COLLABORATIVE STAGE
DATA COLLECTION
SYSTEM - INTRODUCTION

CODING INSTRUCTIONS
PART I, SECTION 1:
GENERAL INSTRUCTIONS

FCDS Annual Meeting
Orlando, Florida
July 23, 2010

BACKGROUND AND INTRODUCTION

- Collaborative Stage is a Data Collection System
- Collaborative Stage is NOT a Staging System
- What’s the Difference?
- Why not just record the physician TNM/Stage Group?
- Who is responsible for assigning stage?
- What is impact on treatment?

BACKGROUND AND INTRODUCTION

- CS is based on data items traditionally collected
  - Tumor size
  - Extension
  - Lymph node status
  - Metastatic status
- Computer algorithm(s) assign stage element(s) and/or stage group by staging system criteria
  - AJCC TNM, 6th edition
  - AJCC TAM, 7th edition
  - Summary Stage 1977
  - Summary Stage 2000
COLLABORATIVE STAGE DATA COLLECTION SYSTEM
BACKGROUND AND INTRODUCTION

- Response to multiple accepted staging systems
- Hybrid Coding System – clinical/pathologic/best
- Eliminates duplication data collection
- Enhances data sharing opportunities
- Provides stable system for comparison over time

- 2010 AJCC TNM, 7th edition enhancements
  - Anatomic Staging Framework
    - Site-based
    - Site/Histology-based
    - Site/Histology/Other-based
  - Non-Anatomic Site Specific Factors – Genetic
  - Non-Anatomic Site Specific Factors – Clinical
  - Non-Anatomic Site Specific Factors – Prognostic

COLLABORATIVE STAGE DATA COLLECTION SYSTEM
BACKGROUND AND INTRODUCTION

- CS data fields
  - CSv1 – 15 data fields
  - CSv2 – 41 data fields – not all required by FCDS

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COLLABORATIVE STAGE DATA COLLECTION SYSTEM
BACKGROUND AND INTRODUCTION

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COLLABORATIVE STAGE DATA COLLECTION SYSTEM

BACKGROUND AND INTRODUCTION

• CS Core Data Fields
  • Not all CS data fields are used to derive stage
  • Not all CS data fields are required for collection
  • FCDS requires only NPCR-Required CSv2 data items

• CS Site Specific Factor Data Fields
  • Some SSF data fields are used to derive stage
  • Most SSF data fields are NOT used to derive stage
  • Many new SSF data fields capture prognostic data
  • Some new SSF data fields were established for future
  • FCDS requires only NPCR-Required SSF data items

CODING CSV2: A STEP-BY-STEP PROCESS

1. Read and understand how to use and apply the Abstracting and General Rules and site-specific schema
2. Read the medical record carefully to determine primary site and histology (including ICD-O-3 codes)
3. Make mental notes about tissues, lymph nodes, and distant sites involved by tumor – jot them down on paper
4. Select the correct schema – software may do this for you
5. Verify you are in the correct schema by looking at the site and histology inclusion codes and any special notes included at the beginning of each schema
6. Start assigning codes according to coding guidelines
7. Read notes included in each schema
8. Follow schema specific instructions for each data field
9. Code site-specific factors as required
10. Your software may automatically generate output values for TNM 6th and 7th editions, Summary Stage, etc. Or you may need to press a button to “derive” these outputs.

CONGRATULATIONS !!!
ABSTRACTING RULES RELEVANT TO CSV2

- **Timing Rule** – “use all information gathered through completion of surgery(ies) in first course of treatment, or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer.”

- **Disease Progression** – “further direct extension, regional node involvement, or distant metastasis known to have developed after the diagnosis was established.”

- **NOTE**: Information about tumor extension, lymph node involvement, or distant metastasis obtained AFTER disease progression is documented SHOULD BE EXCLUDED from the CS fields.

ABSTRACTING RULES RELEVANT TO CSV2

- Limitations of medical record documentation
  - “Ideal” staging workup – reality check – cannot order all tests for all patients to check all anatomic sites
  - Insurance won’t pay for unnecessary tests
  - Clinicians will order specialty imaging or other diagnostic testing only when part of standard workup, evaluate symptoms or if suspected involvement
  - Clinicians report positive findings (not negative)

ABSTRACTING RULES RELEVANT TO CSV2

- “Inaccessible Sites Rule” is now called the “Inaccessible Lymph Nodes Rule” instructs registrars to “presume that there are no clinically apparent (negative) regional lymph nodes or no distant metastases when the clinician proceeds with usual or standard treatment to the primary site”

- **Rationale**: if the clinician knew or suspected the patient had other sites of cancer involvement – knowledge of such metastases would change the treatment approach.

- **Elimination of MX** – either you have mets or you don’t.
CSV2 GENERAL RULES / INSTRUCTIONS

1. CS data is collected on all cases abstracted.
2. CS data is collected on all sites and histologies.
3. schemas apply to all histologies unless otherwise stated (inclusion/exclusion criteria).
4. Timing Rule – “use all information gathered through completion of surgery(ies) in the first course of treatment, or all information available within four months of the date of diagnosis in the absence of disease progression, whichever is longer.”
5. Site-specific and histology specific guidelines take precedence over general guidelines.

11. Autopsy Reports are used in coding CS the same as pathology reports, apply the same timing rules and inclusion/exclusion criteria.
12. Statement of T, N, or M only. The extent of disease may be described by the clinician only in terms of T (tumor), N (node), and M (metastasis) categories.
   • Code the most specific code that describes each element
   • When no information is available to assign a specific code, but the clinician states T, N, M – code the information corresponding to “Stated as T___ N___ M___.”
   • The medical record documentation takes precedence over the clinician-assigned TNM when there is a discrepancy between documentation in the medical record and the clinician-assigned “T___ N___ M___.”
CSv2 General Rules / Instructions

13. Reportable-by-Agreement Cases – follow instructions of the population-based registry regarding reportability of cases such as high grade dysplasia of esophagus, pancreatic intraglandular neoplasia, and squamous carcinoma of skin sites.

14. No forward compatibility – CSv2 will not convert or derive 7th edition TNM for cases diagnosed prior to 1/1/2010. However, CSv2 will derive both 6th and 7th edition TNM for cases diagnosed on or after 1/1/2010.

15. Lymphoma and hematopoietic disease general excepted – staging rules for solid tumors are not the same as for lymphoma or systemic hematopoietic diseases. Follow the instructions included in the appropriate schema.

Structure and Format of CSv2 Schema

- Schema Name, with any exclusions
- ICD-O-3 Topography/Histology Codes
- Schema Notes
  - General notes that apply to this primary site
- CS Master Table
  - Lists every table associated with the schema
- Data Field Tables
  - Notes before table are coding guidelines for registrars
  - Table with codes, code description, and TNM7, TNM6, SS77 and SS2000 mapping
  - Notes after table explain logic of mapping
- Extra Tables
  - Histology inclusions table (seventh Edition)
  - Histology exclusions table (sixth Edition)

Structure and Format of CSvW2 Schema


**CHOOSING THE CORRECT SCHEMA FOR A CASE**

- **Primary Site** – inclusion/exclusion criteria
  - Site/Subsite inclusions table (seventh Edition)
  - Site/Subsite exclusions table (sixth Edition)

- **Histology** – inclusion/exclusion criteria
  - Histology inclusions table (seventh Edition)
  - Histology exclusions table (sixth Edition)

- **Subsite** – varies

- **Other**

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**CHOOSING THE CORRECT SCHEMA FOR A CASE**

- **Example: Colorectal Primary**
  - Subsite of Colon
    - Appendix
    - Colon
    - Rectum
    - Anus
  - Histology
    - Carcinoma
    - NET (carcinoid)
    - Lymphoma
    - GIST
CAUTION! CAUTION! CAUTION!

- Check all site-specific schema (CSv2, surgery, other) to be sure they are being used appropriately for the site/type of cancer and data item(s) being coded.

- **Note**: The appropriate site or histology schema to use for coding surgical treatment(s) **may be different** from the site or histology schema used for coding the Collaborative Stage data set.

- **Example**: Extra-lymphatic lymphoma of stomach with surgical treatment would use the lymphoma schema for CS, but surgery would be coded using the stomach surgery codes for surgery of primary site.

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**CHOOSING THE CORRECT SCHEMA FOR A CASE**

- A **schema selection algorithm** determines which schema is appropriate to each combination of primary site and histology, perhaps with an additional schema discriminator variable.

- **What is a schema discriminator?**
  - May define a sub-sub site below ICD-O level of detail
  - Re-directs the algorithm to apply correct site schema
  - Re-directs registry software to display correct schema

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**CHOOSING THE CORRECT SCHEMA FOR A CASE**

- Site Schema that include Schema Discriminator (SSF 25)
  - Peritoneum Female Genital
  - Melanoma of Iris / Ciliary Body
  - Extrahepatic Bile Ducts
  - Nasopharynx / Pharyngeal Tonsil
  - Lacrimal Gland / Lacrimal Sac
  - Esophagus / Gastroesophageal Junction / Stomach
### Choosing the Correct Schema for a Case

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Schema</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Male</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>002</td>
<td>Female</td>
<td>PeritoneumFemaleGen</td>
</tr>
<tr>
<td>003</td>
<td>Other (hermaphrodite)</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>004</td>
<td>Transsexual</td>
<td>Peritoneum</td>
</tr>
<tr>
<td>009</td>
<td>Unknown sex</td>
<td>Peritoneum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Schema</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>No involvement of esophagus or EGJ</td>
<td>Stomach</td>
</tr>
<tr>
<td>010</td>
<td>Tumor located in Cardia or EGJ</td>
<td>EsophagusGEJunction</td>
</tr>
<tr>
<td>020</td>
<td>Esophagus or EGJ involved AND distance of tumor midpoint from EGJ 5cm or less</td>
<td>EsophagusGEJunction</td>
</tr>
<tr>
<td>030</td>
<td>Esophagus or EGJ involved AND distance of tumor midpoint from EGJ more than 5cm</td>
<td>Stomach</td>
</tr>
<tr>
<td>040</td>
<td>Esophagus or EGJ involved AND distance of tumor midpoint from EGJ unknown</td>
<td>EsophagusGEJunction</td>
</tr>
<tr>
<td>050</td>
<td>Esophagus and EGJ not involved but distance of tumor midpoint from EGJ is 5cm or less</td>
<td>Stomach</td>
</tr>
</tbody>
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<tr>
<td>010</td>
<td>Perihilar bile duct(s)</td>
<td>BileDuctsPerihilar</td>
</tr>
<tr>
<td>020</td>
<td>Proximal extrahepatic bile duct(s)</td>
<td>BileDuctsPerihilar</td>
</tr>
<tr>
<td>030</td>
<td>Hepatic duct(s)</td>
<td>BileDuctsPerihilar</td>
</tr>
<tr>
<td>030</td>
<td>Stated as Klatskin tumor</td>
<td>BileDuctsPerihilar</td>
</tr>
<tr>
<td>030</td>
<td>Cystic bile duct; cystic duct</td>
<td>CysticDuct</td>
</tr>
<tr>
<td>040</td>
<td>Common bile duct; Common duct, NOS</td>
<td>BileDuctsDistal</td>
</tr>
<tr>
<td>050</td>
<td>Common bile; other bile, subsite of origin not stated</td>
<td>BileDuctsPerihilar</td>
</tr>
</tbody>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Schema</th>
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</thead>
<tbody>
<tr>
<td>050</td>
<td>Diffuse involvement; more than one subsite involved, subsite of origin not stated</td>
<td>BileDuctsPerihilar</td>
</tr>
</tbody>
</table>
**Ambiguous Terminology**
- Determination of cancer stage is BOTH a subjective and objective assessment of how far the cancer has spread. Sometimes a clinician uses “ambiguous terminology” to describe extent rather than + or -.  
- Use the table in Part I, Section 1 under “Ambiguous Terminology” to evaluate whether or not to include or exclude information based on use of ambiguous terms.  
- **Note:** The CSV2 list of ambiguous terms is NOT the same list as the MPH Rules list of ambiguous terms!!  
- Any site-specific schema instructions or terms used within a given site-specific schema take precedence over generic use and application of ambiguous terms.

**Coding “None” vs. “Unknown”**
- Regional lymph nodes for some primary sites are not easily examined by palpation, observation, physical examination, or other clinical methods.  
- **Assign code “00” when:**  
  - There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration.  
  - Clinically low stage of disease (T1, T2, or localized).  
  - Patient receives what would be usual treatment to the primary site (treatment appropriate to stage of disease).

**CSV2 Data Elements**

CS Tumor Size - Instructions

- Any schema-specific instructions for coding this data item take priority over general rules and instructions.

- Record the largest dimension or diameter of the primary tumor:
  - Prior to neoadjuvant treatment
  - Priority order
  - Pathology report
  - Operative report
  - Diagnostic imaging report
  - Physical examination
  - Other

- Record CS Tumor Size in millimeters.

- Record the diameter of the primary tumor, not the depth or thickness of the tumor.

- Do not add pieces or chips together.

- Multifocal/multicentric tumors – code largest tumor.

- Record the size of the invasive component when in situ and invasive components present in the same tumor.

- Round the tumor size only if it is described in fractions of millimeters – do not round up centimeter.

- Codes 991-995 – non-specific size - greater than xyz.

- Code 998 – circumferential, diffuse, etc. always takes precedence over actual size of tumor.

- "Stated As" – in absence of measured tumor size – record "stated as T__" as noted by a clinician in the medical record.

- Text Documentation: Always document the source and rationale for your choice of codes in text!!
CS Tumor Size - Instructions

- Code 988 – size not applicable
  - Hematopoietic/lymphoid neoplasms (examples: multiple myeloma, leukemia, MDS, lymphoma)
  - Kaposi Sarcoma
  - Melanoma Choroid
  - Melanoma Iris
  - Melanoma Ciliary Body

CS Extension - Instructions

- Identifies contiguous (adjacent) growth (extension) of the primary tumor within the organ of origin or its direct extension (invasion) outside the organ of origin and/or into neighboring organs.
- Code the farthest documented extension of the primary tumor prior to neoadjuvant treatment
- Code the highest applicable specific number
- “Stated As” – in absence of documented tumor extension within and/or outside the primary tumor – record “stated as T_” as noted by a clinician in the medical record.

CS Extension - Instructions

- Do not include discontinuous metastasis to distant sites in this field. These are coded in CS Mets at Dx
  - 4 Exceptions – GYN Sites
    - Corpus uteri
    - Ovary
    - Fallopian tube
    - Female peritoneum
- Involved Organ Not Listed in Schema – If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area
CS EXTENSION - INSTRUCTIONS

- In Situ Pathology with Nodal or Metastatic Tumor:
  - **DO NOT CODE CS Extension as in situ if there is any evidence of nodal or metastatic involvement**; use the code for Localized, NOS, if there is no better information.

- **Text Documentation**: Always document the source and rationale for your choice of codes in text!!

CS TUMOR SIZE/EXT EVAL - INSTRUCTIONS

- This field records how the codes for the two items “CS Tumor Size” and “CS Extension” were determined, based on the diagnostic methods employed.
- It is used primarily to derive the staging basis for the T category in the TNM system.
- Documents the report or procedure from which the information about the farthest extension or largest size of the primary tumor was obtained.
- **MAY NOT BE the numerically highest Eval code.**

CS TUMOR SIZE/EXT EVAL - INSTRUCTIONS

- **When the only procedure is a polypectomy**. In some situations, an endoscopic procedure may remove the entire tumor, and the TS/Ext Eval must be coded to reflect the correct staging basis for tumor extension.
  - Code TS/Ext Eval = 3 (pathologic) when there is no tumor at the margin of resection after the polypectomy.
  - Code TS/Ext Eval = 1 (endoscopic/diagnostic biopsy) when there is tumor at the margin of resection after the polypectomy.
- **When the patient has further surgery**
  - Code TS/Ext Eval = 3 (pathologic) when there is no primary tumor in resection, use extension information from polypectomy.
  - Code Eval = 3 (pathologic) when more tumor is found at resection, use extension information from resection and polypectomy.
CS LYMPH NODES - INSTRUCTIONS

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

- Criteria for involvement are site-specific and may include the location, laterality, size and/or number of involved regional lymph nodes.

- Involved distant lymph nodes coded in CS Mets at Dx.

- Record the specific involved regional lymph node chain(s) farthest from the primary site (clinical or pathological lymph node involvement).

CS LYMPH NODES - INSTRUCTIONS

- Regional Lymph Nodes Listed in each Schema – WHY?

- Synonyms – pathologists, surgeons, and other clinicians may refer to lymph node chains using a variety of synonyms. If you do not find the involved lymph node chain in the schema, check for synonyms or refer to a medical dictionary.

- Priority Order – use the following priority order:
  - Pathology
  - Diagnostic Imaging
  - Physical Examination

CS LYMPH NODES - INSTRUCTIONS

- Terms Meaning Lymph Node Involvement - The terms “fixed” or “matted” and “mass in hilum, mediastinum, retroperitoneum, and/or mesentery” with no specific information as to tissue involved is coded as involvement for solid tumors.

- Terms NOT Meaning Lymph Node Involvement – The terms “palpable,” “enlarged,” “visible swelling,” “shotty,” or “lymphadenopathy” should be ignored UNLESS there is a statement of involvement by the clinician.

- For Lymphomas – Any positive mention of lymph nodes indicates involvement.
CS LYMPH NODES - INSTRUCTIONS

- **Inaccessible Lymph Nodes Rule** – Code CS LN = 000 (none) when the following three conditions are met:
  1. No mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing or surgical exploration.
  2. Clinically low stage (T1, T2, or localized) disease.
  3. Patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician).

- **Direct Tumor Extension Into Lymph Node** – If there is direct extension of primary tumor into a regional lymph node, code the involved node in this field.

- **Isolated Tumor Cells (ITCs) in Lymph Nodes** – ITCs are single cells or small clusters of epithelial cells in regional lymph nodes whose metastatic potential is unknown.
  - ITCs are coded according to site-specific guidelines.
    - Breast – Code ITCs as negative lymph nodes.
    - Cutaneous Melanoma – Code ITCs as positive lymph nodes.
    - Merkel Cell Carcinoma – Code ITCs as positive lymph nodes.

- **“Stated As”** – when the only indication of lymph node involvement is the physician statement of N category from TNM staging system or other staging reference – record “stated as N__” as noted by a clinician in the medical record.

CS REG NODES EVAL - INSTRUCTIONS

- **This field records how the codes for the item “CS Lymph Nodes” was determined, based on the diagnostic methods employed (and their intent).**
  - When the lymph node procedure is part of the routine workup, the staging basis is clinical (CS Lymph Nodes Eval codes 0, 1, 5, 9).
    - Example: regional node biopsy or sentinel lymph node procedure intended to help choose treatment plan...part of clinical staging.
  - When the intent of the lymph node procedure is therapeutic (treatment), the staging basis is pathologic (CS Reg Nodes Eval codes 2, 3, 6).
CS REG NODES EVAL - INSTRUCTIONS
- It is used primarily to derive the staging basis for the T category in the TNM system.
- Document the staging basis for the farthest (away from the primary tumor) involved lymph nodes
- Pathology information takes priority
- Sentinel Nodes - coding guidelines for positive sentinel lymph nodes in CS Lymph Nodes Eval are site-specific. In general, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging.

REGIONAL NODES POSITIVE - INSTRUCTIONS
- Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.
- This field is also called Reg LN Pos
- Record regional lymph nodes positive only
- The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

REGIONAL NODES POSITIVE - INSTRUCTIONS
- Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection.
- However, if the positive aspiration or core biopsy is from a lymph node in a different node region, include the node in the count of Regional Nodes Positive.
- Code 95 – Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
REGIONAL NODES POSITIVE - INSTRUCTIONS

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

- **Code 98** – Use code 98 in several situations.
  - The assessment of lymph nodes is clinical only.
  - No lymph nodes are removed and examined.
  - A “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic exam.

- **Code 98** – When Regional Nodes Positive = 98, Regional Nodes Examined = 00.

REGIONAL NODES POSITIVE - INSTRUCTIONS

- **Code 99** – for the primary sites and histologies listed, Regional Nodes Positive = 99.
  - Placenta
  - Brain and Cerebral Meninges
  - Other Parts of Central Nervous System
  - Hodgkin and non-Hodgkin Lymphoma
  - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  - Other and Ill-Defined Primary Sites
  - Unknown Primary Site

REGIONAL NODES EXAMINED - INSTRUCTIONS

- Records the total number of regional lymph nodes removed and examined by the pathologist.

- This field is also called Reg LN Exam.

- **Code 00** – Use Code 00 in several situations.
  - The assessment of lymph nodes is clinical.
  - No lymph nodes are removed and examined.
  - A “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
REGIONAL NODES EXAMINED - INSTRUCTIONS

- Code 00 – When Regional Nodes Examined = 00, Regional Nodes Positive = 98.
- Codes 95, 96, 97, and 98 – See CSv2 Manual
- Code 99 – for the primary site/histologies listed, Regional Nodes Examined = 99.
  - Placenta
  - Brain and Cerebral Meninges
  - Other Parts of Central Nervous System
  - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  - Hodgkin and non-Hodgkin Lymphoma

CS METS AT DX - INSTRUCTIONS

- Record distant site(s) of metastatic involvement at time of diagnosis
- Discontinuous or hematogenous metastases - Tumor spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or to a site remote from the primary tumor.
- Disease Progression – DO NOT record remote or distant metastasis known to have developed after the extent of disease was established at time of diagnosis
- Text Documentation: Always document the source and rationale for your choice of codes in text!!

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<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether (bone, liver, brain, lung) is involved</td>
</tr>
</tbody>
</table>
CS METS EVAL - INSTRUCTIONS

- This field records how the codes for “CS Mets at Dx” were determined, based on the diagnostic methods employed.
- It is used primarily to derive the staging basis for the M category in the TNM system.
- Documents the best evidence used to determine the M category
- Pathologic M1 takes priority

CS SITE SPECIFIC FACTORS 1-25

- Records additional information needed to generate stage or prognostic/predictive factors that have an effect on stage or survival
  - Required for TNM Mapping
  - Tumor Markers – proteomics, molecular genetics, etc.
  - Lab Values – alpha fetoprotein, hCG
  - Prognostic/Predictive Items – Gleason, IPI, FLIPI, IPS
  - Special Interest – microsatellite instability
  - Other Clinically Significant Information – history of clinical conditions, toxic exposures, genetic mutations

CS SITE SPECIFIC FACTORS 1-25

- Values mean different things for different SSFs
  - 000 – 000 value
  - 000 – Not found
  - 000 – None counted
  - 000 – Not present
  - 988 – Not Applicable – UNIVERSAL CODE (was 888)
  - 997 – Test Ordered – result not in chart
  - 998 – Test not done (not ordered and not performed)
  - 999 – Unknown or no information (not documented)
  - Facility does not offer this test
  - No report of the test in the medical record
  - Not stated in medical record
LYMPH-VASCULAR INVASION

- The absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.
- The presence of lymph-vascular invasion may affect the patient’s prognosis.
- DO NOT CODE peri-neural invasion in this field.
- The presence or absence of lymph-vascular invasion is required for mapping T for some cancer sites
  - Testis
  - Penis

Code Description

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Lymph-vascular invasion not present (absent)/Not identified</td>
</tr>
<tr>
<td>1</td>
<td>Lymph-vascular invasion present/Identified</td>
</tr>
<tr>
<td>8</td>
<td>Not applicable</td>
</tr>
<tr>
<td>9</td>
<td>Unknown if lymph-vascular invasion present/Indeterminate</td>
</tr>
</tbody>
</table>

- Code from the pathology report – primary tumor only
  - Use the CAP Checklist or Synoptic Report

GRADE PATH VALUE

- Not an FCDS Required Field
- Grade Path Value is paired with Grade Path System to describe the original grade of the tumor.
- This field supplements but does not replace the field Grade/Differentiation (NAACCR Item #440)
- Code the histologic grade or differentiation reported in the medical record.
  - This is the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system.
GRADE PATH VALUE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recorded as Grade I or 1</td>
</tr>
<tr>
<td>2</td>
<td>Recorded as Grade II or 2</td>
</tr>
<tr>
<td>3</td>
<td>Recorded as Grade III or 3</td>
</tr>
<tr>
<td>4</td>
<td>Recorded as Grade IV or 4</td>
</tr>
<tr>
<td>Blank</td>
<td>No 2, 3, or 4 grade system available/Unknown</td>
</tr>
</tbody>
</table>

NOTE: Do not convert the terms well, moderately, or poorly differentiated, low/high, or anaplastic into codes in this field.
CS OUTPUTS

- T-element – AJCC 7th edition
- N-element – AJCC 7th edition
- M-element – AJCC 7th edition
- TNM Stage Group – AJCC 7th edition
- T-element – AJCC 6th edition
- N-element – AJCC 6th edition
- M-element – AJCC 6th edition
- TNM Stage Group – AJCC 6th edition
- Summary Stage 1977 AND Summary Stage 2000