Ulceration (Melanoma Skin)

Organization	Field Name	ID	Required
KCR	Ulceration	34123	yes
SEER	Ulceration	3936	yes

Note 1 Physician statement of microscopically confirmed ulceration (e.g., based on biopsy or surgical resection) can be used to code this data item.

Note 2 Ulceration can only be confirmed by microscopic examination. Do not use findings from physical exam.

- It is possible for a patient to present with an ulcerated lesion noted on physical exam, but this is not the same thing as ulceration seen on a microscopic exam

Note 3 Melanoma ulceration is the absence of an intact epidermis overlying the primary melanoma based upon microscopic (histopathological) examination.

- Code 1 if any biopsy (punch, shave, excisional, etc.) or wide excision is positive for ulceration in the presence of an underlying melanoma
- Code 0 if all specimens are negative OR one specimen is negative and the other is unknown
- Ulceration must be caused by an underlying melanoma. Ulceration caused by trauma from a previous procedure should not be coded as positive for this SSDI

Note 4 Code 9 if there is microscopic examination and there is no mention of ulceration.

- This instruction **does** apply to in situ tumors

Code	Description
0	Ulceration not identified/not present
1	Ulceration present
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Cannot be determined by the pathologist Pathology report does not mention ulceration Ulceration not assessed or unknown if assessed