

Section V

Stage of Disease at Diagnosis

SEER Program
Coding and Staging Manual 2016



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SEER Registrar Staging Assistant (SEER*RSA)

SEER has developed a staging database referred to as the [SEER*RSA](#) that provides information about each cancer (primary site/histology/other factors defined) schema. SEER*RSA includes the T, N, and M categories for each site schema, as well as the applicable Site-Specific Factors for each schema. When incorporated into central registry or abstracting software, the API (SEER*RSA) will provide the registrars with definitions and helpful information to aid in the correct assignment of T, N, and M categories. It will also derive a clinical and a pathologic stage group based on the categories provided (stored in separate fields from the directly assigned stage group) and this will derive a combined category for each component (T, N, M, and stage group) based on assessment of both clinical and pathologic categories to allow for analysis of SEER cancer data over time.

For each of the 153 schemas collected by SEER registries, the following are available

- Clinical T, N, and M
- Pathologic T, N, and M
- Clinical and Pathologic Stage Group
- Site-specific factors

[SEER*RSA](#) is available online through the SEER website. An internet connection is required.

Within the tables for Clinical and Pathologic T, N, and M data items, the definition from TNM 7th edition for each (sub)category is provided, along with additional information to assist the registrar in assigning the correct (sub)category. The applicable stage groups are also available, along with the applicable TNM combinations for each stage group.

For all schemas, including those that do not have TNM staging, information regarding the appropriate SEER Summary Stage 2000 chapter and a link to the online SEER Summary Stage 2000 manual is included.

Site-specific factors are included for all the applicable schemas. These are the same site-specific factors that have been used since the release of CSV2 in 2010. For each site-specific schema, the requirements for SEER, NPCR, CoC and Canada are also listed. Defaults are documented and may be used, as applicable.

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TNM Staging

Introduction to the TNM Classification

For cases diagnosed January 1, 2016 and forward, SEER requires that cancers be staged using TNM. TNM is a staging classification that assigns a clinical stage and a pathologic stage to each primary cancer. Each stage is composed of T (Primary Tumor), N (Regional Lymph Nodes), and M (Distant Metastasis). T, N, and M combinations are summarized as stage group.

T is assigned based on the extension of the 'primary tumor'. In some sites the tumor size is used to assign the T category. N is based on the involvement of regional lymph nodes, and M represents spread to distant lymph nodes or other generally discontinuous organs. The stage group summarizes the three TNM components (and additional information for selected cancer schemas) into a single clinical or pathologic value.

In order to assign TNM, the registrar should

- Be knowledgeable of the general staging rules and when site-specific rules for sites/histologies take precedence, since some sites/histologies have site-specific rules that override the general rules
Note: Pathologic information may actually be clinical under site-specific rules. This is especially true with regard to the M category
- Use [SEER*RSA](#) to determine what is included in the clinical and pathologic classifications for the site-histology combination
- Review all available information in the medical record
- Determine if the case meets the eligibility criteria for clinical and/or pathologic staging
- Determine clinical versus pathologic timeframes

UICC TNM Seventh Edition

The *International Union Against Cancer (UICC) Classification of Malignant Tumors Seventh Edition* is used in SEER*RSA as the framework for assigning TNM and stage group. The rules of classification and staging in the UICC 7th edition correspond with those appearing in the seventh edition of the *AJCC Cancer Staging Manual (2009)* and have approval of all national TNM committees. (UICC, 7th edition, pg. 4)

Justification for the TNM System *

The practice of dividing cancer cases into groups according to so-called stages arose from the fact that survival rates were higher for cases in which the disease was localized than for those in which the disease had extended beyond the organ of origin. These groups were often referred to as 'early' cases and 'late' cases, implying some regular progression with time. In fact, the stage of disease at the time of

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diagnosis may be a reflection not only of the rate of growth and extension of the neoplasm but also of the type of tumor and of the tumor-host relationship.

The anatomic staging of cancer is hallowed by tradition, and for the purpose of analysis of groups of patients, it is often necessary to use such a method. The UICC believes that it is important to reach agreement on the recording of accurate information on the anatomic extent of the disease for each site, because the precise clinical description of malignant neoplasms and histopathologic classification may serve a number of related objectives. These objectives include

1. To aid the clinician in the planning of treatment
2. To give some indication of prognosis
3. To assist in evaluation of the results of treatment
4. To facilitate the exchange of information between treatment centers
5. To contribute to the continuing investigation of human cancer
6. To support cancer control activities

The principal purpose to be served by international agreement on the classification of cancer cases by extent of disease is to provide a method of conveying clinical experience to others without ambiguity.

There are many bases or axes of tumor classification, e.g., the anatomic site, the clinical and pathologic extent of disease, the reported duration of symptoms or signs, the gender and age of the patient, and the histologic type and grade. All of these bases or axes represent variables that are known to have an influence on the outcome of the disease. Classification by anatomic extent of disease as determined clinically and histopathologically are those with which the TNM system primarily deals.

The clinician's immediate task is to make a judgment as to prognosis and a decision as to the most effective course of treatment. This judgment and this decision require, among other things, an objective assessment of the anatomic extent of the disease. In accomplishing this, the trend is away from 'staging' to meaningful description, with or without some form of summarization.

To meet the stated objectives, a system of classification is needed

1. Whose basic principles are applicable to all sites regardless of treatment; and
2. That may be supplemented later by information that becomes available from histopathology and/or surgery

The TNM system meets these requirements.

*International Union Against Cancer (UICC) *TNM Classification of Malignant Tumors, 7th ed.*, Sobin, LH, Gospodarowicz, M, Wittekind, CH, eds. New York: Wiley, 2009, pgs., 184, 185

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UICC TNM vs. AJCC TNM

The TNM manuals published by the UICC and the American Joint Committee on Cancer (AJCC) have the same premise and, for the most part, have similar definitions with only minor differences. A document comparing UICC and AJCC, plus information about additional enhancements in SEER*RSA, is posted on the SEER website. For those areas where the assignment of T, N, M, or stage group are different, specific instructions are provided for the registrar in this section of the 2016 SEER Coding and Staging Manual and [SEER*RSA](#).

For SEER registries, follow the UICC guidelines when there is a difference.

In addition, the UICC uses the British spelling for several words, the most common being tumour (tumor), oesophagus (esophagus), or coeliac (celiac). The American spelling is used in the resources developed by SEER.

Reportability and TNM

The UICC TNM 7th Edition includes TNM definitions for some neoplasms that are not reportable to population-based cancer registries. For example, high grade dysplasia of the esophagus and pancreatic intraglandular neoplasia (PAIN) of the pancreas, also called severe ductal dysplasia, are not reportable to SEER; however, they are staged in TNM.

Follow the SEER reportability rules. Do not base reportability decisions on TNM. A site-histology combination staged in TNM is not an indication of reportability. See the [SEER manual](#) for reportability.

Death Certificate Only (DCO) Cases

Assign 88 (not applicable) for Death Certificate (DCO) **only** cases in all T, N, and M data fields. For clinical and pathologic (prefix/suffix) descriptors, assign 0. For clinical staged by and pathologic staged by, assign 8. Code 88 will be derived in Derived Clinical Stage Group and Derived Pathologic Stage Group. If your registry manually assigns clinical stage group or pathologic stage group, code 88.

Use of Autopsy Information in TNM

Use the designation of 'a' when autopsy information is used to assign the pathologic TNM. Autopsy classification is used when there was no evidence of cancer prior to the patient's death and should include all clinical and pathologic information collected at the time of death and autopsy. Record information from an autopsy in the pathologic fields when it adheres to the [Pathologic Staging](#) rules.

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Non-definitive (Ambiguous) Terminology

Most of the time, registrars will have definitive statements of involvement; however, for those situations where involvement is described with non-definitive (ambiguous) terminology, use the guidelines below to determine the appropriate assignment of T, N, and M. Per UICC, non-definitive (ambiguous) terminology is not used for assigning T, N, or M; however, this terminology can be used in conjunction with other information, including how the patient is being treated.

Determination of the cancer stage is both a subjective and objective assessment by the physician(s) of how far the cancer has spread. If possible, look at the physician documentation that he/she used to make informed decisions on how to treat the patient when you are unable to determine the extent of involvement due to the use of non-definitive terminology. For example, assign the TNM based on involvement when the patient was treated as though adjacent organs or nodes were involved.

Use the following lists to interpret the intent of the clinician **ONLY** when physician documentation is not available and/or there is no specific statement of involvement in the medical record. The clinician's definitions/descriptions and choice of therapy have priority over these lists because individual clinicians may use these terms differently.

Note 1: Terminology in the schema takes priority over this list. Some schemas interpret certain words as involvement; such as 'encasing' the carotid artery for a head and neck site.

Note 2: This is **not** the same list used for determining reportability as published in the SEER manual or in Section One of the Facility Oncology Registry Data Standards (FORDS) manual. This is **not** the same list of ambiguous terminology provided for the [Multiple Primary and Histology Coding Rules](#) published and maintained by the SEER Program.

Use the following lists as a guide **when no other information is available**.

Involved

adherent	incipient invasion
apparent(ly)	induration
appears to	infringe/infringing
comparable with	into*
compatible with	intrude
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to

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Not involved

abuts	extension to without invasion/ involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

* interpret as involvement whether the description is clinical or operative/pathologic

** interpret as involvement of other organ or tissue

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Assigning T,N,M, and Descriptors

The TNM system for describing the anatomic extent of disease is based on the assessment of three components:

T – The extent of the primary tumor

N – The absence or presence and extent of regional lymph node metastasis

M – The absence or presence of distant metastasis

The addition of numbers and categories (including subcategories) to these three components indicates the extent of the malignant disease, thus:

T0, T1, T2, T3, T4	N0, N1, N2, N3	M0, M1
T1a, T1b, T2a, T2b	N1a, N1b, N2a, N2b	M1a, M1b

In effect, the system is a ‘shorthand notation’ for describing the extent of a particular malignant tumor.

The general rules below are applicable to site and histology combinations for which TNM is defined. Not all site and histology combinations can be staged in TNM.

Use the Detailed TNM Schema Mapping spreadsheet to determine whether TNM is defined for a primary site/histology combination. Assign 88 for the TNM data items and record [SEER Summary Stage 2000](#) for site/histology combinations that do not TNM stage.

Note: *Site-specific and histology-specific guidelines take precedence over general guidelines.* Always read the [SEER*RSA](#) notes pertaining to a specific site or histology schema. Notes are found on the general schema page, within the individual data items, and in the Registrar Notes section.

- 1. Assign TNM whether the case is microscopically confirmed or not.** A description of the type of diagnostic confirmation is collected in a separate data item. The diagnostic confirmation field can be used to exclude non-microscopically confirmed cases during analysis as necessary. Rare cases that do not have a biopsy or cytology of the tumor can be staged, but survival should be analyzed separately. These cases should not be included in overall disease survival stage analyses.
- 2. Two TNM classifications are defined.**
 - a. Clinical classification:** The pretreatment clinical classification designated TNM is essential to select and evaluate therapy. This is based on evidence acquired before treatment. Such evidence arises from physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant examinations.
 - b. Pathologic classification:** The postsurgical histopathologic classification designated TNM is used to guide adjuvant therapy and provides additional data to estimate prognosis and calculate end results. This is based on evidence acquired before treatment, supplemented or modified by

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additional evidence acquired from surgery and from pathologic examination. The pathologic assessment of the primary tumor (pT) entails a resection of the primary tumor or a biopsy adequate to evaluate the highest pathologic T category. The pathologic assessment of the regional lymph nodes (pN) entails removal of the lymph nodes adequate to validate the absence of regional lymph node metastasis (pN0), or sufficient to evaluate the highest pN category. *An excisional biopsy of a lymph node without pathologic assessment of the primary tumor is insufficient to fully evaluate the pN category and is a clinical classification.* The pathologic assessment of distant metastasis (pM) entails microscopic examination.

Note: Autopsy reports are used the same way as pathology reports, applying the same rules for inclusion and exclusion within the timing rules.

3. Clinical TNM and/or pathologic TNM categories are usually combined into stage groups. The TNM classifications and stage groups, once established, should not be updated to reflect disease progression or success or failure of treatment.
4. If there is doubt concerning the correct T, N, or M category to which a particular case should be assigned, choose the lower (i.e., less advanced) category. This will also be reflected in the stage grouping. This does not apply to selecting subcategory (e.g., T2a) versus “NOS” (e.g., T2).

Example 1: Lung tumor stated to be either T3 or T4. Without further information, assign the T3 as the lower, less advanced, category.

Example 2: If a physician documents a clinical T2 for a prostate patient, do not assign the lowest subcategory of T2a. Assign the T2 [NOS].

5. Definitions of TNM categories and stage grouping have been telescoped (or expanded) into additional subcategories for clinical or research purposes. For example, in the UICC manual chapter for Lip and Oral Cavity, T4a and T4b subcategories exist. The T4 category has been telescoped to allow the registrar to capture at least the category level information when the subcategory information is not available to further characterize the tumor. See [SEER*RSA](#) for current definitions.
6. The word “metastatic” can refer to local or regional spread or to distant metastasis. “Metastatic” may be used to indicate a T3 or T4 lesion or metastasis to regional lymph nodes. In some instances, non-contiguous spread is not M1 depending on the site-specific rules.

Example: T3a for Ovary is microscopic peritoneal metastasis.

7. TNM has additional Descriptors (or symbols) that identify special situations. These symbols will not be incorporated into the T, N, M by any of the standard setters at this time, although some of the information will be captured in the Descriptor fields as described below.
 - a. m Symbol: The suffix m, in parentheses (m), would be used to indicate the presence of multiple primary tumors reported as a single primary.

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- i. This information can be found in [Clinical Stage \(Prefix/Suffix\) Descriptor](#) and the [Pathologic Stage \(Prefix/Suffix\) Descriptor](#) data elements.
- b. y Symbol: A y prefix indicates the pathologic TNM assignment is based on information available during or following multimodality therapy.
 - i. Information regarding neoadjuvant (preoperative) therapy can be recorded in the [Pathologic Stage \(Prefix/Suffix\) Descriptor](#) (codes 4 and 6).
- c. r Symbol: Recurrent tumors or retreatment classification: when classified after a disease-free interval, are identified by the prefix r.
 - i. For 2016, the allowable categories for TNM do not permit indication that staging refers to a recurrent tumor.
- d. a Symbol: The prefix a indicates that classification is first determined at autopsy.
 - i. Autopsy information is being collected as appropriate but will not be indicated as ‘a.’

Stage Grouping

1. The TNM system is used to describe and record the anatomic extent of disease. For purposes of tabulation and analysis, it is useful to condense these categories into stage groups. The stage groups begin at stage 0 and go up to stage IV. For consistency, in most instances, carcinoma in situ is categorized Stage 0. The grouping of stages is intended to ensure, as far as possible, that each group is more or less homogeneous in respect to survival, and that the survival rates of these groups for each cancer site are distinctive.
2. Although the anatomic extent of disease, as categorized by TNM, is a very powerful prognostic indicator in cancer, it is recognized that many factors have a significant impact on predicting outcomes. Some additional factors have been incorporated into stage grouping for certain sites; for example, grade in soft tissue sarcoma, age in thyroid cancer, and PSA and Gleason score for prostate cancer.
3. Make sure the clinical T, N, and M match the clinical stage group and the pathologic T, N, and M match the pathologic stage group. Software edits have been developed based on the UICC tables for stage groups.
 - a. Refer to the staging tables in [SEER*RSA](#) for a complete listing of the TNM combinations that result in a valid stage group.
 - b. SEER will continue to allow certain “NOS” categories that were collected in the prior Collaborative Staging (CS) System.

Use of Blanks in Coding

For each of the data items, clinical T, N, M and pathologic T, N, M, specific instructions are provided for the use of blanks. In general, the pathologic data items will be blank when no surgery is performed: pT (blank), pN (blank), and pM (blank).

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SEER*RSA Schemas

The primary site code and histology code for a case determine the applicable cancer “schema” for TNM staging. There are 153 schemas in [SEER*RSA](#) and they are identical to the 153 schemas defined for CS v. 02.05. The [TNM Schema Mapping Quick Reference](#) spreadsheet lists the 153 schemas and the corresponding UICC 7th Edition, AJCC 7th Edition, and SEER Summary Stage 2000 chapters.

SEER will be using an enhanced version of the seventh edition of the UICC. All of these staging systems are intended primarily for adult cancers, although some schemas applicable to pediatric cases, such as retinoblastoma, are included. Collect TNM data elements for all cases, regardless of the patient’s age.

SEER Summary Stage 2000 is required for all 2016 cases. SEER Summary Stage 2000 will be derived from CS data for SEER registries collecting CS in 2016. SEER Summary Stage 2000 must be directly assigned in registries not collecting CS in 2016.

Site/histology combinations and TNM definitions

Three situations are explained below

- Site/histology combinations within schemas for which TNM is not defined
- TNM is not defined for 22 of the 153 schemas
- Some site/histology combinations have partial TNM definitions

Site/histology combinations within schemas not covered by TNM

Code 88 for the TNM elements, Clinical T, N, and M; Pathologic T, N, and M. Refer to [SEER*RSA](#) for site/histology combinations that are not covered by TNM.

Example: The bladder schema includes primary sites C670-C679 with histologies 8000-9136, 9141-9582, 9700-9701; however, the TNM staging definitions apply only to 8000-8576, 8940-8950, and 8980-8981. For histology 8890/3, Leiomyosarcoma, NOS, TNM staging is not applicable (code 88).

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Schemas for which TNM is Not Defined

The table below shows the schemas (based on primary site/histology combinations) for which TNM is not defined (i.e., not applicable).

Note: SEER Summary Stage 2000 is collected for all schemas, including schemas listed in the table.

List of Cancer Schemas Not Defined in TNM

Adnexa Uterine Other	Male Genital Other	Middle Ear
Biliary Other	Heme Retic	Myeloma Plasma Cell Disorder
Brain	Ill Defined Other	Pharynx Other
CNS Other	Intracranial Gland	Respiratory Other
Digestive Other	Kaposi Sarcoma	Sinus Other
Endocrine Other	Lacrimal Sac	Trachea
Eye Other	Melanoma Eye Other	Urinary Other
Genital Female Other	Melanoma Sinus Other	

Code 88 for the data items indicated below for the schemas listed above.

- Clinical T
- Pathologic T
- Clinical N
- Pathologic N
- Clinical M
- Pathologic M

**Note: Clinical Stage group 88 and Pathologic Stage Group 88 will be derived*

Note: Refer to [SEER*RSA](#) for information on which [SEER Summary Stage 2000](#) chapter to use for these schemas and for all schemas that are TNM staged.

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Primary Site/Histologies with Partial TNM Definitions

TNM is partially defined for the following schemas

- Placenta (Gestational Trophoblastic Tumors): N is not defined
 - Code 88 for clinical and pathologic N
- Lymphoma: T, N, and M are not defined (Ann Arbor Stage used)
 - Code 88 for clinical and pathologic T, N, and M
 - Stage Group is defined; clinical and pathologic stage group data elements must be assigned manually
 - Assign 99 if stage group is unknown
- For the following schemas, T, N, and M are defined; however, stage group is not defined. Code 88 for the stage group.
 - Conjunctiva
 - Lacrimal Gland
 - Melanoma Conjunctiva
 - Orbit
 - Retinoblastoma
- Lymphoma Ocular Adnexa
 - Lymphomas of the ocular adnexa are included in the UICC Hodgkin & non-Hodgkin Lymphoma chapter
 - For 2016, SEER registries are required to collect Clinical Stage Group and Pathologic Stage Group for lymphomas of the ocular adnexa using the Hodgkin & non-Hodgkin Lymphoma Stage Group definitions.
 - Code 88 for clinical and pathologic T, N, and M
 - Stage Group is defined; clinical and pathologic stage group data elements must be assigned manually
 - Assign 99 if stage group is unknown

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Schemas Where Tis (In Situ) Not Defined

Per TNM, in situ is a very rare diagnosis for the following schemas and is not allowed in the T category definition.

Adrenal Gland	Melanoma Gum Lower	Melanoma Pharynx Other
Carcinoid Appendix	Melanoma Gum Other	Melanoma Sinus Ethmoid
Corpus Adenosarcoma	Melanoma Gum Upper	Melanoma Sinus Max
Corpus Sarcoma	Melanoma Hypopharynx	Melanoma Tongue Ant
GIST Appendix	Melanoma Iris	Mycosis Fungoides
GIST Colon	Melanoma Larynx Glottic	NET Ampulla
GIST Esophagus	Melanoma Larynx Other	NET Colon
GIST Peritoneum	Melanoma Larynx Subglottic	NET Rectum
GIST Rectum	Melanoma Larynx Supraglottic	NET Small Intestine
GIST Small Intestine	Melanoma Lip Lower	Orbit
GIST Stomach	Melanoma Lip Other	Ovary
Kidney Parenchyma	Melanoma Lip Upper	Parotid Gland
Lacrimal Gland	Melanoma Lip Upper	Placenta
Liver	Melanoma Mouth Other	Prostate
Melanoma Buccal Mucosa	Melanoma Nasal Cavity	Salivary Gland Other
Melanoma Choroid	Melanoma Nasopharynx	Submandibular Gland
Melanoma Ciliary Body	Melanoma Oropharynx	Thyroid
Melanoma Epiglottis Anterior	Melanoma Palate Hard	
Melanoma Floor Mouth	Melanoma Palate Soft	

Code 88 for the data items indicated below for an in situ diagnosis for the schemas listed above.

- Clinical T
- Pathologic T
- Clinical N
- Pathologic N
- Clinical M
- Pathologic M

**Note: Clinical Stage group 88 and Pathologic Stage Group 88 will be derived*

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Assigning Stage when only information available is Stage Group

Assignment of T, N, and M data items when the ONLY information available is stage group, i.e. no other information on extent of disease or T, N, or M.

1. Determine whether the stage group is pathologic or clinical
 - a. When clinical or pathologic is not known
 - i. Assume the stage group is clinical when
 - a) patient is presenting for neoadjuvant therapy
 - b) patient is coming in for surgery
 - ii. Assume the stage group is pathologic when
 - a) patient is post-surgery
 - b) patient is coming in for ADJUVANT therapy, assume there was surgery
 - iii. Assume the stage group is clinical when there is no basis to assume as instructed above
2. Assign the given clinical or pathologic stage group and leave the corresponding T, N, and M components blank.
3. FIGO Stages: Assign the applicable clinical or pathologic stage group and leave the corresponding T, N, and M components blank for the following FIGO stages only.

Schema	FIGO Stage
Cervix	IIIB
Vulva	III [NOS], IIIA, IIIB, IIIC, IVA
Vagina	III
Corpus Carcinoma	III [NOS], IIIC [NOS], IIIC1, IIIC2
Corpus Adenosarcoma	IIIC
Corpus Sarcoma	IIIC
Ovary	IIIC
Peritoneum Female Gen	IIIC
Fallopian Tube	III [NOS], IIIC
Placenta	All stages can have T and M assigned

Refer to the registrar notes for the applicable schema in [SEER*RSA](#) when FIGO stage is the only information available for schemas not listed in the table above.

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Examples of Stage Group Only cases

- Example 1:** Patient presents for neoadjuvant therapy for Stage IIC rectal tumor.
Assign Clinical Stage group IIC. Leave the clinical T, N, and M data items as blank.
- Example 2:** Patient presents for adjuvant therapy, post mastectomy for Stage IIB breast tumor. No other information available.
Assign Pathologic Stage group IIB. Leave pathologic T, N, and M data items blank. The documented stage group is pathologic (post mastectomy).
- Example 3:** Patient presents for chemotherapy for Stage IVA liver tumor.
Assign Clinical Stage group IVA. Leave clinical T, N, and M data items blank.
- Example 4:** Physician documents Breast tumor, Stage IIIC. No other information available.
Assign Clinical Stage group IIIC. Leave clinical T, N, and M data items blank. Default to clinical when unable to determine if clinical or pathologic.
- Example 5:** Patient with Stage IV Merkel cell carcinoma presents for treatment.
Assign Clinical Stage group IV. Leave clinical T, N, and M data items blank.
- Example 6:** Patient presents for adjuvant therapy, post-surgical resection for Stage IIIA melanoma. No other information available.
Assign Pathologic Stage group IIIA. Leave pathologic T, N, and M data items blank.
- Example 7:** Patient with Stage II bladder tumor, post-cystectomy with lymph node dissection, presents for chemotherapy.
Assign Pathologic Stage group II. Leave pathologic T, N, and M data items blank.
- Example 8:** Patient with Stage IA breast cancer presents for follow up exam.
Assign Clinical Stage group IA. Leave clinical T, N, and M data items blank.

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CS Data Items

For those registries that are not assigning CSv0205 for 2016 cases, leave ALL CS data items, except site-specific factors, blank.

For those who are continuing to use CSv0205 for 2016 cases, make sure to fill in all the data items used in CSv0205, except the following data items:

- CS Mets at Dx Bone

- CS Mets at Dx Brain

- CS Mets at Dx Liver

- CS Mets at Dx Lung

There are 6 new Mets at Dx fields that are to be used for all cases.

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Data Items For Assigning Stage of Disease at Diagnosis

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Clinical Staging

Timing of Data Collection

Clinical staging includes any information obtained about the extent of cancer before initiation of definitive treatment, including active surveillance, or within four months after date of diagnosis, whichever is shorter.

The following are part of the clinical workup

- Presenting symptoms
- Physical examination
- Imaging examination
- Endoscopic examination
- Biopsy of primary site
- Diagnostic biopsy
- Fine needle aspiration biopsy
- Resection of single lymph node/sentinel node(s) with clinical T
- Surgical observation without resection
- Laboratory tests
- Other non-invasive clinical evidence
- All information obtained prior to neoadjuvant (preoperative) treatment

Do not use information from an autopsy for clinical staging. See [Pathologic Staging](#) for autopsy only cases.

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Tumor Size - Clinical

Item Length: 3

NAACCR Item #:752

NAACCR Name: Tumor Size Clinical

Description

This data item records the size of a solid primary tumor **before any treatment**.

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
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters 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 <ul style="list-style-type: none">• Rectosigmoid and rectum (C19.9, C20.9)• Colon (C18.0, C18.2-C18.9) If no size is documented Circumferential <ul style="list-style-type: none">• Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: three-fourths or more; linitis plastica <ul style="list-style-type: none">• Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS <ul style="list-style-type: none">• Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse <ul style="list-style-type: none">• Breast (C50.0-C50.6, C50.8-C50.9)

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Code	Description
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed Not applicable (See Instruction 10) [SEER Note: Tumor measurement only describes pieces or chips]

Coding Instructions

Note 1: Record tumor size only in millimeters (mm). Convert to millimeters from centimeters when size of tumor is measured in centimeters.

Note 2: This field cannot be blank.

Record size in specified order

1. The largest measurement of the primary tumor (*invasive portion*) from physical exam, imaging, or other diagnostic procedures **before any form of treatment**
2. 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

Coding Rules

1. Tumor size is the **largest dimension** of the tumor, **not necessarily the depth or thickness** of the tumor.
2. **Code the largest size of the primary tumor before neoadjuvant (preoperative) treatment.** Use code 999 if size is unknown.

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

SEER Note 1: Tumor size noted in a resection operative report is a clinical tumor size, and not a pathologic tumor size.

SEER Note 2: Check the Clinical History/Clinical Impression/Clinical Information section of the pathology report for information on the clinical size of the tumor.

3. Record 'less than'/'greater than' Tumor Size

- a. Record the tumor size as 1 mm less when tumor size is reported as 'less than x mm' or 'less than x cm'.

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- i. For example, if size is < 10 mm, code size as 009.
 - ii. Often measurements are given in cm, such as < 1 cm, which is coded as 009, or < 2 cm, which is coded as 019.
 - iii. Code 001 when stated as less than 1 mm.
- b. Record the tumor size as 1 mm more 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 cm 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)
- c. Record tumor size 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. For example, “between 2 and 3 cm” is coded as 025 since $2 + 3 = 5$ divided by $2 = 2.5$.

SEER Note: “Approaching” may be used to determine tumor size.

For example, “approaching 10 cm” is coded as 099.

4. **Rounding:** Round the tumor size only if it is described in fractions (decimals) of millimeters.
- a. 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).
 - b. 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 when tumor size is greater than 1 millimeter
 - c. 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 to 7 mm and code as 007.

Cancer in polyp described as 2.3 millimeters in size. 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 mm breast cancer. Round down to 5 mm and code as 005.

5. **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.
6. **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

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among imaging and radiographic techniques, unless the physician specifies the imaging that is most accurate.

7. **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.
8. **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.
9. **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 (C809)

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

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Clinical T

Item Length: 4 (Left justified)

NAACCR Item #: 940

NAACCR Name: TNM Clin T

Clinical T – Primary Tumor*

Code	Definition
< BLANK >	Not recorded
cX	cTX
c0	cT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
c1MI	cT1mi, pT1 mic
c1	cT1
c1A	cT1a
c1A1	cT1a1
c1A2	cT1a2

Code	Definition
c1B	cT1b
c1B1	cT1b1
c1B2	cT1b2
c1C	cT1c
c1D	cT1d
c2	cT2
c2A	cT2a
c2A1	cT2a1
c2A2	cT2a2
c2B	cT2b
c2C	cT2c
c2D	cT2d

Code	Definition
c3	cT3
c3A	cT3a
c3B	cT3b
c3C	cT3c
c3D	cT3d
c4	cT4
c4A	cT4a
c4B	cT4b
c4C	cT4c
c4D	cT4d
c4E	cT4e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific T (sub)categories used.

Coding Instructions

1. If you are unable to determine if a documented T is clinical or pathologic, default to clinical.
2. **Clinical evaluation for T:** Clinical T is based on all clinical evaluations done prior to definitive treatment, including surgery. Clinical evaluation includes: physical examination, imaging examination, or other non-invasive clinical evidence, endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy.
3. **Priority of imaging/radiographic techniques:** Information on extent of the primary tumor from imaging/radiographic techniques can be used to assign clinical T. If an involved organ or tissue is not specifically mentioned in the Clinical T descriptions or the registrar notes in [SEER*RSA](#), approximate the location from listed structures in the same anatomic area and assign the clinical T based on that information.
4. **Neoadjuvant (preoperative) therapy:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, assign the farthest T identified **prior** to the neoadjuvant (preoperative) treatment.

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5. **In situ:** For tumors diagnosed as in situ during a clinical workup, assign Clinical as (pTis). This is because in situ tumors cannot be assigned by imaging alone; histologic confirmation is needed.

Example: Breast needle core biopsy reveals an in situ lesion. No other procedures done. Assign Clinical as (pTis).
6. **Assign the farthest documented extension of the primary tumor (T).** Do not include discontinuous metastases to distant sites (these sites are coded in [Clinical M](#)) except for some sites in TNM such as: corpus uteri, ovary, fallopian tube, and female peritoneum.
 - a. For some schemas, e.g., Breast, Lung, and Kidney, direct (contiguous) extension to certain specific sites is listed under M. If the structure involved by direct extension is not listed in the T categories, look for it in M. If the specific structure involved by direct extension is not listed in either T or M, assign as farthest contiguous extension in T.

Example: CT scan shows probable renal cell carcinoma of left kidney directly invading liver; assign cM1 for liver involvement.
7. In the case of multiple tumors that are reported as a single primary, the tumor with the highest T category should be classified and the multiplicity should be indicated in the clinical stage and pathologic stage descriptors. To indicate multiple tumors, see [Clinical Stage \(Prefix/Suffix\) Descriptor](#) (code 3).
8. **Inferring primary tumor involvement from stated T category or a stage:** If the only indication of primary tumor involvement in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes B, assign the appropriate T.
 - a. If the physician documents a T category and there is no discrepancy with the documentation in the medical record, assign the T category documented by the physician.
 - b. If there is a discrepancy between documentation in the medical record and the physician's assignment of T, the documentation takes precedence.
 - c. When there is doubt that the documentation in the medical record is complete and the physician's assignment of the T category differs from the stage assignment that the medical record supports, it is the registrar's responsibility to determine the correct T category. The registrar is to use all the information available, including review of the treatment plans according to NCCN, ASCO guidelines or the ACR appropriateness.
9. **No evidence of primary tumor:** Assign T0 when there is no evidence of the primary tumor.
10. **Use of category codes when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., T1a, T1b, T2a); use the subcategories if information is available. "Not Otherwise Specified" (NOS) designations are included in the registrar notes of the category codes (e.g., T1 [NOS]) and these should only be used when the correct subcategory cannot be determined. The "NOS" wording is not official TNM descriptive terminology.

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11. **Discontinuous or distant metastases:** Discontinuous metastases are usually assigned in the M field. Some exceptions include: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in T.

12. **Highest T confirmed on biopsy:** If a diagnostic biopsy (clinical work up) shows that a structure in the highest T category is involved by the primary tumor, then assign clinical T to the highest T value.

Example: Prostate needle core biopsy including rectal tissue that is histologically confirmed to be involved by prostatic adenocarcinoma. Rectal biopsy done.

13. **Document choice of T assignment in text.** It is strongly recommended that the choice of T category be documented in a related STAGING text field on the abstract.

14. **Assign Clinical T 'cTX' when**

- a. Clinical classification criteria met, evaluation done
 - i. Physician unable to assess T
 - ii. Extension cannot be determined OR
 - iii. Tumor size (TS) unknown for T categories where TS needed to determine T
- b. Physician assigns cTX, no other information available to determine T.

Note: Criteria for clinical T includes: Physical exam, imaging, endoscopy, biopsy, surgical exploration.

Example 1: Normal physical exam, screening colonoscopy shows a 2 cm tumor with biopsy positive for colon carcinoma. Assigning a Clinical T value for colon requires information about the layers of muscular wall invasion, which cannot be determined from the clinical workup that was done in this case. Assign cTX.

Example 2: Clinical evaluation of breast tumor states “confined to breast” but no size is provided. Assign Clinical T as code TX since size determines the T category for tumors confined to the breast.

15. **Code Clinical T '88' when**

- a. Clinical T is not defined for the specific site/histology.
 - i. Schema not TNM defined. [See List of Schemas Not Defined in TNM.](#)
 - ii. Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas on [SEER*RSA](#) to determine which histologies stage.
- b. In situ case but no pTis is defined by TNM. See List of [Schemas Where Tis Coding of In Situ Tumor Not Defined.](#)

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16. Leave Clinical T blank when

- a. Clinical classification criteria not met.
- b. Clinical classification criteria met, evaluation done
 - i. No information about diagnostic workup
 - ii. Results not documented in record
- c. Clinical evaluation of primary tumor not done or unknown if done.
- d. Tumor first detected on surgical resection (no clinical workup).

Example: Incidental finding of carcinoma during gallbladder removal for cholecystitis. The cancer was not suspected prior to surgery, so there was no clinical evaluation of the tumor.

- e. Evidence of metastatic disease [(cM1) or (pM1)], no other workup
- f. Only Clinical Stage Group documented (no T, N, or M information available). See [Assigning Stage when only Information Available is Stage Group](#).

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Clinical N

Item Length: 4 (Left justified)

NAACCR Item #: 950

NAACCR Name: TNM Clin N

Clinical N – Regional lymph nodes*

Code	Definition
< BLANK >	Not recorded
cX	cNX
c0	cN0
c0A	cN0a
c0B	cN0b
c1	cN1
c1A	cN1a
c1B	cN1b
c1C	cN1c

Code	Definition
c2	cN2
c2A	cN2a
c2B	cN2b
c2C	cN2c
c3	cN3
c3A	cN3a
c3B	cN3b
c3C	cN3c
c4	cN4
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific N (sub)categories used.

Coding Instructions

1. If you are unable to determine if a documented N is clinical or pathologic, default to clinical.
2. If possible, look at the physician documentation that was used to make an informed decision on how to treat the patient and assign the Clinical N. If the patient was treated as though regional nodes were involved, assign Clinical N based on that involvement. When physician documentation is not available and/or there is no specific statement of involvement in the medical record, use the following instructions to interpret the intent of the clinician. Because individual clinicians may use these terms differently, the clinician’s definitions/descriptions and choice of therapy have priority over these guidelines.
 - a. **Terms meaning lymph node involvement:** For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are recorded as involvement of lymph nodes.
 - b. Any other terms, such as “palpable,” “enlarged,” “visible swelling,” “shotty,” or “lymph-adenopathy” should be ignored, unless there is a statement of involvement by the clinician.
 - c. For lymph nodes of the head and neck, the terms “fixed and matted” also imply extranodal extension of metastases in the lymph nodes.
 - d. The terms “homolateral,” “ipsilateral,” and “same side” are used interchangeably.

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3. **Clinical evaluation for N:** Clinical N is based on all clinical evaluations done prior to definitive, including surgery. Clinical evaluation includes: physical examination, imaging examination or other non-invasive clinical evidence, endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, excision or regional or sentinel lymph nodes without removal of the primary tumor, or other invasive techniques, including surgical observation without biopsy.
- a. **Inaccessible lymph node:** For certain primary sites, regional lymph nodes are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated. In other words, these are “inaccessible” lymph nodes. As examples, the regional lymph nodes for such primary sites as bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach are inaccessible (this is not an all-inclusive list).

For clinical N, regional lymph nodes may be assigned as **clinically NO (negative)** instead of clinically NX (unknown) when **ALL** three of the following conditions are met

- i. There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing, or surgical exploration
- ii. The patient has clinically low stage (T1, T2, or localized) disease
- iii. The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician), or patient is offered usual treatment but refuses it.

These guidelines apply primarily to localized or early (T1, T2) stage in the TNM system for inaccessible lymph nodes. When there is reasonable doubt that the tumor is not localized, the code(s) for unknown information should be used.

Example: When there is clinical evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (T3a/regional direct extension) and regional lymph node involvement is not mentioned, it would be correct to assign Clinical NX for unknown lymph node involvement in the absence of any specific information regarding regional nodes.

- b. **Accessible lymph nodes:** For “accessible” lymph nodes that can be observed, palpated, or examined without instruments, such as the regional nodes for the breast, oral cavity, skin, salivary gland, thyroid, and other organs, the abstractor should look for some description of the regional lymph nodes. A statement such as “remainder of examination negative” is sufficient to assign clinical NO for clinically negative regional lymph nodes.

Note: If there is mention of a clinical evaluation but no mention of positive lymph nodes, a clinical NO can be assigned.

4. **Priority of imaging/radiographic techniques:** Information on regional lymph nodes from imaging/radiographic techniques can be used to assign clinical N.

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5. **Neoadjuvant (preoperative) therapy:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, assign the farthest Clinical N identified *prior* to the neoadjuvant (preoperative) treatment.
6. **Tis tumors:** Assign clinical N0 for lymph node involvement.
 - a. When the primary tumor is described as in situ/noninvasive, use the appropriate code for “no lymph node involvement” in the relevant site-specific-factor.
7. **Tis tumors with nodal involvement:** If evidence of nodal involvement is associated with a Tis tumor, this would indicate that an area of invasion was missed and the primary tumor is not a Tis. The T category should be assigned as appropriate, so that the involved lymph nodes can be assigned appropriately for the case.
8. **Record the specific involved regional lymph node chain(s) farthest from the primary site.** Regional lymph nodes are listed for each schema. Generally, the regional lymph nodes in the chain(s) closest to the primary site have lower N categories, while nodes farther away from the primary or in farther lymph node chains have higher N categories, although there are exceptions due to lymph drainage patterns. If a lymph node chain is not listed, check the registrar notes in [SEER*RSA](#), Appendix C of the [Hematopoietic Manual](#), anatomy book, ICD-O-3, or medical dictionary for a synonym. If the lymph node chain or its synonym are not listed in regional lymph nodes, assign the involved node(s) in M (distant metastasis).
9. **Direct tumor extension into lymph node:** If direct extension of the primary tumor into a regional lymph node is shown clinically and the case fulfills overall site-specific clinical staging requirements, assign the involved node(s) in Clinical N.
10. **Lymph nodes, NOS:** Lymph nodes which are not specified as regional or distant should be assumed to be regional nodes. If the only information available is “lymph nodes involved,” assign the code N1.
 - a. This rule also applies to coding lymph node involvement in site-specific factors.
11. **Head and neck schemas:** For the head and neck schemas, the N code is based on several different criteria: the size of the lymph node, single vs. multiple nodes, and unilateral vs. bilateral. If even one involved node is in a higher category, assign the appropriate N in the higher category. For cases where size, laterality or number of nodes involved are relevant, use the following guidelines:
 - a. Assign N1 for the following
 - i. Positive ipsilateral lymph node, not stated if single or multiple
 - ii. Positive lymph node, not stated if ipsilateral, bilateral, or contralateral
 - iii. Positive lymph node, size not stated
 - b. Assign N2b for multiple lymph nodes, not stated if ipsilateral, bilateral, or contralateral.
 - c. Assign N2c for bilateral lymph nodes, size not stated.

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12. **Coding size of lymph node:** When size of involved regional lymph nodes is required.

- a. For clinical N only, code the size of the entire node.
- b. If the size given is described as a mass or nodule, code the size of the mass or nodule.

Example: Patient presents with 6 cm hard upper jugular (Level II) neck mass. Needle biopsy of mass shows metastatic squamous carcinoma. Panendoscopy finds lesion on soft palate. *Code clinical N as 2A (Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension)*

Code Site-Specific Factor 1 (size of lymph node) as 060

Code Site-Specific Factor 3 as 010 (level II node involved)

Code Site-Specific Factors 4-6 as 000 (no upper level nodes involved)

Code Site-Specific Factor 7 as 010 (upper level nodes involved)

Code Site-Specific Factor 8 as 010 (nodes involved clinically, no extracapsular extension clinically)

Code Site-Specific Factor 9 as 998 (Fine needle aspiration or needle biopsy only of regional nodes)

- c. Information about location, number and size of lymph nodes may be used to assign cN and one or more site-specific factors. If clinical and pathologic information are available, use the pathologic information for the Site-Specific factors.

Exception: If neoadjuvant (preoperative) therapy is given, use the clinical information for the Site-Specific factor.

13. **Inferring lymph node involvement from stated N category or a stage:** If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, assign the appropriate N category.

- a. If the physician documents an N category and there is no discrepancy with the documentation in the medical record, assign the N category documented by the physician.
- b. If there is a discrepancy between documentation in the medical record and the physician's assignment of N, the documentation takes precedence.
- c. When there is doubt that the documentation in the medical record is complete and the physician's assignment of the N category differs from the stage assignment that the medical record supports. It is the registrar's responsibility to determine the correct N category. The registrar is to use all the information available, including review of the treatment plans according to NCCN, ASCO guidelines or the ACR appropriateness.

14. **Use of category codes when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., N1a, N1b, N2a); use the subcategories if information is available. "Not Otherwise Specified" (NOS) designations are included in the registrar notes of the category (e.g., N1 [NOS]) and these should only be assigned when the correct subcategory cannot be determined. The "NOS" wording is not official TNM descriptive terminology.

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15. **Sentinel lymph nodes:** The sentinel lymph node is the first lymph node to receive lymphatic drainage from a primary tumor. If it contains metastatic tumor, this indicates that other lymph nodes may contain tumor. If it does not contain metastatic tumor, other lymph nodes are not likely to contain tumor. Occasionally there is more than one sentinel lymph node.
 - a. Involved nodes found during sentinel lymph node procedures are classified as positive regional nodes. However, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes are classified as clinical if there is no resection of the primary tumor.
16. **N categories in Skin (Non-melanoma) and Scrotum schemas:** For these two schemas, UICC only has an N2 in the Carcinoma of Skin chapter, while AJCC has subcategories N2a, N2b, and N2c. If a record comes in with N2a, N2b, or N2c, reassign it to N2. N2 and the subcategories of N2 all result in the same Stage Grouping.
17. **Highest N confirmed on biopsy:** If a diagnostic biopsy (clinical work up) shows that a structure in the highest N category is involved, assign Clinical N to the highest N value.
18. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum:** Assign N1c if the only information available is clinically identified tumor nodules in pericolic fat and the primary tumor is localized or maps to T1 or T2. If both tumor deposits and regional lymph nodes are involved, record the involved nodes in Clinical N.
19. **Document choice of N assignment in text.** It is strongly recommended that the choice of N category be documented in a related STAGING text field on the abstract.
20. **Assign Clinical N 'cNX' when**
 - a. Clinical classification criteria met, evaluation done
 - i. Physician unable to assess N
 - ii. Regional lymph node involvement cannot be determined or findings inconclusive
 - b. Physician assigns cNX, no other information available to determine N
21. **Code Clinical N '88' when**
 - a. Clinical N is not defined for the specific site/histology.
 - i. Schema not TNM defined. See [List of Schemas Not Defined in TNM](#).
 - ii. Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas on [SEER*RSA](#) to determine which histologies stage.
 - b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).

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22. Leave Clinical N blank when

- a. Clinical classification criteria not met.
- b. Clinical classification criteria met, evaluation done:
 - i. No information about diagnostic workup
 - ii. Results not documented in patient record
- c. Tumor first detected on surgical resection (no clinical workup)
- d. Evidence of metastatic disease [(cM1) or (pM1)], no other workup
- e. Only Clinical Stage Group documented (no T, N, or M information available). See [Assigning Stage When Only Information Available is Stage Group](#).

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Clinical M

Item Length: 4 (Left justified)

NAACCR Item #: 960

NAACCR Name: TNM Clin M

Clinical M – Distant metastasis*

Code	Definition
< BLANK >	Not recorded
c0	cM0
c0I+	cM0(i+)
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific M (sub)categories used.

Coding Instructions

1. If you are unable to determine if a documented M is clinical or pathologic, default to clinical.
2. Based on the UICC *Classification of Malignant Tumours* seventh edition, determination of the clinical M classification **only requires history and physical examination**. Imaging of distant organ sites is not required to assign clinical M0. In other words, the registrar can infer that there are no distant metastases solely based on PE documentation and assign clinical M0 unless distant metastases are identified and classified as clinical M1 based on imaging or pathologic M1 based on positive biopsy.
 - a. Cases in which there are no distant metastases as determined by clinical and/or radiographic methods are designated as cM0. Cases in which one or more distant metastases are identified by clinical and/or radiographic methods are designated cM1. A case is classified as clinically free of metastases (cM0) unless there is documented evidence of metastasis by clinical means or by biopsy of a metastatic site (pathologic). Assign cM0 if there is documentation available for any staging assessment, or if there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis.

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3. **MX category:** MX is **not valid** in the seventh edition TNM manual and will result in errors. MX is inappropriate as clinical assessment of metastasis can be based on physical examination alone.
 - a. This rule, introduced in the UICC seventh edition, permits data collectors to record no distant metastasis clinically as none (cM0) rather than unknown (again, based on clinical evaluation) when there is no information on distant metastasis.
4. Assign the highest applicable M for pathologic metastasis at diagnosis.
 - a. **Clinical (cM0)** may be assigned when there is no evidence of metastasis on clinical evaluation.
 - b. **Clinical (cM1)** may be assigned when there is clinical evidence of metastasis on clinical evaluation, no evidence on path and no histologic confirmation.
 - c. **Clinical (pM1)** may be assigned when there is histologic confirmation of mets.

Note: Assign Pathologic M1 as well.
5. For a few schemas such as Breast, Lung, and Kidney, the pathologic M category may include direct extension of the primary tumor into distant organs or tissues. If the structure involved by direct extension is not listed in T, look for the structure in M. Record the structure in the appropriate T or M component as listed. If the specific structure involved by contiguous extension is not listed in either T or M, assign the highest T available.
6. **Discontinuous or hematogenous metastases:** This field represents distant metastasis (M category) that is known at the time of diagnosis or found during the initial staging workup prior to first course of treatment. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to distant lymph nodes or to site(s) distant from the primary site.

Exceptions include: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastasis in the pelvis or abdomen are assigned in T.
7. **Disease progression:** Metastasis known to have developed after the initial extent of disease was established (in other words, disease progression) or after the start of treatment should be excluded when determining the farthest extent of disease at the time of diagnosis.
8. **Isolated Tumor Cells (ITCs), Circulating Tumor Cells (CTCs), and Disseminated Tumor Cells (DTCs):** ITC's, CTCs and DTCs are small clusters of tumor cells not greater than 0.2 mm in largest dimension found in distant sites such as bone, circulating blood, or bone marrow and having uncertain prognostic significance.
 - a. For breast, assign clinical M0(i+) when a biopsy of a distant site shows ITCs, CTCs or DTCs detected by IHC or molecular techniques.
 - b. For other sites, CTCs and DTCs are assigned cM0.

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9. **Use of category codes when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., M1a, M1b, M1c); use the subcategories if information is available. “Not Otherwise Specified” (NOS) designations are included in the registrar notes of the category (e.g., M1 [NOS]) and these should only be assigned when the correct subcategory cannot be determined. The “NOS” wording is not official TNM descriptive terminology.
10. **Neoadjuvant (preoperative) therapy:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, assign the farthest M identified *prior* to the neoadjuvant (preoperative) treatment.
11. **Inferring distant metastases from stated M category or a stage:** If the only indication of distant metastases in the record is the physician’s statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes D, assign the appropriate M category.
12. **Document choice of M assignment in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis be documented, as well as the choice of M category in a related STAGE text field on the abstract.
13. **Code Clinical M ‘88’ when**
 - a. Clinical M is not defined for the specific site/histology.
 - i. Schema not TNM defined. See [List of Schemas Not Defined in TNM](#).
 - ii. Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas on [SEER*RSA](#) to determine which histologies stage.
 - b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).
14. **Leave Clinical M blank when**
 - a. Clinical classification criteria not met
 - b. Clinical classification criteria met, evaluation done
 - iii. No information about diagnostic workup
 - iv. Results not documented in patient record
 - c. Clinical evaluation of T and N not done, no evidence metastatic disease
 - d. Tumor first detected on surgical resection (no clinical workup)

Note: For situations like this, the cM0 would be assigned in the pathologic M.
 - e. Only Clinical Stage Group documented (no T, N, or M information available). See [Assigning Stage When Only Information Available is Stage Group](#).

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Clinical Stage Group

Item Length: 4 (Left justified)

NAACCR Item #: 970

NAACCR Name: TNM Clin Stage Group

Description

Clinical Stage Group is the detailed site-specific field used to assign the clinical stage as defined by TNM.

This field is manually assigned and is required by SEER registrars for the following: Lymphoma, LymphomaOcularAdnexa, Occult Lung Tumors and cases where the only information available is clinical stage group. This field can be submitted for other sites. If Clinical Stage Group is not assigned, leave blank.

Code	Definition
0	Stage 0
0A	Stage 0A
0IS*	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
OC	Occult (Lung)

**Applicable for Renal Pelvis/Ureter, Bladder and Urethra*

Coding Instructions

1. If you are unable to determine if a documented TNM stage group is clinical or pathologic, default to clinical.
2. The clinical T, N, and M must match the stage group. Software edits have been developed based on the UICC TNM tables for stage groups.
 - a. SEER will continue to allow certain “NOS” stages that were collected in CS. Refer to [SEER*RSA](#) and the staging tables for a complete listing of the combinations that result in a valid stage group.
3. Refer to [SEER*RSA](#) or the most recent TNM Cancer Staging manual for staging rules and categories as there are site-specific rules that may apply in addition to the general rules.

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4. Use all available information to assign the Clinical Stage Group. If no information is available, record as documented by the treating physician(s) or managing physician.
 - a. **Lymphoma and Lymphoma Ocular Adnexa:** The Clinical Stage Group for these two schemas are manually assigned in the Clinical Stage Group. There are no T, N, and M data elements for these in TNM See the Lymphoma and Lymphoma Ocular Adnexa schemas in the [SEER*RSA](#).
 - b. Any mention of the terms including fixed, matted, mass in the hilum, mediastinum, retroperitoneum, and/or mesentery, palpable, enlarged, shotty, lymphadenopathy are all regarded as involvement for lymphomas when assigning stage.
5. CoC hospitals are required to collect the AJCC TNM data items for lymphoma ocular adnexa. These can be collected and submitted to SEER.
6. **Occult lung tumors:** Occult stage for non small cell carcinoma of the lung is assigned when cancer cells are found in the sputum and tumors are not visible. Many times, no other evidence of cancer is indicated. When that is the case, assign TX for cancer cells seen, but the tumor cannot be located. Assign cN0 and cM0 to indicate the tumor has not spread. TX, N0, M0=OC (Occult carcinoma)
 - a. TX, N0, M0 in lung will derive an unknown stage. For occult lung carcinomas, the TNM Clinical Stage Group 'OC' must be manually assigned.
7. **Manually assign** documented Clinical Stage Group in this field when that is the only information available and it is not possible to determine what the T, N, or M categories are.
 - a. If it's not possible to determine if the documented stage group is clinical or pathologic, default to clinical stage group. See [Assigning Stage when Only Information Available is Stage Group](#).
8. **Code Clinical Stage Group '88' when**
 - a. Clinical Stage is not defined for this site/histology. See [List of Schemas Not Defined in TNM](#).
 - b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).
9. **Assign Clinical Stage Group '99' when**
 - a. Clinical T, N, and M are blank (cannot be assigned) OR
 - b. Clinical Stage Group cannot be determined from the T, N, and M components

Note: The stage group can sometimes be determined even with unknown T or N values; for example in Breast, an N3 M0 cancer is assigned Stage Group IIIC, regardless of the T value (listed as "any T" in the stage group table.)

Exception: Any T and/or Any with a cM1, c(pM1) will provide a known Stage Group IV.

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Clinical Stage (Prefix/Suffix) Descriptor

Item Length: 1

NAACCR Item #: 980

NAACCR Name: TNM Clin Descriptor

Description

Clinical Stage Descriptor is the prefix or suffix used in conjunction with clinical TNM fields. The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the clinical T, N, and M categories prior to treatment. The descriptors are adjuncts to stage group, and do not change the stage group.

Code	Description	Description
0	None [SEER Note: Stage group unknown (99) or not applicable (88)]	There are no prefix or suffix descriptors that would be used for this case
1	E (Extranodal, lymphomas only)	A lymphoma case involving an extranodal site
2	S (Spleen, lymphomas only)	A lymphoma case involving the spleen
3	M (Multiple primary tumors in a single site)	This is one primary with multiple tumors in the primary site at the time of diagnosis
5	E & S (Extranodal and spleen, lymphomas only)	A lymphoma case with involvement of both an extranodal site and the spleen
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. This field cannot be blank
2. Code the clinical stage (prefix/suffix) descriptor prior to start of therapy.
3. If a physician has not recorded the descriptor, registrars will code this item based on the best available information, without necessarily requiring additional contact with the physician.
4. For cases that have unknown stage (99) or are not applicable for TNM staging (88). Assign 0.

Note: Code 0 will include the Summary Stage only schemas and DCO's.

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Staged By (Clinical Stage)

Item Length: 2

NAACCR Item #: 990

NAACCR Name: TNM Clin Staged By

Description

Staged by (Clinical Stage) identifies the person who assigned the clinical TNM staging elements.

Code	Description
00	Not staged [SEER Note: Clinical Stage group is coded unknown (99)]
10	Physician, NOS, or physician type not specified in codes 11-15 [SEER Note: Managing physician, NOS]
11	Surgeon
12	Radiation Oncologist
13	Medical Oncologist
14	Pathologist
15	Multiple Physicians; tumor board, etc.
20	Cancer registrar
30	Cancer registrar and physician
40	Nurse, physician assistant, or other non-physician medical staff
50	Staging assigned at another facility
60	Staging by Central Registry [SEER Note: Use code 60 if the stage is modified or assigned by the central
88	Case is not eligible for staging [SEER Note: Site/histology combinations not staged according to TNM or in situ cases where Tis is not defined (Clinical Stage group code 88)]
99	Staged but unknown who assigned stage

Note 1: Refer to the most recent version of [FORDS](#) for additional coding instructions.

Note 2: This field cannot be blank.

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Pathologic Staging

Timing of Data Collection

Pathologic staging includes any information obtained about extent of cancer through completion of definitive surgery(ies) as part of first course treatment or identified within four months after date of diagnosis, whichever is longer.

The following are part of the pathologic workup:

- Surgical resection WITH or WITHOUT pre-surgical systemic treatment or radiation performed
- No surgical resection done, histologic confirmation of highest T and highest N classification
- Evidence obtained from autopsy within the time frame of pathologic staging

For patients who have neoadjuvant (preoperative) therapy, assign pathologic stage and code the [Pathologic Stage \(Prefix/Suffix\) Descriptor](#) as 4 (Y classification) or 6 (M & Y classification).

Note: If you are unable to determine if a documented T, N, and M data items or Stage Group is clinical or pathologic, default to clinical.

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Tumor Size - Pathologic

Item Length: 3

NAACCR Item #:754

NAACCR Name: Tumor Size Pathologic

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
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 (98.9 cm) millimeters 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 <ul style="list-style-type: none"> • Rectosigmoid and rectum (C19.9, C20.9) • Colon (C18.0, C18.2-C18.9) If no size is documented Circumferential <ul style="list-style-type: none"> • Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica <ul style="list-style-type: none"> • Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS <ul style="list-style-type: none"> • Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse <ul style="list-style-type: none"> • 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 Not applicable (See Instructions 11 and 13, below) [SEER Note: Tumor measurement only describes pieces or chips]

Coding Instructions

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Note 1: Record tumor size only in millimeters (mm). Convert to millimeters from centimeters when size of tumor is measured in centimeters (cm).

Note 2: This field cannot be blank.

Record size:

1. Code the largest size of the primary tumor (*invasive portion*) measured on the surgical resection specimen when **surgery is administered as part of the first definitive treatment**.
 - 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 only a pathology report is available.

Example 1: 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 2: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

SEER Note 1: Tumor size noted in a resection operative report is a clinical tumor size, not a pathologic tumor size.

SEER Note 2: The pathologic tumor size is recorded from the surgical resection specimen when surgery (including after neoadjuvant therapy) is administered as part of the first definitive treatment.

Coding Rules:

1. Tumor size is the **largest dimension** of the tumor, **not necessarily the depth or thickness of the tumor**.
2. Include pathologic information obtained **through completion of definitive surgery** if the surgery is included as first course of treatment.
3. Information on size **from imaging/radiographic techniques cannot be used** to code Tumor Size – Pathologic.
4. **Recording ‘less than’/‘greater than’ tumor size**
 - a. Record the tumor size as 1 mm less 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 cm, such as < 1 cm, code as 009; or < 2 cm, coded as 019.
 - iii. Code 001 when stated as less than 1 mm.

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- b. Record the tumor size as 1 mm more 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 cm, such as > 1 cm , code as 011; or > 2 cm , code as 021.
 - c. Code 989 when described as anything greater than 989 mm (98.9 cm).
 - d. Record tumor size as the midpoint between the two when tumor size is reported between two sizes; i.e., add the two sizes together and divide by two. For example, “between 2 and 3 cm” is coded as 025 since $2 + 3 = 5$ divided by $2 = 2.5$.
5. **Rounding:** Round the tumor size only if it is described in fractions of millimeters.
- a. 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).
 - b. 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 when tumor size is greater than 1 millimeter.
 - c. 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 to 7 mm and code as 007.

Cancer in polyp described as 2.3 millimeters in size. 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 mm breast cancer. Round down to 5 mm and code as 005.

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. 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

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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).

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 field.

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. Record tumor size as 999 when the only measurement describes pieces or chips.

12. **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.

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 (C809)

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

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Pathologic T

Item Length: 4 (Left justified)

NAACCR Item #: 880

NAACCR Name: TNM Path T

Pathologic T – Primary Tumor*

Code	Definition
< BLANK >	Not recorded
pX	pTX
p0	pT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
p1MI	pT1mi, pT1 mic
p1	pT1
p1A	pT1a
p1A1	pT1a1
p1A2	pT1a2

Code	Definition
p1B	pT1b
p1B1	pT1b1
p1B2	pT1b2
p1C	pT1c
p1D	pT1d
p2	pT2
p2A	pT2a
p2A1	pT2a1
p2A2	pT2a2
p2B	pT2b
p2C	pT2c
p2D	pT2d

Code	Definition
p3	pT3
p3A	pT3a
p3B	pT3b
p3C	pT3c
p3D	pT3d
p4	pT4
p4A	pT4a
p4B	pT4b
p4C	pT4c
p4D	pT4d
p4E	pT4e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific T (sub)categories used.

Coding Instructions

- If you are unable to determine if a documented T is clinical or pathologic, default to clinical.
- Pathologic evaluation for T:** Pathologic T is based on all clinical evaluations done prior to definitive surgery, plus all information through completion of definitive surgery(ies) in the first course of treatment in the absence of disease progression or within 4 months of diagnosis, whichever is longer.

Note 1: Requirements for the specific type of surgery needed for pathologic staging vary by site; registrars must verify these in the TNM manual when determining if there is enough information to assign Pathologic T. For example, transurethral resection of a prostate carcinoma does not fulfill the site-specific pathologic staging requirement of prostatectomy.

Note 2: Operative findings during resection are included in Pathologic T, even if not confirmed by pathology. For this reason, documentation of surgical findings in the abstract text is crucial.

Example: During a colectomy the surgeon describes a colon tumor as adherent to the bladder (T4b) but elects not to remove any bladder tissue; pathology shows colon tumor perforating the visceral peritoneum (T4a) with positive margins. Assign pT4b based on surgeon's statement of bladder involvement.

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Exception: If pathology clearly disproves the surgical impression, the pathology takes precedence. In the colectomy example above, if the pathology had shown tumor extending only into the subserosa with benign adhesions on the outer surface of the serosa and negative margins, the operative impression of bladder involvement would have been disproven and pT3 would be assigned based on the pathology report.

3. **Neoadjuvant (preoperative) treatment:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, assign the farthest T category based on information about the surgery after the neoadjuvant (preoperative) treatment and code the Pathologic stage (Prefix/suffix) Descriptor as 4 (classification during or after initial multimodality therapy) or 6 (multiple primary tumors AND initial multimodality therapy).
 - a. **Complete response:** If there is complete response due to neoadjuvant therapy and there was no evidence of metastatic disease clinically (cM0), assign pT0, pN0, p(cM0).
4. **In situ tumors:** Assign pTis for in situ tumors. (See also clinical T for instructions for additional information about how to assign in situ cases).

Exception: For bladder in situ tumors, a Pathologic Tis can only be assigned if a cystectomy (partial or total) is done. A TURB does not qualify for pathologic staging.

5. **In situ pathology with nodal or metastatic tumor:** Do not use pTis for in situ if there is any evidence of nodal or metastatic involvement. The T category should be assigned as appropriate.

Exception: If neoadjuvant therapy is given for an invasive tumor, but at definitive surgery the tumor is only in situ, assign pTis and the nodes and mets as appropriate (i.e., can be positive). Code the [Pathologic stage \(Prefix/suffix\) Descriptor](#) as 4 (classification during or after initial multimodality therapy) or 6 (multiple primary tumors AND initial multimodality therapy).

6. **Invasive tumors following a clinical diagnosis of in situ:** For cases that are clinically diagnosed as in situ with a pathologic confirmation on biopsy followed by a pathologic confirmation of invasion on resection, assign the following

Clinical: pTis, cN0, cM0

Pathologic: pT1 or higher as appropriate

Example: Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. Assign pT as pT1mi for microscopic invasion because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist.

7. **Record the farthest documented extension of the primary tumor (T).** Do not include discontinuous metastases to distant sites (these sites are recorded in M [distant metastasis]) except for some sites in TNM such as: corpus uteri, ovary, fallopian tube, and female peritoneum.
 - a. For some schemas, (e.g., breast, lung, and kidney) direct (contiguous) extension to certain specific sites is listed under M [distant metastasis]. If the structure involved by direct extension is not listed in the T [primary tumor] categories, look for it in M [distant metastasis]. If the

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specific structure involved by direct extension is not listed in either T or M, assign it in T as further contiguous extension (T4).

Example: Mastectomy specimen shows primary tumor in upper outer quadrant directly invading the axillary skin; assign the skin involvement as pM1.

8. In the case of multiple tumors that are reported as a single primary, the tumor with the highest T category should be classified and the multiplicity should be indicated in the clinical stage and pathologic stage descriptors. To indicate multiple tumors, see [Pathologic Stage \(Prefix/Suffix\) Descriptor](#) (codes 3 or 6).
9. **Microscopic residual or positive tumor margins.** The presence of microscopic residual disease or positive tumor margins does not alter the T category.
10. **Inferring primary tumor involvement from stated T category or a stage:** If the only indication of primary tumor involvement in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes B, assign the appropriate T.
 - a. If the physician documents a T category and there is no discrepancy with the documentation in the medical record, assign the T category documented by the physician.
 - b. If there is a discrepancy between documentation in the medical record and the physician's assignment of T, the documentation takes precedence.
 - c. When there is doubt that the documentation in the medical record is complete and the physician's assignment of the T category differs from the stage assignment that the medical record supports. It is the registrar's responsibility to determine the correct T category. The registrar is to use all the information available, including review of the treatment plans according to NCCN, ASCO guidelines or the ACR appropriateness.
11. **Use of category codes when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., T1a, T1b, T2a); use the subcategories if information is available. "Not Otherwise Specified" (NOS) designations are included in the registrar notes of the category (e.g., T1 [NOS]) and these should only be assigned when the correct subcategory cannot be determined. The "NOS" wording is not official TNM descriptive terminology.
12. **Discontinuous or distant metastases:** Discontinuous metastases are usually assigned in the M field. Some exceptions include: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are assigned in T.

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13. **Highest T confirmed on biopsy:** If a diagnostic biopsy (clinical work up) shows that the highest T is involved, the pathologic T can be assigned to the highest T category when the highest N category is also biopsied and positive and there is no resection of the primary tumor.

Example: Large uterus tumor, sigmoid colon biopsy confirmed invasion by endometrioid carcinoma, and positive CT-guided biopsy of a paraaortic lymph node. Since overall pathologic staging criteria have been satisfied by microscopic confirmation of the highest T and highest N category for this site, assign pathologic T4.

Note: For sites where the highest T is further divided into subcategories (T4a, T4b), histologic confirmation of the highest main category (T4) is sufficient unless the sub-category would change the overall Stage Group.

14. **Highest T confirmed on biopsy and there is a resection of primary tumor:** If a diagnostic biopsy (clinical work up) shows that the highest T is involved, the pathologic T can be assigned to the highest T category when there is at least one node biopsied and there is resection of the primary tumor.
15. **Document choice of T assignment in text.** It is strongly recommended that the choice of T category be documented in a related STAGING text field on the abstract

16. **Assign Pathologic T “pTX” when**

- a. Pathologic classification criteria met, evaluation done:
 - i. Physician unable to assess T
 - ii. Surgical resection of primary tumor, extension not stated
 - iii. Tumor size (TS) unknown for T categories where TS needed to determine T

Note: Criteria for pathologic T includes: Resection of primary tumor, may require resection of organ/structure.

Example: Pathology report based on mastectomy states tumor “confined to breast” but no tumor size is provided. Assign pTX since size determines the T category for tumors confined to the breast.

17. **Code Pathologic T ‘88’ when**

- a. Pathologic T is not defined for the specific site/histology.
 - i. Schema not TNM defined. See [List of Schemas Not Defined in TNM](#).
 - ii. Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas in [SEER*RSA](#) to determine which histologies stage.
- b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).

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18. Leave Pathologic T blank when

- a. Pathologic classification criteria not met

Example: There is no surgical resection of primary tumor

- b. Pathologic classification criteria met, evaluation done:
 - i. Results not documented in patient record
 - ii. No surgical resection of known primary tumor (not T0) OR
 - iii. Resection insufficient for site-specific pathologic assessment

Note: Some schemas require resection of the organ, not just the primary tumor, for pathologic staging. For example, at least a partial cystectomy is needed to assign a pathologic T for bladder.

- c. No surgical resection of primary tumor and there isn't a positive biopsy of a structure in the highest T category and highest N category
- d. Evidence of metastatic disease (pM1), no other workup
- e. Only Pathologic Stage Group documented (no T, N, or M information available). See [Assigning Stage When Only Information Available is Stage Group](#).

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Pathologic N

Item Length: 4 (Left justified)

NAACCR Item #: 890

NAACCR Name: TNM Path N

Pathologic N – Regional lymph nodes*

Code	Definition
< BLANK >	Not recorded
pX	pNX
c0	cN0
p0	pN0
p0I-	pN0i-
p0I+	pN0i+
p0M-	pN0m-
p0M+	pN0m+
p1MI	pN1mi
p0A	pN0a
p0B	pN0b
p1	pN1
p1A	pN1a

Code	Definition
p1B	pN1b
p1C	pN1c
p2	pN2
p2A	pN2a
p2B	pN2b
p2C	pN2c
p3	pN3
p3A	pN3a
p3B	pN3b
p3C	pN3c
p4	pN4
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific N (sub)categories used.

Coding Instructions

1. If you are unable to determine if a documented N is clinical or pathologic, default to clinical.
2. The reliability of the pathologic N classification depends on the number of histologically examined regional lymph nodes. For some of the schemas, a statement regarding the number of lymph nodes ordinarily included in the lymph node dissection specimen is included in the note section. If the excised or removed lymph nodes are negative, but the number ordinarily examined is not met, pathologic N0 may still be assigned/classified in this situation. The proper coding of the number of lymph nodes positive and examined (e.g., 0/4) characterizes the reliability of the pathologic N classification.
3. **Pathologic evaluation for N:** Pathologic N is based on all clinical evaluations done prior to definitive surgery, plus all information through completion of definitive surgery(ies) in the first course of treatment in the absence of disease progression or within 4 months of diagnosis, whichever is longer.
4. **Criteria for pathologic N:** In order to assign Pathologic N, the case as a whole must fulfill the site-specific requirements for pathologic staging. In most cases, this requires resection of the primary tumor and sometimes resection of the entire organ.

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- a. When pathologic T (pT) is available, any microscopic evaluation of lymph nodes is pathologic (pN) except for excision of a lymph node when there is no resection of primary site.

Example 1: Breast lumpectomy showing carcinoma with clear margins and negative excision of one axillary lymph node. Since resection of the primary tumor with at least macroscopically clear margins is sufficient for pathologic staging of breast (pT), the lymph node biopsy is assigned pN0.

Example 2: A primary oropharynx tumor with laryngoscopic biopsy confirming squamous cell carcinoma extending into the larynx (pT4); patient has subsequent removal of 2 neck lymph nodes with no further surgery. Since the pT in this case is based only on biopsy of the highest T category, and the oropharynx pathologic staging requirement of resection is not satisfied, the lymph node excision is determined to be part of the clinical work-up, and would not be included in Pathologic N.

5. **Neoadjuvant (preoperative) treatment:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, assign the farthest involved regional lymph nodes based on information about the surgery after the neoadjuvant (preoperative) treatment and record the [Pathologic Stage \(Prefix/Suffix\) Descriptor](#) as 4 (classification during or after initial multimodality therapy) or 6 (multiple primary tumors AND initial multimodality therapy).

6. **Use of Pathologic (cN0):** For in situ tumors, a p(cN0) may be assigned when no nodes are examined.
Exception: For bladder in situ tumors, a Pathologic Tis (and p(cN0)) can only be assigned if a cystectomy (partial or total) is done. A TURB does not qualify for pathologic staging.

7. **Tis tumors with nodal involvement:** If evidence of nodal involvement is associated with a Tis tumor, this would indicate that an area of invasion was missed and the primary tumor is not a Tis. The T category should be assigned as appropriate, so that the involved lymph nodes can be assigned appropriately for the case.

- a. When the primary tumor is described as in situ/noninvasive, use the appropriate code for “no lymph node involvement” in the relevant site-specific-factor.

Exception: If neoadjuvant therapy is given for an invasive tumor, but at definitive surgery the tumor is only in situ, code as pTis and the nodes and mets as appropriate (i.e., can be positive).

8. **Record the specific involved regional lymph node chain(s) farthest from the primary site.** Regional lymph nodes are listed for each schema. Generally, the regional lymph nodes in the chain(s) closest to the primary site have lower N categories, while nodes farther away from the primary or in farther lymph node chains have higher N categories, although there are exceptions due to lymph drainage patterns. If a lymph node chain is not listed, check the registrar notes in [SEER*RSA](#), Appendix C of the [Hematopoietic Manual](#), anatomy book, ICD-O-3, or medical dictionary for a synonym. If the lymph node chain or its synonym are not listed in regional lymph nodes, assign the involved node(s) in M (distant metastasis).

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9. **Direct tumor extension into lymph node:** If direct extension of the primary tumor into a regional lymph node is proven pathologically and the case fulfills overall site-specific pathologic staging requirements, assign the involved node(s) in Pathologic N.
10. **Lymph nodes, NOS:** Lymph nodes which are not specified as regional or distant should be assumed to be regional nodes. If the only information available is “lymph nodes involved,” assign N1.
 - a. This rule also applies to coding lymph node involvement in site-specific factors.
11. **Pathologic information takes precedence.** If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, pathologic information takes precedence if no neoadjuvant (preoperative) treatment was administered. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement.
12. **Micrometastasis:** Cases with micrometastases no greater than 0.2 cm in size, are identified by the addition of ‘(mi)’, (e.g., pN1mi).

Note: Breast is currently the only schema where pathologic N1mi is recorded.
13. **Head and neck schemas:** For the head and neck schemas, N is assigned based on several different criteria: the size of the lymph node, single vs multiple nodes, and unilateral vs. bilateral. If even one involved node is in a higher category than another involved node, use the appropriate N in the higher category. For cases where size, laterality, or number of nodes involved are relevant, use the following guidelines
 - a. Assign N1 for the following
 - i. Positive ipsilateral lymph node, not stated if single or multiple
 - ii. Positive lymph node, not stated if ipsilateral, bilateral, or contralateral
 - iii. Positive lymph node, size not stated
 - b. Assign N2b for multiple lymph nodes, not stated if ipsilateral, bilateral or contralateral
 - c. Assign N2c for bilateral lymph nodes, size not stated
14. **Recording size of lymph node:** When size of involved regional lymph nodes is required
 - a. For pathologic N, record the size of the metastasis if known. If the size of the metastasis is not known, record the size of the entire lymph node.
 - b. If the size given is described only as a mass or nodule, record the size of the mass or nodule.
 - c. Information about location, number, and size of lymph nodes may be used to assign pathologic N and one or more site-specific factors. If clinical and pathologic information are available, use the pathologic information for the site-specific factors.
15. **Inferring lymph node involvement from stated N category or a stage:** If the only indication of lymph node involvement in the record is the physician’s statement of an N category from the TNM

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staging system or a stage from a site-specific staging system, such as Dukes C, assign the appropriate N category.

- a. If the physician documents an N category and there is no discrepancy with the documentation in the medical record, assign the N category documented by the physician.
 - b. If there is a discrepancy between documentation in the medical record and the physician's assignment of N, the documentation takes precedence.
 - c. When there is doubt that the documentation in the medical record is complete and the physician's assignment of the N category differs from the stage assignment that the medical record supports. It is the registrar's responsibility to determine the correct N category. The registrar is to use all the information available, including review of the treatment plans according to NCCN, ASCO guidelines or the ACR appropriateness.
16. **Use of categories when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., N1a, N1b, N2a); use the subcategories if information is available. "Not Otherwise Specified" (NOS) designations are included in the registrar notes of the category (e.g., N1 [NOS]) and these should only be assigned when the correct subcategory cannot be determined. The "NOS" wording is not official TNM descriptive terminology.
17. **Sentinel lymph nodes:** The sentinel lymph node is the first lymph node to receive lymphatic drainage from a primary tumor. If it contains metastatic tumor, this indicates that other lymph nodes may contain tumor. If it does not contain metastatic tumor, other lymph nodes are not likely to contain tumor. Occasionally there is more than one sentinel lymph node.
- a. Involved nodes found during sentinel lymph node procedures are classified as positive regional nodes. However, whether the involved sentinel lymph nodes are assigned Clinical N or Pathologic N will depend on whether the primary tumor meets the criteria for clinical or pathologic staging.
 - b. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor.
18. **Isolated Tumor Cells (ITCs) [SEER only requires for breast cancer]:** ITCs are single tumor cells or small clusters of cells not more than 0.2 mm in greatest extent that can be detected by routine H and E stains or immunohistochemistry. An additional criterion has been proposed to include a cluster of fewer than 200 cells in a single histological cross-section. ITCs do not typically show evidence of metastatic activity (e.g., proliferation or stromal reaction) or penetration of vascular lymphatic sinus walls. Cases with ITCs in lymph nodes or at distant sites should be classified as N0 or clinical M0, respectively. The same applies to cases with findings suggestive of tumor cells or their component by non-morphological techniques, such as flow cytometry or DNA analysis. Their classification is as follows:

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Pathologic N Classification	Description of Pathologic N including ITCs
pN0	No regional lymph node metastasis histologically, no examination for isolated tumor cells (ITCs)
pN0(i-)	No regional lymph node metastasis histologically, negative morphological findings for ITC
pN0(i+)	No regional lymph node metastasis histologically, positive morphological findings for ITC
pN0(mol-)	No regional lymph node metastasis histologically, negative non-morphological findings for ITC
pN0(mol+)	No regional lymph node metastasis histologically, positive non-morphological findings for ITC

- a. For breast, ITCs are assigned as negative lymph nodes (pN0(i+) or pN0(mol+))
- b. For cutaneous melanoma and Merkel Cell carcinoma only, ITCs are assigned as positive lymph nodes

19. **N categories in Skin (Non-melanoma) and Scrotum schemas:** For these two schemas, UICC only has a N2 in the Carcinoma of Skin chapter, while AJCC has N2a, N2b, and N2c. If a record comes in with N2a, N2b, or N2c, reassign it to N2. N2 and the subcategories of N2 all result in the same Stage Grouping.

20. **Tumor deposits (satellites):** Macro- or microscopic tumor nests or nodules, in the lymph drainage area of a primary carcinoma without histological evidence of residual lymph node in the nodule, may represent discontinuous spread, venous invasion (V1/2), or a totally replaced lymph node. If a nodule is stated by the pathologist to be a totally replaced lymph node (generally having a smooth contour), it should be recorded as a positive lymph node, and each such nodule should be counted separately as a lymph node in the final pN determination.

21. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid, and rectum:** Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node.

- a. If there are tumor deposits and involved regional lymph nodes, assign the information on regional lymph nodes in pathologic N, the number of positive nodes in Regional Nodes Positive, and the number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits.

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22. **Highest N confirmed on biopsy:** If a diagnostic biopsy (clinical work up) shows that the highest N is involved, the pathologic N can be assigned to the highest N category when the highest T category is also biopsied and positive and there is no resection of the primary site.

Example: Large uterus tumor, sigmoid colon biopsy confirmed invasion by endometrioid carcinoma, and positive CT-guided biopsy of a paraaortic lymph node. Since overall pathologic staging criteria have been satisfied by microscopic confirmation of the highest T and highest N category for this site, assign pathologic N1.

Note: For sites where the highest N is further divided into subcategories (N2a, N2b), histologic confirmation of the highest main category (N2) is sufficient *unless* the sub-category would change the overall Stage Group.

23. **Highest N confirmed on biopsy and resection of primary tumor:** If a diagnostic biopsy (clinical work up) shows that the highest N is involved, the pathologic N can be assigned to the highest N category when there is resection of the primary tumor.
24. Record the number of regional lymph nodes examined and number of regional lymph nodes positive based on the pathological examination (including core biopsies, fine needle aspiration (FNA), and excisional biopsies OR in dissection) of any regional lymph nodes.
25. **Document choice of N assignment in text.** It is strongly recommended that the choice of N category be documented in a related STAGING text field on the abstract.

26. **Assign Pathologic N ‘pNX’ when**

- a. Pathologic classification criteria met, evaluation done:
- Physician unable to assess N
 - Surgical resection primary tumor, no regional lymph nodes removed OR involvement of regional lymph nodes not documented

Note 1: Criteria for pathologic N: Resection of nodes WITH pT (surgical resection primary)

Note 2: A lymph node biopsy (core/FNA) or removal of a single lymph node WITHOUT resection of primary tumor qualifies only as clinical staging and not pathologic staging.

- b. Physician assign pNX, no other information available to determine N

27. **Code Pathologic N ‘88’ when**

- a. Pathologic N is not defined for the specific site/histology.
- Schema not TNM defined. See [List of Schemas Not Defined in TNM](#).
 - Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas in [SEER*RSA](#) to determine which histologies stage.

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- b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).

28. Leave Pathologic N blank when

- a. Pathologic classification criteria not met

Example: Patient with bladder tumor has a TURB, which does not meet classification criteria for pathologic T.

- b. No surgical resection of primary tumor and there isn't a positive biopsy of a structure in the highest T category and highest N category
- c. Evidence of metastatic disease (pM1), no other workup
- d. Only Pathologic Stage Group documented (no T, N, or M information available). See [Assigning Stage When Only Information Available is Stage Group](#).

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Pathologic M

Item Length: 4 (Left justified)

NAACCR Item #: 900

NAACCR Name: TNM Path M

Pathologic M – Distant metastasis*

Code	Definition
< BLANK >	Not recorded
c0	cM0
c0I+	cM0(i+)
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e
88	Not applicable

***Note:** See the individual schemas/TNM chapters for the specific M (sub)categories used.

Coding Instructions

1. If you are unable to determine if a documented M is clinical or pathologic, default to clinical.
2. Based on the UICC seventh edition, pM0 and pMX are no longer valid categories.
3. **MX category:** MX is **not** valid in seventh edition of the TNM manual and will result in errors. MX is inappropriate as clinical assessment of metastasis can be based on physical examination alone.
 - a. This rule, introduced in the UICC seventh edition, permits data collectors to record distant metastasis clinically as none (clinical M0) rather than unknown (again, based on clinical evaluation) when the clinician proceeds with usual treatment of the primary site, since this action presumes that there are no distant metastasis that would otherwise change the treatment approach.
 - b. Per the AJCC TNM webinar trainings, it's okay to assign p(cM0) for 'minimal info' cases (e.g. path-only).

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- c. Specific documentation of a physical exam is not necessary to assign p(cM0).
 - d. Pathologic assessment of metastasis (pM1) requires a biopsy positive for cancer at the metastatic site. Pathologic M0 is undefined and cannot be used.
4. Assign the highest applicable M for pathologic metastasis at diagnosis.
- a. **Pathologic (cM0)** may be assigned when there is a pT and/or pN and there is no CLINICAL evidence of metastasis.
 - b. **Pathologic (cM1)** may be assigned when there is clinical evidence of metastatic disease (clinical M1) but it is not histologically proven and there is a pT and/or pN.
 - c. **Pathologic (pM1)** may be assigned when there is a positive biopsy from a metastatic site.

Note: Clinical (pM1) may also be assigned if this is done during clinical workup. (See cM)

5. For a few schemas such as Breast, Lung, and Kidney, the pathologic M category may include direct extension of the primary tumor into distant organs or tissues. If the structure involved by direct extension is not listed in T, look for the structure in M. Record the structure in the appropriate T or M component as listed. If the specific structure involved by contiguous extension is not listed in either T or M, code the highest T available.
6. **Discontinuous or hematogenous metastases:** This field represents distant metastases (the “M” category of TNM) that are known at the time of diagnosis or found during the initial staging workup prior to first course of treatment. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or to a site remote from the primary tumor.

Exceptions include: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastasis in the pelvis or abdomen are assigned in T

7. **Disease progression:** Metastasis known to have developed after the initial extent of disease was established (in other words, disease progression) should be excluded when determining the farthest extent of disease at the time of diagnosis.
8. **Isolated tumor cells (ITCs), circulating tumor cells (CTCs), or disseminated tumor cells (DTCs):** If found in distant sites, see Clinical M. ITCs, CTCs and DTCs are small clusters of tumor cells not greater than 0.2 mm in largest dimension found in distant sites such as bone, circulating blood, or bone marrow and having uncertain prognostic significance.
- a. For breast, pathologically detected ITCs, CTCs and DTCs are assigned as p(cM0(i+)); only histologically proven mets greater than 0.2 mm are assigned pathologic M1.
9. **Neoadjuvant (preoperative) treatment:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, record histologically confirmed metastasis *based on information about the surgery after the neoadjuvant (preoperative) treatment* and record the [Pathologic stage \(Prefix/Suffix\) Descriptor](#) as 4

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(classification during or after initial multimodality therapy) or 6 (multiple primary tumors AND initial multimodality therapy).

Exception: if neoadjuvant therapy is given for an invasive tumor, but at definitive surgery the tumor is only in situ, assign pTis and the nodes and mets as appropriate (i.e., can be positive).

10. **Inferring distant metastases from stated M category or a stage:** If the only indication of distant metastases in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes D, assign the appropriate M category. If unable to determine if the M category is based on clinical or pathologic information, assign p(cM1).
11. **Use of categories when there are subcategories:** Some schemas include subcategories for T, N and M (e.g., M1a, M1b, M1c); use the subcategories if information is available. "Not Otherwise Specified" (NOS) designations are included in the registrar notes of the category (e.g., M1 [NOS]) and these should only be assigned when the correct subcategory cannot be determined. The "NOS" wording is not official TNM descriptive terminology.
12. **Document choice of M assignment in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis be documented, as well as the choice of M category in a related STAGE text field on the abstract.
13. **Code Pathologic M '88' when**
 - a. Pathologic M is not defined for the specific site/histology.
 - i. Schema not TNM defined. See [List of Schemas Not Defined in TNM](#).
 - ii. Primary site/histology not TNM defined. (For example, sarcoma of breast is collected in the Breast TNM chapter; however, it is not TNM staged). See the individual schemas in [SEER*RSA](#) to determine which histologies stage.
 - b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).
14. **Leave Pathologic M blank when**
 - a. Pathologic classification criteria not met
 - b. No pathologic workup for the T and N categories and no pathologic evidence of metastasis
 - c. Only Pathologic Stage Group documented (no T, N, or M information available). See [Assigning Stage When Only Information Available is Stage Group](#).

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Pathologic Stage Group

Item Length: 4 (Left justified)

NAACCR Item #: 910

NAACCR Name: TNM Path Stage Group

Description

Pathologic Stage Group is the detailed site-specific field used to assign the pathologic stage as defined by TNM.

This field is manually assigned and is required by SEER registrars for the following: Lymphoma, LymphomaOcularAdnexa, Occult Lung Tumors and cases where only information available is pathologic stage group. This field can be submitted for other sites. If Pathologic Stage Group is not assigned, leave blank.

Code	Definition
0	Stage 0
0A	Stage 0A
0IS*	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown
OC	Occult (Lung)

**Applicable for Renal Pelvis/Ureter, Bladder and Urethra*

Coding Instructions

1. If you are unable to determine if a documented TNM stage group is clinical or pathologic, default to clinical.
2. The pathologic T, N, and M must match the stage group. Software edits have been developed based on the UICC TNM tables for stage groups.
 - a. SEER will continue to allow certain “NOS” stages that were collected in CS. Refer to [SEER*RSA](#) and the staging tables for a complete listing of the combinations that result in a valid stage group.

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3. Refer to [SEER*RSA](#) or the most recent TNM Cancer Staging manual for staging rules and coding categories as there are site-specific rules that may apply in addition to the general rules.
4. Use all available information to assign the Pathologic Stage Group. If no information is available, assign as documented by the treating physician(s) or managing physician.
5. **Lymphoma and Lymphoma Ocular Adnexa:** The Pathologic Stage Group for these two schemas are manually assigned in the Pathologic Stage Group. There are no T, N, and M data elements for these in TNM See the Lymphoma and Lymphoma Ocular Adnexa schemas in [SEER*RSA](#).
 - a. Any mention of the terms including fixed, matted, mass in the hilum, mediastinum, retroperitoneum, and/or mesentery, palpable, enlarged, shotty, lymphadenopathy are all regarded as involvement for lymphomas when assigning stage.
 - b. CoC hospitals are required to collect the AJCC TNM data items for lymphoma ocular adnexa. These can be collected and submitted to SEER.

Note: Pathologic Staging is rarely done for Lymphomas. See registrar notes in [SEER*RSA](#) for when a case is eligible for pathologic staging for lymphomas.

6. **Occult lung tumors:** Occult stage for non small cell carcinoma of the lung is assigned when cancer cells are found in the sputum and tumors are not visible. Many times no other evidence of cancer is indicated. When that is the case: TX is assigned for cancer cells were seen, but the tumor cannot be located. N0 and M0 are assigned to indicate the tumor has not spread. TX, N0, M0=Occult carcinoma.

Note: TX, N0, M0 in lung will derive an unknown stage. For occult lung carcinomas, the TNM Pathologic Stage Group 'OC' must be manually assigned.

7. If clinical M is coded as 0, 1, 1A, 1B, or 1C, then pT, pN, and cM may be used to stage the case. If Pathologic Stage Group cannot be determined from the T, N, and M components, then assign it as unknown (99).
8. **Manually assign** documented Pathologic Stage Group in this field when that is the only information available and it is not possible to determine what the T, N, or M categories are.
 - a. If it's not possible to determine if the documented stage group is clinical or pathologic, default to clinical stage group. See [Assigning Stage When Only Information Available is Stage Group](#).
9. **Assign Pathologic Stage group '88' when**
 - a. Pathologic Stage is not defined for this site/histology. See [List of Schemas Not Defined in TNM](#).
 - b. In situ case but no pTis is defined by TNM. See [List of Schemas Where Tis Coding of In Situ Tumor Not Defined](#).

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10. Assign Pathologic Stage group '99' when

- a. Pathologic T, N, and M are blank (cannot be assigned) OR
- b. Pathologic Stage Group cannot be determined from the T, N, and M components

Note: The stage group can sometimes be determined even with unknown T or N values; for example in Breast, an N3 M0 cancer is assigned Stage Group IIIC, regardless of the T value (listed as “any T” in the stage group table.)

Exception: Any T and/or Any with a pM1, p(cM1) will provide a known Stage Group IV.

- c. Patient has complete response with neoadjuvant therapy (pT0, pN0, p(cM0))

Note: This only applies to patients who were cM0 at time of clinical workup.

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Pathologic Stage (Prefix/Suffix) Descriptor

Item Length: 1

NAACCR Item #: 920

NAACCR Name: TNM Path Descriptor

Description

Pathologic Stage Descriptor is the prefix or suffix used in conjunction with pathologic TNM fields. The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the pathologic T, N, and M categories after completion of surgical treatment. The descriptors are adjuncts to stage group, and do not change the stage group.

Code	Description	Definition
0	None [SEER Note: Stage group unknown (99) or not applicable (88)]	There are no prefix or suffix descriptors that would be used for this case
1	E (Extranodal, lymphomas only)	A lymphoma case involving an extranodal site
2	S (Spleen, lymphomas only)	A lymphoma case involving the spleen
3	M (Multiple primary tumors in a single site)	This is one primary with multiple tumors in the organ of origin at the time of diagnosis
4	Y (Classification during or after initial multimodality therapy)-pathologic staging only	Neoadjuvant treatment given before staging
5	E & S (Extranodal and spleen, lymphomas only)	A lymphoma case with involvement of both an extranodal site and the spleen
6	M & Y (Multiple primary tumors and initial multimodality therapy)	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy)
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. This field cannot be blank
2. Record the pathologic stage (prefix/suffix) descriptor after completion of surgical treatment.
3. If a physician has not recorded the descriptor, registrars will record this item based on the best available information, without necessarily requiring additional contact with the physician.
4. For cases that have unknown stage (99) or are not applicable for TNM staging (88). Assign 0.

Note: Code 0 will include the Summary Stage only schemas and DCO's.

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Staged By (Pathologic Stage)

Item Length: 2

NAACCR Item #: 930

NAACCR Name: TNM Path Staged By

Description

Staged by (Pathologic Stage) identifies the person who assigned the pathologic TNM staging elements.

Code	Description
00	Not staged
10	Physician, NOS, or physician type not specified in codes 11-15
11	Surgeon
12	Radiation Oncologist
13	Medical Oncologist
14	Pathologist
15	Multiple Physicians; tumor board, etc.
20	Cancer registrar
30	Cancer registrar and physician
40	Nurse, physician assistant, or other non-physician medical staff
50	Staging assigned at another facility
60	Staging by Central Registry
88	Case is not eligible for staging
99	Staged but unknown who assigned stage

Note 1: Refer to the most recent version of [FORDS](#) for additional coding instructions

Note 2: This field cannot be blank

Other Stage-Related Data Items

Section V: Stage of Disease at Diagnosis

TNM Edition Number

Item Length: 2

NAACCR Item #: 1060

NAACCR Name: TNM Edition Number

Description

TNM Edition Number indicates the edition of the TNM manual that was used to manually assign the TNM categories for patient.

Code	Description
00	Not staged (cases that have (TNM) staging scheme and staging was not done)
01	First edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), recommend for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+)
U7	UICC Seventh Edition (published 2009), recommended for SEER registries for use with cases diagnosed 2016+ (see #2 below)*
88	Not applicable (cases that do not have an (TNM staging scheme)
99	Edition unknown

Coding Instructions

1. Record based on the edition of the TNM manual that was used to stage the case.
2. Standard setters other than SEER are following AJCC 7th edition guidelines. Thus, many abstracts received at the central registry will be set to 07. If data received by the central registry are **not** changed, the 07 would remain unchanged. If stage in an abstract is assigned by SEER registry staff (either in the office or in the field), or data received in AJCC seventh edition is modified at the central registry, UICC guidelines should be followed and the TNM Edition Number should be set to U7 and staged by field to be Central Registry (“Staged by” field is 60).

Note: The U7 value should ONLY be sent to SEER, it MUST be converted to 07 before sending to other standard setters.

Section V: Stage of Disease at Diagnosis

Lymph-vascular Invasion

Item Length: 1

NAACCR Item #: 1182

NAACCR Name: Lymph-vascular Invasion

Description

Indicates whether lymphatic duct or blood vessel invasion of the primary tumor is identified in the pathology report.

Note: SEER requires Lymph-vascular Invasion (LVI) recorded for penis and testis cases only. SEER registries may submit LVI for other sites when available. Record 8 for sites other than penis and testis when LVI is not available or when not applicable (see #4).

Code	Description
0	Lymph-vascular Invasion stated as Not Present
1	Lymph-vascular Invasion Present/Identified
8	Not applicable
9	Unknown/Indeterminate/not mentioned in path report

Coding Instructions

- Code from pathology report(s).** Code the absence or presence of lymph-vascular invasion as described in the medical record.
 - The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from other sections of the pathology report or a physician's statement, in that order.
 - Do not code perineural invasion in this field.
 - Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection.)
 - If lymph-vascular invasion is identified in any primary tumor specimen, code as present/identified.
 - LVI is impossible for benign, borderline or in situ cases. These cases should be coded to 0.

Section V: Stage of Disease at Diagnosis

- f. For cases treated with neoadjuvant (preoperative) therapy, refer to table below to code this field. However, if documentation in the medical record conflicts with this table, code lymph-vascular invasion based on the documentation in the medical record.

LVI on pathology report PRIOR to neoadjuvant (preoperative) therapy	LVI on pathology report AFTER neoadjuvant (preoperative) therapy	<i>Code LVI to</i>
0 - Not present/Not identified	0 - Not present/Not identified	<i>0 - Not present/Not identified</i>
0 - Not present/Not identified	1 - Present/Identified	<i>1 - Present/Identified</i>
0 - Not present/Not identified	9 - Unknown/Indeterminate	<i>9 - Unknown/Indeterminate</i>
1 - Present/Identified	0 - Not present/Not identified	<i>1 - Present/Identified</i>
1 - Present/Identified	1 - Present/Identified	<i>1 - Present/Identified</i>
1 - Present/Identified	9 - Unknown/Indeterminate	<i>1 - Present/Identified</i>
9 - Unknown/Indeterminate	0 - Not present/Not identified	<i>9 - Unknown/Indeterminate</i>
9 - Unknown/Indeterminate	1 - Present/Identified	<i>1 - Present/Identified</i>
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	<i>9 - Unknown/Indeterminate</i>

2. Use **code 0** when the pathology report indicates that there is no lymph-vascular invasion. This includes cases of purely in situ carcinoma, which biologically do not access lymphatic or vascular channels below the basement membrane.
3. Use **code 1** when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.
 - a. **Synonyms** include, but are not limited to
 - i. Angiolymphatic invasion
 - ii. Blood vessel invasion
 - iii. Lymph vascular emboli
 - iv. Lymphatic invasion
 - v. Lymphovascular invasion
 - vi. Vascular invasion
4. Use **code 8** for the following schemas
 - a. Lymphoma
 - b. Heme Retic
 - c. Myeloma Plasma Cell Disorder
 - d. Schemas other than Penis and Testis if the registry has opted not to collect it

Section V: Stage of Disease at Diagnosis

5. Use **code 9** when
 - a. There is no microscopic examination of a primary tissue specimen
 - b. The primary site specimen is cytology only or a fine needle aspiration
 - c. The biopsy is only a very small tissue sample
 - d. It is not possible to determine whether lymph-vascular invasion is present
 - e. The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
 - f. Lymph-vascular invasion is not mentioned in the pathology report
 - g. Primary site is unknown
6. Clarification between codes 8 and 9
 - a. Code 8 should only be used in the following situations
 - i. Standard-setter does not require this item and you are not collecting it.
 - ii. Those histologies noted above described in code 8 for which LVI is always not applicable.
 - b. For those cases where there is no information/documentation from the pathology report or other sources, use code 9

Section V: Stage of Disease at Diagnosis

Mets at Dx – Bone

Item Length: 1

NAACCR Item #:1112

NAACCR Name: Mets at Dx–Bone

New data item for diagnosis year 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

- Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. This field should not be coded for bone marrow involvement.
 - Bone involvement may be single or multiple
 - Information about bone involvement may be clinical or pathologic
 - Code this field for bone metastases even if the patient had any neoadjuvant (preoperative) systemic therapy
 - This field should be coded for all solid tumors, Kaposi Sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
- Use of codes:** Assign the code that best describes whether the case has bone metastases at diagnosis.
 - Use code 0 when the medical record
 - Indicates that there are no distant (discontinuous) metastases at all
 - Includes a clinical or pathologic statement that there are no bone metastases
 - Includes imaging reports that are negative for bone metastases

Section V: Stage of Disease at Diagnosis

- 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 lung and liver metastases 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 as 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 combination for which a code for 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 coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

*[**SEER Note:** Mets at Dx-Bone is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

- d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has bone metastases; for example, when there is documentation of carcinomatosis but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

Section V: Stage of Disease at Diagnosis

Mets at Dx – Brain

Item Length: 1

NAACCR Item #: 1113

NAACCR Name: Mets at Dx-Brain

New data item for diagnosis year 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

- Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. This field should not be coded for involvement of spinal cord or other parts of the central nervous system.
 - Brain involvement may be single or multiple
 - Information about brain involvement may be clinical or pathologic
 - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
 - This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
- Use of codes.** Assign the code that best describes whether the case has brain metastases at diagnosis.
 - Use code 0 when the medical record
 - Indicates that there are no distant (discontinuous) metastases at all
 - Includes a clinical or pathologic statement that there are no brain metastases
 - Includes imaging reports that are negative for brain metastases
 - 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 lung and liver metastases but not brain

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- 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 as an unknown primary (C809) and brain is mentioned as a distant metastatic site
- c. Use code 8 (Not applicable) for the following site/histology combination for which a code for 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 coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

*[SEER Note: Mets at Dx-Brain is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

- d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has brain metastases; for example, when there is documentation of carcinomatosis but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

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Mets at Dx – Liver

Item Length: 1

NAACCR Item #: 1115

NAACCR Name: Mets at Dx-Liver

New data item for diagnosis year 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

- Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis.
 - Liver involvement may be single or multiple
 - Information about liver involvement may be clinical or pathologic
 - Code this field whether or not the patient had any neoadjuvant (preoperative) systemic therapy
 - This field should be coded for all solid tumors, Kaposi Sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
- Use of codes:** Assign the code that best describes whether the case has liver metastases at diagnosis.
 - Use code 0 when the medical record
 - Indicates that there are no distant (discontinuous) metastases at all
 - Includes a clinical or pathologic statement that there are no liver metastases
 - Includes imaging reports that are negative for liver metastases
 - 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 lung and brain metastases but not liver

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- 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 as an unknown primary (C809) and liver is mentioned as a distant metastatic site

- c. Use code 8 (Not applicable) for the following site/histology combination for which a code for 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 coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

*[SEER Note: Mets at Dx-Liver is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

- d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has liver metastases; for example, when there is documentation of carcinomatosis but liver is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

Section V: Stage of Disease at Diagnosis

Mets at Dx – Lung

Item Length: 1

NAACCR Item #: 1116

NAACCR Name: Mets at Dx-Lung

New data item for diagnosis year 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. This field should not be coded for pleural or pleural fluid involvement.
 - 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 any neoadjuvant (preoperative) systemic therapy unless determined to be disease progression
 - d. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary 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

Section V: Stage of Disease at Diagnosis

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

Example: Use code 0 when the patient has liver and brain metastases 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
 - a) Do not assign code 1 for a lung primary with multifocal involvement of the same lung
 - iii. Indicates that the patient is diagnosed as an unknown primary (C809) and lung is mentioned as a distant metastatic site
- c. Use code 8 (Not applicable) for the following site/histology combination for which a code for 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 coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

*[**SEER Note:** Mets at Dx-Lung is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

- d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has lung metastases; for example, when there is documentation of carcinomatosis but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

Section V: Stage of Disease at Diagnosis

Mets at Dx – Distant Lymph Node(s)

Item Length: 1

NAACCR Item #: 1114

NAACCR Name: Mets at Dx-Distant LN

New data item for diagnosis year 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

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 any neoadjuvant (preoperative) systemic therapy
 - d. This field should not be coded for regional lymph node involvement with the exception of lymph nodes for placenta which are M1
 - e. This field should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites

SEER Note 1: Lymph nodes not listed as regional lymph nodes are to be classified as distant lymph nodes using the TNM definitions.

SEER Note 2: For unknown primaries, unless involved lymph nodes are stated to be distant lymph nodes, assign code 9 for unknown.

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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 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 lung and liver metastases 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
 - ii. Indicates that the patient is diagnosed as an unknown primary (C809) and distant lymph node(s) are mentioned as a metastatic site.
 - c. Use code 8 (Not applicable) for the following site/histology combination for which a code for 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 coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

[SEER Note: Mets at Dx-Distant lymph nodes is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

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- d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has distant lymph node metastases; for example, when there is documentation of carcinomatosis but distant lymph node(s) are not specifically mentioned as a metastatic site. 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).

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Mets at Dx – Other

Item Length: 1

NAACCR Item #: 1117

NAACCR Name: Mets at Dx-Other

New data item for diagnosis year 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 Diagnosis – Bone, Mets at Diagnosis – Brain, Mets at Diagnosis – Liver, Mets at Diagnosis – Lung, and Mets at Diagnosis – 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
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

- 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.
 - Other involvement may be single or multiple
 - Information about other involvement may be clinical or pathologic
 - Code this field whether or not the patient had any preoperative (neoadjuvant) systemic therapy
 - This field should be coded for all solid tumors, Kaposi Sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
- Use of codes:** Assign the code that best describes whether the case has other metastases at diagnosis.

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- 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 lung and liver metastases only

- b. Use code 1 when the medical record
 - i. indicates that the patient has distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung or distant lymph node(s)
 - ii. includes but not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin
- c. Use code 8 (Not applicable) for the following site/histology combination for which a code for distant metastasis is not clinically relevant.*

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

*[**SEER Note:** Mets at Dx-Other is to be coded for Lymphomas (9590-9699, 9702-9727, 9735, 9737-9738 (All sites) and 9811-9818, 9823, 9827, 9837 (All sites EXCEPT C420, C421, C424))]

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

Section V: Stage of Disease at Diagnosis

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.

This data item is not required for SEER. This item can be derived from Tumor Size-Clinical and Tumor Size-Pathologic.

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	<p>SITE-SPECIFIC CODES</p> <p>Alternate descriptions of tumor size for specific sites:</p> <p>Familial/multiple polyposis:</p> <ul style="list-style-type: none"> • Rectosigmoid and rectum (C19.9, C20.9) • Colon (C18.0, C18.2-C18.9) <p>If no size is documented:</p> <p>Circumferential:</p> <ul style="list-style-type: none"> • Esophagus (C15.0-C15.5, C15.8-C15.9) <p>Diffuse; widespread: 3/4s or more; linitis plastica:</p> <ul style="list-style-type: none"> • Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) <p>Diffuse, entire lung or NOS:</p> <ul style="list-style-type: none"> • Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9)

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Code	Description
	Diffuse: <ul style="list-style-type: none"> • 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 Not applicable (See Section 15, below.)

Coding Instructions

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 1: 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 2: 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 (preoperative) therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant (preoperative) treatment; if unknown code size as 999.

Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant (preoperative) 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, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

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Coding Rules

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 as 001*.

5.2 mm breast cancer. *Round down 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, but it should be taken as low priority, 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.

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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 1: 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 2: 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 field.

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.

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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

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

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Regional Nodes Positive

Item Length: 2

NAACCR Item #: 820

NAACCR Name: Regional Nodes Positive

Description

Records the exact number of regional nodes examined by the pathologist and found to contain metastasis. This data item must be collected on all cases

Codes	Description
00	All nodes examined are negative
01-89	1-89 nodes are positive (code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration OR core biopsy of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	It is unknown whether nodes are positive; not applicable; not stated in patient record

Coding Instructions

- Regional lymph nodes only.** Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.
 - For Kaposi sarcoma, retinoblastoma, and lymphoma ocular adnexa, while all lymph node involvement (regional and distant) is coded in N, only count positive regional lymph nodes and not the distant N1 nodes in this field.
- This field is based on pathologic information only.** This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
- True **in situ cases** cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

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4. **Nodes positive is cumulative.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
 - a. The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
 - b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also [Use of Code 95](#) below.

Example 1: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and [Regional Nodes Examined](#) as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

Example 2: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. **Code Regional Nodes Positive as 01 and [Regional Nodes Examined](#) as 06.**
 - c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code Regional Nodes Positive as 04 and [Regional Nodes Examined](#) as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**
 - d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code Regional Nodes Positive as 07 and [Regional Nodes Examined](#) as 14.**
5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.
6. **Positive Nodes in Multiple Primaries in Same Organ.** If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the

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nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

Example: A breast case is two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. **Code Regional Nodes Positive as 03 and [Regional Nodes Examined](#) as 11 for both primaries.**

7. **Isolated Tumor Cells (ITCs)** in lymph nodes. For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
 - a. For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.
8. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
 - a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and [Regional Nodes Examined](#) as 95.**

- b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code Regional Nodes Positive as 95 and [Regional Nodes Examined](#) as the 06 nodes surgically resected.**

9. **Code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant (preoperative) chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes show

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chemotherapy effect. **Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code [Regional Nodes Examined](#) as 10.**

Note 1: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided, even if this means slightly undercounting the number of nodes positive.

Note 2: If the aspirated node is the only one that is microscopically positive, use code 95.

Note 3: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

10. **Code 98** may be used in several situations:

- a. When the assessment of lymph nodes is clinical only
- b. When no lymph nodes are removed and examined.
- c. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination
- d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

11. **Code 99.** If it is unknown whether regional lymph nodes are positive

- a. **Primary sites always coded 99.** For the following schemas, the Regional Nodes Positive field is always coded as 99.
 - i. Brain
 - ii. CNS Other
 - iii. Heme Retic
 - iv. Ill-Defined Other (includes unknown primary [C809])
 - v. Intracranial Gland
 - vi. Lymphoma (excluding Mycosis Fungoides [9700/3] and Sezary Syndrome [9701/3])
 - vii. Myeloma Plasma Cell Disorder
 - viii. Placenta

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Regional Nodes Examined

Item Length: 2

NAACCR Item #: 830

NAACCR Name: Regional Nodes Examined

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologists. This data item must be collected on all cases.

Code	Description
00	No nodes were examined
01-89	1-89 nodes are examined (code exact number of nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration OR core biopsy regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes are examined; not applicable; not stated in patient record

Coding Instructions

- Regional lymph nodes only.** Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.
 - For Kaposi sarcoma, retinoblastoma, and lymphoma ocular adnexa, while all lymph node involvement (regional and distant) is coded in N, only count positive regional lymph nodes and not the distant N1 nodes in this field.

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2. **This field is based on pathologic information only.** This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.
3. **Code 00** may be used in several situations
 - a. When the assessment of lymph nodes is clinical.
 - b. When no lymph nodes are removed and examined.
 - c. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
 - d. If Regional Nodes Examined is coded 00, [Regional Nodes Positive](#) is coded as 98.
4. Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist.
 - a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.
 - b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code [Regional Nodes Positive](#) as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

- c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code [Regional Nodes Positive](#) as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**

- d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code [Regional Nodes Positive](#) as 07 and Regional Nodes Examined as 14.**

5. **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.

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6. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code [Regional Nodes Positive](#) as 95 and Regional Nodes Examined as 95.**
7. **Lymph node excision biopsy.** If a lymph node excision biopsy was performed, code the number of nodes removed, if known.
8. Definition of **“sampling” (code 96)**. A lymph node “sampling” is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
9. Definition of **“dissection” (code 97)**. A lymph node “dissection” is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
10. **Multiple lymph node procedures.** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
11. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use **code 98**.
12. **Code 99.** If it is unknown whether nodes were removed or examined, code as 99
 - a. Primary sites always coded 99. For the following schemas, the Regional Nodes Examined field is always coded as 99.
 - i. Brain
 - ii. CNS Other
 - iii. Heme Retic
 - iv. Ill-Defined Other (includes unknown primary [C809])
 - v. Intracranial Gland
 - vi. Lymphoma (excluding Mycosis Fungoides [9700/3] and Sezary Syndrome [9701/3])
 - vii. Myeloma Plasma Cell Disorder
 - viii. Placenta

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Site-Specific Factors 1-24

Item Length: 3

NAACCR Item #: See table below

NAACCR Name: CS Site-Specific Factor 1-24

Description

Identifies additional information needed to generate stage, or prognostic factors that can have an effect on stage or survival.

Data Item	NAACCR Number	Data Item	NAACCR Number
Site-Specific Factor 1	2880	Site-Specific Factor 13	2867
Site-Specific Factor 2	2890	Site-Specific Factor 14	2868
Site-Specific Factor 3	2900	Site-Specific Factor 15	2869
Site-Specific Factor 4	2910	Site-Specific Factor 16	2870
Site-Specific Factor 5	2920	Site-Specific Factor 17	2871
Site-Specific Factor 6	2930	Site-Specific Factor 18	2872
Site-Specific Factor 7	2861	Site-Specific Factor 19	2873
Site-Specific Factor 8	2862	Site-Specific Factor 20	2874
Site-Specific Factor 9	2863	Site-Specific Factor 21	2875
Site-Specific Factor 10	2864	Site-Specific Factor 22	2876
Site-Specific Factor 11	2865	Site-Specific Factor 23	2877
Site-Specific Factor 12	2866	Site-Specific Factor 24	2878

Coding Instructions

1. For most site-specific factors, the site-specific factor contains information defining whether the factor is based on clinical or pathologic information. For those instances where there are no clear instructions and there is both clinical and positive pathologic information, code the site-specific factor based on the positive pathologic information.
2. Refer to the coding instructions in [SEER*RSA](#) or SEER*DMS.

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3. Refer to the site and histology-specific instructions in the CS Manual (v02.05.50) for coding instructions. Registrars are not required to report information for these data items that are not readily available in the patient record.

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Site-Specific Factor 25

Item Length: 3

NAACCR Item #: 2879

NAACCR Name: CS Site-Specific Factor 25

Description

Identifies additional information needed to generate stage, or prognostic factors that can have an effect on stage or survival.

Site-Specific Factor 25 (SSF 25) is used to discriminate between staging schemas or between TNM chapters where site and histology alone are insufficient. Use of this item is limited to specific subsites and histologies as shown below.

SSF 25 applies to the following schemas:

- Bile Ducts Distal
- Bile Ducts Perihilar
- Cystic Duct
- Esophagus GE Junction
- Lacrimal Gland
- Lacrimal Sac
- Melanoma Ciliary Body
- Melanoma Iris
- Nasopharynx
- Pharyngeal Tonsil
- Stomach

Note: For those collecting CS, SSF25 for Peritoneum/Peritoneum Female Genital still needs to be coded.

Coding Instructions

1. Refer to the coding instructions in the [SEER*RSA](#) or SEER*DMS.
2. Refer to the site and histology-specific instructions in the CS Manual (v02.05.50) for coding instructions.

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Site-Specific Factors No Longer Applicable for Registries collecting TNM only (effective with cases 1/1/2016)

These SSFs are no longer required because the T, N, or M already incorporates the information from the SSFs. For those registries collecting TNM only, these SSFs will no longer be required, nor will they show up in the schema. For those registries that have DMS, a 988 will automatically be filled into these fields since they are still part of the NAACCR record.

For registries continuing to collect CS, these SSFs still need to be collected since they are part of the CS algorithm to derive T, N, M or Stage.

Schema	SSF	Name of SSF	TNM component
Appendix	2	Clinical Assessment of Regional lymph nodes	cN
Bile Ducts Intrahepatic	10	Tumor Growth Pattern	T4
Carcinoid Appendix	2	Clinical Assessment of Regional Lymph nodes	cN
Colon	2	Clinical Assessment of Regional Lymph nodes	cN
Esophagus	1	Clinical Assessment of Regional Lymph nodes	cN
Esophagus GE Junction	1	Clinical Assessment of Regional Lymph nodes	cN
Melanoma Skin	3	Clinical Assessment of Regional Lymph nodes	cN
Merkel cell (4 schemas)	3	Clinical Assessment of Regional Lymph nodes	cN
NETColon	2	Clinical Assessment of Regional Lymph nodes	cN
NETRectum	2	Clinical Assessment of Regional Lymph nodes	cN
NETStomach	1	Clinical Assessment of Regional Lymph nodes	cN
Prostate	3	CS Extension-Pathologic Extension	pT
Rectum	2	Clinical Assessment of Regional Lymph nodes	cN
Retinoblastoma	1	Extension Evaluated at Enucleation	pT
Small Intestine	2	Clinical Assessment of Regional Lymph nodes	cN
Skin Eyelid	3	Clinical Status of Lymph node	cN
Stomach	1	Clinical Assessment of Regional Lymph nodes	cN

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Derived SEER Data Items

These data items are calculated by SEER and are new for year 2016.

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Derived SEER Clinical Stage Group

Item Length: 5

NAACCR Item #: 3610

NAACCR Name: Derived SEER Clin Stg Grp

New data item for diagnosis year 2016.

Description

This is a derived field.

The SEER Program developed an algorithm to calculate clinical stage group based on the clinical T, N, and M components and additional information as needed. Once the clinical T, N, and M categories are known, and other data items as appropriate, the algorithm will derive the stage group. The results are stored in this field, separate from the directly assigned clinical stage group (NAACCR #970).

The field will be left blank if the algorithm has not been run; it will be 88 if TNM does not apply to the schema or site/histology combination, and will be 90 if the algorithm has been run but there were data errors that prevented the derivation of this field. You must correct the T, N, and M categories and any other necessary field to obtain a valid stage group (see list below).

Code	Definition
0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown

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Derived SEER Pathologic Stage Group

Item Length: 5

NAACCR Item #: 3605

NAACCR Name: Derived SEER Path Stg Grp

New data item for diagnosis year 2016.

Description

This is a derived field.

The SEER Program developed an algorithm to calculate pathologic stage group based on the pathologic T, N, and M categories and additional information as needed. Once the pathologic T, N, and M categories are known, and other data items as appropriate, the algorithm will derive the stage group. The results are stored in this field, separate from the directly assigned stage group (NAACCR #910).

The field will be left blank if the algorithm has not been run; will be code 88 if TNM does not apply to the schema or site/histology combination or there is an insitu tumor where no in situ is recognized, and will be 90 if the algorithm has been run but there were data errors that prevented the derivation of this field. You must correct the T, N, and M categories and any other necessary field to obtain a valid stage group (see list below).

Code	Definition
0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown

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Derived SEER Combined T

Item Length: 5

NAACCR Item #: 3616

NAACCR Name: Derived SEER Combined T

New data item for diagnosis year 2016.

Description

This is a derived field based on Clinical T (NAACCR #940) and Pathologic T (NAACCR #880).

SEER has derived a combined (clinical and pathologic) T from CS for diagnosis years 2004 – 2015. SEER will continue derivation of a combined T category in order to evaluate trends in cancer incidence by stage over time. SEER developed an algorithm to combine the clinical and pathologic information for the T category into a Derived Combined T category. The Combined T is used in conjunction with Combined N and Combined M categories to derive a Combined Stage.

Code	Definition
(blank)	Not derived
X	TX
0	T0
A	Ta
IS	Tis
ISPU	Tispu
ISPD	Tispd
1MI	T1mi, T1 mic
1	T1
1A	T1a
1A1	T1a1
1A2	T1a2

Code	Definition
1B	T1b
1B1	T1b1
1B2	T1b2
1C	T1c
1D	T1d
2	T2
2A	T2a
2A1	T2a1
2A2	T2a2
2B	T2b
2C	T2c
2D	T2d

Code	Definition
3	T3
3A	T3a
3B	T3b
3C	T3c
3D	T3d
4	T4
4A	T4a
4B	T4b
4C	T4c
4D	T4d
4E	T4e
88	Not applicable

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Derived SEER Combined N

Item Length: 5

NAACCR Item #: 3618

NAACCR Name: Derived SEER Combined N

New data item for diagnosis year 2016.

Description

This is a derived field based on Clinical N (NAACCR #950) and Pathologic N (NAACCR #890).

SEER has derived a combined (clinical and pathologic) N category from CS for diagnosis years 2004 – 2015. SEER will continue derivation of a combined N category in order to evaluate trends in cancer incidence by stage over time. SEER developed an algorithm to combine the clinical and pathologic information for the N category into a Derived Combined N category. The Combined N is used in conjunction with the Combined T and Combined M categories to derive a Combined Stage.

Code	Definition
(blank)	Not derived
X	NX
0	N0
0I-	N0i-
0I+	N0i+
0M-	N0m-
0M+	N0m+
1MI	N1mi
0A	N0a
0B	N0b
1	N1
1A	N1a

Code	Definition
1B	N1b
1C	N1c
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
4	N4
88	Not applicable

Section V: Stage of Disease at Diagnosis

Derived SEER Combined M

Item Length: 5

NAACCR Item #: 3620

NAACCR Name: Derived SEER Combined M

New data item for diagnosis year 2016.

Description

This is a derived field based on Clinical M (NAACCR #960) and Pathologic M (NAACCR #900).

SEER has derived a combined (clinical and pathologic) M from CS for diagnosis years 2004 – 2015. SEER will continue derivation of a combined M category in order to evaluate trends in cancer incidence by stage over time. SEER developed an algorithm to combine the clinical and pathologic information for the M category into a Derived Combined M category. The Combined M category is used in conjunction with the Combined T and Combined N categories to derive a Combined Stage.

Code	Definition
(blank)	Not derived
0	M0
0I+	M0(i+)
1	M1
1A	M1a
1B	M1b
1C	M1c
1D	M1d
1E	M1e
88	Not applicable

Section V: Stage of Disease at Diagnosis

Derived SEER Combined T Source (Clinical or Pathologic)

Item Length: 1

NAACCR Item #: 3622

NAACCR Name: Derived SEER Cmb T Src

New data item for diagnosis year 2016.

Description

A computer algorithm derives the Combined T category based on the respective clinical and pathologic T components plus any additional information as needed. Based on the algorithm, the computer chooses to use just the clinical component, just the pathologic components, or in a few rare instances to combine information from both the clinical and pathologic to determine the Derived SEER Combined T category. This field documents the source of the information used for the Derived Combined T category.

Code	Description
1	Clinical
2	Pathologic
3	Clinical and pathologic information used
9	Unknown

Section V: Stage of Disease at Diagnosis

Derived SEER Combined N Source (Clinical or Pathologic)

Item Length: 1

NAACCR Item #: 3624

NAACCR Name: Derived SEER Cmb N Src

New data item for diagnosis year 2016.

Description

A computer algorithm derives the Combined N category based on the respective clinical and pathologic N components plus any additional information as needed. Based on the algorithm, the computer chooses to use just the clinical component, just the pathologic component, or in a few rare instances to combine information from both the clinical and pathologic components to determine the Derived SEER Combined N category. This field documents the source of the information used for the Derived Combined N category.

Code	Description
1	Clinical
2	Pathologic
3	Clinical and pathologic information used
9	Unknown

Section V: Stage of Disease at Diagnosis

Derived SEER Combined M Source (Clinical or Pathologic)

Item Length: 1

NAACCR Item #: 3626

NAACCR Name: Derived SEER Cmb M Src

New data item for diagnosis year 2016.

Description

A computer algorithm derives the Combined M category based on the respective clinical and pathologic M components plus any additional information as needed. Based on the algorithm, the computer chooses to use just the clinical component, just the pathologic component, or in a few rare instances to combine information from both the clinical and pathologic components to determine the Derived SEER Combined M category. This field documents the source of the information used for the Derived Combined M category.

Code	Description
1	Clinical
2	Pathologic
3	Clinical and pathologic information used
9	Unknown

Section V: Stage of Disease at Diagnosis

Derived SEER Combined Stage Group

Item Length: 5

NAACCR Item #: 3614

NAACCR Name: Derived SEER Cmb Stg Grp

New data item for diagnosis year 2016.

Description

The SEER Combined Stage Group is derived based on Derived SEER Combined T (NAACCR #3616), Derived SEER Combined N (NAACCR #3618), and Derived SEER Combined M (NAACCR #3620) and other data items as appropriate. A computer algorithm derives the category stored in this field.

SEER has derived a combined (clinical and pathologic) stage group from CS for diagnosis years 2004 – 2015. SEER will continue derivation of a combined stage group in order to evaluate trends in cancer incidence by stage over time. SEER developed an algorithm to combine the clinical and pathologic information for stage group into a Derived Combined Stage Group.

The field will be left blank if the algorithm has not been run, will be code 88 if TNM does not apply to the schema or site/histology combination, and will be 90 if the algorithm has been run but there were data errors that prevented the derivation of this field. You must correct the T, N, and M categories and any other necessary field to obtain a valid stage group (see list below).

Code	Definition
0	Stage 0
0A	Stage 0A
0IS	Stage 0is
1	Stage I
1A	Stage IA
1A1	Stage IA1
1A2	Stage IA2
1B	Stage IB
1B1	Stage IB1
1B2	Stage IB2
1C	Stage IC

Code	Definition
1S	Stage IS
2	Stage II
2A	Stage IIA
2A1	Stage IIA1
2A2	Stage IIA2
2B	Stage IIB
2C	Stage IIC
3	Stage III
3A	Stage IIIA
3B	Stage IIIB
3C	Stage IIIC

Code	Definition
3C1	Stage IIIC1
3C2	Stage IIIC2
4	Stage IV
4A	Stage IVA
4A1	Stage IVA1
4A2	Stage IVA2
4B	Stage IVB
4C	Stage IVC
OC	Occult
88	Not applicable
99	Unknown

Section V: Stage of Disease at Diagnosis

SEER Summary Stage Data Items

Section V: Stage of Disease at Diagnosis

SEER Summary Stage 1977

Item Length: 1

NAACCR Item #: 760

NAACCR Name: SEER Summary Stage 1977

Description

This data item is required only for SEER registries that elect to have SEER submit their data to NAACCR. Cases diagnosed before January 1, 2001 should be assigned a summary stage according to *SEER Summary Staging Guide*.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Section V: Stage of Disease at Diagnosis

SEER Summary Stage 2000

Item Length: 1

NAACCR Item #: 759

NAACCR Name: SEER Summary Stage 2000

Description

SEER registries may manually code SEER Summary Stage (NAACCR item #759) or use CS to derive Summary Stage (NAACCR item #3020). SEER Summary Stage 2000 is required for SEER registries that elect to have SEER submit their data to NAACCR for cases diagnosed January 1, 2001 or after. Summary Stage 2000 should be assigned according to the [SEER Summary Staging Manual-2000](#).

Summary Stage 2000 should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer and uses both clinical and pathologic information.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Coding Instructions

1. Use Code 8 for benign (/0) and borderline (/1) brain/CNS cases.