

Stage of Disease at Diagnosis

**DATE OF SURGICAL DIAGNOSTIC
AND STAGING PROCEDURE**Item Length: 8
NAACCR Item #1280**Description**

Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Instructions for CodingRecord the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) was performed at this or any facility.

Code	Definition
MMDDCCYY	The date of surgical diagnostic and staging procedure is the month, day, and year (MMDDCCYY) of the procedure at this or any facility. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
00000000	When no surgical procedure was performed. Diagnosed at autopsy.
99999999	When it is unknown whether a surgical procedure was performed, the date is unknown, or the case was identified by death certificate only.

Month	Day	Year
00	00	0000
01 January	01	Use four-digit year
02 February	02	9999 Year unknown
03 March	03	
04 April	...	
05 May	...	
06 June	30	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Note: Prior to January 1, 2003, the date recorded in this item may have indicated the date on which a palliative surgical procedure was performed.**Examples:**

Code	Definition
09992005	If the exact date of the surgical diagnostic and/or staging procedure is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.

Code	Definition
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

**SURGICAL DIAGNOSTIC AND STAGING
PROCEDURE**

Item Length: 2
 Allowable Values: 00–07, 09
 NAACCR Item #1350
 Revised 09/06, 09/08

Description

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Instructions for Coding:

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) to code these procedures.

Code	Definition
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Examples:

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #740
(Revised 01/04, 09/08)

Description

Identifies the surgical procedure(s) performed in an effort to diagnose and/or stage disease at this facility.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Instructions for Coding

- Record the type of procedure performed as part of the initial diagnosis and workup at this facility.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site at This Facility* (NAACCR Item #670) to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672) to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site at This Facility* (NAACCR Item #670) to code these procedures.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure at This Facility* (NAACCR Item #3280) to code these procedures.

Code	Definition
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

CLINICAL T

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #940
 Revised 09/06, 01/08, 09/08

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known *prior* to the start of any therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical T staging element must be recorded for Class of Case 1 and 2.
- It is strongly recommended that the clinical T staging element be recorded for Class of Case 0 cases if the patient's workup at the facility allows coding of clinical T.
- Code clinical T as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical T, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1C	T1c
X	TX	2	T2
0	T0	2A	T2a
A	Ta	2B	T2b
IS	Tis	2C	T2c
SU	Tispu	3	T3
SD	Tispd	3A	T3a
1M	T1mic	3B	T3b
1	T1	3C	T3c
1A	T1a	4	T4
A1	T1a1	4A	T4a
A2	T1a2	4B	T4b
1B	T1b	4C	T4c
B1	T1b1	4D	T4d
B2	T1b2	88	Not applicable

CLINICAL N

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #950
 Revised 09/06, 01/08, 09/08

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known *prior* to the start of any therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical N staging element must be recorded for *Class of Case* 1 and 2.
- It is strongly recommended that the clinical N staging element be recorded for Class of Case 0 cases if the patient's workup at the facility allows coding of clinical N.
- Record clinical N as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical N, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
1	N1
1A	N1a
1B	N1b
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
88	Not applicable

CLINICAL M

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #960
 Revised 09/06, 01/08, 09/08

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known *prior* to the start of any therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- The clinical M staging element must be recorded for *Class of Case 1* and *2*.
- It is strongly recommended that the clinical M staging element be recorded for *Class of Case 0* cases if the patient's workup at the facility allows coding of clinical M.
- Record clinical M as documented by the first treating physician or managing physician in the medical record.
- If the managing physician has not recorded clinical M, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(leave blank)	Not recorded.
X	MX
0	M0
1	M1
1A	M1a
1B	M1b
1C	M1c
88	Not applicable

CLINICAL STAGE GROUP

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #970
 Revised 09/06, 01/08, 09/08

Description

Identifies the anatomic extent of disease based on the T, N, and M elements known *prior* to the start of any therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the clinical stage, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".
- If the value is only one digit, then record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
0	Stage 0	2B	Stage IIB
0A	Stage 0A	2C	Stage IIC
0S	Stage 0is	3	Stage III
1	Stage I	3A	Stage IIIA
1A	Stage IA	3B	Stage IIIB
A1	Stage IA1	3C	Stage IIIC
A2	Stage IA2	4	Stage IV
1B	Stage IB	4A	Stage IVA
B1	Stage IB1	4B	Stage IVB
B2	Stage IB2	4C	Stage IVC
1C	Stage IC	OC	Occult
1S	Stage IS	88	Not applicable
2	Stage II	99	Unknown
2A	Stage IIA		

CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1

Allowable Values: 0–6, 9

NAACCR Item #980

Revised 09/06, 01/08, 09/08

Description

Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor *prior* to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.
- If the managing 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.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label	Description
0	None	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 .
4	Y–Classification during or after initial modality therapy, pathologic staging only	Not applicable for clinical stage.
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.

STAGED BY (CLINICAL STAGE)

Item Length: 1
 Allowable Values: 0–9
 NAACCR Item #990
 Revised 09/06, 01/08, 09/08

Description

Identifies the person who documented the clinical AJCC staging elements and the Stage Group.

Rationale

Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its approved cancer program cancer registries. Data captured in this field can be used to evaluate the accuracy and completeness of staging recorded in the registry and form the basis for quality management and improvement studies.

Instructions for Coding

- Record the person who documented the clinical AJCC staging elements and the Stage Group.
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and Stage Group must be recorded by the same person.
- The staging elements (T, N, M) and the Stage Group must be recorded.

Code	Label	Definition
0	Not staged	Staging was not assigned.
1	Managing physician	Staging was assigned by the managing physician.
2	Pathologist	Staging was assigned by the pathologist only.
3	Pathologist and managing physician	Staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Staging was assigned by the cancer registrar and any of the physicians specified in codes 1–4.
7	Staging assigned at another facility	Staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC site scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

PATHOLOGIC T

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #880
 Revised 09/06, 01/08, 09/08

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known *following* the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, to design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code pathologic T as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathologic T, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic T be recorded for Class of Case 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition
(leave blank)	Not recorded.	1C	T1c
X	TX	2	T2
0	T0	2A	T2a
A	Ta	2B	T2b
IS	Tis	2C	T2c
SU	Tispu	3	T3
SD	Tispd	3A	T3a
1M	T1mic	3B	T3b
1	T1	3C	T3c
1A	T1a	4	T4
A1	T1a1	4A	T4a
A2	T1a2	4B	T4b
1B	T1b	4C	T4c
B1	T1b1	4D	T4d
B2	T1b2	88	Not applicable

PATHOLOGIC N

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #890
 Revised 09/06, 01/08, 09/08

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known *following* the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code pathologic N as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded pathologic N, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic N be recorded for Class of Case 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition
(leave blank)	Not recorded.
X	NX
0	N0
I-	N0(i-)
I+	N0(i+)
M-	N0(mol-)
M+	N0(mol+)
1	N1
1A	N1a
1B	N1b
1C	N1c
1M	N1mi

Code	Definition
2	N2
2A	N2a
2B	N2b
2C	N2c
3	N3
3A	N3a
3B	N3b
3C	N3c
88	Not applicable

PATHOLOGIC M

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #900
 Revised 09/06, 01/08, 09/08

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known *following* the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Code pathologic M as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathologic M, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the treating physician(s).
- Truncate the least significant subdivision of the category from the right as needed.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic M be recorded for Class of Case 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition
(leave blank)	Not recorded.
X	MX
0	M0
1	M1
1A	M1a
1B	M1b
1C	M1c
88	Not applicable

PATHOLOGIC STAGE GROUP

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #910
 Revised 09/06, 01/08, 09/08

Description

Identifies the anatomic extent of disease based on the T, N, and M elements known *following* the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the pathologic stage, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- To assign stage group when some, but not all, T, N and/or M components can be determined, interpret missing components as "X".
- If pathologic M (NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM (NAACCR Item # 880, 890, 960) may be used to complete the pathologic stage group.
- If the value is only one digit, record to the left and leave the second space blank.
- Truncate the least significant subdivision of the category from the right as needed.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The CoC recommends that pathologic stage group be recorded for Class of Case 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition
0	Stage 0	2A	Stage IIA
0A	Stage 0A	2B	Stage IIB
0S	Stage 0is	2C	Stage IIC
1	Stage I	3	Stage III
1A	Stage IA	3A	Stage IIIA
A1	Stage IA1	3B	Stage IIIB
A2	Stage IA2	3C	Stage IIIC
1B	Stage IB	4	Stage IV
B1	Stage IB1	4A	Stage IVA
B2	Stage IB2	4B	Stage IVB
1C	Stage IC	4C	Stage IVC
1S	Stage IS	88	Not applicable
2	Stage II	99	Unknown

PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
 Allowable Values: 0–6, 9
 NAACCR Item #920

Revised 09/06, 01/08

Description

Identifies the AJCC pathologic stage (prefix/suffix) descriptor known *following* the completion surgical therapy.

Rationale

Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. The CoC requires that AJCC TNM staging be used in its approved cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Instructions for Coding

- Record the pathologic stage (prefix/suffix) descriptor as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars *should* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label	Definition
0	None	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	Not applicable for clinical stage.
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.

STAGED BY (PATHOLOGIC STAGE)

Item Length: 1
 Allowable Values: 0–9
 NAACCR Item #930
 Revised 09/06, 01/08, 09/08

Description

Identifies the person who recorded the pathologic AJCC staging elements.

Rationale

Data captured in this field can be used to evaluate the accuracy and completeness of staging and form the basis for quality management and improvement studies.

Instructions for Coding

- Record the person who documented the pathologic AJCC staging elements and the stage group.
- If code 1, 2, or 5 is used, then all of the staging elements (T, N, and M) and Stage Group must be recorded by the same person.
- The staging elements (T, N, M) and the stage group must be recorded.

Code	Label	Definition
0	Not staged	Staging was not assigned.
1	Managing physician	Staging was assigned by the managing physician.
2	Pathologist	Staging was assigned by the pathologist only.
3	Pathologist and managing physician	Staging was assigned by the pathologist and the managing physician.
4	Cancer Committee chair, cancer liaison physician, or registry physician advisor	Staging was assigned by the Cancer Committee chair, cancer liaison physician, or the registry physician advisor during a quality control review.
5	Cancer registrar	Staging was assigned by the cancer registrar only.
6	Cancer registrar and physician	Staging was assigned by the cancer registrar and any of the physicians specified in 1–4.
7	Staging assigned at another facility	Staging was assigned by a physician at another facility.
8	Case is not eligible for staging	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC scheme.
9	Unknown; not stated in patient record	It is unknown whether or not the case was staged.

SEER SUMMARY STAGE 2000

Item Length: 1
 Allowable Values: 0–5, 7, 9
 NAACCR Item #759
 Revised 09/04

Description

Provides a site-specific description of the extent of disease at diagnosis.

Rationale

SEER Summary Stage 2000 is used by the CoC to describe disease spread at diagnosis for cancers with no AJCC TNM staging schema. It is a prognostic factor used in the analysis of patient care and outcomes.

Instructions for Coding

- Code this data item for cases diagnosed prior to January 1, 2004.
- Record the SEER Summary Stage 2000 code for all cases that do not have a defined AJCC staging schema.
- Use code 8 for non-malignant tumors only.
- Refer to the *SEER Summary Staging Manual 2000* for site-specific coding instructions. This information can be found online at <http://seer.cancer.gov/tools/ssm/>.

Code	Definition
0	In situ.
1	Localized.
2	Regional by direct extension.
3	Regional to lymph nodes.
4	Regional (both codes 2 and 3).
5	Regional, NOS.
7	Distant metastasis/systemic disease.
8	Not applicable (non-malignant tumor).
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified); death certificate only.

CS TUMOR SIZE

Item Length: 3

Allowable Values: 000–995, 999

NAACCR Item #2800

Revised 09/06, 09/08

Description

Records the largest dimension or diameter of the **primary tumor** in millimeters.

Rationale

Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Staging to derive some TNM-T codes.

Instructions for Coding

- Refer to site/histology-specific instructions in the current *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.
- To convert centimeters to millimeters, multiply the dimension by 10.

Code	Definition
000	Indicates no mass or no tumor found; for example, when a tumor of a stated primary site is not found, but the tumor has metastasized.
001–988	Exact size in millimeters.
989	989 millimeters or larger.
990	Microscopic focus or foci only; no size of focus is given.
991	Described as less than 1 cm.
992	Described as less than 2 cm; greater than 1 cm; or between 1 cm and 2 cm.
993	Described as less than 3 cm; greater than 2 cm; or between 2 cm and 3 cm.
994	Described as less than 4 cm; greater than 3 cm; or between 3 cm and 4 cm.
995	Described as less than 5 cm; greater than 4 cm; or between 4 cm and 4 cm.
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; size not stated; not stated in patient record.

CS EXTENSION

Item Length: 2

Allowable Values: 00–80, 95, 99

NAACCR Item #2810

Revised 09/06, 09/08

Description

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in *CS Extension*.

Rationale

Tumor extension at diagnosis is a prognostic indicator used by Collaborative Staging to derive some TNM-T codes and some SEER Summary Stage codes.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	In situ; non-invasive	Tis	IS	IS
	SITE/HISTOLOGY-SPECIFIC CODES			
80	Further contiguous extension			
95	No evidence of primary tumor	T0	U	U
99	Unknown extension; primary tumor cannot be assessed; not stated in patient record	TX	U	U

CS TUMOR SIZE/EXT EVAL

Item Length: 1

Allowable Values: 0–3, 5, 6, 8, 9

NAACCR Item #2820

Revised 09/06, 09/08

Description

Records how the codes for the two items *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) were determined, based on the diagnostic methods employed.

Rationale

This item is used by Collaborative Staging to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging.	c*
2	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation; OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Meets criteria for AJCC pathologic staging. Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on clinical evidence.	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on pathologic evidence.	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy).	a
9	Unknown if surgical resection done. Not assessed; cannot be assessed. Unknown if assessed. Not documented in patient record. For sites with no TNM schema: not applicable	c

* For some primary sites, code 1 may be a pathologic staging basis.

CS LYMPH NODES

Item Length: 2
 Allowable Values: 0–80, 90
 NAACCR Item #2830
 Revised 09/06, 09/08

Description

Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale

The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Staging to derive some TNM-N codes and SEER Summary Stage codes.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	None; no regional lymph node involvement	N0	None	None
	SITE/HISTOLOGY-SPECIFIC CODES			
90	Unknown; regional lymph nodes cannot be assessed; not stated in patient record	NX	U	U

For schemas that do not use CS Lymph Nodes field:

Code	Description
88	Not applicable

CS REG NODES EVAL

Item Length: 1

Allowable Values: 0–3, 5, 6, 8, 9

NAACCR Item #2840

Revised 09/06, 09/08

Description

Records how the code for *CS Lymph Nodes* (NAACCR Item #2830) was determined, based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	Staging Basis
0	No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No regional lymph nodes removed for examination. Evaluation based on endoscopic examination, diagnostic biopsy including fine needle aspiration of lymph node(s) or other invasive techniques, including surgical observation without autopsy. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging.	c
2	No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Regional lymph nodes removed for examination (removal of at least 1 lymph node) without pre-surgical systemic treatment or radiation; OR lymph nodes removed for examination, unknown if pre-surgical systemic treatment or radiation performed Meets criteria for AJCC pathologic staging.	p
5	Regional lymph nodes removed for examination with pre-surgical systemic treatment or radiation, and lymph node evaluation based on clinical evidence	c
6	Regional lymph nodes removed for examination with pre-surgical systemic treatment or radiation, but lymph node evaluation based on pathologic evidence	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record For sites that have no TNM staging: Not applicable	c

CS METS AT DX

Item Length: 2
 Allowable Values: 00, 10, 40, 50, 99
 NAACCR Item #2850
 Revised 09/06, 09/08

Description

Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale

The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Staging to derive TNM-M codes and SEER Summary Stage codes.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
00	No; none	M0	None	None
10	Distant lymph node(s)	M1	D	D
40	Distant metastasis except code 10 Distant metastasis, NOS Carcinomatosis	M1	D	D
	SITE/HISTOLOGY-SPECIFIC CODES			
50	(40) + (10)	M1	D	D
99	Unknown; distant metastasis cannot be assessed; not stated in patient record	MX	U	U

CS METS EVAL

Item Length: 2

Allowable Values: 0–3, 5, 6, 8, 9

NAACCR Item #2860

Revised 09/06, 09/08

Description

Records how the code for *CS Mets at Dx* (NAACCR Item #2850) was determined based on the diagnostic methods employed.

Rationale

This data item is used by Collaborative Staging to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	Staging Basis
0	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No pathologic examination of metastatic tissue performed. Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No autopsy evidence used. Does not meet criteria for AJCC pathologic staging of distant metastasis.	c
2	No pathologic examination of metastatic tissue done prior to death, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Pathologic examination of metastatic tissue performed without pre-surgical systemic treatment or radiation; OR pathologic examination of metastatic tissue performed, unknown if pre-surgical systemic treatment or radiation performed Meets criteria for AJCC pathologic staging of distant metastasis.	p
5	Pathologic examination of metastatic tissue performed with pre-surgical systemic treatment or radiation, and metastasis based on clinical evidence	c
6	Pathologic examination of metastatic tissue performed with pre-surgical systemic treatment or radiation, but metastasis based on pathologic evidence	y
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy	a
9	Not assessed; cannot be assessed; unknown if assessed; not documented in patient record. For sites with no TNM staging: Not applicable	c

CS SITE-SPECIFIC FACTOR 1

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2880
 Revised 04/07, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 2

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2890
 Revised 09/06, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 3

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2900
 Revised 04/07, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 4

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2910
 Revised 09/06, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 5

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2920
 Revised 09/06, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description
000	None
	SITE/HISTOLOGY-SPECIFIC CODES
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

CS SITE-SPECIFIC FACTOR 6

Item Length: 3
 Allowable Values: 000–999
 NAACCR Item #2930
 Revised 09/06, 09/08

Description

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

Rationale

Site-specific factors are used to record additional staging information needed by Collaborative Staging to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Instructions for Coding

- Refer to site/histology-specific instructions in the most recent *Collaborative Staging Manual and Coding Instructions (CS Manual)* for additional information.

Code	Description	TNM Mapping	SS77 Mapping	SS2000 Mapping
000	None			
	SITE/HISTOLOGY-SPECIFIC CODES			
999	Unknown; [site-specific title] cannot be assessed; Not documented in patient record			

For schemas that do not use this site-specific factor:

Code	Description
888	Not applicable for this site

DERIVED AJCC T

Item Length: 2
 NAACCR Item #2940
 Added 01/04, Revised 09/08

Description

This item is the derived AJCC “T” staging element from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived AJCC T can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* “T” descriptions.

T Storage Code	Display String
99	TX
00	T0
01	Ta
05	Tis
06	Tispu
07	Tispd
10	T1
11	T1 mic
19	T1NOS
12	T1a
13	T1a1
14	T1a2
15	T1b
16	T1b1
17	T1b2
18	T1c
20	T2

T Storage Code	Display String
29	T2NOS
21	T2a
22	T2b
23	T2c
30	T3
39	T3NOS
31	T3a
32	T3b
33	T3c
40	T4
49	T4NOS
41	T4a
42	T4b
43	T4c
44	T4d
88	NA

DERIVED AJCC T DESCRIPTOR

Item Length: 1
NAACCR Item #2950

Revised 09/04

Description

This item is the derived AJCC “T Descriptor” from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. The Derived AJCC T Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a “y prefix” to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Surgical resection performed after pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC N

Item Length: 2
 NAACCR Item #2960
 Added 01/04

Description

This item is the derived AJCC “N” staging element from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived AJCC N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* for “N” descriptions.

N Storage Code	Display String
99	NX
00	N0
09	N0NOS
01	N0(i-)
02	N0(i+)
03	N0(mol-)
04	N0(mol+)
10	N1
19	N1NOS
11	N1a
12	N1b
13	N1c

N Storage Code	Display String
18	N1mi
20	N2
29	N2NOS
21	N2a
22	N2b
23	N2c
30	N3
39	N3NOS
31	N3a
32	N3b
33	N3c
88	NA

DERIVED AJCC N DESCRIPTOR

Item Length: 1
 NAACCR Item #2970
 Revised 09/04

Description

This item is the derived AJCC “N Descriptor” from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. The Derived AJCC N Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a “y prefix” to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Lymph nodes removed for examination after pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC M

Item Length: 2
 NAACCR Item #2980
 Added 01/04

Description

This item is the derived AJCC “M” staging element from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived AJCC M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- The display string is the corresponding label that is displayed on the screen or in reports. The meaning of these display strings will be clear to the registrar or physician user.
- Refer to the applicable *AJCC Cancer Staging Manual* for “M” descriptions.

M Storage Code	Display String
99	MX
00	M0
10	M1
11	M1a
12	M1b
13	M1c
19	M1NOS
88	NA

DERIVED AJCC M DESCRIPTOR

Item Length: 1
NAACCR Item #2990

Revised 09/04

Description

This item is the derived AJCC “M Descriptor” from coded fields using the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. The Derived AJCC M Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process.

Instructions for Coding

- This data item is autocoded and is not recorded by registry staff.
- For those cases in which classification is performed during or following initial multimodality therapy, the category is identified by a “y prefix” to be derived from the computerized algorithm.
- Refer to the applicable *AJCC Cancer Staging Manual* for prefix definitions.

Code	Description
c	Clinical stage.
p	Pathologic stage.
a	Autopsy stage.
y	Pathologic examination of metastatic tissue performed after pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable.
0	Not derived.

DERIVED AJCC STAGE GROUP

Item Length: 2
 NAACCR Item #3000
 Added 01/04

Description

This item is the derived AJCC “Stage Group” from the detailed site-specific codes using the CS from the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived AJCC Stage Group can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes.

Instructions for Coding

Refer to the applicable *AJCC Cancer Staging Manual* for “Stage Group” descriptions.

AJCC Storage Code	Display String
00	0
01	0a
02	0is
10	I
11	INOS
12	IA
13	IA1
14	IA2
15	IB
16	IB1
17	IB2
18	IC
19	IS
23	ISA
24	ISB
20	IEA
21	IEB
22	IE
30	II
31	IINOS
32	IIA

AJCC Storage Code	Display String
33	IIB
34	IIC
35	IIEA
36	IIEB
37	IIE
38	IISA
39	IISB
40	IIS
41	IIESA
42	IIESB
43	IIES
50	III
51	IINOS
52	IIIA
53	IIIB
54	IIIC
55	IIIEA
56	IIIEB
57	IIIE
58	IIISA
59	IIISB

AJCC Storage Code	Display String
60	IIS
61	IIESA
62	IIESB
63	IIES
70	IV
71	IVNOS
72	IVA
73	IVB
74	IVC
88	NA
90	OCCULT
99	UNK

DERIVED SS1977

Item Length: 1
 Allowable Values: 0–5, 7, 9
 NAACCR Item #3010
 Revised 09/08

Description

This item is the derived “SEER Summary Stage 1977” from the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived SS1977 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

Instructions for Coding

Refer to the *SEER Summary Staging Manual, 1977* for descriptions of the site-specific categories.

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 metastases/systemic disease.
8	Not applicable
9	Unstaged, unknown, or unspecified.
(blank)	Not derived.

DERIVED SS2000

Item Length: 1
 Allowable Values: 0–5, 7, 9
 NAACCR Item #3020
 Revised 09/08

Description

This item is the derived “SEER Summary Stage 2000” from the CS algorithm.

Rationale

Collaborative Staging (CS) was developed to provide a single uniform set of codes and rules for coding the elements necessary to derive “best stage” for the major staging systems in current use. Derived SS2000 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes.

Instructions for Coding

Refer to the *SEER Summary Staging Manual, 2000* for descriptions of the site-specific categories.

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 metastases/systemic disease.
8	Not applicable
9	Unstaged, unknown, or unspecified.
(blank)	Not derived.

