomas with bone marrow involvement (Stage IV disease)

       Note: Does **not** include lymphomas or lymphoma/leukemias where primary site is C421 (bone marrow)

    c. Use **code 2** when the medical record

       i. Indicates that the patient has carcinomatosis

         a) Carcinomatosis is a condition in which cancer is spread widely throughout the body, or, in some cases, to a relatively large region of the body.

       Note: It is possible to have metastatic disease to a specific organ AND also have carcinomatosis. If a patient has metastatic disease to bone, brain, liver, lung or distant nodes AND carcinomatosis, use code 1 for the appropriate field (bone, brain, liver, lung, or distant nodes) and use code 2 for carcinomatosis. If a patient has metastatic disease to a site other than bone, brain, liver, lung or distant nodes AND carcinomatosis, assign code 2 for carcinomatosis. Code 2 for carcinomatosis takes priority.

       Example 1: Patient with colon cancer noted to have mets to the stomach and carcinomatosis. Code "Mets at Dx - Other" as 2 for carcinomatosis.

       Example 2: Patient with breast cancer noted to have mets to the liver and carcinomatosis. Code "Mets at Dx - Liver" as 1 and "Mets at Dx - Other" as 2.

d. Use **code 8** (Not applicable) for the following site/histology combinations for which distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	Description
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734, 9820, 9826, 9831-9834	Other hematopoietic neoplasm coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

e. Use **code 9** when it cannot be determined whether the patient has metastases other than bone, brain, liver, lung, and distant lymph node(s).