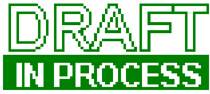

Collaborative Stage for TNM 7 - Revised 07/14/2009 [Schema]

MelanomaSkin

CS Tumor Size

Code	Description
000	No mass/tumor found
001-988	001 - 988 millimeters (code exact size in millimeters)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus given
991	Described as "less than 1 cm"
992	Described as "less than 2 cm," or "greater than 1 cm," or "between 1 cm and 2 cm"
993	Described as "less than 3 cm," or "greater than 2 cm," or "between 2 cm and 3 cm"
994	Described as "less than 4 cm," or "greater than 3 cm," or "between 3 cm and 4 cm"
995	Described as "less than 5 cm," or "greater than 4 cm," or "between 4 cm and 5 cm"
999	Unknown; size not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 11/29/2009 [Schema]

MelanomaSkin

CS Extension

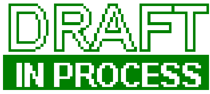
- Note 1: If there is a discrepancy between the Clark level and the pathologic description of extent, use the higher (more extensive) code.
- Note 2: Satellite lesions/nodules or in-transit metastases are coded under CS Lymph Nodes.
- Note 3: Ulceration of the melanoma is coded in Site-Specific Factor 2.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	In situ: noninvasive; intraepidermal Clark's level I Basement membrane of the epidermis is intact	Tis	Tis	IS	IS
100	Papillary dermis invaded Clark's level II	^	*	L	L
200	Papillary-reticular dermal interface invaded Clark's level III	^	*	L	L
300	Reticular dermis invaded Clark's level IV	^	*	L	L
400	Skin/dermis, NOS Localized, NOS	^	*	L	L
500	Subcutaneous tissue invaded (through entire dermis) Clark's level V	^	*	L	RE
800	Further contiguous extension: Underlying cartilage, bone, skeletal muscle	^	*	D	D
950	No evidence of primary tumor	T0	T0	U	U

999	Unknown extension Primary tumor cannot be assessed (e.g., shave biopsy or regressed melanoma) Not documented in patient record	^	*	U	U

- ^ For Extension codes 100-800 and 999 ONLY, the T category for AJCC 7th Edition staging is assigned based on the values of CS Site-Specific Factor 1, Measured Thickness, CS Site-Specific Factor 2, Ulceration, and for certain cases CS Site-Specific Factor 7, Primary Tumor Mitotic Count/Rate, as shown in the Thickness and Ulceration AJCC 7 table.
- * For Extension codes 100 - 800, and 999 ONLY, the T category for AJCC 6th Edition staging is assigned based on the values of CS Site-Specific Factor 1, Measured Thickness, and CS Site-Specific Factor 2, Ulceration, as shown in the Thickness and Ulceration AJCC 6 table.

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 08/10/2009 [Schema]

MelanomaSkin

CS Tumor Size/Ext Eval

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	Does not meet criteria for AJCC pathologic staging: No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used.	c
2	Meets criteria for AJCC pathologic staging: No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
3	Either criteria meets AJCC pathologic staging: Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed AND 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. No surgical resection done. Evaluation based on positive	p

	biopsy of highest T classification.	
5	Does not meet criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6).	c
6	Meets criteria for AJCC y-pathologic (yp) staging: Surgical resection performed AFTER neoadjuvant therapy AND tumor size/extension based on pathologic evidence, because pathologic evidence at surgery is more extensive than clinical evidence before treatment.	yp
8	Meets criteria for autopsy (a) staging: 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	c

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 12/16/2009 [Schema]

MelanomaSkin

CS Lymph Nodes

- Note 1: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.
- Note 2: Satellite lesions/nodules or in-transit metastasis are coded under CS Lymph Nodes.
- Note 3: Use codes 100-120 if there is regional node involvement without satellite nodule(s) or in-transit metastases. Use codes 130-150 if there are satellite nodule(s) or in-transit metastases but there is either no regional lymph node involvement, or involvement of regional nodes is not stated. Use codes 200-220 if both satellite nodules(s)/in-transit metastases and regional lymph node(s) are present.
- Note 4: According to AJCC, "there is no lower threshold of tumor burden defining the presence of regional nodal metastasis. Specifically, nodal tumor deposits less than 0.2 mm in diameter (previously used as the threshold for defining nodal metastasis), are included in the staging of nodal disease as a result of the consensus that smaller volumes of metastatic tumor are still clinically significant". This means that any finding of melanoma in lymph nodes, regardless of size and including Isolated Tumor Cells (ITCs), should be coded positive lymph nodes in this field.

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
000	None; no regional lymph node involvement	N0	N0	NONE	NONE

100	Regional lymph nodes by primary site: (includes bilateral or contralateral nodes for head, neck, and trunk) HEAD AND NECK SITES: All subsites: Cervical, NOS Lip: Mandibular, NOS: Submandibular(submaxillary) Eyelid/canthus: Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular External ear/auditory canal: Mastoid (post-/retro-auricular) (occipital) Preauricular Face, Other (cheek, chin forehead, jaw, nose and temple): Facial, NOS: Buccinator (buccal) Nasolabial Mandibular, NOS: Submandibular (submaxillary) Parotid, NOS: Infra-auricular Preauricular Scalp: Mastoid (post-/retro-auricular) (occipital) Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Neck: Axillary Mandibular, NOS Mastoid (post-/retro-auricular)	^	*	RN	RN

	Parotid, NOS: Infra-auricular Preauricular Spinal accessory (posterior cervical) Supraclavicular (transverse cervical) UPPER TRUNK: Axillary Cervical Internal mammary Supraclavicular LOWER TRUNK: Superficial inguinal (femoral) ARM/SHOULDER: Axillary Epitrochlear for hand/forearm Spinal accessory (posterior cervical) for shoulder LEG/HIP: Popliteal for heel and calf Superficial inguinal (femoral) VULVA/PENIS/SCROTUM: Deep inguinal: Rosenmuller or Cloquet node Superficial inguinal (femoral) ALL SITES: Regional lymph node(s), NOS				
120	Regional lymph node(s) by primary site: HEAD AND NECK SITES: Lip: Facial, NOS Buccinator (buccal) Nasolabial Mandibular, NOS Submental Parotid, NOS Infra-auricular Preauricular Eyelid/canthus: Facial, NOS: Mandibular, NOS	^	*	D	RN

	Submental Face, Other (cheek, chin, forehead, jaw, nose, and temple): Mandibular, NOS Submental Neck: Mandibular, NOS Submental				
125	Stated as N1 [NOS] with no other information on nodes	N1NOS	N1NOS	RN	RN
130	Satellite nodule(s) or in-transit metastases, NOS (distance from primary tumor not stated) WITHOUT regional lymph node involvement or involvement of regional nodes not stated.	N2c	N2c	RE	RE
140	Satellite nodule(s) or in-transit metastases less than or equal to 2cm from primary tumor WITHOUT regional lymph node involvement or involvement of regional nodes not stated.	N2c	N2c	RE	RE
150	Satellite nodule(s) or in-transit metastases greater than 2cm from primary tumor WITHOUT regional lymph node involvement or involvement of regional nodes not stated.	N2c	N2c	RE	RN
155	Stated as N2 [NOS] with no other information on nodes	N2NOS	N2NOS	RN	RN
170	Matted lymph nodes in code 100	N3	N3	RN	RN
180	Matted lymph nodes in code 120	N3	N3	D	RN
200	Satellite nodule(s) or in-transit metastases WITH regional lymph nodes listed in code 100.	N3	N3	RE +RN	RE+RN

220	Satellite nodule(s) or in-transit metastases WITH regional lymph nodes listed in code 120.	N3	N3	D	RE+RN
225	Stated as N3 with no other information on nodes	N3	N3	RN	RN
800	Lymph nodes, NOS	^	*	RN	RN
999	Unknown; not stated Regional lymph node(s) cannot be assessed Not documented in patient record	NX	NX	U	U

- ^ For codes 100, 120, and 800 ONLY, the N category depends on the values in Reg LN Pos and SSF 3, as shown in the CS Nodes Pos and Clinical Status table.
- * For codes 100, 120, and 800 ONLY, the N category depends on the values in Reg LN Pos and SSF 3, as shown in the CS Nodes Pos and Clinical Status table.

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 06/30/2008 [Schema]

MelanomaSkin

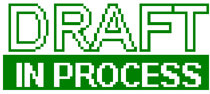
CS Lymph Nodes Eval

- Note: This item reflects the validity of the classification of the item CS Lymph Nodes only according to diagnostic methods employed.

Code	Description	Staging Basis
0	No regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination. Evidence based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c
1	No regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination. Evidence based on endoscopic examination, diagnostic biopsy including fine needle aspiration of lymph node(s), satellite nodule(s) or in-transit metastases (nodules) or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used.	c
2	No regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	Regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination (removal of at least one lymph node, satellite nodule(s) or in-transit metastasis) WITHOUT pre-surgical systemic treatment or radiation OR lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination, unknown if pre-surgical systemic treatment or radiation performed.	p

5	Regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination WITH pre-surgical systemic treatment or radiation, BUT lymph node, satellite nodule(s) or in-transit metastases (nodules) evaluation based on clinical evidence.	c
6	Regional lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination WITH pre-surgical systemic treatment or radiation, and lymph node (s), satellite nodule(s) or in-transit metastases (nodules) evaluation based on pathological evidence.	yp
8	Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes, satellite nodule(s) or in-transit metastases (nodules) removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Please click here if you would like to email a comment about the content of this table.



Collaborative Stage for TNM 7 - Revised 06/30/2008 [Schema]

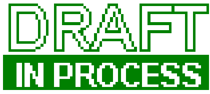
MelanomaSkin

Reg LN Pos

- Note 1: Record this field even if there has been preoperative treatment.
- Note 2: Although satellite nodules and in-transit metastasis are coded under CS Lymph Nodes, DO NOT count as Reg LN Pos in this field.

Code	Description
00	All nodes examined negative.
01-89	1 - 89 nodes positive (code exact number of nodes positive)
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node(s)
97	Positive nodes - number unspecified
98	No nodes examined
99	Unknown if nodes are positive; not applicable Not documented in patient record

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 06/30/2008 [Schema]

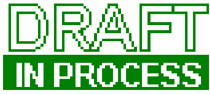
MelanomaSkin

Reg LN Exam

- Note: Although satellite nodules and in-transit metastasis are coded under CS Lymph Nodes, DO NOT count as Reg LN Exam in this field.

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

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 12/29/2009 [Schema]

MelanomaSkin

CS Mets at DX

Code	Description	TNM 7 Map	TNM 6 Map	SS77 Map	SS2000 Map
00	No; none	M0	M0	NONE	NONE
05	Metastases to underlying cartilage, bone, skeletal muscle (excluding direct extension)	^	*	D	D
10	Distant lymph node(s)	^	*	D	D
40	Distant metastasis, NOS	^	*	D	D
42	Metastases to skin or subcutaneous tissue beyond regional lymph nodes	^	*	D	D
43	Lung	^	*	D	D
44	All other visceral sites Carcinomatosis Other distant sites	M1c	M1c	D	D
52	10 + 42 (Metastases to distant nodes + Skin or subcutaneous tissue beyond nodes)	^	*	D	D
53	10 + 43 (Metastases to distant nodes + Lung)	^	*	D	D
54	10 + 44 (Metastases to distant nodes + All other visceral sites)	M1c	M1c	D	D
99	Unknown Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

- ^ For codes 05, 10, 40, 42, 43, 52 and 53 ONLY, the M category is assigned based on the status of serum LDH as coded in Site-Specific Factor 4 LDH table

and shown in the Mets at DX and LDH table.

- * For codes 05, 10, 40, 42, 43, 52 and 53 ONLY, the M category is assigned based on the status of serum LDH as coded in Site-Specific Factor 4 LDH table and shown in the Mets at DX and LDH table.

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 08/10/2009 [Schema]

MelanomaSkin

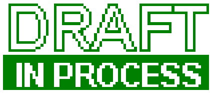
CS Mets Eval

- Note: This item reflects the validity of the classification of the item CS Mets at DX only according to the diagnostic methods employed.

Code	Description	Staging Basis
0	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastatic tissue performed or pathologic examination was negative.	c
1	Does not meet criteria for AJCC pathologic staging of distant metastasis: Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastatic tissue performed or pathologic examination was negative.	c
2	Meets criteria for AJCC pathologic staging of distant metastasis: No pathologic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p

3	Meets criteria for AJCC pathologic staging of distant metastasis: Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation OR specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed OR specimen from metastatic site microscopically positive prior to neoadjuvant treatment.	p
5	Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.	c
6	Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis: Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence.	yp
8	Meets criteria for AJCC autopsy (a) staging of distant metastasis: Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 11/29/2009 [Schema]

MelanomaSkin

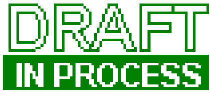
CS Site-Specific Factor 1
Measured Thickness (Depth), Breslow's Measurement

- Note: Code MEASURED THICKNESS (Depth) of tumor (Breslow's measurement), not size. Record actual measurement in hundredths of millimeters from the pathology report.

Code	Description
000	No mass/tumor found
001-979	0.01 - 9.79 millimeters Code exact measurement in HUNDREDTHS of millimeters. Examples: 001 0.01 millimeter 002 0.02 millimeters 010 0.1 millimeter 074 0.74 millimeters 100 1 millimeter 105 1.05 millimeters 979 9.79 millimeters
980	9.80 millimeters or larger
981-988	OBSOLETE DATA CONVERTED V0200 Data converted to 980 9.81-9.88 millimeters
989	OBSOLETE DATA CONVERTED V0200 Data converted to 980 9.89 millimeters or larger

990	OBSOLETE DATA CONVERTED V0102 This code was made obsolete in CS Version 1 and should no longer be used. Cases were converted to code 999. Microinvasion; microscopic focus or foci only; no size given
999	Microinvasion; microscopic focus or foci only and no depth given Not documented in patient record Unknown; depth not stated

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 11/13/2009 [Schema]

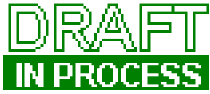
MelanomaSkin

CS Site-Specific Factor 2
Ulceration

- Note 1: Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon histopathological examination.
- Note 2: If there is no documentation or no mention of ulceration in the pathology report, assume ulceration is not present and code 000.

Code	Description
000	No ulceration present
001	Ulceration present
999	Unknown Not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.

 *Collaborative Stage for TNM 7 - Revised 11/13/2009* [Schema]

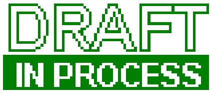
MelanomaSkin

CS Site-Specific Factor 3
Clinical Status of Lymph Node Mets

- Note 1: Assign code 000 if either there is no lymph node involvement (CS Lymph Nodes is coded 000) OR there are in-transit metastases or satellite nodules, but no regional lymph node involvement (CS Lymph Nodes is coded 130, 140 or 150).
- Note 2: Assign code 000 if there are clinically apparent lymph node metastases but they are pathologically negative.
- Note 3: AJCC defines microscopic lymph node metastases or "micrometastases" as those which are clinically inapparent by palpation and/or imaging but are pathologically positive. Therefore, assign code 001 if lymph nodes are negative on palpation and/or imaging but are positive on pathology.
- Note 4: Assign code 001 if there is microscopic confirmation of lymph node metastases but there is no documentation of the clinical status.
- Note 5: Assign code 002 if there are clinically apparent lymph node metastases whether they are confirmed by pathology or pathology is not performed.

Code	Description
000	No lymph node metastases
001	Clinically occult (microscopic) lymph node metastases only
002	Clinically apparent (macroscopic) lymph node metastases
999	Unknown if nodes are involved Unknown or no information Not documented in patient record

Please click here if you would like to email a comment about the content of this table.



Collaborative Stage for TNM 7 - Revised 11/29/2009 [Schema]

MelanomaSkin

CS Site-Specific Factor 4
LDH

- Note: Per AJCC, "An elevated serum LDH should be used only when there are 2 or more determinations obtained more than 24 hours apart, because an elevated serum LDH on a single determination can be falsely positive as a result of hemolysis or other factors unrelated to melanoma metastases."

Code	Description
000	Test not done, test was not ordered and was not performed
002	Within normal limits
004	Range 1: Less than 1.5 x upper limit of normal for LDH assay Stated as elevated, NOS
005	Range 2: 1.5 - 10 x upper limit of normal for LDH assay
006	Range 3: More than 10 x upper limit of normal for LDH assay
008	Ordered, but results not in chart
999	Unknown Not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 12/31/2009 [Schema]

MelanomaSkin

CS Site-Specific Factor 5
LDH VALUE

- Note 1: Code the LDH value prior to treatment or within 6 weeks of diagnosis. Give priority to the first test performed.
- Note 2: Record the value of the LDH test for values 001 through 800.
- Note 3: Record the range of the LDH test for values 801 and greater.
  A. Codes 801 - 825 are ranges of 20.
  B. Codes 826 - 863 are ranges of 50.
  C. Codes 864 - 921 are ranges of 100.
  D. Code 922 is for a value of 10001 or greater.
- Note 4: Per AJCC, "To confirm the elevated serum LDH for staging purposes, it is recommended to obtain two or more determinations obtained more than 24 h apart, since an elevated serum LDH on a single determination can be falsely positive due to hemolysis or other factors unrelated to melanoma metastases."

Code	Description
001-800	Value is 001 - 800 (record exact value)
801	Range of values are 801 - 820
802	Range of values are 821 - 840
803	Range of values are 841 - 860
804	Range of values are 861 - 880
805	Range of values are 881 - 900
806	Range of values are 901 - 920
807	Range of values are 921 - 940
808	Range of values are 941 - 960
809	Range of values are 961 - 980
810	Range of values are 981 - 1000

811	Range of values are 1001 - 1020
812	Range of values are 1021 - 1040
813	Range of values are 1041 - 1060
814	Range of values are 1061 - 1080
815	Range of values are 1081 - 1100
816	Range of values are 1101 - 1120
817	Range of values are 1121 - 1140
818	Range of values are 1141 - 1160
819	Range of values are 1161 - 1180
820	Range of values are 1181 - 1200
821	Range of values are 1201 - 1220
822	Range of values are 1221 - 1240
823	Range of values are 1241 - 1260
824	Range of values are 1261 - 1280
825	Range of values are 1281 - 1300
826	Range of values are 1301 - 1350
827	Range of values are 1351 - 1400
828	Range of values are 1401 - 1450
829	Range of values are 1451 - 1500
830	Range of values are 1501 - 1550
831	Range of values are 1551 - 1600
832	Range of values are 1601 - 1650
833	Range of values are 1651 - 1700
834	Range of values are 1701 - 1750
835	Range of values are 1751 - 1800
836	Range of values are 1801 - 1850
837	Range of values are 1851 - 1900
838	Range of values are 1901 - 1950
839	Range of values are 1951 - 2000

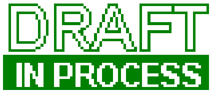
840	Range of values are 2001 - 2050
841	Range of values are 2051 - 2100
842	Range of values are 2101 - 2150
843	Range of values are 2151 - 2200
844	Range of values are 2201 - 2250
845	Range of values are 2251 - 2300
846	Range of values are 2301 - 2350
847	Range of values are 2351 - 2400
848	Range of values are 2401 - 2450
849	Range of values are 2451 - 2500
850	Range of values are 2501 - 2550
851	Range of values are 2551 - 2600
852	Range of values are 2601 - 2650
853	Range of values are 2651 - 2700
854	Range of values are 2701 - 2750
855	Range of values are 2751 - 2800
856	Range of values are 2801 - 2850
857	Range of values are 2851 - 2900
858	Range of values are 2901 - 2950
859	Range of values are 2951 - 3000
860	Range of values are 3001 - 3050
861	Range of values are 3051 - 3100
862	Range of values are 3101 - 3150
863	Range of values are 3151 - 3200
864	Range of values are 3201 - 3300
865	Range of values are 3301 - 3400
866	Range of values are 3401 - 3500
867	Range of values are 3501 - 3600
868	Range of values are 3601 - 3700

869	Range of values are 3701 - 3800
870	Range of values are 3801 - 3900
871	Range of values are 3901 - 4000
872	Range of values are 4001 - 4100
873	Range of values are 4101 - 4200
874	Range of values are 4201 - 4300
875	Range of values are 4301 - 4400
876	Range of values are 4401 - 4500
877	Range of values are 4501 - 4600
878	Range of values are 4601 - 4700
879	Range of values are 4701 - 4800
880	Range of values are 4801 - 4900
881	Range of values are 4901 - 5000
882	Range of values are 5001 - 5100
883	Range of values are 5101 - 5200
884	Range of values are 5201 - 5300
885	Range of values are 5301 - 5400
886	Range of values are 5401 - 5500
887	Range of values are 5501 - 5600
888	Range of values are 5601 - 5700
889	Range of values are 5701 - 5800
890	Range of values are 5801 - 5900
891	Range of values are 5901 - 6000
892	Range of values are 6001 - 6100
893	Range of values are 6101 - 6200
894	Range of values are 6201 - 6300
895	Range of values are 6301 - 6400
896	Range of values are 6401 - 6500
897	Range of values are 6501 - 6600

898	Range of values are 6601 - 6700
899	Range of values are 6701 - 6800
890	Range of values are 6801 - 6900
891	Range of values are 6901 - 7000
892	Range of values are 7001 - 7100
893	Range of values are 7101 - 7200
894	Range of values are 7201 - 7300
895	Range of values are 7301 - 7400
896	Range of values are 7401 - 7500
897	Range of values are 7501 - 7600
898	Range of values are 7601 - 7700
899	Range of values are 7701 - 7800
900	Range of values are 7801 - 7900
901	Range of values are 7901 - 8000
902	Range of values are 8001 - 8100
903	Range of values are 8101 - 8200
904	Range of values are 8201 - 8300
905	Range of values are 8301 - 8400
906	Range of values are 8401 - 8500
907	Range of values are 8501 - 8600
908	Range of values are 8601 - 8700
909	Range of values are 8701 - 8800
910	Range of values are 8801 - 8900
911	Range of values are 8901 - 9000
912	Range of values are 9001 - 9100
913	Range of values are 9101 - 9200
914	Range of values are 9201 - 9300
915	Range of values are 9301 - 9400
916	Range of values are 9401 - 9500

917	Range of values are 9501 - 9600
918	Range of values are 9601 - 9700
919	Range of values are 9701 - 9800
920	Range of values are 9801 - 9900
921	Range of values are 9901 - 10000
922	Value is 10001 or greater
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
995	Stated as within normal limits, no further information in the chart
996	Stated as elevated, no further information in the chart
997	Test ordered, results not in chart
998	Test not done
999	Unknown or no information Not documented in patient record

Please click here if you would like to email a comment about the content of this table.


Collaborative Stage for TNM 7 - Revised 12/31/2009 [Schema]

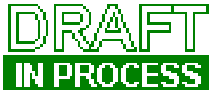
MelanomaSkin

CS Site-Specific Factor 6
LDH Upper Limits of Normal

- Note 1: Record upper limits of normal used for the LDH test recorded in SSF5 as listed on the laboratory report or in the medical record.
- Note 2: Upper limits of normal for LDH vary widely depending on the lab. Common upper limits can be 200, 250, 618, or other values. The upper limit of normal is needed to evaluate the LDH value recorded in SSF5.
- Note 3: Code 888 from CSv1 was converted to 988 in CSv2.

Code	Description
001-979	Upper limit of normal is 001 - 979 (record exact upper limit of normal)
988	Not applicable: Information not collected for this case (May include cases converted from code 888 used in CSv1 for "Not applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.)
997	Upper limit of normal not in chart
998	Test not done
999	Unknown or no information Not documented in patient record

Please click here if you would like to email a comment about the content of this table.



Collaborative Stage for TNM 7 - Revised 11/29/2009 [Schema]

MelanomaSkin

CS Site-Specific Factor 7
Primary Tumor Mitotic Count/Rate

- Note 1: According to CAP, "A mitotic rate of 1 or more mitotic figure per square millimeter is a powerful adverse prognostic factor for cutaneous melanoma."
- Note 2: Mitotic rate/count is assessed on all primary tumors and is tabulated as the average number of mitoses per millimeter squared The proportion of cells in a tissue that are undergoing mitosis are expressed as a mitotic index or, roughly, as the number of cells in mitosis in each microscopic high-power field in tissue sections.
- Note 3: Record the mitotic rate/count as documented in the pathology report.
- Note 4: If there is no documentation or no mention of mitotic rate in the pathology report, code 999.

Code	Description
000	Mitotic rate <1 per millimeter squared
001-010	1 - 10 mitoses per millimeter squared Code exact measurement Examples: 001 = 1 mitosis per millimeter squared 002 = 2 mitosis per millimeter squared 010 = 10 mitoses per millimeter squared
011	11 mitoses per millimeter squared or greater
988	Not applicable: Information not collected for this case
998	No histologic examination of primary site.
999	Unknown Not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 11/13/2009 [Schema]

MelanomaSkin

CS Site-Specific Factor 8
Primary Tumor Regression

- Note 1: Regression is most often recognized in relation to the radial growth phase (RGP). Characteristic features include segmental absence of in-situ melanoma cells or melanoma cells microinvasive into the papillary dermis. The papillary dermis shows patchy lymphocytic inflammation, diffuse coarse fibrosis and collections of melanophages. Intact melanoma is usually evident on one or both sides of the area of regression. Regressive changes may be seen without residual flanking melanoma cells and (after scrutiny of multiple tissue levels) may be viewed as constituting putative complete regression of the lesion. Vertical growth phase regression is less common and is usually seen as an area within a tumorigenic compartment that is replaced by lymphocytes and fibrosis and often also by melanophages constituting "tumoral melanosis".
- Note 2: Record the primary tumor regression as recorded in the pathology report. If the primary tumor regression is "not identified" the registrar should code as absent.

Code	Description
000	No regression present Regression not identified Regression absent
001	Regression present
988	Not applicable: Information not collected for this case
998	No histologic exam of primary site
999	Unknown Not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.

Collaborative Stage for TNM 7 - Revised 11/15/2009 [Schema]

MelanomaSkin

CS Site-Specific Factor 9
Vertical Growth Phase

- Note 1: The vertical growth phase (VGP) represents a stage of progression in which invasive melanoma cells have attained the capacity for survival and proliferation in the dermis which may then lead to the formation of an expansile tumor mass. Individual melanoma cells or small clusters of cells invading the superficial dermis do not necessarily represent vertical growth phase. While the presence of VGP is usually obvious in a thick melanoma, in a thin melanoma the minimal definition of VGP is the presence of 1 or more dermal clusters larger than the largest epidermal cluster (tumorigenic VGP) and/or the presence of any mitotic activity in the dermis (mitogenic VGP), either of which indicates the capacity for proliferation in the dermis. The VGP may occur in the presence or absence of an adjacent radial growth phase (RGP), which may be in situ or invasive. RGP is defined as melanoma without VGP. Nodular melanoma exhibits only a vertical growth phase without a radial growth phase; there may be an intraepidermal component above but not (beyond an arbitrary limit of 3 rete ridges) adjacent to the VGP.
- Note 2: Record the VGP as recorded in the pathology report. When the VGP is "not identified" registrars should code as absent.

Code	Description
000	No vertical growth phase present Vertical growth phase not identified Vertical growth phase absent
001	Vertical growth phase present
988	Not applicable: Information not collected for this case
998	No histologic exam of primary site
999	Unknown Not stated Not documented in patient record

Please click here if you would like to email a comment about the content of this table.