

BREAK

Will start back at 2:00

EOD

Extent of Disease



General Coding Instructions

- Do not use this system for any cases diagnosed prior to 1/1/2018.
- Note: ALWAYS check site-specific EOD 2018 schemas for exceptions and/or additional information
- EOD Schema-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology schema
- EOD schemas apply to ALL primary sites and specified histologies. Most schemas are based on primary site, while some are based on histology alone.
- For ALL sites, EOD is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue cannot be, or was not removed.
- In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report



- EOD should include all information available within four months of diagnosis in the absence of disease progression or upon completion of surgery(ies) in first course of treatment, whichever is longer.
- Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the EOD stage. Be sure to review the clinical information carefully to accurately determine the extent of disease
- If the operative/pathology information disproves the clinical information, use the operative/pathology information



- Information for EOD from a surgical resection after neoadjuvant treatment may be used, but ONLY if the extent of disease is greater than the pre-treatment clinical findings
- Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when coding the EOD fields
- Autopsy reports are used in coding EOD just as are pathology reports, applying the same rules for inclusion and exclusion



Death Certificate Only Cases

Death Certificate only (DCO) cases

- Code the following for DCO's, unless more specific codes can be assigned
 - EOD Primary Tumor: 999
 - EOD Regional Nodes: 999
 - EOD Mets: 99



- T, N, M information may be used to code EOD 2018 when it is the only information available
- Use the medical record documentation to assign EOD when there is a discrepancy between the T, N, M information and the documentation in the medical record. If you have access to the physician, please query to resolve the discrepancy
- When there is doubt that documentation in the medical record is complete, code the EOD corresponding to the physician staging
Example: Patient diagnosed at community hospital with limited workup. Staging note from medical oncologist suggesting missing results from further outside test



EOD Primary Tumor

NAACCR #772

Description

EOD Primary Tumor is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs.

- See also EOD Regional Nodes [NAACCR Data item #774] and EOD Mets [NAACCR Data item #776]. Effective for cases diagnosed 1/1/2018 and forward

Rationale

EOD Primary tumor is used to calculate Derived EOD 2018 T (when applicable) [NAACCR Data item #785] and Derived Summary Stage 2018 [NAACCR Data item #762]. Derivation will occur at the level of the central registry.

Note: ALWAYS check site-specific EOD 2018 schemas for exceptions and/or additional information



Code	Description
000	In situ, intraepithelial, noninvasive, non-infiltrating
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	No evidence of primary tumor
999	Unknown; extension not stated Primary tumor cannot be assessed Not documented in patient record Death Certificate Only

- Assign the farthest documented contiguous extension of the primary tumor
- Code the farthest documented contiguous direct extension of tumor away from the primary site
- If an involved organ or tissue is not specifically mentioned in the code descriptions, approximate the location from listed structures in the same anatomic area and assign the appropriate code based on that information
- EOD Primary Tumor codes are hierarchical with the exception of code 800



Clinical Vs Pathological Codes

- Some schemas have EOD extension codes that are noted as “clinical assessment only” or “pathological assessment only.”
- Clinical assessment codes should be used when there is a clinical work up only and there is no surgical resection of the primary tumor or site. This includes physical exam, imaging and biopsy
 - **Exception:** If patient has neoadjuvant therapy, and the clinical assessment is greater than the pathological assessment, then the clinical assessment code would take priority
- Pathological assessment codes can be used when there is a surgical resection of the primary tumor or site



- A “localized, NOS” code is provided for those cases in which the only description is “localized with no further information.” “NOS” codes should be used only after an exhaustive search for more specific information.
- Pathological findings take priority over clinical findings
- Assign the highest code representing the greatest extension pathologically (based on pathology report), when available
- If there is no applicable pathology, assign the highest code representing the greatest extension clinically. Imaging takes precedence over physical examination
- If extension is positive based on imaging and/or physical exam, but is confirmed to be negative on pathological exam, then code EOD Primary Tumor based on the pathological findings



Neoadjuvant Therapy

If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy:

- Code the clinical information if that is the farthest extension documented
- If the post-neoadjuvant surgery shows more extensive disease, code the extension based on the post-neoadjuvant information
- When the clinical and pathological information are the same, code the extension based on the clinical information



In-Situ Tumors

- In situ tumors: Assign code 000 for in situ tumors.
Exception: For some schemas, e.g., Breast, there may be multiple categories of in situ codes. Use schema-specific instructions and codes.
- In situ tumors with nodal or metastatic involvement: In the event of an in situ tumor with nodal or metastatic involvement, assign EOD Primary Tumor as in situ and code the EOD Regional Nodes and/or EOD Mets appropriately. This is a change from previous versions of EOD and Summary Stage.
- Note: Behavior would be /3 for these tumors. The primary tumor is in situ; however, there is evidence of an invasive component due to the positive lymph nodes or metastatic involvement



- When multiple tumors are reported as a single primary, code the furthest direct extension from any tumor.
- Discontinuous or distant metastases: Discontinuous/discontiguous metastases are usually coded in the EOD Mets field. Some exceptions include: mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in EOD Primary Tumor.
- For some schemas, e.g., Breast, Lung, and Kidney, direct (contiguous) extension to certain specific sites is listed under EOD Mets. If the structure involved by direct extension is not listed in EOD Primary Tumor categories, look for it in EOD Mets. If the specific structure involved by direct extension is not listed in either data item, assign the highest known contiguous extension code in EOD Primary Tumor



Code 800

- Code 800 when there is no evidence of the primary tumor (occult primary).
- Use code 800 when clinically and/or pathologically there is no evidence of the primary tumor. This code does not apply to those cases where a biopsy removes all the tumor and there is no residual tumor on the surgical resection
- When EOD Primary Tumor is coded 800
- Tumor Size Clinical should be coded to 000 when there is no surgical resection for the primary tumor or site, but clinically no primary tumor was identified
- Tumor Size Pathological should be coded to 000 when the suspected primary tumor or site is resected, but no tumor is found. If no surgical resection is done, code 999



Code 999

- Assign code 999 when there is no information on primary tumor extent.
- Code 999 is to be used by default for death certificate only (DCO) cases; however, assign the appropriate EOD Primary Tumor code when specific primary tumor extension information is available on a DCO



Document Choice In TEXT

Document choice of EOD Primary Tumor code in text

- It is strongly recommended that the assessment of the primary tumor extension be documented, as well as the choice of the EOD Primary Tumor code in a related STAGE text field on the abstract
- While primary tumor extension can be found in a variety of places, it's most commonly found in one or both:
 - Pathology Report
 - Operative report



EOD Regional Nodes

NAACCR #774

Description

EOD Regional Nodes is part of the EOD 2018 data collection system and is used to classify the regional lymph nodes involved with cancer at the time of diagnosis. See also EOD Primary Tumor [NAACCR Data item #772] and EOD Mets [NAACCR Data item #776]. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

EOD Regional Nodes is used to calculate Derived EOD 2018 N (when applicable) [NAACCR Data item #815] and Derived Summary Stage 2018 [NAACCR Data item #762]. Derivation will occur at the level of the central registry.

- ALWAYS check site specific EOD 2018 schemas for exceptions and/or additional information



Code	Description
000	No regional lymph node involvement
	SCHEMA-SPECIFIC CODES WHERE NEEDED
800	Regional lymph node(s), NOS Lymph node(s), NOS
888	Use for these sites only: Brain; CNS Other; HemeRetic; Ill-Defined Other (includes unknown primary site); Intracranial Gland; Lymphoma; Lymphoma-CLL/SLL, Plasma Cell Myeloma
999	Unknown; regional lymph node(s) not stated Regional lymph node(s) cannot be assessed Not documented in patient record Death Certificate Only

- Record the specific involved regional lymph node chain(s) farthest from the primary site. Regional lymph nodes are listed for each schema. EOD Regional Nodes are hierarchical, with the exception of code 800
- Generally, the regional lymph nodes in the chain(s) closest to the primary site have lower codes, while nodes farther away from the primary or in farther lymph node chains have higher codes, although there are exceptions due to lymph drainage patterns



- If a lymph node chain is not listed, check the abstractor notes in SEER*RSA, Appendix C of the Hematopoietic Manual, an anatomy textbook, ICD-O-3, or a medical dictionary for a synonym. If the lymph node chain or its synonym are not listed in regional lymph nodes, code the involved node(s) in EOD Mets
- **Tip for coding lymph nodes:** If not possible to determine if a lymph node is regional or distant, check the scheme for a site that is nearby

Example: If unable to determine if a listed regional node for esophagus is regional or distant, check the stomach EOD regional nodes. If the lymph node chain is listed as regional for stomach, assume the named lymph node is not an obscure name for a lymph node chain and that it is probably distant for the esophagus



Clinical vs Pathological Codes

- Some schemas have EOD regional node codes that are noted as “clinical assessment only” or “pathological assessment only.”
- Clinical assessment codes should be used when there is a clinical work up only and there is no surgical resection of the primary tumor or site. This includes physical exam, FNA, needle core biopsy, sentinel node biopsy, or lymph node excision
 - **Exception:** If patient has neoadjuvant therapy, and the clinical assessment is greater than the pathological assessment, then the clinical assessment code would take priority
- Pathological assessment codes can be used when there is a surgical resection of the primary tumor or site in conjunction with a FNA, Sentinel Lymph Node biopsy or lymph node dissection. The FNA or sentinel lymph node biopsy can be done during the clinical workup and then followed by a negative lymph node dissection



- Pathological findings take priority over clinical findings: It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement. See next section for coding instructions when neo-adjuvant therapy is administered.
- Code the lymph node involvement at diagnosis pathologically (based on pathology report), when available.
- If there is no applicable histology, assign lymph node involvement based on clinical findings. Imaging takes precedence over physical examination.
- If nodes are determined positive based on imaging and then confirmed to be negative on pathological exam, then code EOD Regional Nodes based on the negative pathological findings
- Exception: Assign code 800, “Regional lymph node(s), NOS or Lymph node(s), NOS” only when there is lymph node involvement, but no available information regarding the specific node(s) involved



Neoadjuvant Therapy

If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy

- Code the clinical information if that is the most extensive lymph node involvement documented
- If the post-neoadjuvant surgery shows more extensive lymph node involvement, code the regional nodes based on the post-neoadjuvant information
- If the clinical and pathological information are the same, code regional lymph nodes based on the clinical information



Lymph Node Involvement Terms

- For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are recorded as involvement of lymph nodes
- Other terms, such as “palpable,” “enlarged,” “visible swelling,” “shotty,” or “lymphadenopathy” should be ignored for solid tumors, unless there is a statement of involvement by the clinician or the patient was treated as though regional nodes were involved
 - Example:** Palpable axillary lymph nodes found, consistent with mets. Record as involvement of lymph nodes.
 - Example:** Enlarged renal hilar nodes found on CT, positive for cancer. Record as involvement of lymph nodes
- The terms “homolateral,” “ipsilateral,” and “same side” are used interchangeably



- Code EOD Regional Nodes 000 (negative) instead of 999 (unknown) when ALL three of the following conditions are met:
 - There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing, or surgical exploration
 - The patient has localized disease
 - The patient receives what would be the standard treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician), or patient is offered usual treatment but refuses it
- These guidelines apply only to localized cancers. Assign code 999 when there is reasonable doubt that the tumor is localized
- Example: When there is evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (regional disease) and regional lymph node involvement is not mentioned, it would be correct to code 999 for unknown lymph node involvement in the absence of any specific information regarding regional nodes



In-situ Tumors

- In situ tumors (behavior /2): Code 000 for lymph node involvement.
 - Pure in situ tumors (behavior /2) cannot have lymph node mets
- For Breast and Thyroid, there are multiple lymph node codes indicating no regional lymph node involvement (depending on whether lymph nodes were pathologically examined or not)
- In situ tumors with metastatic nodal involvement: In the event of an in-situ tumor with metastatic nodal involvement,
 - Assign EOD Primary Tumor as in situ (code 000) **and**
 - Code EOD Regional Nodes appropriately (positive)
 - This is a change from prior versions of EOD
- Behavior would be /3 for these tumors.
 - The primary tumor is in situ; however, there is evidence of an invasive component due to the positive lymph nodes



- Direct tumor extension into lymph node: If direct extension of the primary tumor into a regional lymph node is shown, code the involved node(s) in EOD Regional Nodes
- Isolated Tumor cells (ITCs): For some schemas, ITCs are counted as positive regional nodes, while other schemas count them as negative. See the individual schemas to determine how to code ITCs.
- Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum:
 - These can occur WITH or WITHOUT regional lymph node involvement
- Assign the appropriate code according to guidelines in individual schemas. Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. If there are Tumor Deposits and node involvement, code only the information on node involvement in this field. Specific information on Tumor Deposits is coded in the data item: Tumor Deposits [NAACCR Data Item #3934]



Sentinel Lymph Nodes

- Sentinel lymph nodes: Involved nodes found during sentinel lymph node procedures are classified as positive regional nodes
- The sentinel lymph node is the first lymph node to receive lymphatic drainage from a primary tumor
- If it contains metastatic tumor, this indicates that other lymph nodes may contain tumor. If it does not contain metastatic tumor, other lymph nodes are not likely to contain tumor. Occasionally there is more than one sentinel lymph node



Code 800

Use code 800 for the following situations:

- Lymph node assignment for the EOD schema is based on location (specifically listed lymph nodes) and the only documentation available is that lymph nodes are involved.
- Lymph node assignment for the EOD is based on number and/or size and the only documentation available is that lymph nodes are involved.
- Statement of “regional lymph nodes involved,” with no further information on location, number and/or size.
- Unidentified nodes included with the resected primary site.
- Nodes may be identified in the operative or pathology report (including the final diagnosis), microscopic or gross description.
- Lymph nodes which are not specified as regional or distant should be assumed to be regional nodes



Code 999

Assign code 999 when there is no information on regional lymph node involvement and the primary tumor is not localized.

Code 999 is to be used by default for death certificate only (DCO) case: however, assign the appropriate EOD Regional Nodes code when specific regional lymph node involvement information is available for a DCO



Document Choice in TEXT

Document choice of EOD Regional Nodes code in text.

It is strongly recommended that the positive and negative assessment of regional lymph node(s) be documented, as well as the choice of the EOD Regional Nodes code in a related STAGE text field on the abstract

Information on regional node status can be found on physical exam, scans and pathology reports



EOD METS

NAACCR #776

Description

EOD Mets is part of the EOD 2018 data collection system and is used to classify the distant site(s) of metastatic involvement at time of diagnosis. See also EOD Primary Tumor [NAACCR Data item #772] and EOD Regional Nodes [NAACCR Data item #774]. Effective for cases diagnosed 1/1/2018 and forward

Rationale

EOD Mets is used to calculate Derived EOD 2018 M (when applicable) [NAACCR Data item #795] and Derived Summary Stage 2018 [NAACCR Data item #762]. Derivation will occur at the level of the central registry.

Note: ALWAYS check site-specific EOD 2018 schemas for exceptions and/or additional information



- Determination of EOD Mets requires only history and physical examination
 - Imaging of distant organs is not required
 - When a case lacks any extensive workup, the registrar can infer that there are no distant metastases based solely on physical exam documentation
- Assign 00 for cases in which there are no distant metastases as determined by clinical, radiographic and/or pathologic methods
- A case is classified as clinically free of metastases (code 00) unless there is documented evidence of metastasis by clinical means or by cytological/pathological examination of a metastatic site.



For a few schemas, the EOD Mets category may include direct extension of the primary tumor into distant organs or tissues

Examples:

- Breast
 - Lung
 - Kidney
 - Ovary
- If the structure involved by direct extension is not listed in EOD Primary Tumor, look for the structure in EOD Mets
 - If the specific structure involved by contiguous extension is not listed in either EOD Primary Tumor or EOD Mets, assign the highest available code in EOD Primary Tumor



- Positive pathological findings take priority over clinical findings
- Assign the highest applicable code for metastasis at diagnosis pathologically (based on pathology report), when available
- Not every metastatic site may be biopsied; however, for purposes of coding this data item, each metastatic site, whether confirmed clinically or pathologically, should be included, which may mean that clinical evidence would take priority over pathological
 - **Example:** Colon cancer with microscopically confirmed metastases to Liver (code 10 for involvement of one organ); however, per imaging, mets also noted in the peritoneum and distant lymph nodes. EOD Mets would be coded to 50 (peritoneum involved with or without distant lymph nodes/organs) based on the clinical evidence of mets
- If there is no applicable pathology or the pathology does not show metastasis, code EOD Mets based on clinical findings
- Imaging takes precedence over physical examination



Neoadjuvant Therapy

If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy:

- Code the clinical information description that identifies the most extensive metastasis
- **However:** If the post-neoadjuvant surgery shows additional or more extensive metastasis, code EOD Mets based on the post-neoadjuvant information
- If the clinical and pathological information are the same, code mets based on the clinical information



In situ tumors with metastatic involvement:

- In the event of an in-situ tumor with metastatic involvement,
 - Assign EOD Primary Tumor as in-situ (code 000) and
 - Code EOD Mets appropriately (positive)
 - This is a change from prior versions of EOD
- Behavior would be /3 for these tumors
 - The primary tumor is in situ; however, there is evidence of an invasive component due to the metastatic involvement



Code 99

- Code 99 is to be used ONLY for death certificate only (DCO) case
 - **However:** Assign the appropriate EOD Mets code when specific metastatic information is available on a DCO
- **Per rule 1b:** When it is unknown if there are distant metastases, **code 00**



Questions?