

CLINICAL T

Item Length: 2
 Alphanumeric
 Upper-case
 Left Justified
 NAACCR Item #940
 (Revised 09/04, 01/08)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor *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.
- Code clinical T as documented by the first treating physician(s) 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 first treating physician(s).
- 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 coding rules.

Code	Definition	Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.	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 09/04, 01/08)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor *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.
- Record clinical N as documented by the first treating physician(s) 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 first 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 coding rules.

Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.
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 09/04, 01/08)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor *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 M staging element must be recorded.
- Record clinical M as documented by the first treating physician(s) 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 first 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 coding rules.

Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.
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 09/04, 01/08)

Description

Identifies the anatomic extent of disease based on the T, N, and M elements *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(s) 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 first treating 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 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 coding 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 09/04, 01/08)

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(s) 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 first treating physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for coding 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 09/04, 01/08)

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.
- 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 09/04, 01/08)

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor *following* the completion 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) 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 treating physician(s).
- 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 coding rules.
- The CoC recommends that pathologic T be recorded for class 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition	Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.	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 09/04, 01/08)

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor *following* the completion 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) 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 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 coding rules.
- The CoC recommends that pathologic N be recorded for class 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.
X	NX
0	N0
I-	N0(i-)
I+	N0(i+)
M-	N0(mol-)
M+	N0(mol+)
1	N1
1A	N1a
1B	N1b

Code	Definition
1C	N1c
1M	N1mi
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 09/04, 01/08)

Description

Identifies the presence or absence of distant metastasis (M) of the tumor *following* the completion 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) 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 coding rules.
- The CoC recommends that pathologic M be recorded for class 1 and 2 cases diagnosed on or after January 1, 2008.

Code	Definition
(leave blank)	Not recorded by the physician or available in the medical record.
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 09/04, 01/08)

Description

Identifies the anatomic extent of disease based on the T, N, and M elements *following* the completion 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) 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 treating 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 #s 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 coding rules.
- The CoC recommends that pathologic stage group be recorded for class 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 09/04, 01/08)

Description

Identifies the AJCC pathologic stage (prefix/suffix) descriptor *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) 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 treating physician(s).
- Refer to the current *AJCC Cancer Staging Manual* for coding 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 09/04, 01/08)

Description

Identifies the person who documented the pathologic AJCC staging elements and the stage group.

Rationale

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 pathologic AJCC staging elements and the stage group.
- 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.