

Tumor Size Summary

Organization	Field Name	ID	Required
KCR	Tumor Size Summary (TumorSizeSummary)	30933	yes
NAACCR	Tumor Size Summary	756	yes

Field length: 3

Tumor Size Summary is the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers.

Tumor size that is independent of stage is also useful for quality assurance efforts.

Instructions for Coding

Note: All measurements should be in millimeters (mm).

Record size in specified order:

- Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
 - If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.
 - Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).
 - Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).
- If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.
 - Example: Patient has a 2.2 cm mass in the oropharynx; find needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).
- If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment.
- If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2mm-988mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given

998	<p>SITE-SPECIFIC CODES</p> <p>Alternate descriptions of tumor size for specific sites:</p> <p>Familial/multiple polyposis:</p> <p>Rectosigmoid and rectum (C19.9, C20.9)</p> <p>Colon (C18.0, C18.2-C18.9)</p> <p>If no size is documented:</p> <p>Circumferential:</p> <p>Esophagus (C15.0-C15.5, C15.8 C15.9)</p> <p>Diffuse; widespread: 3/4s or more; linitis plastica:</p> <p>Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9)</p> <p>Diffuse, entire lung or NOS:</p> <p>Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9)</p> <p>Diffuse:</p> <p>Breast (C50.0-C50.6, C50.8-C50.9)</p>
999	<p>Unknown; size not stated; Not documented in patient record; Size of tumor cannot be assessed;</p> <p>No excisional biopsy or tumor resection done; The only measurement(s) describes pieces or chips; Not applicable</p>

Note: All measurements should be in millimeters (mm).

Instructions for Coding

1. Record the size in the specified order

a. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.

i. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP

protocol or pathology report checklist).

ii. If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

Example 1: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

Example 2: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

b. If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

Example: Patient has a 2.2 cm mass in the oropharynx; find needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy.

Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22 mm).

c. If no surgical resection, then largest measurement of the tumor from the imaging, physical exam, or other diagnostic procedures in this order of priority prior to any other form of treatment.

d. If a, b, and c do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

2. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.

3. Record tumor size stated less than or greater than as follows

a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less

Examples: Tumor size is stated as: < 1 cm, code as 009; < 2 cm, code as 019, < 3 cm, code as 029; < 4 cm, code as 039; < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.

b. If tumor size is reported as more than or greater than x mm or more than x cm, code size as 1 mm more

Examples: Tumor size is stated as: >10 mm or >1 cm, code as 011; > 2 cm, code as 021; > 3 cm, code as 031; > 4 cm, code as 041; > 5 cm, code as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.

c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two

Examples: Tumor size is between 2 and 3 cm, code as 025. Code size as 025 since $2 + 3 = 5$ divided by 2 = 2.5 cm (or 025 mm).

4. Record the higher tumor size when stated as a range

Example: Tumor size is 8-10 mm or tumor size is 8 to 10 mm. Code size as 010 since 10 mm is the higher of the values in the range.

5. Round the tumor size only if it is described in fractions of millimeters

a. When tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter.

See Exception for breast cancer.

b. Do not round tumor size expressed in centimeters to the nearest whole centimeter; rather, convert the measurement to millimeters by moving the decimal point one space to the right

Note 1: Record tumor size as 001 (do not round down to 000) when the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm).

Note 2: Code 001 when tumor size is 1 mm.

Exception to rounding rules for BREAST primaries: Round tumor sizes greater than 1.0 mm and up to 2.4 mm to 2 mm (002). The purpose of this exception is so that the

size recorded in the Tumor Size data item will derive the correct AJCC TNM Primary Tumor (T) category for breast primaries. Do not apply this instruction to any other site.

Examples:

- Breast cancer described as 6.5 millimeters in size. Round up to 7 mm and code as 007.
- Breast cancer described as 1.3 mm in size. Round up to 2 mm and code as 002.
- 2.3 millimeters cancer in a polyp. Round down to 2 mm and code 002.
- Hypopharynx: Focus of cancer described as 1.4 mm in size. Round down to 1 mm and code as 001.
- 5.2 cm breast cancer. Convert to millimeters and code 052.
- 2.5 cm rectal cancer. Do not round, record as 025 millimeters.

6. Priority of imaging/radiographic technique

a. Use information on size from imaging/radiographic techniques to code the tumor size when there is no more specific size information from pathology or operative report. It should be taken as a lower priority, but over a physical exam.

b. Record the largest size in the record when there are tumor size discrepancies among imaging and radiographic reports, regardless of the imaging technique reports unless the physician specifies which imaging is most accurate

7. Code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, if the tumor is described as a "cystic mass" and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

8. Record the size of the invasive component, if given.

a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller

Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm)

b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report, or clinical examination.

Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm)

9. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy

specimen or the complete resection of the primary tumor

Example 1: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

Example 2: Anal canal tumor is 2.5 cm from proximal to distal (3.5 cm in circumference). Record tumor size as 035. The circumferential measurement is the largest measurement in this example. In this case, the pathologist usually cuts the anus and rectum open

like a tube; the circumference is measured flat.

10. Record the size as stated for purely in situ lesions

11. Multifocal/multicentric tumors: Code the size of the largest invasive tumor, or the largest in situ tumor if all tumors are in situ, when the tumor is multifocal or when multiple tumors are reported as a single primary.

12. Assign code 000 when

a. No residual tumor is found

i. Neoadjuvant therapy has been administered and the resection shows no residual tumor

b. Schema is Cervical Lymph Nodes and Unknown Primary 00060

c. EOD Primary Tumor is coded 800 (No evidence of primary tumor) for any schema except for those listed in Coding Instruction 14

13. Assign tumor size for benign and borderline tumors in the schemas Brain, CNS Other, Intracranial Gland, and Medulloblastoma when provided; do not default to 999

14. Assign code 999 when

a. Size is unknown and for the following sites and schemas/schema IDs

i. Any case coded to primary site C420, C421, C423, C424, C770-C779, or C809

ii. HemeRetic 00830

1. Excluding Spleen (C422)

iii. Kaposi Sarcoma 00458

iv. Lymphoma 00790

v. Lymphoma-CLL/SLL 00795

vi. Melanoma Choroid and Ciliary Body 00672

vii. Melanoma Iris 00671

viii. Plasma Cell Disorders 00822

ix. Plasma Cell Myeloma 00821

b. The only measurement describes pieces or chips in a pathology report. Do not add the size of pieces or chips together to create a whole; they may not be from the same location, or they may represent only a very small portion of a large tumor.

However, when the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size.

c. The only measurement is for calcifications that span given distance or a cluster of microcalcifications. Do not record the size of calcifications as tumor size. If there is no measurement of the mass or tumor, record 999.

d. Neoadjuvant therapy has been administered and resection was performed. Do not use a post-neoadjuvant size to code pathologic tumor size; however, you may use the clinical tumor size if available.

15. Document the information to support coded tumor size in the appropriate text data item of the abstract Tumor size is important for staging of tumors in the following table of schemas. For more information about schemas and schema IDs, go to the [SSDI Manual, Appendix A](#).

Table. Schemas for which Tumor Size Affects Staging

Schema	Schema ID
Adrenal Gland	00760
Anus	00210
Bile Duct Distal	00260
Bile Ducts Intrahepatic	00230
Bone Appendicular Skeleton	00381
Bone Pelvis	00383
Breast	00480

Buccal Mucosa	00076
Cervix	00520
Conjunctiva	00650
Corpus Sarcoma	00541
Cutaneous Carcinoma of Head and Neck	00150
Floor of Mouth	00074
GIST	00430
Gum	00073
Hypopharynx	00112
Kidney Parenchyma	00600
Lacrimal Gland	00690
Lip	00071
Liver	00220
Lung	00360
Major Salivary Glands	00080
Merkel Cell Skin	00460
Mouth Other	00077
NET Adrenal Gland	00770
NET Appendix	00320
NET Colon and Rectum	00330
NET Pancreas	00340
NET Stomach	00290
Orbital Sarcoma	00700
Oropharynx (p16-)	00111
Oropharynx HPV-Mediated (p16+)	00100
Palate Hard	00075
Pancreas	00280
Primary Cutaneous Lymphomas (excluding MF and SS)	00812
Retroperitoneum	00440
Skin Eyelid	00640
Soft Tissue Head and Neck	00400
Soft Tissue Trunk and Extremities	00410
Thyroid	00730
Thyroid Medullary	00740
Tongue Anterior	00072
Vagina	00510
Vulva	00500