

# COLLABORATIVE STAGING MANUAL AND CODING INSTRUCTIONS VERSION 01.04.01

## SUMMARY OF UPDATES

### New Codes

Schema	Data Item	Pages
Hypopharynx	CS Extension	153-154
Stomach	CS Lymph Nodes	176
Colon	CS Lymph Nodes	189
Rectum	CS Lymph Nodes	196
Lung	CS Extension	319
Breast	CS Lymph Nodes	374-375
Fallopian tube	CS Extension	408-409

### New Site-Specific Factors

Schema	Data Item	Description	Pages
Stomach	SSF1	Clinical Assessment Regional Nodes	177
Colon	SSF2	Clinical Assessment Regional Nodes	190-191
Rectum	SSF2	Clinical Assessment Regional Nodes	198

### Clarifications to Existing Items/Codes

Major clarifications are briefly described below. This list is not intended to be exhaustive. Please make note of updates when referencing individual schema. Updated information can be identified by a vertical bar symbol on the left side of the item on the replacement pages.

#### Lung

A clarification has been added to note 6 in the CS Extension field; a single negative cytologic exam of pleural fluid is not sufficient to disregard pleural effusion as a staging element.

#### Breast

For Site Specific Factors 1 and 2 (Estrogen and Progesterone Receptors, respectively) the following notes were added concerning situations where multiple ER or PR values are recorded, or when patients receive neoadjuvant therapy:

- A. In cases where ER and PR are reported on more than one tumor specimen, record the highest value (if any sample is positive, record as positive).
- B. If neoadjuvant therapy is given, record the assay from tumor specimens prior to neoadjuvant therapy.
- C. If neoadjuvant therapy is given and there are no ER or PR results from pre-treatment specimens, report the findings from post-treatment specimens.

**Note 2:** In general, ER/PR is only done on one sample. In cases where it is done on more than one sample, there is not necessarily any reason to think that the most accurate is the test done on the "largest" tumor specimen. Clinically, treatment will be based on any positive test - in other words, given the benefit and minimal toxicity of hormonal therapy, most patients will be given the "benefit of the doubt" and given hormonal therapy if any ER test is positive.

### **Cervix**

A note has been added to CS TS/Ext Eval explaining how to consider cone biopsies when coding this field:

**Note:** If a cone biopsy removes all of the tumor, (for example, negative margins) code CS TS/Ext eval as 3. If there is residual tumor after a cone biopsy, (for example, positive margins) code CS TS/Ext eval as 1.

### **Prostate**

The notes for the CS Extension field have been revised to better define "apparent" vs. "inapparent" tumors. Essentially, a clinically apparent tumor is palpable or visible through the use of imaging studies. There is no list of terms synonymous with "apparent" or "inapparent" that registrars may use.

The new notes instruct registrars to use code 30, which maps to T2, NOS, in the absence of a clear physician's statement of "apparent" or "inapparent."

### **Bladder**

Notes 2 and 3 for CS Extension previously included definite and inferred statements/descriptions of non-invasion for bladder cancer in general. The new version clearly indicates that these descriptions are only applicable to papillary transitional cell carcinomas.