## Colon

### CS Tumor Size

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>No mass/tumor found</td>
</tr>
<tr>
<td>001-988</td>
<td>001 - 988 millimeters (code exact size in millimeters)</td>
</tr>
<tr>
<td>989</td>
<td>989 millimeters or larger</td>
</tr>
<tr>
<td>990</td>
<td>Microscopic focus or foci only, no size of focus given</td>
</tr>
<tr>
<td>991</td>
<td>Described as &quot;less than 1 cm&quot;</td>
</tr>
<tr>
<td>992</td>
<td>Described as &quot;less than 2 cm,&quot; or &quot;greater than 1 cm,&quot; or &quot;between 1 cm and 2 cm&quot;</td>
</tr>
<tr>
<td>993</td>
<td>Described as &quot;less than 3 cm,&quot; or &quot;greater than 2 cm,&quot; or &quot;between 2 cm and 3 cm&quot;</td>
</tr>
<tr>
<td>994</td>
<td>Described as &quot;less than 4 cm,&quot; or &quot;greater than 3 cm,&quot; or &quot;between 3 cm and 4 cm&quot;</td>
</tr>
<tr>
<td>995</td>
<td>Described as &quot;less than 5 cm,&quot; or &quot;greater than 4 cm,&quot; or &quot;between 4 cm and 5 cm&quot;</td>
</tr>
<tr>
<td>998</td>
<td>Familial/multiple polyposis (M-8220/8221)</td>
</tr>
<tr>
<td>999</td>
<td>Unknown; size not stated</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

Please click here if you would like to email a comment about the content of this table.
Collaborative Stage for TNM 7 - Revised 08/25/2009 [Schema]

Colon

CS Extension

- Note 1: Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum; code depth of invasion or extracolonic spread as indicated.
- Note 2: Codes 600-800 are used for contiguous extension from the site of origin. Discontinuous involvement is coded in CS Mets at DX.
- Note 3: Tumor that is adherent to other organs or structures, macroscopically, is classified T4b. However, if no tumor is present in the adhesion, microscopically, the classification should be pT3.
- Note 4: High grade dysplasia and severe dysplasia are generally not reportable in cancer registries, but if a registry does collect it, code 000 should be used.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>In situ; noninvasive; intraepithelial</td>
<td>Tis</td>
<td>Tis</td>
<td>IS</td>
<td>IS</td>
</tr>
<tr>
<td>050</td>
<td>(Adeno)carcinoma in a polyp or adenoma, noninvasive</td>
<td>Tis</td>
<td>Tis</td>
<td>IS</td>
<td>IS</td>
</tr>
<tr>
<td>100</td>
<td>Invasive tumor confined to mucosa, NOS (including intramucosal, NOS)</td>
<td>Tis</td>
<td>Tis</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>110</td>
<td>Lamina propria, including lamina propria in the stalk of a polyp</td>
<td>Tis</td>
<td>Tis</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>120</td>
<td>Confined to and not through the muscularis mucosae, including muscularis mucosae in the stalk of a polyp.</td>
<td>Tis</td>
<td>Tis</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>130</td>
<td>Confined to head of polyp, NOS</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>140</td>
<td>Confined to stalk of polyp, NOS</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>150</td>
<td>Invasive tumor in polyp, NOS</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>Page</td>
<td>Description</td>
<td>Stage</td>
<td>Stage</td>
<td>Localised</td>
<td>Perineural</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>160</td>
<td>Invades submucosa (superficial invasion), including submucosa in the stalk of a polyp</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>170</td>
<td>Stated as T1, NOS</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>200</td>
<td>Muscularis propria invaded, Stated as T2, NOS</td>
<td>T2</td>
<td>T2</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>260</td>
<td>Stated as T2, NOS</td>
<td>T2</td>
<td>T2</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>300</td>
<td>Localized, NOS Confined to colon, NOS</td>
<td>T1</td>
<td>T1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>310</td>
<td>Extension through wall, NOS Extension through muscularis propria or muscularis, NOS Non-peritonealized pericolic tissues invaded</td>
<td>T3</td>
<td>T3</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>320</td>
<td>Perimuscular tissue invaded</td>
<td>T3</td>
<td>T3</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>330</td>
<td>Subserosal tissue/(sub)serosal fat invaded</td>
<td>T3</td>
<td>T3</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>340</td>
<td>Transmural, NOS</td>
<td>T3</td>
<td>T3</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>350</td>
<td>Stated as T3, NOS</td>
<td>T3</td>
<td>T3</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>360</td>
<td>Fat, NOS</td>
<td>T3</td>
<td>T3</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>370</td>
<td>Extension to: Adjacent tissue(s), NOS Connective tissue Mesenteric fat Mesentery Mesocolon Pericolic fat Ascending and descending colon Retroperitoneal fat Transverse colon/flexures Gastrocolic ligament Greater omentum</td>
<td>T3</td>
<td>T3</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>380</td>
<td>Adherent to other organs or structures, but no microscopic tumor found in adhesion(s)</td>
<td>T3</td>
<td>T3</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>390</td>
<td>Stated as T4, NOS</td>
<td>T4</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
</tr>
</tbody>
</table>
Collaborative Stage

<table>
<thead>
<tr>
<th>Page</th>
<th>Invasive or Lymphatic Spread</th>
<th>T4a</th>
<th>T4</th>
<th>RE</th>
<th>RE</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>Invasion of/through serosa (mesothelium) (visceral peritoneum) Stated as T4a, NOS</td>
<td>T4a</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>550</td>
<td>Any of [(420) to (450)] + (500)</td>
<td>T4a</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>570</td>
<td>Adherent to other organs or structures, NOS</td>
<td>T4b</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
</tr>
<tr>
<td>600</td>
<td>All colon sites: Small intestine Cecum: Greater omentum Ascending colon: Greater omentum Liver, right lobe Transverse colon and flexures: Gallbladder/bile ducts Kidney Liver Pancreas Spleen Stomach Descending colon: Greater omentum Pelvic wall Spleen Sigmoid colon: Greater omentum Pelvic wall T4b</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
<td></td>
</tr>
<tr>
<td>650</td>
<td>All colon sites: Abdominal wall Retroperitoneum (excluding fat) T4b</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
<td></td>
</tr>
<tr>
<td>660</td>
<td>Ascending colon: Right kidney Right ureter Descending colon: Left kidney Left ureter T4b</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
<td></td>
</tr>
<tr>
<td>690</td>
<td>Stated as T4b, NOS T4b</td>
<td>T4</td>
<td>RE</td>
<td>RE</td>
<td></td>
</tr>
<tr>
<td>Stage</td>
<td>Location Description</td>
<td>T4b</td>
<td>T4</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------</td>
<td>-----</td>
<td>----</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>700</td>
<td>Cecum, ascending, descending and sigmoid colon: Fallopian tube, Ovary, Uterus</td>
<td>T4b</td>
<td>T4</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>750</td>
<td>All colon sites unless otherwise stated above: Adrenal (suprarenal) gland, Bladder, Diaphragm, Fistula to skin, Gallbladder, Other segment(s) of colon via serosa</td>
<td>T4b</td>
<td>T4</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>800</td>
<td>Further contiguous extension: Cecum: Kidney, Liver, Ureter, Transverse colon and flexures: Ureter, Sigmoid colon: Cul de sac (rectouterine pouch), Ureter, Other contiguous extension</td>
<td>T4b</td>
<td>T4</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>950</td>
<td>No evidence of primary tumor</td>
<td>T0</td>
<td>T0</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>999</td>
<td>Unknown extension, Primary tumor cannot be assessed, Not documented in patient record</td>
<td>TX</td>
<td>TX</td>
<td>U</td>
<td>U</td>
</tr>
</tbody>
</table>
Colorectal Cancer Staging

### Colon

#### CS Tumor Size/ Ext Eval

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Does not meet criteria for AJCC pathologic staging:</td>
<td>c</td>
</tr>
<tr>
<td></td>
<td>No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Does not meet criteria for AJCC pathologic staging:</td>
<td>c</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Meets criteria for AJCC pathologic staging:</td>
<td>p</td>
</tr>
<tr>
<td></td>
<td>No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Either criteria meets AJCC pathologic staging:</td>
<td>p</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No surgical resection done. Evaluation based on positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collaborative Stage</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 5 | Does not meet criteria for AJCC yp-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). |

| 6 | Meets criteria for AJCC yp-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. |

| 8 | Meets criteria for autopsy (a) staging:  
   Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy) |

| 9 | Unknown if surgical resection done  
   Not assessed; cannot be assessed  
   Unknown if assessed  
   Not documented in patient record |
Collaborative Stage for TNM 7 - Revised 09/29/2009

Colon

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: One or more malignant satellite peritumoral nodules in the pericolorectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule may represent discontinous spread, venous invasion with extravascular spread or a totally replaced lymph node. If the primary tumor is localized and maps to T1 or T2 and this is the only information you have on lymph nodes, use code 050. The total number of tumor deposits must also be coded in SSF4. If there are tumor deposits and node involvement, code the information on node involvement. That is, do not use code 050.
- Note 3: Inferior mesenteric nodes are coded in CS Mets at DX for cecum, ascending colon, transverse colon, and hepatic flexure. Superior mesenteric nodes are coded in CS Mets at DX for all colon sites.
- Note 4: The number of positive regional nodes is required to calculate the correct N category for this site. Codes 400-470 are for use when this number is not available, but the pathology report assigns an N1 or N2 category. If information about the number of positive nodes is available, use codes 100, 200, or 300 rather than codes 400 - 470. The actual number of involved nodes will be coded in Reg LN Pos.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>None; no regional lymph node involvement</td>
<td>N0</td>
<td>N0</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>050</td>
<td>Tumor deposit(s) in the subserosa, or non-peritonealized pericolic or perirectal tissues without regional nodal metastasis</td>
<td>N1c</td>
<td>N1</td>
<td>RN</td>
<td>RN</td>
</tr>
</tbody>
</table>
| 100 | Regional lymph nodes for all colon sites:  
| Colic (NOS)  
| Epicolic (adjacent to bowel wall)  
| Mesocolic (NOS)  
| Paracolic/pericolic |
| 200 | Regional lymph nodes, for specific subsites:  
| Cecum:  
| Cecal: anterior (prececal), posterior (retrocecal); NOS  
| Ileocolic  
| Right colic  
| Ascending colon:  
| Ileocolic  
| Middle colic  
| Right colic  
| Transverse colon and flexures:  
| Inferior mesenteric for splenic flexure only  
| Left colic for splenic flexure only  
| Middle colic  
| Right colic for hepatic flexure only  
| Descending colon:  
| Inferior mesenteric  
| Left colic  
| Sigmoid  
| Sigmoid colon:  
| Inferior mesenteric  
| Sigmoidal (sigmoid mesenteric)  
| Superior hemorrhoidal  
| Superior rectal |
| 300 | Regional lymph nodes for all colon sites:  
| Mesenteric, NOS  
| Regional lymph node(s), NOS |
| 400 | Stated as N1 pathologic  
| N1NOS  
| N1  
| RN  
| RN |
| 410 | Stated as N1a pathologic  
| N1a  
| N1  
| RN  
| RN |
| 420 | Stated as N1b pathologic  
| N1b  
| N1  
| RN  
| RN |
| 450 | Stated as N2 pathologic  
| N2NOS  
| N2  
| RN  
<p>| RN |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>N1a</th>
<th>N1</th>
<th>N2</th>
<th>N3</th>
<th>N4</th>
</tr>
</thead>
<tbody>
<tr>
<td>460</td>
<td>Stated as N2a pathologic</td>
<td>N2a</td>
<td>N2</td>
<td>RN</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>470</td>
<td>Stated as N2b pathologic</td>
<td>N2b</td>
<td>N2</td>
<td>RN</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>800</td>
<td>Lymph nodes, NOS</td>
<td>^</td>
<td>*</td>
<td>RN</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>Unknown; not stated</td>
<td>NX</td>
<td>NX</td>
<td>U</td>
<td>U</td>
<td></td>
</tr>
</tbody>
</table>

- * For codes 100-300 and 800 ONLY: when CS Lymph Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation 6th Table, using Reg LN Pos and CS Site-Specific Factor 2; when CS Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation 6th Table Also Used When CS Reg Nodes Eval is Not Coded using Reg LN Pos.
- ^ For codes 100-300 and 800 ONLY: when CS Lymph Nodes Eval is 0, 1, 5, or 9, the N category is assigned from the Lymph Nodes Clinical Evaluation 7th Table, using Reg LN Pos and CS Site-Specific Factor 2; when CS Regional Nodes Eval is 2, 3, 6, 8, or not coded, the N category is determined from the Lymph Nodes Pathologic Evaluation 7th Table Also Used When CS Reg Nodes Eval is Not Coded using Reg LN Pos.

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

CS Lymph Nodes Eval

- **Note 1:** This field is used primarily to derive the staging basis for the N category in the TNM system. It records how the code for the item "CS Lymph Nodes" was determined based on the diagnostic methods employed and their intent.

- **Note 2:** In the 7th edition of the AJCC manual, the clinical and pathologic classification rules for the N category were changed to reflect current medical practice. The N is designated as clinical or pathologic based on the intent (workup versus treatment) matching with the assessment of the T classification. When the intent is workup, the staging basis is clinical, and when the intent is treatment, the staging basis is pathologic.
  
  A. Microscopic assessment including biopsy of regional nodes or sentinel nodes if being performed as part of the workup to choose the treatment plan, is therefore part of the clinical staging. When it is part of the workup, the T category is clinical, and there has not been a resection of the primary site adequate for pathologic T classification (which would be part of the treatment).
  
  B. Microscopic assessment of regional nodes if being performed as part of the treatment is therefore part of the pathologic staging. When it is part of the treatment, the T category is pathologic, and there has been a resection of the primary site adequate for pathologic T classification (all part of the treatment).

- **Note 3:** Microscopic assessment of the highest N category is always pathologic (code 3).

- **Note 4:** If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.

- **Note 5:** Only codes 5 and 6 are used if the node assessment is performed after neoadjuvant therapy.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Collaborative Stage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Does not meet criteria for AJCC pathologic staging: No regional lymph nodes removed for examination. Evidence based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.</td>
<td>c</td>
</tr>
<tr>
<td>1</td>
<td>Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria: No regional lymph nodes removed for examination. Evidence based on endoscopic examination, or other invasive techniques including surgical observation, without biopsy. No autopsy evidence used. OR Fine needle aspiration, incisional core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup, WITHOUT removal of the primary site adequate for pathologic T classification (treatment).</td>
<td>c</td>
</tr>
<tr>
<td>2</td>
<td>Meets criteria for AJCC pathologic staging: No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).</td>
<td>p</td>
</tr>
<tr>
<td>3</td>
<td>Meets criteria for AJCC pathologic staging based on at least one of the following criteria: Any microscopic assessment of regional nodes (including FNA, incisional core needle bx, excisional bx, sentinel node bx or node resection), WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category. OR Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.</td>
<td>p</td>
</tr>
<tr>
<td>5</td>
<td>Does not meet criteria for AJCC yp-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6).</td>
<td>c</td>
</tr>
<tr>
<td>6</td>
<td>Meets criteria for AJCC yp-pathologic (yp) staging: Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on pathologic evidence, because the pathologic evidence at surgery is more extensive than clinical evidence before treatment.</td>
<td>y</td>
</tr>
</tbody>
</table>
### Collaborative Stage

<table>
<thead>
<tr>
<th>8</th>
<th>Meets criteria for AJCC autopsy (a) staging: Evidence from autopsy; tumor was unsuspected or undiagnosed prior to autopsy.</th>
</tr>
</thead>
</table>
| 9 | Unknown if lymph nodes removed for examination  
    Not assessed; cannot be assessed  
    Unknown if assessed  
    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 03/30/2009

Colon

Reg LN Pos

- Note: Record this field even if there has been preoperative treatment.

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

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

### Reg LN Exam

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

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

#### CS Mets at DX

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>SS77 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>No; none</td>
<td>M0</td>
<td>M0</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>08</td>
<td>Cecum, ascending, hepatic flexure and transverse colon: Superior mesentric lymph nodes only</td>
<td>M1a</td>
<td>M1</td>
<td>RN</td>
<td>D</td>
</tr>
<tr>
<td>08</td>
<td>OBSOLETE DATA RETAINED V0200 See codes 15 and 25 Distant lymph node(s) other than code 08 For all colon sites: Common iliac Distant lymph node(s), NOS External iliac Para-aortic Retroperitoneal For cecum, appendix, ascending colon, transverse colon, and hepatic flexure; Inferior mesenteric For splenic flexure, descending colon, and sigmoid colon: Superior mesenteric</td>
<td>ERROR</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Page</td>
<td>Metastasis Details</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 4</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>15</td>
<td>Metastasis to a single distant lymph node chain other than code 08</td>
<td>M1a</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>For all colon sites:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Common iliac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distant lymph node(s), NOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>External iliac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Para-aortic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retroperitoneal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For cecum, appendix, ascending colon, transverse colon, and hepatic flexure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inferior mesenteric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For splenic flexure, descending colon, and sigmoid colon:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Superior mesenteric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Metastasis to a single distant organ</td>
<td>M1a</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>22</td>
<td>Stated as M1a, NOS</td>
<td>M1a</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>25</td>
<td>Metastasis to more than one distant lymph node chain other than code 08</td>
<td>M1b</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>For all colon sites:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Common iliac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distant lymph node(s), NOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>External iliac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Para-aortic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retroperitoneal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For cecum, ascending colon, transverse colon, and hepatic flexure:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inferior mesenteric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Superior mesenteric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For splenic flexure, descending colon, and sigmoid colon:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Superior mesenteric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Metastases to more than one distant organ</td>
<td>M1b</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td></td>
<td>Metastases to the peritoneum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinomatosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stated as M1b, NOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>(08 or 15 or 25) PLUS (20 or 30) Distant lymph nodes plus other distant metastases</td>
<td>M1b</td>
<td>M1</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Code</th>
<th>Distant Metastases</th>
<th>Other Distant Metastases</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>OBSOLETE DATA RETAINED V0200 See codes 20, 30 and 60 Distant metastases except distant lymph node(s) (codes 08-10) Carcinomatosis</td>
<td>ERROR</td>
<td>M1</td>
<td>D</td>
</tr>
<tr>
<td>50</td>
<td>OBSOLETE DATA RETAINED V0200 See code 35 (40) + ((08) or (10)) Distant lymph node(s) plus other distant metastases</td>
<td>ERROR</td>
<td>M1</td>
<td>D</td>
</tr>
<tr>
<td>60</td>
<td>Distant metastasis, NOS M1, NOS</td>
<td>M1NOS</td>
<td>M1</td>
<td>D</td>
</tr>
<tr>
<td>99</td>
<td>Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record</td>
<td>M0</td>
<td>MX</td>
<td>U</td>
</tr>
</tbody>
</table>

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

**CS Mets Eval**

- Note 1: This item reflects the validity of the classification of the item CS Mets at DX only according to the diagnostic methods employed.
- Note 2: If a specific subcategory of M1 will be derived from CS Mets at DX, then determine if there was any pathological evidence for the highest subcategory. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the highest subcategory, select an Eval code that will derive a "c" staging basis. See also CS Mets Eval in Part 1.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Staging Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><strong>Does not meet criteria for AJCC pathologic staging of distant metastasis:</strong> Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No microscopic examination of metastatic specimen performed or microscopic examination was negative.</td>
<td>C</td>
</tr>
<tr>
<td>1</td>
<td><strong>Does not meet criteria for AJCC pathologic staging of distant metastasis:</strong> Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No microscopic examination of metastatic specimen performed or microscopic examination was negative.</td>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cell</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2    | Meets criteria for AJCC pathologic staging of distant metastasis:  
No microscopic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy). |
| 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. |
| 5    | Does not meet criteria for AJCC yp-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. |
| 6    | Meets criteria for AJCC yp-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. |
| 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. |
| 9    | Not assessed; cannot be assessed  
Unknown if assessed  
Not documented in patient record |
Please click here if you would like to email a comment about the content of this table.
## Colon

### CS Site-Specific Factor 1
#### Pre-Operative Carcinoembryonic Antigen (CEA)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Test not done</td>
</tr>
<tr>
<td>010</td>
<td>Positive/elevated</td>
</tr>
<tr>
<td>020</td>
<td>Negative/normal; within normal limits</td>
</tr>
<tr>
<td>030</td>
<td>Borderline; undetermined whether positive or negative</td>
</tr>
<tr>
<td>998</td>
<td>Test ordered; results not in chart</td>
</tr>
<tr>
<td>999</td>
<td>Unknown or no information</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

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

CS Site-Specific Factor 2
Clinical Assessment of Regional Lymph Nodes

- Note: In the rare instance that the number of clinically positive nodes is stated but a clinical N category is not stated, code 1-3 nodes as 100 (N1), and 4 or more nodes as 200 (N2).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Nodes not clinically evident</td>
</tr>
<tr>
<td>100</td>
<td>Clinically N1</td>
</tr>
<tr>
<td>200</td>
<td>Clinically N2</td>
</tr>
<tr>
<td>400</td>
<td>Clinically positive regional nodes, NOS</td>
</tr>
<tr>
<td>888</td>
<td>OBSOLETE DATA CONVERTED V0200</td>
</tr>
<tr>
<td></td>
<td>See code 988: Not applicable for this site.</td>
</tr>
<tr>
<td>988</td>
<td>OBSOLETE DATA CONVERTED AND RETAINED V0200</td>
</tr>
<tr>
<td>999</td>
<td>Unknown if nodes are clinically evident</td>
</tr>
</tbody>
</table>
Colon

CS Site-Specific Factor 3
Pre-Operative Carcinoembryonic Antigen (CEA) Lab Value

- Note: Record the highest CEA lab value recorded in the medical record prior to treatment. A pretreatment CEA of 7 nanograms/milliliter (ng/ml) would be recorded as 070.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>0 ng/ml</td>
</tr>
<tr>
<td>001</td>
<td>0.1 or less ng/ml</td>
</tr>
<tr>
<td>002-979</td>
<td>0.2-97.9 ng/ml</td>
</tr>
<tr>
<td>980</td>
<td>98.0 or greater ng/ml</td>
</tr>
<tr>
<td>988</td>
<td>OBSOLETE DATA CONVERTED AND RETAINED V0200 Code 888 was used in version 1 and was converted to 988 for version 2.</td>
</tr>
<tr>
<td>997</td>
<td>Test ordered, results not in chart</td>
</tr>
<tr>
<td>998</td>
<td>Test not done (test was not ordered and was not performed)</td>
</tr>
<tr>
<td>999</td>
<td>Unknown or no information Not documented in patient record</td>
</tr>
</tbody>
</table>

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

CS Site-Specific Factor 4
Tumor Deposits

- Note 1: Tumor deposits are defined as one or more satellite peritumoral nodules in the pericolorectal adipose tissue of a primary carcinoma without histologic evidence of residual lymph node in the nodule may represent discontinuous spread, venous invasion with extravascular spread or a totally replaced lymph node.
- Note 2: Record the number of tumor deposits whether or not there are positive lymph nodes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>None</td>
</tr>
<tr>
<td>001-080</td>
<td>1-80 Tumor Deposits (code exact number of tumor deposits)</td>
</tr>
<tr>
<td>081</td>
<td>Greater than 80 Tumor Deposits</td>
</tr>
<tr>
<td>888</td>
<td>OBSOLETE DATA CONVERTED V0200. See code 988: Not applicable for this site.</td>
</tr>
<tr>
<td>988</td>
<td>OBSOLETE DATA CONVERTED AND RETAINED V0200</td>
</tr>
<tr>
<td>998</td>
<td>Tumor deposits identified, number unknown</td>
</tr>
<tr>
<td>999</td>
<td>Unknown if tumor deposits are present. Not documented in patient record</td>
</tr>
</tbody>
</table>
Colon

**CS Site-Specific Factor 5**

**Tumor Regression Grade**

- **Note 1:** Record the pathologic response to preoperative adjuvant treatment as documented on the pathology report. If the specific tumor regression grade is not stated on the pathology report, code as unknown (999).
- **Note 2:** Tumor Regression Grade should only be assessed on the primary tumor.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 000  | Tumor Regression Grade 0  
Complete Response - No viable cancer cells  
No residual tumor |
| 010  | Tumor Regression Grade 1  
Moderate Response - Single or small groups of cancer cells |
| 020  | Tumor Regression Grade 2  
Minimal Response - Residual cancer outgrown by fibrosis |
| 030  | Tumor Regression Grade 3  
Poor Response - Minimal or no tumor kill; extensive residual cancer |
| 888  | OBSOLETE DATA CONVERTED V0200  
See code 988: Not applicable for this site. |
| 988  | OBSOLETE DATA CONVERTED AND RETAINED V0200 |
| 998  | No preoperative treatment or no surgery  
No histologic confirmation |
| 999  | Unknown  
Not documented in patient record |

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

CS Site-Specific Factor 6
Circumferential Resection Margin (CRM)

- Note 1: Tumor involvement of the circumferential resection margin (CRM) appears to be a strong prognostic factor for local or systemic recurrences and survival after surgery.
- Note 2: The CRM may also be referred to as the circumferential radial margin.
- Note 3: According to AJCC 7th edition, "the CRM is the surgically dissected non-peritonealized surface of the specimen. It corresponds to any aspect of the colorectum that is not covered by a serosal layer of mesothelial cells and must be dissected from the retroperitoneum or subperitoneum in order to remove the viscus. In contradistinction, serosalized surfaces of the colorectum are not dissected; they are naturally occurring anatomic structures and are not surgical margins. The circumferential surface of surgical resection specimens of ascending colon, descending colon or upper rectum is only partially peritonealized, and the demarcation between the peritonealized surface and the non-peritonealized surface (corresponding to the CRM) of such specimens is not always easily appreciated on pathologic examination."
- Note 4: Record in millimeters to the first decimal point, the distance between leading edge of tumor and nearest edge of surgically dissected margin as recorded in the pathology report. For example, if the CRM is 2 millimeters, code 020. If the margin IS involved (positive), use code 000.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 000   | Margin IS involved with tumor
       | Circumferential resection margin positive
       | Described as "less than 1 millimeter" |
| 001-009 | .1-.9 millimeters (code exact size in millimeters) |
| 010-980 | 1- 98 millimeters (code exact size in millimeters) |
| 888   | OBSOLETE DATA CONVERTED V0200
<pre><code>   | See code 988: Not applicable for this site. |
</code></pre>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>991</td>
<td>Margins clear, distance from tumor not stated. Circumferential resection margin negative.</td>
</tr>
<tr>
<td>992</td>
<td>Described as &quot;less than 2 mm,&quot; or &quot;greater than 1 mm,&quot; or &quot;between 1 mm and 2 mm&quot;.</td>
</tr>
<tr>
<td>993</td>
<td>Described as &quot;less than 3 mm,&quot; or &quot;greater than 2 mm,&quot; or &quot;between 2 mm and 3 mm&quot;.</td>
</tr>
<tr>
<td>994</td>
<td>Described as &quot;less than 4 mm,&quot; or &quot;greater than 3 mm,&quot; or &quot;between 3 mm and 4 mm&quot;.</td>
</tr>
<tr>
<td>995</td>
<td>Described as &quot;less than 5 mm,&quot; or &quot;greater than 4 mm,&quot; or &quot;between 4 mm and 5 mm&quot;.</td>
</tr>
<tr>
<td>996</td>
<td>Described as &quot;greater than 5 mm&quot;.</td>
</tr>
<tr>
<td>997</td>
<td>No Residual Tumor identified on specimen.</td>
</tr>
<tr>
<td>988</td>
<td>OBSOLETE DATA CONVERTED AND RETAINED V0200 Code 888 was used in version 1 and was converted to 988 for version 2.</td>
</tr>
<tr>
<td>998</td>
<td>Patient did not have surgery. No histologic confirmation.</td>
</tr>
<tr>
<td>999</td>
<td>Unknown. CRM not mentioned. Not documented in patient record.</td>
</tr>
</tbody>
</table>

Please click here if you would like to email a comment about the content of this table.
Collaborative Stage for TNM 7 - Revised 09/21/2009

Colon

CS Site-Specific Factor 7
Microsatellite Instability

- Note: The Microsatellite Instability (MSI) test is a genetic test performed on tumor tissue to look for differences in length of certain non-functioning sections of DNA. The differences are caused by problems with the genes that normally repair DNA. MSI testing is less expensive and faster than testing for the defects in the functional genes. A high-positive MSI result may indicate that the gene repair problem is related to the development of the cancer, and that the patient may have HNPCC (Hereditary NonPolyposis Colorectal Cancer, also known as Lynch syndrome.) A low-positive or stable MSI result (stable meaning that there are no differences in the lengths) means it is unlikely that the cancer is genetic.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>020</td>
<td>MSI Stable; No microsatellite instability</td>
</tr>
<tr>
<td>040</td>
<td>MSI unstable low; Positive, low</td>
</tr>
<tr>
<td>050</td>
<td>MSI unstable high; Positive, high</td>
</tr>
<tr>
<td>060</td>
<td>MSI unstable, NOS; Positive, NOS</td>
</tr>
<tr>
<td>997</td>
<td>Test ordered, results not in chart</td>
</tr>
<tr>
<td>998</td>
<td>Test not done (test was not ordered and was not performed)</td>
</tr>
<tr>
<td>999</td>
<td>Unknown or no information Not documented in patient record</td>
</tr>
</tbody>
</table>

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

**Colon**

**CS Site-Specific Factor 8**

**Perineural Invasion**

- **Note:** Code the presence or absence of perineural invasion as documented in the pathology report.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>None; no perineural invasion present</td>
</tr>
<tr>
<td>010</td>
<td>Perineural invasion present</td>
</tr>
<tr>
<td>998</td>
<td>No histologic examination of primary site</td>
</tr>
<tr>
<td>999</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td>Not documented in patient record</td>
</tr>
</tbody>
</table>

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

Colon

**CS Site-Specific Factor 9**

**KRAS**

- Note: KRAS is a gene which belongs to a class of genes known as oncogenes. When mutated, oncogenes have the potential to cause normal cells to become cancerous. Studies suggest that KRAS gene mutations are often present in colorectal cancer.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>010</td>
<td>Abnormal (mutated)</td>
</tr>
<tr>
<td>020</td>
<td>Normal (wild type)</td>
</tr>
<tr>
<td>997</td>
<td>Test ordered, results not in chart</td>
</tr>
<tr>
<td>998</td>
<td>Test not done (test was not ordered and was not performed)</td>
</tr>
<tr>
<td>999</td>
<td>Unknown, Not documented in patient record</td>
</tr>
</tbody>
</table>
Collaborative Stage

Colon

CS Site-Specific Factor 10
18q Loss of Heterozygosity (LOH)

- Note: This is a special assay test used to identify loss of heterozygosity on the long arm of chromosome 18, which contains several genes with potential importance in colorectal cancer pathogenesis and progression.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>010</td>
<td>Test positive for loss of heterozygosity</td>
</tr>
<tr>
<td>020</td>
<td>Test negative for loss of heterozygosity</td>
</tr>
<tr>
<td>997</td>
<td>Test ordered, results not in chart</td>
</tr>
<tr>
<td>998</td>
<td>Test not done (test was not ordered and was not performed)</td>
</tr>
</tbody>
</table>
| 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.