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Canadian Cancer Registry Manuals

AJCC TNM 6th Edition Staging Input Data Dictionary

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AJCC TNM 6th Edition Staging Input Data Dictionary

The tumours that are reportable to the Canadian Cancer Registry (CCR) Staging Database are selected:

- According to the International Classification of Diseases for Oncology-3rd Edition (ICD-0-3).
- For **primary** cancers diagnosed on or after January 1st 2003 only.
 - O Do not submit "r" recurrent tumours
- ➤ With an ICD-O-3 behaviour code of
 - o /2 (in situ) for Colorectal and Breast or
 - o /3 (malignant) for Colorectal, Breast and Prostate

Specific histologies are **excluded from the AJCC colorectal, breast and prostate** staging systems and will be excluded from the CCR staging database, (see exclusions listing below).

Note: For morphology the selection criteria is based on the first three digits only.

Inclusions:

Format ICD-O-3-Topography: C__._ Colorectal C18.0-C18.9; C19.9; C20.9

Breast C50.0-C50.9

Prostate C61.9

Exclusions:

Prostate

In situ /2 in situ

Format ICD-O-3-Morphology: ____

Colorectal

Melanoma 8720-8790

Sarcoma 8710-8713; 8800-8921; 8990-8991; 9040-9044; 9120-9136; 9140-9142, 9150-

9252; 9370-9373; 9580-9582

Other specified cancers 8680-8700; 8950-8983; 9000-9030; 9060-9110; 9260-9365;

9380-9539

Mesothelioma 9050-9055 Lymphoma 9590-9729

Hematopoietic 9731-9769; 9800-9964; 9970-9975; 9980-9989

Breast

Carcinoid 8240-8249 Melanoma 8720-8790

Sarcoma 8710-8713; 8800-8921; 8990-8991; 9040-9044; 9120-9136; 9140-9142, 9150-

9252; 9370-9373; 9580-9582

Other specified cancers 8680-8700; 8930-8936, 8950-8974; 9000-9016; 9030; 9060-9110; 9260-9365;

9380-9539

Mesothelioma 9050-9055 Lymphoma 9590-9729

Hematopoietic 9731-9769; 9800-9964; 9970-9975; 9980-9989

Prostate

Papillary TCC 8130-8131 Melanoma 8720-8790 Sarcoma 8710-8713; 8800-8921; 8990-8991; 9040-9044; 9120-9136; 9140-9142,

9150-9252; 9370-9373; 9580-9582

Other specified cancers 8680-8700; 8930-8936; 8950-8983; 9000-9030; 9060-9110;

9260-9365; 9380-9539

Mesothelioma 9050-9055 Lymphoma 9590-9729

Hematopoietic 9731-9769; 9800-9964; 9970-9975; 9980-9989

General rules

Please refer to the breast, colorectal and prostate chapter specific guidelines in the **AJCC Cancer Staging Manual, Sixth Edition**, as these take precedence over the general guidelines.

The <u>AJCC TNM staging scheme</u> is based on the evaluation of the \underline{T} , \underline{N} , and \underline{M} components and the assignment of a stage grouping.

The <u>T</u> element designates the size or depth of invasion of the primary tumour. The numerical value increases with tumour size and depth of invasion. For example:

- > a small lesion confined to the organ of origin would be coded as T1;
- larger tumour size or deeper extension into adjacent structures, tissues, capsules, or ligaments as T2;
- larger tumour size or extension beyond the organ of origin but confined to the region, T3;
- ➤ a massive lesion or one that directly invades another organ or viscera, major nerves, arteries, or bone as T4.

The \underline{N} component designates the presence or absence of tumour in the regional lymph nodes. In some sites

➤ there is an increasing numerical value based on size, fixation, or capsular invasion. In other sites

➤ the numerical value is based on multiple nodal involvement or number and location of the regional lymph nodes.

The $\underline{\mathbf{M}}$ component identifies the presence or absence of distant metastases, including lymph nodes that are not regional.

The stage group is assigned using the table listed in each chapter. Stage 0 reflects minimal involvement, usually carcinoma in-situ, whereas Stage IV indicates either greatest tumour involvement or distant metastasis.

Histologic grade and age may impact staging in certain sites, the structure of TNM varies by site.

References:

http://www.training.seer.cancer.gov/module_staging_cancer/unit03_sec03_part00_ajcc.html

American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 6th Edition CCCR Committee on Data and Quality Management - Clinical Core Data Set, March 2001

Collaborative Staging Task Force of the American Joint Committee on Cancer. *Collaborative Staging Manual and Coding Instructions, version 1.0.* Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Publication Number 04-5496.

Facility Oncology Registry Standards (FORDS) manual, revised for 2004. Published by the American College of Surgeons (ACoS) and the Commission on Cancer (COC), 2004.

NAACCR Standards for Cancer Registries, Volume II- Data Standards and DD, Eighth Edition

AJCC TNM 6 staging input record layout Effective beginning with 2003 data

Field	Size	Position	Type	Description	Page
S1	2	1-2	N	Reporting Province/Territory	6
S2	12	3-14	AN	Patient Identification Number (PIN)	7
S3	9	15-23	AN	Tumour Reference Number (TRN)	8
S4	9	24-32	AN	CCR Identification Number (CCRID)	9
S5	8	33-40	N	Date of diagnosis	10
S6	1	41	N	Staging record type	11
S7	4	42-45	AN	ICD-O-3 Topography	12
S8	4	46-49	N	ICD-O-3 Morphology	13
S 9	1	50	AN	ICD-O-3 M behaviour code	14
S10	9	51-59	AN	Clinical T	15
S11	3	60-62	AN	Clinical N	16
S12	3	63-65	AN	Clinical M	17
S13	9	66-74	AN	Pathologic T	18
S14	6	75-80	AN	Pathologic N	19
S15	3	81-83	AN	Pathologic M	20
S16	4	84-87	AN	Clinical TNM stage group	21
S17	4	88-91	AN	Pathologic TNM stage group	22
S18	4	92-95	AN	TNM stage group	23
S19	2	96-97	N	TNM edition number	24

Staging record Field definition Validation edit no. 01

Item name: Reporting Province/Territory

Field no.: S1

Length: 2

Type: Numeric

Description: The Standard Geographic Code (SGC) of the province/territory

submitting the *staging record* to the CCR. Refer to *Residency Guidelines in Canada*, Appendix Q of the CCR Input Data Dictionary.

<u>Note 1</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR

database.

Values & meaning: 10: Newfoundland and Labrador

11: Prince Edward Island

12: Nova Scotia

13: New Brunswick

24: Québec

35: Ontario

46: Manitoba

47: Saskatchewan

48: Alberta

59: British Columbia

60: Yukon Territory

61: Northwest Territories

62: Nunavut

Staging record Field definition Validation edit no. 02

Item name: Patient Identification Number (PIN)

Equivalent to field T2 (PIN), CCR Input Data Dictionary

Field no.: S2

Length: 12

Type: Alphanumeric

Description: The unique identification number assigned by the provincial/territorial

registry to each new patient registered. It cannot be updated or

reused.

Note 1: Should be left justified, followed by blanks as required.

<u>Note 2</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR

database.

Values & meaning: Can be composed of any unique combination of numbers and upper

case alphabetic (A to Z). The following special characters are not allowed: accents, embedded blank (), period (.), apostrophe (') and

hyphen (-).

Cannot be all blank.

Staging record Field definition Validation edit no. 03

Item name: Tumour Reference Number (TRN)

Equivalent to field T3 TRN, CCR Input Data Dictionary

Field no.: S3

Length: 9

Type: Alphanumeric

Description: A unique identification number assigned by the provincial/territorial

cancer registry, as a reference to each new tumour reported to the

CCR. It cannot be updated or reused.

For each patient, the tumour reference number must be unique as its purpose is to distinguish between multiple primary tumours. The tumour reference number is part of the identification key of each *tumour record*.

<u>Note 1</u>: Should be left justified, followed by blanks as required; if not, the CCR will left justify the Tumour Reference Number.

<u>Note 2</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR database.

Values & meaning: Can be composed of any combination, unique to the patient, of

numbers, upper case alphabetic (A to Z), without accents, and the following special characters: blank (), period (.), apostrophe ('), and

hyphen (-).

Cannot be all blank.

Staging record Field definition Validation edit no. 04

Item name: CCR Identification Number (CCRID)

Equivalent to field T4 CCRID, CCR Input Data Dictionary

Field no.: S4

Length: 9

Type: Alphanumeric

Description: A unique number assigned by Statistics Canada to each new patient at

the time of the initial registration of the patient in the CCR.

<u>Note 1</u>: This field will be blank when the registration is first submitted to the CCR by a provincial/territorial cancer registry. However, any subsequent changes to this registration must contain the CCRID.

<u>Note 2</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR database.

Values & meaning: All blank or numeric.

All blank: New patient registration (no CCRID has been assigned yet)

Cannot all be zeros (000000000)

Number must be validated (see CCR Input Data Dictionary Routine

No. 03).

Staging record Field definition Validation edit no. 05

Item name: Date of Diagnosis (2003 data only)

Equivalent to field T12 Date of Diagnosis, CCR Input Data

Dictionary

Field no.: S5

Length: 8

Type: Numeric

Description: The date attached to the earliest known encounter with the health care

system for that tumour.

This may refer to: a) the date of first admission (inpatient or outpatient) to a hospital, clinic or other institution for the treatment of the tumour in question; or b) the date of first diagnosis of the tumour by a physician or the date of the first pathology report; or c) the date of death for cases diagnosed by death certificate only.

The Date of Diagnosis should not be later than 3 months after the earliest encounter with the health care system for that tumour. It includes century, year, month and day.

<u>Note 1</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR database.

<u>Note 2</u>: When an update is made to Fields S5, S7, S8, and S9 on the tumour record in the CCR database an update to the staging record must also be submitted.

Values & meaning: Format: YYYYMMDD

YYYY: Four digit year

2003 - xxxx: Valid years (where xxxx = diagnosis

year)

MM: Month

01-12: Valid months

99: Month unknown (Day of Diagnosis must also

be coded as unknown)

DD: Day

01-31: Valid days99: Day unknown

Cannot be all 9's

Valid dates are subsequently edited according to CCR Routine #01, #

02

All blank: Only when Staging Record Type (Field S6) =3.

Staging record Field definition Validation edit no. 06

Item name: Staging Record Type

Field no.: S6

Length: 1

Type: Numeric

Description: The code which identifies whether the *staging record* is new to the

CCR or is an update of an existing staging record, or whether the

staging record currently on the registry is to be deleted.

Values & meaning: 1: New record

2: Update record

3: Delete record

Staging record Field definition Validation edit no. 07

Item name: ICD-O-3 - Topography

Equivalent to field T15 Topography, CCR Input Data Dictionary

Field no.: S7

Length: 4

Type: Alphanumeric

Description: The site of origin of the neoplasm coded according to the International

Classification of Diseases for Oncology (3rd edition) – Topography

Section.

Omit any period (.) in the code.

<u>Note 1</u>: Refer to page 1 for listing of inclusions. For additional detail please see chapter specific guidelines in the AJCC Cancer Staging

Manual, Sixth Edition.

<u>Note 2</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR

database.

<u>Note 3</u>: When an update is made to Fields S5, S7, S8, and S9 on the tumour record in the CCR database an update to the staging record

must also be submitted.

Values & meaning: All blank: Only when Staging Record Type (Field S6) =3.

Staging record Field definition Validation edit no. 08

Item name: ICD-O-3 - Morphology

Equivalent to field T21M Morphology, CCR Input Data Dictionary

Field no.: S8

Length: 4

Type: Numeric

Description: The histological description of the neoplasm, coded according to the

International Classification of Diseases for Oncology 3rd edition -

Morphology Section.

<u>Note 1</u>: Refer to page 1 for listing of exclusions. For additional detail please see chapter specific guidelines in the AJCC Cancer Staging

Manual, Sixth Edition.

Note 2: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR

database.

Note 3: When an update is made to Fields S5, S7, S8, and S9 on the

tumour record in the CCR database an update to the staging record

must also be submitted.

Values & meaning: NNNN: Four-digit morphology code

All blank: Only when Staging Record Type (Field S6) =3.

Staging record Field definition Validation edit no. 09

Item name: ICD-O-3 - M Behaviour Code

Equivalent to field T21B Behaviour Code, CCR Input Data

Dictionary

Field no.: S9

Length: 1

Type: Numeric

Description: The behaviour associated with the histological description of the

neoplasm, reported in Field S8.

Note 1: The cases with Behaviour Codes "0", "1", "6" and "9" are not

TNM staged.

Note 2: /2 (in situ) is not staged for Prostate (PIN III)

<u>Note 3</u>: Fields S1, S2, S3 S4, S5, S7, S8 and S9 will be used to match tumours in the staging database to the tumour record on the CCR

database.

<u>Note 4</u>: When an update is made to Fields S5, S7, S8, and S9 on the tumour record in the CCR database an update to the staging record

must also be submitted.

Omit any slash (/) in the code.

Values & meaning: 2: Carcinoma in situ

Intraepithelial Non-infiltrating Non-invasive

3: Malignant, primary site

All blank: Only when Staging Record Type (Field S6) =3.

Staging record Field definition Validation edit no. 10

Item name: Clinical T

Field no.: S10

Length: 9

Type: Alphanumeric

Description: Site specific code that evaluates the primary tumour clinically (T) and

reflects the tumour size and/or extension as recorded.

Clinical stage is assigned prior to any cancer-directed treatment and

should not be changed based on subsequent information.

Values & meaning: Code 99 Unknown, not staged

Code X Primary tumour cannot be assessed

Clinical T- Breast	Clinical T- Prostate	Clinical T- Colorectal
TX	TX	TX
T0	T0	T0
Tis		Tis
TisDCIS		
TisLCIS		
TisPagets		
T1	T1	T1
T1mic		
T1a	T1a	
T1b	T1b	
T1c	T1c	
T2	T2	T2
	T2a	
	T2b	
	T2c	
T3	T3	T3
	T3a	
	T3b	
T4	T4	T4
T4a		
T4b		
T4c		
T4d		
99	99	99

Staging record Field definition Validation edit no. 11

Item name: Clinical N

Field no.: S11

Length: 3

Type: Alphanumeric

Description: Site specific code that identifies the absence or presence of clinical

regional lymph node (N) metastasis and describes the extent of

regional lymph node metastasis as recorded.

Clinical stage is assigned prior to any cancer-directed treatment and

should not be changed based on subsequent information.

Values & meaning: Code 99 if Unknown, not staged

Code X Regional LNs cannot be assessed

Clinical N- Breast	Clinical N- Prostate	Clinical N-Colorectal
NX	NX	NX
N0	N0	N0
N1	N1	N1
N2		N2
N2a		
N2b		
N3		
N3a		
N3b		
N3c		
99	99	99

Staging record Field definition Validation edit no. 12

Item name: Clinical M

Field no.: S12

Length: 3

Type: Alphanumeric

Description: Site specific code that identifies the presence or absence of clinical

distant metastasis (M) as recorded.

Clinical stage is assigned prior to any cancer-directed treatment and

should not be changed based on subsequent information.

Values & meaning: Code 99 if Unknown, not staged

Code X Distant metastasis cannot be assessed

Clinical M- for Breast	Clinical M- Prostate	Clinical M-Colorectal
MX	MX	MX
M0	M0	M0
M1	M1	M1
	M1a	
	M1b	
	M1c	
99	99	99

Staging record Field definition Validation edit no. 13

Item name: Pathologic T

Field no.: S13

Length: 9

Type: Alphanumeric

Description: Site specific code that evaluates the primary tumour pathologically (T)

and reflects the tumour size and/or extension as recorded.

Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from

pathologic examination.

Values & meaning: Code 99 if Unknown, not staged

Code X Primary tumour cannot be assessed

Pathologic T- for Breast	Pathologic T- Prostate	Pathologic T- Colorectal
TX	TX	TX
T0		T0
Tis		Tis
TisDCIS		
TisLCIS		
TisPagets		
T1		T1
T1mic		
T1a		
T1b		
T1c		
T2	T2	T2
	T2a	
	T2b	
	T2c	
T3	T3	T3
	T3a	
	T3b	
T4	T4	T4
T4a		
T4b		
T4c		
T4d		
99	99	99

Staging record Field definition Validation edit no. 14

Item name: Pathologic N

Field no.: S14

Length: 6

Type: Alphanumeric

Description: Site specific code identifies the absence or presence of pathological

regional lymph node (N) metastasis and describes the extent of

regional lymph node metastasis as recorded.

Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from

pathologic examination.

Values & meaning: Code 99 if Unknown, not staged

Code X Regional LNs cannot be assessed

Pathologic N- Breast	Pathologic N- Prostate	Pathologic N-Colorectal
NX	NX	NX
N0	N0	N0
N0i-		
N0i+		
N0mol-		
N0mol+		
N1	N1	N1
N1mi		
N1a		
N1b		
N1c		
N2		N2
N2a		
N2b		
N3		
N3a		
N3b		
N3c		
99	99	99

Staging record Field definition Validation edit no. 15

Item name: Pathologic M

Field no.: S15

Length: 3

Type: Alphanumeric

Description: Site specific code identifies the presence or absence of pathological

distant metastasis (M) as recorded.

Pathological stage uses all data for clinical staging; the evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from

pathologic examination.

Values & meaning: Code 99 if Unknown, not staged

Code X Distant metastasis cannot be assessed

Pathologic M- Breast	Pathologic M- Prostate	Pathologic M-Colorectal
MX	MX	MX
M0	M0	M0
M1	M1	M1
	M1a	
	M1b	
	M1c	
99	99	99

Staging record Field definition Validation edit no. 16

Item name: Clinical TNM Stage Group

Field no.: S16

Length: 4

Type: Alphanumeric

Description: Site specific code identifies the anatomic extent of disease based on

the clinical T, N and M elements as recorded in Validation edits S10-

S12.

Values & meaning: Code 99 if Unknown, not staged

Code X Stage grouping cannot be assessed

Stage Grouping-Breast	Stage Grouping-Prostate	Stage Grouping-Colorectal
X	X	X
I	I	I
	П	
IIA		IIA
IIB		IIB
	Ш	
IIIA		IIIA
IIIB		IIIB
IIIC		IIIC
IV	IV	IV
99	99	99

Staging record Field definition Validation edit no. 17

Item name: Pathologic TNM Stage Group

Field no.: S17

Length: 4

Type: Alphanumeric

Description: Site specific code identifies the anatomic extent of disease based on

the pathologic T, N and M elements as recorded in Validation edits

S13-S15.

Values & meaning: Code 99 if Unknown, not staged

Code X Stage grouping cannot be assessed

Stage Grouping-Breast	Stage Grouping-Prostate	Stage Grouping-Colorectal
X	X	X
I	I	I
	II	
IIA		IIA
IIB		IIB
	III	
IIIA		IIIA
IIIB		IIIB
IIIC		IIIC
IV	IV	IV
99	99	99

Staging record Field definition Validation edit no. 18

Item name: TNM Stage Group

Field no.: S18

Length: 4

Type: Alphanumeric

Description: Site specific code that identifies the stage group when the T, N, M

values are missing or incomplete as identified in Validation Edits S10-S15. If clinical and pathological stage group are both mentioned,

pathological takes precedence over clinical.

Note 1: Field S18 may or may not have a relationship with fields S10-

S15.

Values & meaning: Code 99 if Unknown, not staged

Code X Stage grouping cannot be assessed

Stage Grouping-Breast	Stage Grouping-Prostate	Stage Grouping-Colorectal
X	X	X
I	I	I
	II	
IIA		IIA
IIB		IIB
	III	
IIIA		IIIA
IIIB		IIIB
IIIC		IIIC
IV	IV	IV
99	99	99

Staging record Field definition Validation edit no. 19

Item name: TNM Edition Number

Field no.: S19

Length: 2

Type: Numeric

Description: Identifies the edition of the *Cancer Staging Manual* used to stage the

case. TNM codes have changed over time and conversion is not always possible. Therefore, a case-specific indicator is needed to

allow grouping of cases for comparison.

Values & meaning:

Code	Label
00	Not staged (AJCC staging scheme applies however site not staged).
01	AJCC Sixth Edition
02	AJCC Seventh Edition
11	International Union Against Cancer (UICC) Sixth Edition
12	International Union Against Cancer (UICC) Seventh Edition
98	AJCC Staged, but the edition is unknown
99	UICC Staged, but the edition is unknown

AJCC TNM 6th edition staging technical notes

For PTCRS submitting AJCC TNM 6TH edition stage data to the CCR

1. Extra descriptors used in the AJCC Cancer Staging Manual, sixth edition, described on pages 7-8 of the manual.

Prefixes:

"y" - staging is performed after treatment

"a" - stage determined at autopsy

Suffix:

"m" - multiple primary tumours in a single site

These prefixes and suffixes do not affect the stage grouping but they identify pieces of information that requires these cases to be analyzed separately.

It was decided by the Staging Implementation Working Group that the additional descriptors would not be collected on the national database, as they could not be collected consistently across the country.

Therefore, if a Registry collects the "y" descriptor for an eligible staging record, the validation fields should be entered as follows for these cases, where no clinical information is available:

Staging Validation Edit #	Item name	Value
13	Pathologic T	X
14	Pathologic N	X
15	Pathologic M	X
17	Pathologic Stage Group	X
10	Clinical T	99
11	Clinical N	99
12	Clinical M	99
16	Clinical Stage Group	99
19	TNM Edition Number	01

If there are actual values available for the Clinical T, N, M and Stage Group, these should be submitted, in place of the '99'.

This will ensure that the cases are included on the staging database.

Do not submit any cases with an "r" prefix, meaning recurrent tumour.

2. Do not submit cases that are excluded from the database using the topography or histology as listed on page 2 of the AJCC TNM 6th Staging Input Data Dictionary (**January** ____ **version**).

3. Assigning '99'

If <u>staging data are not available</u> for an eligible case, according to the inclusion and exclusion criteria, then enter '99' for the Pathologic and Clinical Staging fields and '00' for the TNM Edition Number.

If <u>clinical staging data available</u>, <u>but no pathologic staging data</u> are available, code as '99' for pathologic fields.

If your Registry is submitting any or all of the breast, colorectal or prostate staging data, missing staging records should be entered and submitted as '99'

TNM Stage Group (Validation edit no. 18)- if all that is available for a case is the final "best stage" group from the clinician, do not enter any values in the clinical and pathological TNM fields. These fields are unknown and therefore should be coded as '99'.

4. Assigning X

The category 'X' is included in the T, N, M fields as follows:

TX- Primary Tumour cannot be assessed

<u>Example</u>: the tumour is identified, but there is not enough information from clinical observation, imaging or microscopic depth of invasion, size, etc. to assign a value. This could also mean that the patient did not return for further workup or treatment.

NX- Regional Lymph nodes have not been or cannot be evaluated

<u>Example</u>: if initial resection takes place, but further workup or treatment is refused, the status of the regional lymph nodes is not available.

MX- Distant metastases cannot be assessed

<u>Stage Group X</u>- when any of the T, N, M values are 'X', this *may* mean that the case cannot be stage grouped, therefore the case *may* be unstageable. Enter 'X' in the Stage Group, when all of the T, N, M values are 'X' or some of the values are 'X', if it does not lead to a stage group.

If a stage group can be assigned, this should take precedence over an 'X'.

Example

Breast case- TXNXM1 implies a Stage IV case, even though one cannot assess the T or N values. The M1 must be staged as Stage IV.

5. Prostate cases:

If initial diagnosis is through biopsy, and then the patient is put on "watchful waiting" for a period of time, followed by a prostatectomy, then the date of diagnosis should be the date of the biopsy. If the intent of waiting is considered treatment, then the case can only be clinically staged, based on the biopsy information. This initial information can be used for <u>clinical staging</u> information, but there would not be a pathological stage available. This would then be listed with pathologic TNM values of 'X', since the information is not available.

If the intent of the waiting is for surgery, then the information from the prostatectomy can be used for pathologic staging, according to page 5 of the *AJCC Cancer Staging Manual*, *sixth edition*.

- 6. If your Registry is **not staging** any of the three eligible anatomical sites, do not submit a staging record for these cases to the CCR. Submit your tumour and patient records as always.
- 7. If your Registry is submitting breast and colorectal cases, but not prostate, (or some other combination) then submit only staging records for the breast and colorectal cases. Do not submit staging records for the prostate cases.
- 8. Do not leave any fields **blank**, as this may mean that the export program is not working or that the staging information is missing.

References:

AJCC TNM 6th Edition Staging Input Data Dictionary- CCR Report No. 3.2.5

National Cancer Registrars Association- Workbook for Staging of Cancer, second edition.

AJCC Cancer Staging Manual, sixth edition