PRIMARY CUTANEOUS LYMPHOMA STAGING FORM

CLINICAL *Extent of disease before any treatment*	STAGE CATEGORY DEFINITIONS	PATHOLOGIC *Extent of disease through completion of definitive surgery*
❒ y clinical – staging completed after neoadjuvant therapy but before subsequent surgery		❒ y pathologic – staging completed after neoadjuvant therapy AND subsequent surgery
	PRIMARY TUMOR (T) SKIN	
❑ **TX**	Primary tumor cannot be assessed	❑ **TX**
❑ **T1**	Limited patches*, papules, and/or plaques**covering <10% of the skin surface. May further stratify into T1a (patch only) vs T1b (plaque ± patch).	❑ **T1**
❑ **T2**	Patches, papules or plaques covering ≥ 10% of the skin surface. May further stratify into T2a (patch only) vs T2b (plaque ± patch).	❑ **T2**
❑ **T3**	One or more tumors***(≥ 1-cm diameter)	❑ **T3**
❑ **T4**	Confluence of erythema covering ≥ 80% body surface area	❑ **T4**
	REGIONAL LYMPH NODES (N)	
❑ **NX**	Clinically abnormal peripheral lymph nodes; no histologic confirmation	❑ **NX**
❑ **N0**	No clinically abnormal peripheral lymph nodes^; biopsy not required	❑ **N0**
❑ **N1**	Clinically abnormal peripheral lymph nodes; histopathology Dutch grade 1 or NCI LN0-2	❑ **N1**
❑ **N1a**	Clone negative#	❑ **N1a**
❑ **N1b**	Clone positive#	❑ **N1b**
❑ **N2**	Clinically abnormal peripheral lymph nodes; histopathology Dutch grade 2 or NCI LN3	❑ **N2**
❑ **N2a**	Clone negative#	❑ **N2a**
❑ **N2b**	Clone positive#	❑ **N2b**
❑ **N3**	Clinically abnormal peripheral lymph nodes; histopathology Dutch grades 3-4 or NCI LN4; clone positive or negative	❑ **N3**
	DISTANT METASTASIS (M) VISCERAL	
❑ **M0**	No visceral organ involvement (no pathologic M0; use clinical M to complete stage group)	
❑ **M1**	Visceral involvement (must have pathology confirmation^^ and organ involved should be specified)	❑ **M1**
	PERIPHERAL BLOOD INVOLVEMENT (B)	
❑ **B0**	Absence of significant blood involvement: ≤ 5% of peripheral blood lymphocytes are atypical (Sézary) cells‖	❑ **B0**
❑ **B0a**	Clone negative#	❑ **B0a**
❑ **B0b**	Clone positive#	❑ **B0b**
❑ **B1**	Low blood tumor burden: > 5% of peripheral blood lymphocytes are atypical (Sézary) cells but does not meet the criteria of B_2	❑ **B1**
❑ **B1a**	Clone negative#	❑ **B1a**
❑ **B1b**	Clone positive#	❑ **B1b**
❑ **B2**	High blood tumor burden: ≥ 1000/μL Sézary cells^^^ with positive clone#	❑ **B2**
	NOTES	
	* For skin, patch indicates any size skin lesion without significant elevation or induration. Presence/absence of hypo-or hyperpigmentation, scale, crusting, and/or poikiloderma should be noted.	
	**For skin, plaque indicates any size skin lesion that is elevated or indurated. Presence or absence of scale, crusting, and/or poikiloderma should be noted. Histologic features such as folliculotropism or large-cell transformation (> 25% large cells), $CD30^+$ or $CD30^-$, and clinical features such as ulceration are important to document.	
	***For skin, tumor indicates at least one 1-cm diameter solid or nodular lesion	

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with evidence of depth and/or vertical growth. Note total number of lesions, total volume of lesions, largest size lesion, and region of body involved. Also note if histologic evidence of large-cell transformation has occurred. Phenotyping for CD30 is encouraged.

^For node, abnormal peripheral lymph node(s) indicates any palpable peripheral node that on physical examination is firm, irregular, clustered, fixed or 1.5 cm or larger in diameter. Node groups examined on physical examination include cervical, supraclavicular, epitrochlear, axillary, and inguinal. Central nodes, which are not generally amenable to pathologic assessment, are not currently considered in the nodal classification unless used to establish N3 histopathologically.

^^For viscera, spleen and liver may be diagnosed by imaging criteria.

^^^For blood, Sézary cells are defined as lymphocytes with hyperconvoluted cerebriform nuclei. If Sézary cells are not able to be used to determine tumor burden for B_2,then one of the following modified ISCL criteria along with a positive clonal rearrangement of the TCR may be used instead: (1) expanded $CD4^+$ or $CD3^+$ cells with CD4/CD8 ratio of 10 or more, (2) expanded $CD4^+$ cells with abnormal immunophenotype including loss of CD7 or CD26.

A T-cell clone is defined by PCR or Southern blot analysis of the T-cell receptor gene.

ANATOMIC STAGE • PROGNOSTIC GROUPS

CLINICAL

GROUP	T	N	M	B
❑ IA	1	0	0	0,1
❑ IB	2	0	0	0,1
❑ IIA	1,2	1,2	0	0,1
❑ IIB	3	0-2	0	0,1
❑ III	4	0-2	0	0,1
❑ IIIA	4	0-2	0	0
❑ IIIB	4	0-2	0	1
❑ IVA1	1-4	0-2	0	2
❑ IVA2	1-4	3	0	0-2
❑ IVB	1-4	0-3	1	0-2

❑ Stage unknown

PATHOLOGIC

GROUP	T	N	M	B
❑ IA	1	0	0	0,1
❑ IB	2	0	0	0,1
❑ IIA	1,2	1,2	0	0,1
❑ IIB	3	0-2	0	0,1
❑ III	4	0-2	0	0,1
❑ IIIA	4	0-2	0	0
❑ IIIB	4	0-2	0	1
❑ IVA1	1-4	0-2	0	2
❑ IVA2	1-4	3	0	0-2
❑ IVB	1-4	0-3	1	0-2

❑ Stage unknown

PROGNOSTIC FACTORS (SITE-SPECIFIC FACTORS)

Mycosis Fungoides and Sézary only

REQUIRED FOR STAGING: Peripheral blood involvement: _____

CLINICALLY SIGNIFICANT: None

General Notes:
For identification of special cases of TNM or pTNM classifications, the "m" suffix and "y," "r," and "a" prefixes are used. Although they do not affect the stage grouping, they indicate cases needing separate analysis.

m suffix indicates the presence of multiple primary tumors in a single site and is recorded in parentheses: pT(m)NM.

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Histologic Grade (G) *(also known as overall grade)*

Grading system	***Grade***
❑ 2 grade system	❑ Grade I or 1
❑ 3 grade system	❑ Grade II or 2
❑ 4 grade system	❑ Grade III or 3
❑ No 2, 3, or 4 grade system is available	❑ Grade IV or 4

ADDITIONAL DESCRIPTORS

Lymphatic Vessel Invasion (L) and Venous Invasion (V) have been combined into Lymph-Vascular Invasion (LVI) for collection by cancer registrars. The College of American Pathologists' (CAP) Checklist should be used as the primary source. Other sources may be used in the absence of a Checklist. Priority is given to positive results.

- ❑ Lymph-Vascular Invasion Not Present (absent)/Not Identified
- ❑ Lymph-Vascular Invasion Present/Identified
- ❑ Not Applicable
- ❑ Unknown/Indeterminate

Residual Tumor (R)

The absence or presence of residual tumor after treatment. In some cases treated with surgery and/or with neoadjuvant therapy there will be residual tumor at the primary site after treatment because of incomplete resection or local and regional disease that extends beyond the limit of ability of resection.

- ❑ RX Presence of residual tumor cannot be assessed
- ❑ R0 No residual tumor
- ❑ R1 Microscopic residual tumor
- ❑ R2 Macroscopic residual tumor

General Notes (continued):

y prefix indicates those cases in which classification is performed during or following initial multimodality therapy. The cTNM or pTNM category is identified by a "y" prefix. The ycTNM or ypTNM categorizes the extent of tumor actually present at the time of that examination. The "y" categorization is not an estimate of tumor prior to multimodality therapy.

r prefix indicates a recurrent tumor when staged after a disease-free interval, and is identified by the "r" prefix: rTNM.

a prefix designates the stage determined at autopsy: aTNM.

❑ Clinical stage was used in treatment planning (describe): _____

❑ National guidelines were used in treatment planning ❑ NCCN ❑ Other (describe): _____

_____

_____

Physician signature Date/Time

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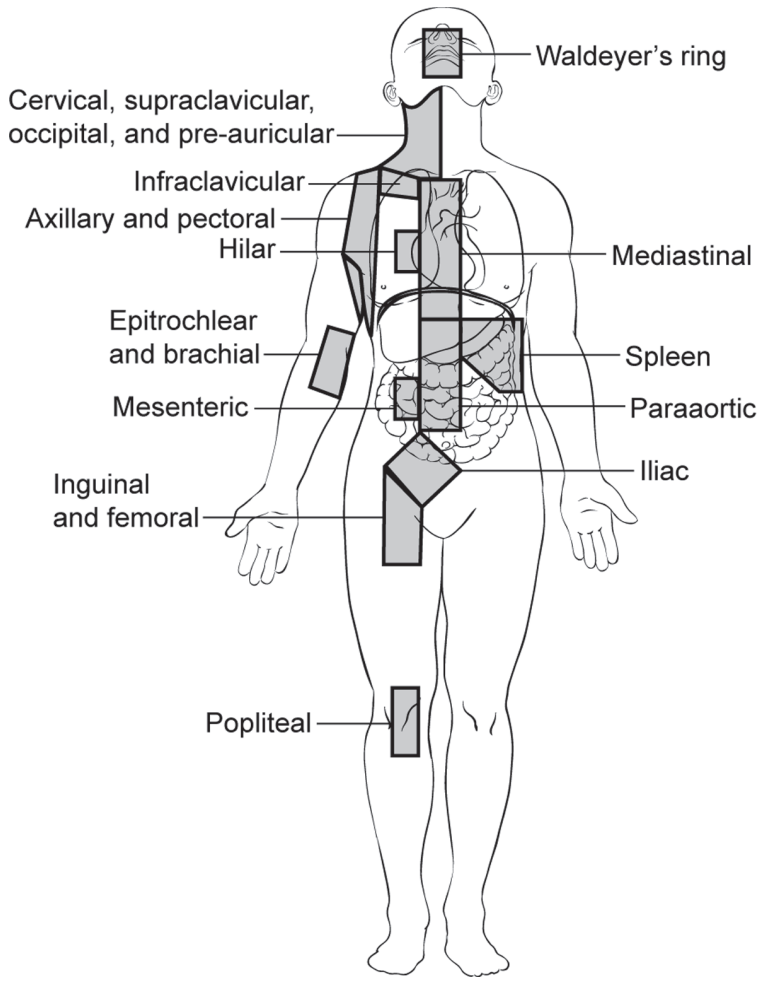
Illustration

Indicate on diagram primary tumor and regional nodes involved.



Lymph nodes above the diaphragm

1. Waldeyer's ring
2. Cervical, supraclavicular, occipital, and pre-auricular
3. Infraclavicular
4. Axillary and pectoral
5. Mediastinal
6. Hilar
7. Epitrochlear and brachial

Lymph nodes below the diaphragm

8. Spleen
9. Mesenteric
10. Paraaortic
11. Iliac
12. Inguinal and femoral
13. Popliteal

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