SEER EOD AND SUMMARY STAGE

ABSTRACTORS TRAINING

OVERVIEW

- What is SEER EOD
- Ambiguous Terminology
- General Guidelines
- EOD Primary Tumor
- EOD Regional Nodes
- EOD Mets
- Site Specific Data Items (SSDI)
- SEER Summary Stage 2018

WHAT IS SEER EOD?

- Effective for cases diagnosed 1/1/2018 and forward (Don't use for cases before 1/1/2018)
- Applies to every site/histology combination, including leukemia and lymphoma cases.
- Consists of:
  - EOD Primary Tumor
  - EOD Regional Nodes
  - EOD Mets

- EOD uses all information available in the medical record

AMBIGUOUS TERMINOLOGY

- If you can't find definitive statement of involvement use the SEER EOD Ambiguous Terminology List to interpret and determine the appropriate assignment of EOD Primary Tumor, EOD Regional Nodes or EOD Mets

IMPORTANT NOTES

- Terminology in the schema takes priority over this list
- Use this list only for EOD 2018 or Summary Stage 2018
- This is ***not*** the same list used for determining reportability as published in the SEER Manual, Hematopoietic Manual, or in Section 1 of the Standards for Oncology Registry Entry (STORE)

EOD GENERAL GUIDELINES

- Be sure to check site-specific EOD 2018 schemas for exceptions and/or additional information
- 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 GENERAL GUIDELINES CONTINUED

- 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

EOD GENERAL GUIDELINES CONTINUED

- 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 (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

EOD GENERAL GUIDELINES CONTINUED

- 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
- EOD Schema-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology schema

EOD PRIMARY TUMOR CODING INSTRUCTIONS

- EOD Primary Tumor is based on layer invasion and extension to adjacent organs/structures
- Assign the farthest documented contiguous extension of the primary tumor
- Localized is only used when you can't find any other information
- Use the highest applicable code, but you also have to use the priority order:
  - Pathology report
  - Imaging
  - Physical Exam

EOD PRIMARY TUMOR CODING INSTRUCTIONS HINTS

- 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
- In situ tumors with nodal or metastatic involvement
- Multiple tumors – code the furthest extension
- Occult Primary – Code 800
- Some sites have additional information needed to be coded for EOD – For example prostate gets EOD Primary Tumor and Prostate Path Extension

EOD Primary Tumor – Colon and Rectum	
Code	**Description**
000	In situ, intraepithelial, noninvasive, non-infiltrating
050	Intramucosal, NOS Lamina propria Mucosa, NOS Confined to, but not through muscularis mucosa
100	Submucosa (superficial invasion) Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Through the muscularis mucosa but not into the muscularis propria Confined to polyp (head, stalk, NOS) Confined to colon, rectum, rectosigmoid, NOS Localized, NOS
200	Muscularis propria invaded Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus
300	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Non-peritonealized pericolic/perirectal tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS Wall, NOS

EOD Primary Tumor – Colon and Rectum (Continued)	
Code	**Description**
400	Adjacent (connective) tissue(s), NOS Fat, NOS Gastrocolic ligament (transverse colon and flexures) Greater omentum (transverse colon and flexures) Mesentery (including mesenteric fat, mesocolon) Pericolic fat Perirectal fat Rectovaginal septum (rectum) Retroperitoneal fat (ascending and descending colon only)
500	Mesothelium Serosa Tunica serosa Invasion through the visceral peritoneum
600	Adherent to other organs or structures clinically with no microscopic examination See Table on SEER EOD
700	All Colon subsites Further contiguous extension
800	No evidence of primary tumor
999	Unknown; extension not stated Primary tumor cannot be assessed Not documented in patient record Death Certificate Only

EOD REGIONAL NODES CODING INSTRUCTION HINTS

- Record the specific involved regional lymph node chain(s) farthest from the primary site
  - If not possible to determine if a lymph node is regional or distant, check the scheme for a site that is nearby
- Use the highest applicable code, but you also have to use the priority order:
  - Pathology report
  - Imaging
  - Physical Exam

EOD REGIONAL NODES CODING INSTRUCTION HINTS

- Accessible and Inaccessible lymph nodes
- 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
- Assign code 999 when there is reasonable doubt that the tumor is localized

EOD REGIONAL NODES CODING INSTRUCTION HINTS

- In situ tumors with metastatic nodal involvement
- If direct extension of the primary tumor into a regional lymph node is shown, code the involved node(s) in EOD Regional Nodes
- For some schemas, ITCs are counted as positive regional nodes, while other schemas count them as negative
- Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum - If there are Tumor Deposits and node involvement, code only the information on node involvement in this field

EOD Regional Nodes – Colon and Rectum	
Code	**Description**
000	No regional lymph node involvement and no tumor deposits (TD)
200	Tumor deposits (TD) in the subserosa, mesentery, mesorectal or nonperitonealized pericolic or perirectal tissues WITHOUT regional nodal metastasis
300	All Colon Subsites
800	Regional lymph node(s), NOS Lymph node(s), NOS
999	Unknown; regional lymph node(s) not stated Regional lymph node(s) cannot be assessed Not documented in patient record Death Certificate Only

EOD Mets – Colon and Rectum	
Code	Description
00	No distant metastasis Unknown if distant metastasis
10	Single distant lymph node chain
20	Single distant organ (except peritoneum)
30	Metastasis to Multiple distant lymph node chains WITH or WITHOUT single distant organ (except peritoneum)
40	Multiple distant organs (except peritoneum) WITH or WITHOUT distant lymph node(s)
50	Peritoneal surface metastasis (peritoneum) WITH or WITHOUT distant lymph node(s) or distant organ(s) Carcinomatosis
70	Distant lymph node(s), NOS Not specified as single or multiple chains Distant metastasis, NOS Not specified as single or multiple organs, or peritoneum
99	Death certificate only (DCO)

SITE SPECIFIC DATA ITEMS

SSDIS

- Go into effect for cases diagnosed 01/01/2018 and forward
- SSF/SSDIs are based on the year of diagnosis, not when the case is abstracted
  - Example: 2017 case abstracted in 2018
    - Code the applicable/required SSFs, not the SSDIs
- Schemas are based on primary site, histology and schema discriminator (when applicable)
- Each Schema tells:
  - Which SSDIs to use
  - What Grade ID to utilize
  - What AJCC 8th Edition chapter to utilize
  - What EOD Schema to utilize
  - What Summary Stage Chapter to utilize

CEA (CARCINOEMBRYONIC ANTIGEN) PRETREATMENT LAB VALUE

Code	Description
0.0	0.0 nanograms/milliliter (ng/m) exactly
0.1-9999.9	0.1-9999.9 ng/ml (Exact value to nearest tenth in ng/ml)
XXXX.1	10,000 ng/ml or greater
XXXX.7	Test ordered, results not in chart
XXXX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XXXX.8 may result in an edit error.)
XXXX.9	Not documented in medical record CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed

CEA (CARCINOEMBRYONIC ANTIGEN) PRETREATMENT INTERPRETATION

Code	Description
0	CEA negative/normal; within normal limits
1	CEA positive/elevated
2	Borderline
3	Undetermined if positive or negative (normal values not available) AND no MD interpretation
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this data item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed

TUMOR DEPOSITS

Code	Description
00	No tumor deposits
01-99	1-99 Tumor deposits (TD) (Exact number of TD)
X1	100 or more Tumor Deposits
X2	Tumor Deposits identified, number unknown
X8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code X8 may result in an edit error.)
X9	Not documented in medical record Cannot be determined by the pathologist Pathology report does not mention tumor deposits No surgical resection done Tumor Deposits not assessed or unknown if assessed

PERINEURAL INVASION

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

Note: If there is no mention of perineural invasion, must code 9. In CS, if there was no mention of perineural invasion, none could be coded. This applies to several data items and is noted in the SSDI manual

CIRCUMFERENTIAL RESECTION MARGIN (CRM)

Code	Description
0.0	Circumferential resection margin (CRM) positive Margin IS involved with tumor Described as "less than 1 millimeter (mm)"
0.1-99.9	Distance of tumor from margin: 0.1- 99.9 millimeters (mm) (Exact size to nearest tenth of millimeter)
XX.0	100 mm or greater
XX.1	Margins clear, distance from tumor not stated Circumferential or radial resection margin negative, NOS No residual tumor identified on specimen
XX.2	Margins cannot be assessed
XX.3	Described as “at least” 1 mm
XX.4	Described as “at least” 2 mm
XX.5	Described as “at least” 3 mm
XX.6	Described as “greater than” 3 mm
XX.7	No resection of primary site Surgical procedure did not remove enough tissue to measure the circumferential or radial resection margin (Examples include: polypectomy only, endoscopic mucosal resection (EMR), excisional biopsy only, transanal disk excision)
XX.8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code XX.8 may result in an edit error.)
XX.9	Not documented in medical record Circumferential or radial resection margin not assessed or unknown if assessed

KRAS	
Code	Description
0	Normal (wild type) Negative for mutations
1	Abnormal (mutated) in codon(s) 12, 13 and/or 61
2	Abnormal (mutated) in codon 146 only
3	Abnormal (mutated), but not in codon(s) 12, 13, 61, or 146
4	Abnormal (mutated), NOS, codon(s) not specified
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record KRAS not assessed or unknown if assessed

MICROSATELLITE INSTABILITY (MSI)

Code	Description
0	Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
1	MSI unstable low (MSI-L)
2	MSI unstable high (MSI-H) AND/OR MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)
8	Not applicable: Information not collected for this case (If this information is required by your standard setter, use of code 8 may result in an edit error.)
9	Not documented in medical record MSI-indeterminate Microsatellite instability not assessed or unknown if assessed

SUMMARY STAGE 2018

SUMMARY STAGE 2018 CODING INSTRUCTION HINTS

- In situ diagnosis **can only be made microscopically**
- Beginning with Summary Stage 2018 there is no Code 5 for Regional, NOS
- Regional lymph nodes are listed for each chapter/site
  - If a lymph node chain is not listed in code 3, then the following resources can be used to help identify regional lymph nodes
    - Appendix C of the Hematopoietic Manual
    - Anatomy textbook
    - ICD-O-3 manual
    - Medical dictionary (synonym)

SUMMARY STAGE 2018 CODING INSTRUCTION HINTS

- Read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as physical exam and diagnostic imaging reports for mention of regional or distant disease
- Pathologic information takes precedence
- It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement

SUMMARY STAGE 2018

Code	Definition
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death certificate only case

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland

QUESTIONS?