TUMOR SIZE SUMMARY	Item Length: 3 NAACCR Item #756 Source of Standard: SEER/CoC Dx Yr Req by MCR: 2016

Description: This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale

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 (See FORDS 2016, p. 142-144):

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

Record size in specified order:
1. Size measured on surgical resection specimen, where surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
    a. 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.
2. If neoadjuvant therapy is 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.
3. If no surgical resection is performed, then use the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (see coding rules below).
4. If 1, 2, and 2 do not apply, use the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules:
1. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor.
2. **Recording less than/greater than tumor size**:
    a. If the tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example, if the size is < 10 mm, code the size as 009. (More examples are available in FORDS 2016).
    b. If the tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if the size is > 10 mm, the size should be coded as 011.
    c. If the 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 then divide by two ("between 2 and 3 cm" is coded as 025).
3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If 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. Do not round tumor size expressed in centimeters to the

nearest whole centimeter (rather, move the decimal point one space to the right, coverting the measurement to millimeters).

4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reporting tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is the most accurate, record the largest size in the record, regardless of which imaging technique reports it.

6. **Always 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.

7. **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.
    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.

8. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**

9. **Record the size as stated for purely in situ lesions.**

10. **Disregard microscopic residual or positive surgical margins when coding tumor size.** Microscopic residual tumor does not affect overall tumor size. The status of the primary tumor margins may be recorded in a separate data item.

11. **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, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record the tumor size as 999.

12. **Multifocal/multicentric tumors:** If the tumor is multifocal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor. If all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when the size is unknown or not applicable.** Sites/morphologies where tumor size is not applicable are listed here.
    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590-9992)
    Kaposi's sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris

14. **Document the information to support coded tumor size in the appropriate text data item of the abstract.**