

Appendix 2: Final Answers and Rationale

This appendix includes all the cases and their data items by group number for each cancer schema. For each case and data item, the following are included

- Case #
- Data Item
- Preferred Answer (% Agree)
- Final Answer (% Agree)
- Rationale

For data items highlighted in blue, these were data items where the preferred answer was changed after review of comments and the records once again.

We would like to thank the registrars who provided excellent feedback, which resulted in updated rationales, changed rationales and for some cases, a change in the preferred answer. This feedback also provided direction for training/education and/or updates to the EOD, Summary Stage 2018 and SSDI manuals.

Group 1 Cases

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Primary Site	C718 (56.7%)	C711 (36.3%)	<p>Per the 2018 Solid Tumor Rules for Malignant CNS and Peripheral Nerves, the priority order for assigning primary site is</p> <ol style="list-style-type: none"> 1. Resection <ul style="list-style-type: none"> • Operative report • Pathology report 2. Biopsy <ul style="list-style-type: none"> • Operative report • Pathology report 3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information) <ul style="list-style-type: none"> • Tumor Board • Code from physician's documentation of original diagnosis from operative report or pathology report OR • Physician's documentation of primary site in the medical record 4. For cases diagnosed by imaging (no pathology/resection or biopsy), use information from scans in the following priority order: MRI, CT, PET, Angiogram <p>No resection done. Biopsy, operative report, takes priority: Right frontal mass</p> <ul style="list-style-type: none"> • Code 711: Frontal lobe
Brain	Histology	9440 (94.7%)	9440 (94.7%)	<p>Biopsy pathology report: Glioblastoma, IDH-wild type</p> <ul style="list-style-type: none"> • Code 9440: Glioblastoma, NOS
Brain	Behavior	3 (99.4%)	3 (99.4%)	<p>Invasive</p> <ul style="list-style-type: none"> • Code 3: Malignant
Brain	Tumor Size Clinical	086 (71.3%)	086 (71.3%)	<p>MRI: greatest tumor dimension is 8.6 cm</p> <ul style="list-style-type: none"> • Code 086
Brain	Tumor Size Pathologic	999	999	<p>Pathological tumor size not available, No resection of primary site</p>

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		(95.9%)	(95.9%)	<ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Brain	EOD Primary Tumor	500 (76.0%)	500 (76.0%)	<p>MRI brain: large heterogeneously enhancing mass involving the corpus callosum extending from the genu to the splenium; involving the entirety of the corpus callosum</p> <ul style="list-style-type: none"> Code 500: Involvement of the corpus callosum
Brain	EOD Regional Nodes	888 (100%)	888 (100%)	<p>Not applicable: Default value (no lymph nodes in the brain)</p> <ul style="list-style-type: none"> Code 888: Not applicable
Brain	Regional Nodes Positive	99 (90.6%)	99 (90.6%)	<p>Not applicable: Default value (no lymph nodes in the brain)</p> <ul style="list-style-type: none"> Code 99: Not applicable
Brain	EOD Mets	00 (90.1%)	00 (90.1%)	<p>MRI Brain states possible CSF spread; however, per the Ambiguous terminology list, possible is not included as something that can indicate involvement</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Brain	SS2018	2 (73.1%)	2 (73.1%)	<p>Large heterogeneously enhancing mass involving the corpus callosum extending from the genu to the splenium; involving the entirety of the corpus callosum, no evidence of metastasis</p> <ul style="list-style-type: none"> Code 2: Regional
Brain	Grade Clinical	4 (79.5%)	4 (79.5%)	<p>Biopsy pathology report: WHO Grade IV</p> <ul style="list-style-type: none"> Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination
Brain	Grade Pathological	9 (65.5%)	9 (65.5%)	<p>Per Note 5, 2nd bullet: Code 9 when there is no resection of the primary site</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Brain	Grade Post Therapy	Blank (78.4%)	Blank (78.4%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Brain	Brain Molecular Markers	05 (80.7%)	05 (80.7%)	<p>Biopsy pathology report: Glioblastoma, IDH-wildtype (9440/3)</p> <ul style="list-style-type: none"> Code 05: Glioblastoma, IDH-wildtype (9440/3)
Brain	Chromosome 1p Status	9 (90.6%)	9 (90.6%)	<p>Chromosome 1p not documented in patient record</p>

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				<ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 1p deletion/LOH not assessed or unknown if assessed
Brain	Chromosome 19q Status	9 (92.4%)	9 (92.4%)	Chromosome 19q not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 19q: LOH not assessed or unknown if assessed
Brain	MGMT	0 (80.7%)	0 (80.7%)	Biopsy pathology report, Addendum: Gene methylation NOT detected Methylation of the MGMT gene was tested using methylation specific PCR technologies. Methylation score: 0.14 (Unmethylated < 2.00; methylated >=2.00) <ul style="list-style-type: none"> Code 0: MGMT methylation absent/not present, unmethylated MGMT
Breast	Primary Site	C504 (31.5%)	C508 (55.8%)	<p>Per Appendix C of the SEER manual, Breast Coding Guidelines, the following priority order is used when there is conflicting information</p> <ol style="list-style-type: none"> Operative Report Pathology Report Mammogram, ultrasound (ultrasound becoming more frequently used) Physical examination <p>Operative report not available. Pathology report, biopsy only, no information on primary site. Mammogram and ultrasound both at 3 o'clock position. PET scan states lower outer quadrant. Mammogram takes priority.</p> <p>Per SEER manual, Breast coding guidelines, code the primary site to 508 when stated as 12, 3, 6, or 9 o'clock position in breast</p> <ul style="list-style-type: none"> Code C508: Overlapping lesion of breast
Breast	Histology	8500 (97.0%)	8500 (97.0%)	Surgical pathology report: Infiltrating ductal carcinoma <ul style="list-style-type: none"> Code 8500: Infiltrating duct carcinoma, NOS
Breast	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant

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Breast	Tumor Size Clinical	038 (41.2%)	038 (41.2%)	<p>Per Tumor Size Clinical instructions, #7:</p> <p>Priority of imaging/ radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, and over a physical exam.</p> <p>Based on this instruction, would go with the 3.8 based on the imaging.</p> <p>This also looks like progression.</p> <p>Coding tumor size of 3.8 conflicts with the T3, which was assigned 6 weeks after initial mammogram with a BIRADS 5.</p> <ul style="list-style-type: none"> Code 038
Breast	Tumor Size Pathologic	999 (95.2%)	999 (95.2%)	<p>Path tumor size not available. No resection of primary site done according to information provided.</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Breast	EOD Primary Tumor	100 (89.1%)	100 (89.1%)	<p>Per physician's notes, enlarging mass, no skin involvement</p> <ul style="list-style-type: none"> Code 100: Any size tumor; Confined to breast tissue and fat including nipple and/or areola, Localized, NOS; EXCLUDES: skin invasion of breast, nipple and areola (see code 200)
Breast	EOD Regional Nodes	000 (90.9%)	000 (90.9%)	<p>Patient had neoadjuvant therapy, followed by lymph node biopsy</p> <p>Per General Instructions: 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 Clinical evaluation: Negative nodes (Code 000), Path evaluation: 0/1 LNs Since they are equal, go with the Clinical Evaluation</p> <ul style="list-style-type: none"> Code 000: No clinical regional lymph node involvement

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Breast	Regional Nodes Positive	00 (75.2%)	00 (75.2%)	Lymph node biopsy pathology report: 0/1 LNs involved, no other evidence of lymph node involvement Per Regional Nodes Positive, any removal of lymph nodes (pathological assessment) can be used here, so the lymph node biopsy can be used here <ul style="list-style-type: none"> Code 00: All nodes examined negative
Breast	EOD Mets	00 (95.8%)	00 (95.8%)	Oncology Provider Note: PET/CT scan showed no evidence of metastatic disease <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Breast	SS2018	1 (90.9%)	1 (90.9%)	Enlarging mass, no skin involvement or evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized, confined to breast
Breast	Grade Clinical	A (2.4%)	1 (90.9%)	Path report states G1. There is no mention of Nottingham, or the three components that go into the Nottingham; however, since G1 is the preferred grading format, assume that this is Nottingham and code accordingly <ul style="list-style-type: none"> Code 1: G1: Low combined histologic grade (favorable), SBR score of 3-5 points
Breast	Grade Pathological	9 (86.7%)	9 (86.7%)	Per Note 6, 2 nd bullet: Code 9 when there is no resection of the primary site <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Breast	Grade Post Therapy	Blank (58.8%)	Blank (58.8%)	Treatment plan was for patient to have neoadjuvant therapy followed by surgery; however, it is unknown if surgery was done. Code 9 should only be used when there is a pathology report from a surgical procedure after neoadjuvant therapy and the grade is not documented. <ul style="list-style-type: none"> Per Note 1, Leave post therapy grade blank when there is no neoadjuvant therapy
Breast	Sentinel Lymph Nodes Examined	99 (7.9%)	99 (7.9%)	SLN bx planned along with mastectomy. No information available for either of these. Ideally, the hospital registrar would follow up and verify whether or not these procedures were done. Assigning 99 would be a better indication to the hospital registrar that follow up is needed. Recommend for situations like this that details would be recorded in the text fields-documenting the plan for mastectomy and SLN bx.

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				<ul style="list-style-type: none"> Code 99: It is unknown whether sentinel nodes were examined, not stated in patient record
Breast	Sentinel Lymph Nodes Positive	99 (7.3%)	99 (7.3%)	<p>SLN bx planned along with mastectomy. No information available for either of these. Ideally, the hospital registrar would follow up and verify whether or not these procedures were done.</p> <p>Assigning 99 would be a better indication to the hospital registrar that follow up is needed. Recommend for situations like this that details would be recorded in the text fields-documenting the plan for mastectomy and SLN bx.</p> <ul style="list-style-type: none"> Code 99: It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record
Breast	ER Summary	0 (97.0%)	0 (97.0%)	<p>Biopsy pathology report: ER Negative</p> <ul style="list-style-type: none"> Code 0: ER negative
Breast	ER Percent Positive	000 (86.1%)	000 (86.1%)	<p>Biopsy pathology report: ER Negative</p> <ul style="list-style-type: none"> Code 000: ER negative, or stated as less than 1%
Breast	ER Allred Score	X9 (65.5%)	X9 (65.5%)	<p>ER is stated as negative; however, a negative ER can be 0% or less than 1% for the proportion score. In addition, the intensity score would be 0 (based on 0%) or 1 (based on less than 1%). Allred score cannot be assigned based on information provided since the physician did not document intensity score.</p> <ul style="list-style-type: none"> Code X9: Not documented in medical record, ER (Estrogen Receptor) Total Allred Score not assessed, or unknown if assessed
Breast	PR Summary	0 (96.4%)	0 (96.4%)	<p>Biopsy pathology report: PR Negative</p> <ul style="list-style-type: none"> Code 0: PR negative
Breast	PR Percent Positive	000 (83.6%)	000 (83.6%)	<p>Biopsy pathology report: PR Negative</p> <ul style="list-style-type: none"> Code 000: PR negative, or stated as less than 1%
Breast	PR Allred Score	X9 (67.3%)	X9 (67.3%)	<p>PR is stated as negative; however, a negative PR can be 0% or less than 1% for the proportion score. In addition, the intensity score would be 0 (based on 0%) or 1 (based on less than 1%). Allred score cannot be assigned based on information provided since the physician did not document intensity score.</p> <ul style="list-style-type: none"> Code X9: Not documented in medical record, PR (Progesterone Receptor) Total Allred Score not assessed, or unknown if assessed

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Breast	HER2 IHC Summary	0 (93.3%)	0 (93.3%)	Biopsy pathology report: HER Breast IHC Automated HER2, HER2 IHC Negative <ul style="list-style-type: none"> Code 0: Negative (Score 0)
Breast	HER2 ISH Summary	9 (80.6%)	9 (80.6%)	HER2 ISH not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Results cannot be determined (indeterminate), HER2 ISH Summary not assessed or unknown if assessed
Breast	HER2 Overall Summary	0 (95.2%)	0 (95.2%)	Biopsy pathology report: HER IHC negative, HER FISH not done <ul style="list-style-type: none"> Code 0: HER2 negative; equivocal
Breast	HER2 SP Copy Number	XX.9 (93.3%)	XX.9 (93.3%)	HER2 SP Copy Number not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Copy Number	XX.9 (92.7%)	XX.9 (92.7%)	HER2 ISH not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Dual Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Ratio	XX.9 (93.3%)	XX.9 (93.3%)	HER2 ISH not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in patient record, Results cannot be determined (indeterminate), HER2 ISH dual probe ratio not assessed or unknown if assessed
Breast	Ki-67	XXX.9 (93.9%)	XXX.9 (93.9%)	Ki-67 not documented in patient record <ul style="list-style-type: none"> Code XXX.9: Not documented in patient record, Ki-67 (MIB-1) not assessed or unknown if assessed
Breast	Lymph Nodes Positive Axillary Level I-II	00 (78.8%)	00 (78.8%)	Lymph node biopsy pathology report: 0/1 LNs involved No other evidence of lymph node involvement <ul style="list-style-type: none"> Code 00: All ipsilateral axillary nodes examined negative
Breast	Multigene Signature Method	9 (93.9%)	9 (93.9%)	Multigene Signature Method not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Multigene Signature Method not assessed or unknown if assessed
Breast	Multigene Signature Results	X9 (93.3%)	X9 (93.3%)	Multigene Signature Results not documented in patient record

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				<ul style="list-style-type: none"> Code X9: Not documented in medical record, Multigene Signature Results not assessed or unknown if assessed
Breast	Oncotype DX Recur Score – DCIS	XX6 (64.2%)	XX6 (64.2%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> XX6: Not applicable, invasive case
Breast	Oncotype DX Recur Score	XX9 (98.2%)	XX9 (98.2%)	Oncotype Dx Recurrence Score not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in medical record, Oncotype Dx Recurrence Score-Invasive not assessed or unknown if assessed
Breast	Oncotype Dx Risk Level – DCIS	6 (64.8%)	6 (64.8%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> 6: Not applicable, invasive case
Breast	Oncotype Dx Risk Level Invasive	9 (95.8%)	9 (95.8%)	Oncotype Dx Risk Level not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Oncotype Dx Risk Level-Invasive not assessed or unknown if assessed
Breast	Response to Neoadjuvant Therapy	9 (79.4%)	9 (79.4%)	Neoadjuvant therapy recommended, available documentation does not document results <ul style="list-style-type: none"> Code 9: Not documented in medical record, Response to neoadjuvant therapy not assessed or unknown if assessed
Colon and Rectum	Primary Site	C186 (88.1%)	C185 (1.8%)	<p>Per the coding guidelines from SEER, the following priority order for assigning primary site for Colon is</p> <ul style="list-style-type: none"> Resected cases <ul style="list-style-type: none"> Operative report with surgeon’s description Pathology report Imaging Non-resected cases <ul style="list-style-type: none"> Polypectomy or excision without resection Endoscopy report <p>Operative report, which takes priority, states the tumor is near the splenic flexure just on the descending side of the splenic flexure</p> <ul style="list-style-type: none"> Code C185: Splenic flexure

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Colon and Rectum	Histology	8140 (97.0%)	8140 (97.0%)	Surgical pathology report: Adenocarcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Colon and Rectum	Behavior	3 (98.8%)	3 (98.8%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Colon and Rectum	Tumor Size Clinical	999 (92.9%)	999 (92.9%)	Clinical tumor size not documented in patient record <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Colon and Rectum	Tumor Size Pathologic	070 (95.8%)	070 (95.8%)	Surgical pathology report: greatest dimension 7 cm <ul style="list-style-type: none"> Code 070
Colon and Rectum	EOD Primary Tumor	500 (90.5%)	500 (90.5%)	Surgical pathology report: Tumor invades the visceral peritoneum. Gross description also states invasion of the serosa <ul style="list-style-type: none"> Code 500: Mesothelium, Serosa, Tunica serosa, Invasion through the visceral peritoneum
Colon and Rectum	EOD Regional Nodes	000 (98.8%)	000 (98.8%)	Surgical pathology report: 0/33 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement and no tumor deposits (TD)
Colon and Rectum	Regional Nodes Positive	00 (99.4%)	00 (99.4%)	Surgical pathology report: 0/33 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Colon and Rectum	EOD Mets	00 (98.2%)	00 (98.2%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Colon and Rectum	SS2018	2 (89.3%)	2 (89.3%)	Invasion of the visceral peritoneum, no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 2: Regional
Colon and Rectum	Grade Clinical	2 (74.4%)	2 (74.4%)	Biopsy pathology report: moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Colon and Rectum	Grade Pathological	3 (14.9%)	3 (14.9%)	Surgical pathology report addendum: moderately to poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Colon and Rectum	Grade Post Therapy	Blank (83.9%)	Blank (83.9%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Colon and Rectum	CEA PreTX Interpretation	9 (91.1%)	9 (91.1%)	CEA PreTx Interpretation not documented in patient record

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				<p>Follow up oncology note states a CEA baseline will be ordered; however, this is done after the diagnosis and treatment of the colon cancer</p> <p>Per Note 2: Record the lab value of the highest CEA test result documented in the medical record prior to treatment or polypectomy. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Colon and Rectum	CEA PreTX Lab Value	XXXX.9 (91.1%)	XXXX.9 (91.1%)	<p>CEA PreTx Lab value not documented in patient record</p> <p>Follow up oncology note states a CEA baseline will be ordered; however, this is done after the diagnosis and treatment of the colon cancer</p> <p>Per Note 2: Record the lab value of the highest CEA test result documented in the medical record prior to treatment or polypectomy. The lab value may be recorded in a lab report, history and physical, or clinical statement in the pathology report.</p> <ul style="list-style-type: none"> Code XXXX.9: Not documented in medical record CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed
Colon and Rectum	Circumferential Resection Margin	10.0 (47.0%)	10.0 (47.0%)	<p>Surgical pathology report: Distance of invasive carcinoma from closest margin: 10 mm from mesenteric. Distance of tumor from margin is stated.</p> <p>Note 3: CRM may also be referred to as the circumferential radial margin or mesenteric margin.</p> <ul style="list-style-type: none"> Code 10.0
Colon and Rectum	KRAS	9 (94.6%)	9 (94.6%)	<p>KRAS not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, KRAS not assessed or unknown if assessed

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Colon and Rectum	Microsatellite Instability	2 (33.3%)	2 (33.3%)	<p>Surgical pathology report: Tumor cells show loss of immunoreactivity for MLHI and PM52. Staining with M2H2 and MSH6 is intact.</p> <p>These are proteins tested for MMR. MSI/MMR is positive due to MMR testing. No documentation of MSI testing</p> <ul style="list-style-type: none"> Code 2: MMR-D (loss of nuclear expression of one or more MMR proteins, MMR protein deficient)
Colon and Rectum	Perineural Invasion	0 (95.2%)	0 (95.2%)	<p>Surgical pathology report: Perineural invasion not identified</p> <ul style="list-style-type: none"> Code 0: Perineural invasion not identified/not present
Colon and Rectum	Tumor Deposits	00 (92.3%)	00 (92.3%)	<p>Surgical pathology report: Tumor deposits not identified</p> <ul style="list-style-type: none"> Code 00: No tumor deposits
Lung	Primary Site	C341 (90.4%)	C341 (90.4%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site</p> <p><i>Note:</i> There are no specific primary site instructions for Lung.</p> <p>Per #2: Code the site in which the primary tumor originated, even if it extends onto/into an adjacent subsite</p> <p>Physician statement of RUL. Operative report states that RUL tumor, but was contiguous with a minor fissure between the upper and middle lobes. Both lobes resected; however, this does not make this an overlapping lesion.</p> <ul style="list-style-type: none"> Code C341: Upper lobe, lung
Lung	Histology	8255 (18.6%)	8140 (48.5%)	<p>Surgical pathology report: Pulmonary adenocarcinoma, solid pattern (90%) and acinar pattern (10%)</p> <p>Per the Solid Tumor Rules for Lung, Histology instructions: Do not code histology when described as: Architecture, Foci/focus, Pattern</p> <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Lung	Behavior	3	3	Invasive histology

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		(100%)	(100%)	<ul style="list-style-type: none"> Code 3: Malignant
Lung	Tumor Size Clinical	020 (95.8%)	020 (95.8%)	Chest Xray: 2 cm lesion in the right upper lobe <ul style="list-style-type: none"> Code 020
Lung	Tumor Size Pathologic	020 (97.0%)	020 (97.0%)	Surgical pathology report: 2 cm mass <ul style="list-style-type: none"> Code 020
Lung	EOD Primary Tumor	300 (71.9%)	300 (71.9%)	Surgical pathology report: 2 cm mass confined to lung, no pleural or visceral involvement, no adjacent structures involved <ul style="list-style-type: none"> Code 300: Any size tumor, Confined to lung, NOS, Localized, NOS
Lung	EOD Regional Nodes	300 (76.0%)	300 (76.0%)	Surgical pathology report: 3/5 lymph nodes positive; additional lymph nodes, 1/5 In positive (10R) (hilar nodes) Per Gross description, the 3/5 lymph nodes were perihilar nodes <ul style="list-style-type: none"> Code 300: Hilar and perihilar nodes
Lung	Regional Nodes Positive	04 (72.5%)	04 (72.5%)	Surgical pathology report: 4/5 LNs <ul style="list-style-type: none"> Code 04
Lung	EOD Mets	00 (96.4%)	00 (96.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Lung	SS2018	3 (76.6%)	3 (76.6%)	Confined to lung, positive nodes, no evidence metastasis <ul style="list-style-type: none"> Code 3: Localized tumor with positive lymph nodes
Lung	Grade Clinical	9 (98.8%)	9 (98.8%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Pathological	9 (97.6%)	9 (97.6%)	Pathological grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Post Therapy	Blank (83.8%)	Blank (83.8%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lung	Separate Tumor Nodules	0 (85.0%)	0 (85.0%)	No separate tumor nodules noted <ul style="list-style-type: none"> Code 0: No separate tumor nodules; single tumor only
Lung	Visceral and Parietal Pleural Invasion	0 (95.8%)	0 (95.8%)	Surgical pathology report: Visceral pleural invasion not identified <ul style="list-style-type: none"> Code 0: No evidence of visceral pleural invasion identified, Tumor does not completely traverse the elastic layer of the pleura, Stated as PLO
Lymphoma	Primary Site	C421	C421	Bone marrow: Peripheral blood positive for CLL/SLL

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CLL/SLL		(62.0%)	(62.0%)	Per Heme Manual, Module 3: PH5: Code the primary site to bone marrow (C421) when the bone marrow is involved or when only peripheral blood is involved <ul style="list-style-type: none"> Code C421: Bone marrow
Lymphoma CLL/SLL	Histology	9823 (100%)	9823 (100%)	Peripheral blood smear: CLL/SLL <ul style="list-style-type: none"> Code 9823: Chronic lymphocytic leukemia/small lymphocytic lymphoma
Lymphoma CLL/SLL	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lymphoma CLL/SLL	Tumor Size Clinical	999 (96.3%)	999 (96.3%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	Tumor Size Pathologic	999 (98.8%)	999 (98.8%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	EOD Primary Tumor	800 (34.4%)	800 (34.4%)	If primary site is C421, EOD Primary Tumor is 800 A new note will be added regarding peripheral blood involvement, also will be added to code 800 in the next release of the EOD manual <ul style="list-style-type: none"> Code 800: Peripheral blood involvement
Lymphoma CLL/SLL	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 888: Not applicable
Lymphoma CLL/SLL	Regional Nodes Positive	99 (97.5%)	99 (97.5%)	Not applicable: Default value <ul style="list-style-type: none"> Code 99: Not applicable
Lymphoma CLL/SLL	EOD Mets	88 (100%)	88 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 88: Not applicable
Lymphoma CLL/SLL	SS2018	7 (44.8%)	7 (44.8%)	If primary site is C421, Summary Stage is 7 A new note will be added regarding peripheral blood involvement, also will be added to code 7 in the next release of the SS2018 manual <ul style="list-style-type: none"> Code 7: Peripheral blood involvement
Lymphoma CLL/SLL	Grade Clinical	8 (100%)	8 (100%)	Grade not applicable for this Heme schema <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma	Grade Pathological	8	8	Grade not applicable for this Heme schema

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
CLL/SLL		(100%)	(100%)	<ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Post Therapy	Blank (63.8%)	Blank (63.8%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lymphoma CLL/SLL	Adenopathy	1 (87.7%)	1 (87.7%)	Oncology consult: Enlarged 2cm left inguinal lymph node along with a smaller right inguinal LN <ul style="list-style-type: none"> Code 1: Adenopathy present, Presence of lymph nodes > 1.5 cm
Lymphoma CLL/SLL	Anemia	0 (77.3%)	0 (77.3%)	Per Record, Hemoglobin is 13.2 <ul style="list-style-type: none"> Code 0: Anemia not present Hgb >=11.0 g/dL
Lymphoma CLL/SLL	B symptoms	0 (94.5%)	0 (94.5%)	Oncology Consult: No evidence of fever, night sweats, weight loss <ul style="list-style-type: none"> Code 0: No B symptoms
Lymphoma CLL/SLL	HIV status	9 (82.8%)	9 (82.8%)	HIV status not documented in medical record Per Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative. <ul style="list-style-type: none"> Code 9: Not documented in medical record, HIV status not assessed or unknown if assessed
Lymphoma CLL/SLL	Lymphocytosis	1 (71.8%)	1 (71.8%)	Labs: noted to have a lymphocytosis in the 60% with WBC ranging between 8.38k/ul in Oct 2017 to 15.96k/ul in Nov 2017 8.38k/ul equivalent to 8380/ul, physician also stated patient had lymphocytosis <ul style="list-style-type: none"> Code 1: Lymphocytosis present Absolute lymphocyte count > 5,000 cells/μL
Lymphoma CLL/SLL	NCCN International Prognostic Index (IPI)	X9 (71.8%)	X9 (71.8%)	NCCN not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Lymphoma CLL/SLL	Organomegaly	0 (87.7%)	0 (87.7%)	Oncology consult: Spleen not palpable on examination. No other mention of organomegaly. <ul style="list-style-type: none"> Code 0: Organomegaly of liver and/or spleen not present
Lymphoma CLL/SLL	Thrombocytopenia	0 (74.2%)	0 (74.2%)	Oncology consult: platelets 310 k. Need to multiple x 1000 for SSDI measurement (/ul) =310,000 <ul style="list-style-type: none"> Code 0: Thrombocytopenia not present Platelets (Plt) >=100,000/μL

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	Primary Site	C445 (98.1%)	C445 (98.1%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Melanoma Skin Office visit: Outside pathology report, Right lower back <ul style="list-style-type: none"> Code C445: Skin of trunk
Melanoma Skin	Histology	8721 (93.2%)	8721 (93.2%)	Surgical pathology report: Shave biopsy, Melanoma, invasive, nodular type <ul style="list-style-type: none"> Code 8721: Nodular melanoma
Melanoma Skin	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Melanoma Skin	Tumor Size Clinical	999 (76.5%)	999 (76.5%)	Tumor Size Clinical not documented in patient record <i>Note:</i> Breslow's depth and Tumor Size are not the same thing. Per H&P, physician documents "2.1 mm melanoma"; however, this is the Breslow's depth and not the size of the tumor <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Melanoma Skin	Tumor Size Pathologic	999 (76.5%)	999 (76.5%)	Tumor Size Pathologic not documented. Tumor Size Clinical unknown. Tumor Size Pathologic states that the incisional/excisional biopsy is pathological when the biopsy entirely removes the tumor. Instruction 12 states: 12. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor The first biopsy removed the tumor entirely, and per SEER's instruction, any tumor size noted would be the pathological tumor size Per Tumor Size Pathologic, #4b: 4. Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy.</p> <p>a. Code the size from the synoptic report (also known as CAP protocol or pathology report checklist) when there is a discrepancy among tumor size measurements in the various sections of the pathology report.</p> <p>b. Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available.</p> <ul style="list-style-type: none"> Code 999
Melanoma Skin	EOD Primary Tumor	300 (90.7%)	300 (90.7%)	<p>Surgical pathology report: Shave biopsy, Clark Level IV</p> <ul style="list-style-type: none"> Code 300: Reticular dermis invaded, Clark level IV
Melanoma Skin	EOD Regional Nodes	400 (72.2%)	400 (72.2%)	<p>Surgical pathology report: Re-excision and SLN biopsy: 2/2 axillary SLNs; clinically occult (detected by SLN biopsy; no palpable LA); no in-transit, satellite, or microsatellite metastasis; staged IIIB (T3aN2aM0)</p> <p>For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes</p> <ul style="list-style-type: none"> Code 400: Two or three clinically occult (detected by SLN biopsy) W/O in-transit, satellite, and/or microsatellite metastasis
Melanoma Skin	Regional Nodes Positive	02 (87.7%)	02 (87.7%)	<p>2/2 axillary SLNs positive</p> <p>For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes</p> <ul style="list-style-type: none"> Code 02
Melanoma Skin	EOD Mets	00 (88.9%)	00 (88.9%)	<p>PET CT and MRI brain showed no evidence of metastatic disease</p> <p>For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes. They would not be counted as distant lymph nodes.</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	SS2018	3 (70.4%)	3 (70.4%)	Clark Level IV tumor (localized), positive regional lymph nodes, no evidence metastasis For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes <ul style="list-style-type: none"> Code 3: Localized tumor with positive regional nodes
Melanoma Skin	Grade Clinical	9 (100%)	9 (100%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Pathological	9 (100%)	9 (100%)	Pathological grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Post Therapy	Blank (82.7%)	Blank (82.7%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Melanoma Skin	Sentinel Lymph Nodes Examined	02 (95.7%)	02 (95.7%)	Surgical pathology report: Re-excision and SLN biopsy, 2/2 axillary SLNs positive For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes <ul style="list-style-type: none"> Code 02
Melanoma Skin	Sentinel Lymph Nodes Positive	02 (95.7%)	02 (95.7%)	Surgical pathology report: Re-excision and SLN biopsy, 2/2 axillary SLNs positive For this case, the positive nodes were axillary, which are not identified as being regional for this skin site; however, the physician treated and staged these as regional lymph nodes <ul style="list-style-type: none"> Code 02
Melanoma Skin	Breslow Thickness	2.1 (80.9%)	2.1 (80.9%)	Surgical pathology report: Shave biopsy, Breslow thickness 2.1 mm <ul style="list-style-type: none"> Code 2.1
Melanoma Skin	Ulceration	0 (97.5%)	0 (97.5%)	Surgical pathology report: Shave biopsy, Ulceration not identified <ul style="list-style-type: none"> Code 0: Ulceration not identified/not present
Melanoma Skin	LDH (Lactate Dehydrogenase)	XXXXX.9 (96.3%)	XXXXX.9 (96.3%)	LDH not documented in patient record

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
	Pretreatment Lab Value			<ul style="list-style-type: none"> Code XXXXX.9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Level	9 (98.8%)	9 (98.8%)	LDH not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Level not assessed or unknown if assessed
Melanoma Skin	LDH Upper Limits of Normal	XX9 (90.7%)	XX9 (90.7%)	LDH not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in patient record, LDH Upper Limit not assessed or unknown if assessed
Melanoma Skin	Mitotic Rate Melanoma	05 (93.8%)	05 (93.8%)	Surgical pathology report: Shave biopsy, Mitotic Figures/mm ² , 5 <ul style="list-style-type: none"> Code 05
Ovary	Primary Site	C569 (100.0%)	C569 (100.0%)	Surgical pathology report: Right ovary <ul style="list-style-type: none"> Code C569: Ovary
Ovary	Histology	8461 (20.8%)	8461 (20.8%)	Surgical pathology report: High-grade serous carcinoma Per the 2018 ICD-O-3 updates: "high grade serous carcinoma" is a new alternate name for 8461 <ul style="list-style-type: none"> Code 8461: Serous surface papillary carcinoma
Ovary	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Ovary	Tumor Size Clinical	085 (34.6%)	085 (34.6%)	Per physician's assessment: Pt is a 70-year-old found to have 2 pelvic masses up to 8.5 cm in size with peritoneal carcinomatosis Per confirmation from SEER, even though there was not a confirmation of malignancy prior to surgical exploration, the size from the imaging can be used as tumor size clinical Can use physician's statement of 8.5 cm <ul style="list-style-type: none"> Code 085

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Ovary	Tumor Size Pathologic	999 (84.9%)	999 (84.9%)	Tumor Size Pathologic not documented in patient record (the size of the specimen, not the tumor itself) was given <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Ovary	EOD Primary Tumor	700 (84.3%)	700 (84.3%)	Surgical pathology report: Macroscopic extension, greater than 2 cm, to omentum or other extra pelvic peritoneal focus <ul style="list-style-type: none"> Code 700: Macroscopic peritoneal implants beyond pelvis, Greater than 2 cm in diameter
Ovary	EOD Regional Nodes	000 (68.6%)	000 (68.6%)	Surgical pathology report: No lymph nodes submitted or found, no mention of lymph nodes noted in the record <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Ovary	Regional Nodes Positive	98 (78.6%)	98 (78.6%)	No regional lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Ovary	EOD Mets	00 (83.0%)	00 (83.0%)	No clinical evidence of metastasis The evidence of “peritoneal carcinomatosis” should be recorded in EOD Primary Tumor. This is an exception for Ovary <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Ovary	SS2018	7 (88.1%)	7 (88.1%)	Macroscopic extension, greater than 2 cm, to omentum or other extra pelvic peritoneal focus, no evidence lymph nodes or metastasis <ul style="list-style-type: none"> Code 7: Distant
Ovary	Grade Clinical	9 (86.2%)	9 (86.2%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Ovary	Grade Pathological	H (93.1%)	H (93.1%)	Surgical pathology report: High grade <ul style="list-style-type: none"> Code H: High grade
Ovary	Grade Post Therapy	Blank (84.9%)	Blank (84.9%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Ovary	CA-125 PreTX Lab Value	1 (97.5%)	1 (97.5%)	Clinic note: Laboratory data, CA-125 348.7, Elevated <ul style="list-style-type: none"> Code 1: Positive/elevated
Ovary	FIGO Stage	37	37	Surgical pathology report: FIGO Stage IIIC

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(90.6%)	(90.6%)	<ul style="list-style-type: none"> Code 37: FIGO Stage IIIC
Ovary	Residual Tumor Volume Post Cytoreduction	00 (54.1%)	00 (54.1%)	<p>Surgical operative report: Findings describe the different areas of involvement found during surgery. Per note, these areas were removed during surgery. No evidence of disease left after surgery. Documented as R0.</p> <ul style="list-style-type: none"> Code 00: No gross residual tumor nodules
Prostate	Primary Site	C619 (100%)	C619 (100%)	<p>Surgical pathology report: Prostate</p> <ul style="list-style-type: none"> Code C619: Prostate
Prostate	Histology	8140 (93.3%)	8140 (93.3%)	<p>Surgical pathology report: Acinar Adenocarcinoma</p> <p>Per Solid Tumor Rules for "Other Sites," Rule H10: Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma</p> <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS Code 8140: Adenocarcinoma, NOS
Prostate	Behavior	3 (99.4%)	3 (99.4%)	<p>Invasive histology</p> <ul style="list-style-type: none"> Code 3: Malignant
Prostate	Tumor Size Clinical	999 (97.0%)	999 (97.0%)	<p>Tumor size clinical not documented in patient record</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	Tumor Size Pathologic	020 (56.7%)	020 (56.7%)	<p>Surgical pathology report: 2 cm size</p> <ul style="list-style-type: none"> Code 020
Prostate	EOD Primary Tumor	220 (15.2%)	300 (5.5%)	<p>Urology Office/Clinic Note: Prostate 2+ enlarged. Both lobes abnormal and indurated. The capsule and seminal vesicles are intact.</p> <p>Per EOD Primary Tumor, Note 3, Bullet 2: If a clinician documents a "tumor," "mass," or "nodule" by physical examination, this can be inferred as apparent. "Tumor," "mass," or "nodule" on imaging can only be used by the registrar if the managing clinician/urologist uses it.</p> <p>There is no documentation of "tumor," "mass," or "nodule" by the physician. Cannot infer that this is an apparent tumor based on the enlargement and the statement of "abnormal" by the physician</p>

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Based on the physician's statement, there is no clinical evidence of extraprostatic extension or seminal vesicle involvement <ul style="list-style-type: none"> Code 300: Localized prostate cancer, not known if clinically apparent or not
Prostate	Prostate Path Exten	600 (45.7%)	400 (42.7%)	Surgical pathology report: Left superior prostate, 2 cm size with invasion of the bilateral seminal vesicles and <i>bladder base</i> margin involvement Note: Margin involvement (bladder base) is no longer part of staging. <ul style="list-style-type: none"> Code 400: Tumor invades the seminal vesicles
Prostate	EOD Regional Nodes	300 (91.5%)	300 (91.5%)	Surgical pathology report: 1/3 lymph nodes positive <ul style="list-style-type: none"> Code 300: Regional lymph nodes
Prostate	Regional Nodes Positive	01 (92.7%)	01 (92.7%)	Surgical pathology report: 1/3 lymph nodes positive <ul style="list-style-type: none"> Code 01
Prostate	EOD Mets	00 (97.0%)	00 (97.0%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Prostate	SS2018	4 (78.7%)	4 (78.7%)	Bladder, NOS involved (regional) and pelvic lymph nodes involved <ul style="list-style-type: none"> Code 4: Regional tumor with positive lymph nodes
Prostate	Grade Clinical	4 (90.2%)	4 (90.2%)	Biopsy pathology report: Clinical Gleason pattern 4+4=8 <ul style="list-style-type: none"> Code 4: Grade Group 4: Gleason score 8
Prostate	Grade Pathological	4 (72.0%)	4 (72.0%)	Surgical pathology report: Pathological Gleason pattern 4+4=8, with a small foci of grade 5. The 5 is the tertiary pattern <ul style="list-style-type: none"> Code 4: Grade Group 4: Gleason score 8
Prostate	Grade Post Therapy	Blank (83.5%)	Blank (83.5%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Prostate	PSA Lab Value	26.1 (73.8%)	26.1 (73.8%)	Labs: PSA 26.1 <ul style="list-style-type: none"> Code 26.1
Prostate	Gleason Patterns Clinical	44 (95.7%)	44 (95.7%)	Biopsy pathology report: Clinical Gleason pattern 4+4=8 <ul style="list-style-type: none"> Code 44
Prostate	Gleason Score Clinical	08 (95.1%)	08 (95.1%)	Biopsy pathology report: Clinical Gleason pattern 4+4=8 <ul style="list-style-type: none"> Code 08: Gleason score 8

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	Gleason Patterns Pathological	44 (50.6%)	44 (50.6%)	Surgical pathology report: One part of prostate Gleason's pattern 4+4=8 and another part of prostate Gleason's pattern 4 + 3 =7. Synoptic report: Primary Gleason pattern: Pattern 4, Secondary Gleason Pattern: Pattern 3, Tertiary Gleason pattern: 5, Total Gleason Score: 7. Go with the pathology report. <ul style="list-style-type: none"> Code 44
Prostate	Gleason Score Pathological	08 (51.8%)	08 (51.8%)	See Gleason Patterns Pathological <ul style="list-style-type: none"> Code 08: Gleason score 8
Prostate	Gleason Tertiary Pattern	50 (87.2%)	50 (87.2%)	Surgical pathology report: Tertiary Gleason pattern: 5 <ul style="list-style-type: none"> Code 50: Tertiary pattern 5
Prostate	Number of Cores Examined	13 (69.5%)	13 (69.5%)	Biopsy pathology report: Total cores examined 13 <ul style="list-style-type: none"> Code 13
Prostate	Number of Cores Positive	06 (88.4%)	06 (88.4%)	Biopsy pathology report: Total cores positive 6 <ul style="list-style-type: none"> Code 06
Soft Tissue Abd/Thor	Primary Site	C220 (91.1%)	C220 (91.1%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Soft Tissue Surgical pathology report: Liver mass <ul style="list-style-type: none"> Code 220: Liver
Soft Tissue Abd/Thor	Histology	8970 (96.2%)	8970 (96.2%)	Surgical pathology report: Liver, hepatoblastoma, epithelial type <ul style="list-style-type: none"> Code 8970: Hepatoblastoma
Soft Tissue Abd/Thor	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Soft Tissue Abd/Thor	Tumor Size Clinical	033 (75.2%)	033 (75.2%)	Abdominal ultrasound: Mildly hyperechoic rounded mass is present at the inferior margin of the right hepatic lobe measuring 2.9 cm. "Nonspecific mass." Second Abdominal ultrasound: There is a right lobe liver mass measuring 3.3 cm. Liver mass as above. This is worrisome for hepatoblastoma. Mesenchymal hamartoma, biliary sarcoma, lymphoma, and hepatocellular carcinoma cannot be excluded.

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Per SEER manual, Tumor Size Clinical #8, Tumor size discrepancies among imaging and radiographic reports: Record the largest size in the record regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies the imaging that is most accurate.</p> <ul style="list-style-type: none"> Code 033
Soft Tissue Abd/Thor	Tumor Size Pathologic	999 (5.1%)	999 (5.1%)	<p>Surgical pathology report: The tumor sizes are described as specimens and not tumor. It is not clear from the descriptions if the 3.0 and 3.1 are composed entirely of tumor (and not tumor plus surrounding tissue).</p> <p>Per the SEER manual, Tumor Size Path, #2 "Record the size of the tumor. The tumor size may be different from the size of the specimen." Based on the pathologist's description of "specimens," it is not clear if these are entirely tumor. So, this rule does not apply.</p> <p>Rule 15 applies: Record tumor size as 999 when the only measurement describes pieces or chips...). Although the case does not mention pieces or chips, it is the closest rule that applies.</p> <p>The staging rule that AJCC uses for multiple tumors coded as one primary, that you code the largest size, does not apply. It is because it is not certain that these are measurements of tumors.</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Soft Tissue Abd/Thor	EOD Primary Tumor	100 (93.6%)	100 (93.6%)	<p>Surgical pathology report: Confined to liver</p> <ul style="list-style-type: none"> Code 100: Confined to organ, NOS, Localized, NOS
Soft Tissue Abd/Thor	EOD Regional Nodes	000 (84.7%)	000 (84.7%)	<p>Surgical pathology report: No lymph nodes included</p> <p>Per Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are</p>

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				negative. Code unknown (999) only when there is no available information on the extent of the patient's disease, for example when a lab-only case is abstracted from a biopsy report and no clinical history is available. <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Soft Tissue Abd/Thor	Regional Nodes Positive	98 (81.5%)	98 (81.5%)	Surgical pathology report: No lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Soft Tissue Abd/Thor	EOD Mets	00 (98.7%)	00 (98.7%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Soft Tissue Abd/Thor	SS2018	1 (96.8%)	1 (96.8%)	Confined to liver with no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized
Soft Tissue Abd/Thor	Grade Clinical	9 (100%)	9 (100%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Grade Pathological	9 (99.4%)	9 (99.4%)	Pathological grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Grade Post Therapy	Blank (87.9%)	Blank (87.9%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Soft Tissue Abd/Thor	Bone Invasion	0 (86.6%)	0 (86.6%)	No mention of bone invasion in imaging reports Per Note 3: Code 0 if relevant imaging is performed and there is no mention of bone invasion <ul style="list-style-type: none"> Code 0: Bone invasion not present/not identified on imaging
Tongue Anterior	Primary Site	C023 (33.8%)	C023 (33.8%)	Per the 2018 Solid Tumor Rules for Head and Neck, the priority order for assigning primary site is: <ol style="list-style-type: none"> Tumor Board: No information from Tumor Board Tissue/pathology from tumor resection or biopsy: Anatomic site: right lateral tongue Scans Physician documentation <p>Per clarification from SEER: Assign C023 for lateral tongue without further information. The tongue has a midline on the dorsal surface and the frenulum on the ventral surface which</p>

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>divide the tongue into left and right halves. Anything on the left half or on the right half can be referred to as "lateral." A lesion arising on the left or right lateral tongue could be on the dorsal surface, the ventral surface, or on the border. See SEER Inquiry 20041032.</p> <p><i>Note:</i> There is physician documentation that states C021: Border of Tongue; however, in this case, the information from the surgical resection takes priority.</p> <ul style="list-style-type: none"> Code C023: Anterior 2/3 of tongue, NOS
Tongue Anterior	Histology	8072 (36.3%)	8070 (58.6%)	<p>Surgical pathology report: Non-keratinizing squamous cell carcinoma (under final diagnosis.) under staging parameters: Squamous cell carcinoma, non-conventional type</p> <p>Per clarification from SEER: The 4th Ed WHO tumors of H&N no longer includes keratinizing SCC and non-keratinizing SCC in the chapter. The histology tables in the Solid Tumor Rules are based on the 4th Ed which is why these two histologies are not listed. Pathologists are discouraged from using these terms, however it takes a while for this to happen in the real world. Since both histologies have different codes from SCC, NOS they are subtypes/variants.</p> <ul style="list-style-type: none"> Code 8070: Squamous cell carcinoma, NOS
Tongue Anterior	Behavior	3 (100%)	3 (100%)	<p>Invasive histology</p> <ul style="list-style-type: none"> Code 3: Malignant
Tongue Anterior	Tumor Size Clinical	014 (31.2%)	999 (32.5%)	<p>12/20/17, laryngoscopy: Ulcerative area on the floor of mouth, 14 mm x 12 mm</p> <p>PET Scan: 7 mm mass just deep to the skin in the right inferior neck inferior to the submandibular gland which shows increased metabolic activity</p> <p>CT neck: Anatomically there is no mass at the base of tongue to correspond with history of tongue cancer. Seen in the right side of the neck is a 7 mm deep to the skin in the subcutaneous tissue.</p> <ul style="list-style-type: none"> Code 999

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Tongue Anterior	Tumor Size Pathologic	009 (93.6%)	009 (93.6%)	Surgical pathology report: 0.9 cm <ul style="list-style-type: none"> Code 009
Tongue Anterior	EOD Primary Tumor	100 (94.3%)	100 (94.3%)	Surgical pathology report: Mass confined to site of origin, 0.4 cm invasion <ul style="list-style-type: none"> Code 100: Group 1 (localized lesion) WITH depth of invasion (DOI) less than or equal to 5 mm OR unknown depth of invasion
Tongue Anterior	EOD Regional Nodes	100 (75.2%)	100 (75.2%)	Surgical pathology report: 1/20 LNS positive. Size of metastasis 0.5 mm (0.05 cm). Negative for ENE. Further LN dissection: 0/23 LNs positive. <ul style="list-style-type: none"> Code 100: CLINICAL or PATHOLOGICAL, Metastasis in a SINGLE ipsilateral lymph node 3 cm or smaller in greatest dimension, Extranodal extension (ENE) negative or unknown
Tongue Anterior	Regional Nodes Positive	01 (96.8%)	01 (96.8%)	Surgical pathology report: 1/43 LNS positive <ul style="list-style-type: none"> Code 01
Tongue Anterior	EOD Mets	00 (98.7%)	00 (98.7%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Tongue Anterior	SS2018	3 (77.1%)	3 (77.1%)	Confined to site of origin, positive lymph node, no evidence of metastasis <ul style="list-style-type: none"> Code 3: Localized lesion with regional lymph node involvement
Tongue Anterior	Grade Clinical	3 (80.3%)	3 (80.3%)	Biopsy pathology report: Poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Tongue Anterior	Grade Pathological	3 (91.7%)	3 (91.7%)	Surgical pathology report: poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Tongue Anterior	Grade Post Therapy	Blank (87.3%)	Blank (87.3%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Tongue Anterior	Extranodal Exten H & N Clin	7 (28.0%)	0 (59.2%)	Per PET/CT scan, there is mild increased metabolic activity of a lymph node. Based on recommendations for LN dissection, evidence of clinical lymphadenopathy. No mention of ENE. <ul style="list-style-type: none"> Code 0: Regional lymph node(s) involved, ENE not present/not identified during diagnostic workup
Tongue Anterior	Extranodal Exten H & N Path	0.0 (89.8%)	0.0 (89.8%)	Surgical pathology report: Negative for extranodal extension

Group 1 Case	Group 1 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 0.0: Lymph nodes positive for cancer but ENE not identified or negative
Tongue Anterior	Human Papilloma Virus (HPV) Status	9 (49.0%)	9 (49.0%)	<p>Per Note 3: Do not record the results of IHC p16 expression in this field Only p16 testing done, no DNA or RNA testing done</p> <ul style="list-style-type: none"> Code 9: Unknown if HPV test detecting viral DNA and or RNA was performed
Tongue Anterior	LN Size	0.5 (61.8%)	0.5 (61.8%)	<p>Surgical pathology report: Lymph node size 0.5 mm</p> <p>Per the coding guidelines in the SSDI manual for this data item: Code the largest diameter of any involved regional lymph nodes for head and neck (cervical lymph nodes)</p> <ul style="list-style-type: none"> Code 0.5

Group 2 Cases

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Primary Site	C718 (53.1%)	C714 (11.7%)	<p>Per the 2018 Solid Tumor Rules for Malignant CNS and Peripheral Nerves, the priority order for assigning primary site is</p> <ol style="list-style-type: none"> 1. Resection <ul style="list-style-type: none"> • Operative report • Pathology report 2. Biopsy <ul style="list-style-type: none"> • Operative report • Pathology report 3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information) <ul style="list-style-type: none"> • Tumor Board • Code from physician's documentation of original diagnosis from operative report or pathology report OR • Physician's documentation of primary site in the medical record 4. For cases diagnosed by imaging (no pathology/resection or biopsy), use information from scans in the following priority order: MRI, CT, PET, Angiogram <p>Resection, operative report, takes priority: Right occipital brain tumor</p> <ul style="list-style-type: none"> • Code C714: Occipital lobe
Brain	Histology	9440 (98.3%)	9440 (98.3%)	<p>Surgical pathology report: Glioblastoma multiforme</p> <ul style="list-style-type: none"> • Code 9440: Glioblastoma, NOS
Brain	Behavior	3 (97.8%)	3 (97.8%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Tumor Size Clinical	094 (35.8%)	094 (35.8%)	<p>MRI done prior to biopsy: 8.4 cm mass MRI done after biopsy, prior to resection: 9.4 cm</p> <p>Per the SEER Manual, Tumor Size Clinical, #1a: The largest size from all information available within four months of the date of diagnosis, in the absence of disease progression when no treatment is administered Between the original MRI and the last MRI, tumor increasing in size</p> <ul style="list-style-type: none"> Both MRIs are done in the clinical time frame and there is no statement from the physician that the tumor is progressing Tumor size can be taken after the biopsy since the biopsy was done only for diagnosis and not for removal of any of the tumor Code: 094
Brain	Tumor Size Pathologic	070 (24.0%)	999 (59.2%)	<p>Surgical pathology report, specimen size 2 cm. This is not the size of the tumor, but the specimen size. Gross description states: brain tumor" is a 7.0 x 5.5 x 2.5 cm aggregate of tan-white and soft tissue, brain and blood clot, which is what the preferred answer was based on; however, this is also not stating the size of the tumor</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Brain	EOD Primary Tumor	100 (78.8%)	100 (78.8%)	<p>Surgical pathology report: Large mass-like area present w/in right posterior parietal, occipital, and temporal regions. Midline shift is noted</p> <p>Midline shift does not affect extension. It must state "crosses the midlines" to be coded to 500</p> <ul style="list-style-type: none"> Code 100: Confined to brain
Brain	EOD Regional Nodes	888 (100%)	888 (100%)	<p>Not applicable: Default value (no lymph nodes in the brain)</p> <ul style="list-style-type: none"> Code 888: Not applicable
Brain	Regional Nodes Positive	99 (86.6%)	99 (86.6%)	<p>Not applicable: Default value (no lymph nodes in the brain)</p> <ul style="list-style-type: none"> Code 99: Not applicable
Brain	EOD Mets	00 (97.2%)	00 (97.2%)	<p>No clinical evidence of metastasis</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	SS2018	1 (79.3%)	1 (79.3%)	Large mass-like area present w/in right posterior parietal, occipital, and temporal regions, midline shift noted, no evidence of metastasis Midline shift does not affect extension. It must state “crosses the midlines” to be coded to 2 <ul style="list-style-type: none"> Code 1: Localized
Brain	Grade Clinical	4 (77.7%)	4 (77.7%)	Biopsy pathology report: Glioblastoma, grade IV <ul style="list-style-type: none"> Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination
Brain	Grade Pathological	4 (83.8%)	4 (83.8%)	Surgical pathology report: Glioblastoma, grade IV <ul style="list-style-type: none"> Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination
Brain	Grade Post Therapy	Blank (73.2%)	Blank (73.2%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Brain	Brain Molecular Markers	87 (62.0%)	87 (62.0%)	Test ordered, results not in chart <ul style="list-style-type: none"> Per documentation, “Molecular testing is ordered on block A2, including MGMT methylation status and IDH1/2 mutational analysis. The molecular testing is pending, and the results will be reported in an addendum.” No addendum available in documentation <ul style="list-style-type: none"> Code 87: Test ordered, results not in chart
Brain	Chromosome 1p Status	9 (81.6%)	9 (81.6%)	Chromosome 1p not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 1p deletion/LOH not assessed or unknown if assessed
Brain	Chromosome 19q Status	9 (82.7%)	9 (82.7%)	Chromosome 19q not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 19q: LOH not assessed or unknown if assessed

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	MGMT	7 (79.3%)	7 (79.3%)	<p>Test ordered, results not in chart</p> <ul style="list-style-type: none"> Per documentation, "Molecular testing is ordered on block A2, including MGMT methylation status and IDH1/2 mutational analysis. The molecular testing is pending, and the results will be reported in an addendum." <p>No results available in documentation</p> <ul style="list-style-type: none"> Code 7: Test ordered, result not in chart
Breast	Primary Site	C501 (21.9%)	C508 (56.2%)	<p>Per Appendix C of the SEER manual, Breast Coding Guidelines, the following priority order is used when there is conflicting information</p> <ol style="list-style-type: none"> Operative Report Pathology Report Mammogram, ultrasound (ultrasound becoming more frequently used) Physical examination <p>Operative report available post neoadjuvant: cancer of nipple and areola of female breast. This is post-neoadjuvant information. Pathology report states no indication of primary site. Mammogram, ultrasound and physical exam all states "3 o'clock."</p> <p>Per SEER manual, Breast coding guidelines, code the primary site to 508 when stated as 12, 3, 6, or 9 o'clock position in breast</p> <ul style="list-style-type: none"> Code C508: Overlapping lesion of breast
Breast	Histology	8500 (97.8%)	8500 (97.8%)	<p>Surgical pathology report: Invasive ductal carcinoma</p> <ul style="list-style-type: none"> Code 8500: Infiltrating duct carcinoma, NOS
Breast	Behavior	3 (99.4%)	3 (99.4%)	<p>Invasive histology</p> <ul style="list-style-type: none"> Code 3: Malignant
Breast	Tumor Size Clinical	020 (92.7%)	010 (2.8%)	<p>Per Tumor Size Clinical instructions, #7:</p> <p>Priority of imaging/ radiographic techniques:</p>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, and over a physical exam.</p> <p>Biopsy done during the clinical time frame. Biopsy showed an “at least” 1 cm tumor.</p> <ul style="list-style-type: none"> • Code 010
Breast	Tumor Size Pathologic	004 (75.3%)	999 (10.7%)	<p>Per Tumor Size Pathologic #4: Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment</p> <p>Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy.</p> <p>Found that there were conflicting notes in Tumor Size Pathologic. The main definition for this data item has: <i>This data item records the size of a solid primary tumor that has been resected. Pathologic classification includes operative and pathological findings of the resected specimens, before initiation of adjuvant Treatment.</i></p> <p>We have confirmed that Tumor Size Pathologic is to be coded prior to neoadjuvant therapy, which is the instruction in the STORE manual for Tumor Size Summary (SEER manual will be corrected)</p> <ul style="list-style-type: none"> • Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Breast	EOD Primary Tumor	100 (93.8%)	100 (93.8%)	<p>Tumor confined to breast</p> <ul style="list-style-type: none"> • Code 100: Any size tumor; Confined to breast tissue and fat including nipple and/or areola, Localized, NOS; EXCLUDES: skin invasion of breast, nipple and areola (see code 200)
Breast	EOD Regional Nodes	000	000	Patient had neoadjuvant therapy, followed by sentinel lymph node biopsy

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(73.0%)	(73.0%)	Per General Instructions: 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 Clinical evaluation: Negative nodes (Code 000), Path evaluation: 0/1 SLNs Since they are equal, go with the Clinical Evaluation <ul style="list-style-type: none"> Code 000: No clinical regional lymph node involvement
Breast	Regional Nodes Positive	00 (96.6%)	00 (96.6%)	Surgical (post-neoadjuvant) pathology report: 0/1 SLNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Breast	EOD Mets	00 (98.9%)	00 (98.9%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Breast	SS2018	1 (96.6%)	1 (96.6%)	Mass confined to breast, no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized, confined to breast
Breast	Grade Clinical	3 (89.9%)	3 (89.9%)	Biopsy pathology report: Nottingham grade III <ul style="list-style-type: none"> Code 3: G3: High combined histologic grade (unfavorable); SBR score of 8-9 points
Breast	Grade Pathological	9 (79.2%)	9 (79.2%)	Per Note 6, 3 rd bullet: Code 9 when Neo-adjuvant therapy is followed by a resection (see post therapy grade) <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Breast	Grade Post Therapy	9 (77.5%)	9 (77.5%)	Surgical (post-neoadjuvant) pathology report: Glandular; Acinar)/Tubular Differentiation: Score __, Nuclear Pleomorphism: Score 3, Mitotic Rate: Score cannot be determined (focus too small, 10 HPF's are not present to evaluate). Overall] Grade: Score cannot be determined Cannot use clinical grade in post-therapy grade <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Breast	Sentinel Lymph Nodes Examined	01 (93.8%)	01 (93.8%)	Surgical (post-neoadjuvant) pathology report: 0/1 SLNs <ul style="list-style-type: none"> Code 01: Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
Breast	Sentinel Lymph Nodes Positive	00 (97.2%)	00 (97.2%)	Surgical (post neoadjuvant) pathology report: 0/1 SLNs <ul style="list-style-type: none"> Code 00: All sentinel nodes examined are negative

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	ER Summary	0 (96.6%)	0 (96.6%)	Biopsy pathology report: ER negative; Tumor stained: 0, Intensity: 0, Allred Score 0 <ul style="list-style-type: none"> Code 0: ER negative
Breast	ER Percent Positive	000 (96.6%)	000 (96.6%)	Biopsy pathology report: ER negative; Tumor stained: 0, Intensity: 0, Allred Score 0 <ul style="list-style-type: none"> Code 000: ER negative, or stated as less than 1%
Breast	ER Allred Score	00 (96.6%)	00 (96.6%)	Biopsy pathology report: ER: negative; Tumor stained: 0, Intensity: 0, Allred Score 0 <ul style="list-style-type: none"> Code 00: Total ER Allred score of 0
Breast	PR Summary	0 (97.8%)	0 (97.8%)	Biopsy pathology report: PR negative; Tumor stained: 0, Intensity: 0, Allred Score 0 <ul style="list-style-type: none"> Code 0: PR negative
Breast	PR Percent Positive	000 (96.1%)	000 (96.1%)	Biopsy pathology report: PR negative; Tumor stained: 0, Intensity: 0, Allred Score <ul style="list-style-type: none"> Code 000: PR negative
Breast	PR Allred Score	00 (95.5%)	00 (95.5%)	Biopsy pathology report: PR negative; Tumor stained: 0, Intensity: 0, Allred Score <ul style="list-style-type: none"> Code 00: Total PR Allred score of 0
Breast	HER2 IHC Summary	1 (61.8%)	1 (61.8%)	Biopsy pathology report: IHC, negative, Score 1+ Note: A negative HER2 from IHC can be Score 0 (code 0) or Score 1 (code 1) <ul style="list-style-type: none"> Code 1: Negative (Score 1+)
Breast	HER2 ISH Summary	0 (91.6%)	0 (91.6%)	Biopsy pathology report: ISH, FISE Analysis HER2 breast: Negative <ul style="list-style-type: none"> Code 0: Negative
Breast	HER2 Overall Summary	0 (93.3%)	0 (93.3%)	Both IHC and ISH tests negative <ul style="list-style-type: none"> Code 0: HER2 negative; equivocal
Breast	HER2 SP Copy Number	XX.9 (73.6%)	XX.9 (73.6%)	HER2 SP Copy Number not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Copy Number	3.7 (39.3%)	3.7 (39.3%)	Biopsy pathology report: HER2 ISH report: Average HER2 signals/nucleus: 3.7, Average C2N 17 signals/nucleus 2.5, HER2/CEN17 signal ratio: 1:3

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				The Average HER2 signals/nucleus is for this field (3.7) <ul style="list-style-type: none"> Code 3.7
Breast	HER2 DP Ratio	1.3 (67.4%)	1.3 (67.4%)	Biopsy pathology report: HER2 ISH report: Average HER2 signals/nucleus: 3.7, Average C2N 17 signals/nucleus 2.5, HER2/CEN17 signal ratio: 1:3 The HER2/CEN17 signal ratio is for this field (1.3) Note: The Average C2N 17 signals/nucleus 2.5 is a control variable and is not recorded <ul style="list-style-type: none"> Code 1.3
Breast	Ki-67	XXX.9 (94.4%)	XXX.9 (94.4%)	Ki-67 not documented in patient record <ul style="list-style-type: none"> Code XXX.9: Not documented in patient record, Ki-67 (MIB-1) not assessed or unknown if assessed
Breast	Lymph Nodes Positive Axillary Level I-II	00 (90.4%)	00 (90.4%)	Surgical pathology report: 0/1 SLNs <ul style="list-style-type: none"> Code 00: All ipsilateral axillary nodes examined negative
Breast	Multigene Signature Method	9 (80.9%)	9 (80.9%)	Multigene Signature Method not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Multigene Signature Method not assessed or unknown if assessed
Breast	Multigene Signature Results	X9 (77.5%)	X9 (77.5%)	Multigene Signature Results not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, Multigene Signature Results not assessed or unknown if assessed
Breast	Oncotype DX Recur Score – DCIS	XX6 (64.6)	XX6 (64.6)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> XX6: Not applicable, invasive case
Breast	Oncotype DX Recur Score	XX9 (94.4%)	XX9 (94.4%)	Oncotype Dx Recurrence Score not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in medical record, Oncotype Dx Recurrence Score-Invasive not assessed or unknown if assessed
Breast	Oncotype Dx Risk Level – DCIS	6 (65.7%)	6 (65.7%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> Code 6: Not applicable, invasive case
Breast	Oncotype Dx Risk Level Invasive	9 (93.8%)	9 (93.8%)	Oncotype Dx Risk Level not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Oncotype Dx Risk Level-Invasive not assessed or unknown if assessed

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	Response to Neoadjuvant Therapy	3 (42.7%)	9 (15.7%)	<p>Per the Pathology report: <i>Treatment Effect in the Breast Probable or definite response to presurgical surgical therapy in the invasive carcinoma</i></p> <p>Per Note 2: Review the medical record for a specific statement by a clinician about the response to neoadjuvant therapy. Response is based on pathology report, imaging and clinical findings.</p> <p>Only have pathology report results, also need results from clinician based on clinical exam</p> <p>SSDI to review this data item further for updates in 2021</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, Response to neoadjuvant therapy not assessed or unknown if assessed
Colon and Rectum	Primary Site	C182 (39.3%)	C183 (33.1%)	<p>Per the coding guidelines from SEER, the following priority order for assigning primary site for Colon is</p> <ul style="list-style-type: none"> Resected cases <ul style="list-style-type: none"> Operative report with surgeon's description Pathology report Imaging Non-resected cases <ul style="list-style-type: none"> Polypectomy or excision without resection Endoscopy report <p>Operative report, which takes priority, states: Tattoo was found in the transverse colon at the level of the hepatic flexure. Surgeon goes onto describe a hepatic flexure mass.</p> <ul style="list-style-type: none"> Code C183: Hepatic flexure
Colon and Rectum	Histology	8480 (75.8%)	8480 (75.8%)	Surgical pathology report: Mucinous Adenocarcinoma

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Per Solid Tumor Rules, Colon H6: Code invasive mucinous adenocarcinoma 8480 when the diagnosis is any of the following: Exactly “mucinous adenocarcinoma” (no modifiers) <ul style="list-style-type: none"> Code 8480: Mucinous adenocarcinoma
Colon and Rectum	Behavior	3 (98.9%)	3 (98.9%)	Invasive <ul style="list-style-type: none"> Code 3: Malignant
Colon and Rectum	Tumor Size Clinical	040 (87.1%)	040 (87.1%)	Imaging: Carcinoma in the mid transverse colon that measures ~ 4 cm in length <ul style="list-style-type: none"> Code 040
Colon and Rectum	Tumor Size Pathologic	047 (96.1%)	047 (96.1%)	Surgical pathology report: 4.7 cm <ul style="list-style-type: none"> Code 047
Colon and Rectum	EOD Primary Tumor	400 (54.5%)	400 (54.5%)	Surgical pathology report: Tumor invades through muscularis propria into pericolorectal tissue. Gross description states that tumor invades the mesenteric fat (mesentery). <ul style="list-style-type: none"> Code 400: Mesentery
Colon and Rectum	EOD Regional Nodes	000 (98.3%)	000 (98.3%)	Surgical pathology report: 0/7 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement and no tumor deposits (TD)
Colon and Rectum	Regional Nodes Positive	00 (98.9%)	00 (98.9%)	Surgical pathology report: 0/7 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Colon and Rectum	EOD Mets	00 (99.4%)	00 (99.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Colon and Rectum	SS2018	2 (59.0%)	2 (59.0%)	Tumor invades through muscularis propria into pericolorectal tissue. Gross description states that tumor invades the mesenteric fat (mesentery), no lymph nodes or metastasis <ul style="list-style-type: none"> Code 2: Regional
Colon and Rectum	Grade Clinical	2 (94.9%)	2 (94.9%)	Biopsy pathology report: moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Colon and Rectum	Grade Pathological	2 (97.2%)	2 (97.2%)	Surgical pathology report: G2, Moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Colon and Rectum	Grade Post Therapy	Blank (77.5%)	Blank (77.5%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Colon and Rectum	CEA PreTX Interpretation	9 (96.1%)	9 (96.1%)	CEA PreTX Interpretation not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Colon and Rectum	CEA PreTX Lab Value	XXXX.9 (94.9%)	XXXX.9 (94.9%)	CEA PreTx Lab value not documented in patient record <ul style="list-style-type: none"> Code XXXX.9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed
Colon and Rectum	Circumferential Resection Margin	6.0 (57.9%)	6.0 (57.9%)	Surgical pathology report: Margins: Distance of tumor from radial margin 6 mm Note 3: CRM may also be referred to as the circumferential radial margin or mesenteric margin. <ul style="list-style-type: none"> Code 6.0
Colon and Rectum	KRAS	9 (97.8%)	9 (97.8%)	KRAS not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, KRAS not assessed or unknown if assessed
Colon and Rectum	Microsatellite Instability	2 (87.6%)	2 (87.6%)	Surgical pathology report: Supplemental, MSI-H (instability observed in 5 of 5 informative markers) <ul style="list-style-type: none"> Code 2: MSI unstable high (MSI-H)
Colon and Rectum	Perineural Invasion	0 (96.6%)	0 (96.6%)	Surgical pathology report, Synoptic Summary <ul style="list-style-type: none"> Code 0: Perineural invasion not identified
Colon and Rectum	Tumor Deposits	00 (93.3%)	00 (93.3%)	Surgical pathology report: Tumor deposits not identified <ul style="list-style-type: none"> Code 00: No tumor deposits
Lung	Primary Site	C340 (38.6%)	C343 (51.5%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site. Note: There are no specific primary site instructions for Lung.

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Per operative report: Tumor originating in left lower lobe bronchus and encroaching on left upper lobe bronchus. Pathology report states "lung" <ul style="list-style-type: none"> • Code C343: Lower lobe, lung
Lung	Histology	8072 (78.4%)	8072 (78.4%)	Surgical pathology report: Invasive squamous cell carcinoma, nonkeratinizing <ul style="list-style-type: none"> • Code 8072: Squamous cell carcinoma, large cell, keratinizing, NOS
Lung	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> • Code 3: Malignant
Lung	Tumor Size Clinical	052 (69.0%)	052 (69.0%)	CT scan of the chest without contrast demonstrated a bilobed lesion in the left lower lobe lung near the left hilum measuring 4.7 x 4.1 x 5.2 cm, with the smaller lobe measuring 2.7 x 4.2 x 3.2 cm <i>Note 1: When there are two masses that are abstracted as one primary, code the largest one in Tumor Size Clinical (do not add masses together)</i> <i>Note 2: Physician states 7 cm; however, there are no radiographic images that state a tumor size of 7 cm. CT scan takes priority</i> <ul style="list-style-type: none"> • Code 052
Lung	Tumor Size Pathologic	065 (96.5%)	065 (96.5%)	Surgical pathology report: 6.5 cm mass <ul style="list-style-type: none"> • Code 065
Lung	EOD Primary Tumor	300 (25.1%)	300 (25.1%)	Surgical pathology report: No visceral pleural invasion. No direct invasion of adjacent structures; pT3. Also staged as clinical IIIA or IIIB (cT4) by radiologist with post obstructive pneumonitis; however, not mentioned in the pathology report. Pathological T3 based on size of tumor. Per EOD General Instructions 3. Pathological findings take priority over clinical findings <ol style="list-style-type: none"> a. Assign the highest code representing the greatest extension pathologically (based on pathology report), when available In this situation, the pathology report findings would be based on the tumor confined to the lung

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 300: Any size tumor, Confined to lung, NOS, Localized, NOS
Lung	EOD Regional Nodes	300 (74.9%)	300 (74.9%)	<p>Surgical pathology report: 3/22 lymph nodes, Nodal Stations Involved: 10L: Hilar</p> <ul style="list-style-type: none"> Code 300: Hilar nodes
Lung	Regional Nodes Positive	03 (95.3%)	03 (95.3%)	<p>Surgical pathology report: 3/22 lymph nodes</p> <ul style="list-style-type: none"> Code 03
Lung	EOD Mets	00 (93.0%)	00 (93.0%)	<p>No clinical evidence of metastasis Note: CT scan states that there are right nodules; however, “nodule” by itself is not diagnostic. Managing physician also stages this as a M0.</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Lung	SS2018	3 (49.1%)	3 (49.1%)	<p>6.5 cm lesion confined to lung, no evidence of pleural effusion or involvement of adjacent organs, positive lymph nodes, no evidence metastasis</p> <p>Radiologist states post obstructive pneumonitis; however, not mentioned in the pathology report. Pathological T3 based on size of tumor</p> <p>Per Summary Stage 2018 General Instructions, #4 For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are important when all malignant tissue cannot be, or was not, removed.</p> <ul style="list-style-type: none"> In the event of a discrepancy between pathology and operative reports concerning excised tissue, <i>priority is given to the pathology report</i> Code 3: Localized tumor with positive regional lymph nodes
Lung	Grade Clinical	2 (77.2%)	2 (77.2%)	<p>Biopsy pathology report: Moderately differentiated</p> <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Lung	Grade Pathological	2 (96.5%)	2 (96.5%)	<p>Surgical pathology report: Moderately differentiated</p> <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Lung	Grade Post Therapy	Blank (79.5%)	Blank (79.5%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lung	Separate Tumor Nodules	0 (80.7%)	0 (80.7%)	Other nodules are noted, but none seem to be referred to as separate tumor nodules. Per the pathology report, there is one tumor. <ul style="list-style-type: none"> Code 0: No separate tumor nodules
Lung	Visceral and Parietal Pleural Invasion	0 (94.2%)	0 (94.2%)	Surgical pathology report: No pleural invasion <ul style="list-style-type: none"> Code 0: No evidence of visceral pleural invasion identified, Tumor does not completely traverse the elastic layer of the pleura, Stated as PLO
Lymphoma CLL/SLL	Primary Site	C421 (52.7%)	C421 (52.7%)	Bone marrow: Peripheral blood positive for CLL/SLL Per Heme Manual, Module 3: PH5: Code the primary site to bone marrow (C421) when the bone marrow is involved or when only peripheral blood is involved <ul style="list-style-type: none"> Code C421: Bone marrow
Lymphoma CLL/SLL	Histology	9823 (100%)	9823 (100%)	Peripheral blood smear: CLL/SLL <ul style="list-style-type: none"> Code 9823: Chronic lymphocytic leukemia/small lymphocytic lymphoma
Lymphoma CLL/SLL	Behavior	3 (98.2%)	3 (98.2%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lymphoma CLL/SLL	Tumor Size Clinical	999 (93.4%)	999 (93.4%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	Tumor Size Pathologic	999 (95.8%)	999 (95.8%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	EOD Primary Tumor	800 (26.9%)	800 (26.9%)	If primary site is C421, EOD Primary Tumor is 800 A new note will be added regarding peripheral blood involvement, also will be added to code 800 in the next release of the EOD manual <ul style="list-style-type: none"> Code 800: Peripheral blood involvement
Lymphoma CLL/SLL	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 888: Not applicable
Lymphoma CLL/SLL	Regional Nodes Positive	99 (95.2%)	99 (95.2%)	Not applicable: Default value <ul style="list-style-type: none"> Code 99: Not applicable
Lymphoma	EOD Mets	88	88	Not applicable: Default value

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
CLL/SLL		(100%)	(100%)	<ul style="list-style-type: none"> Code 88: Not applicable
Lymphoma CLL/SLL	SS2018	7 (82.6%)	7 (82.6%)	<p>If primary site is C421, Summary Stage is 7 A new note will be added regarding peripheral blood involvement, also will be added to code 7 in the next release of the SS2018 manual</p> <ul style="list-style-type: none"> Code 7: Peripheral blood involvement
Lymphoma CLL/SLL	Grade Clinical	8 (100%)	8 (100%)	<p>Grade not applicable for this Heme schema</p> <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Pathological	8 (100%)	8 (100%)	<p>Grade not applicable for this Heme schema</p> <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Post Therapy	Blank (56.9%)	Blank (56.9%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lymphoma CLL/SLL	Adenopathy	1 (94.6%)	1 (94.6%)	<p>PET CT Scan: Diffuse mediastinal lymphadenopathy, measuring 4.0 cm. Oncology consult confirms patient has diffuse lymphadenopathy, including a hypermetabolic lymph node measuring 2.4 cm.</p> <ul style="list-style-type: none"> Code 1: Adenopathy present, Presence of lymph nodes > 1.5 cm
Lymphoma CLL/SLL	Anemia	9 (74.9%)	9 (74.9%)	<p>Hemoglobin not documented in medical record Physician states “elevated white blood cell count” (this is related to lymphocytosis) No info regarding Anemia Per Note 5: If there is no mention of anemia, or relevant lab results, code 9.</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, Anemia not assessed or unknown if assessed
Lymphoma CLL/SLL	B symptoms	1 (89.8%)	1 (89.8%)	<p>Discharge summary: Physician states patient has history of B symptoms, weight loss and night sweats</p> <ul style="list-style-type: none"> Code 1: Any B symptom(s)
Lymphoma CLL/SLL	HIV status	9 (85.0%)	9 (85.0%)	<p>HIV status not documented in medical record Per Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, HIV status not assessed or unknown if assessed

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lymphoma CLL/SLL	Lymphocytosis	1 (32.3%)	6 (37.1%)	Lab value for lymphocytosis not documented. Physician states patient has lymphocytosis. <ul style="list-style-type: none"> Code 6: Lab value unknown, physician states lymphocytosis is present
Lymphoma CLL/SLL	NCCN International Prognostic Index (IPI)	X9 (76.0%)	X9 (76.0%)	NCCN not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Lymphoma CLL/SLL	Organomegaly	0 (77.8%)	0 (77.8%)	PET CT Abdomen: Spleen appears normal, Liver appears homogenous Per Note 3: Organomegaly is defined as presence of enlarged liver and/or spleen on physical examination and is part of the staging criteria <ul style="list-style-type: none"> Code 0: Organomegaly of liver and/or spleen not present
Lymphoma CLL/SLL	Thrombocytopenia	9 (81.4%)	9 (81.4%)	Thrombocytopenia not documented in patient record. Documentation of hemoptysis, but no mention of decreased platelets. Per Note 5: If there is no mention of thrombocytopenia, or the relevant lab tests, code 9 <ul style="list-style-type: none"> Code 9: Not documented in medical record, Thrombocytopenia not assessed or unknown if assessed
Melanoma Skin	Primary Site	C445 (97.1%)	C445 (97.1%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Melanoma Skin Pathology Report: Skin, upper back <ul style="list-style-type: none"> Code C445: Skin of trunk
Melanoma Skin	Histology	8720 (100%)	8720 (100%)	Surgical pathology report: Shave biopsy, Invasive melanoma not otherwise specified <ul style="list-style-type: none"> Code 8720: Malignant melanoma, NOS
Melanoma Skin	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	Tumor Size Clinical	009 (7.0%)	009 (7.0%)	<p>Skin: Lesions (black, "heaped up nevus" 8-10 mm and raised about 5 mm). SEER Program Coding Manual, Tumor Size Clinical section, #5: record between tumor sizes as the midpoint between the two measurements when tumor size is reported to be between two sizes</p> <p>Operative report indicates a 1-2 cm lesion; however, the information from this operative report cannot be used. Information from the operative report can only be used when there is a surgical exploration but there is no definitive surgery done.</p> <p>Per Tumor Size Clinical, #7 Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or <i>operative (surgical exploration) report</i>. It should be taken as a lower priority, and over a physical exam.</p> <ul style="list-style-type: none"> Code 009
Melanoma Skin	Tumor Size Pathologic	010 (24.4%)	010 (24.4%)	<p>Surgical pathology report: Gross examination: Epidermal surface shows a 1 cm raised black irregularly shaped nodule</p> <p>Tumor size pathology indicates that the incisional/excisional biopsy is considered pathological when the biopsy entirely removes the tumor. Instruction 12 states: 12. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.</p> <p>The first biopsy removed the tumor entirely, and per SEER's instruction, any tumor size note would be the pathological tumor size</p> <p>Per Tumor Size Pathologic, #4b:</p>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>4. Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment</p> <p>Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy.</p> <ol style="list-style-type: none"> Code the size from the synoptic report (also known as CAP protocol or pathology report checklist) when there is a discrepancy among tumor size measurements in the various sections of the pathology report. Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available. <ul style="list-style-type: none"> Code 010
Melanoma Skin	EOD Primary Tumor	400 (44.8%)	300 (15.7%)	<p>Surgical pathology report: Shave biopsy, skin of upper back Breslow's thickness 2.9 mm; pT3a. No mention of papillary or reticular surface involvement.</p> <p>Per the "Relationship Between Thickness, Depth of Invasion, and Clark Level Table," found in the Summary Stage 2018 manual, this is a Level IV lesion based on the 2.9 mm measurement and no other mention of invasion into adjacent structures</p> <p>Per the operative report, the physician did dissect all the way through the subcutaneous tissue; however, there is no mention of involvement in the pathology report, which takes priority</p> <ul style="list-style-type: none"> Code 300: Reticular dermis invaded, Clark level IV
Melanoma Skin	EOD Regional Nodes	400 (62.8%)	400 (62.8%)	<p>Surgical pathology report: Re-excision and SLN biopsy: 1 R axillary SLN & 1/2 L axillary LN excision; both showed metastatic malignant melanoma; staged pN2a</p> <p>Per Note 4: bilateral classified as regional for truncal tumors</p> <p>PET scan AFTER re-excision showed clinical evidence of lymph node metastases; however, this information cannot be included</p>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 400: Two or three clinically occult (detected by SLN biopsy) WITHOUT in-transit, satellite, and/or microsatellite metastasis
Melanoma Skin	Regional Nodes Positive	02 (76.2%)	02 (76.2%)	<p>Surgical pathology report: Re-excision and SLN biopsy: 1 R axillary SLN & 1/2 L axillary LN excision; both showed metastatic malignant melanoma; staged pN2a</p> <p>Per the SEER Manual, Sentinel Nodes Examined, #1: Document the total number of nodes sampled during the sentinel node procedure in this data item when both sentinel and non-sentinel nodes are sampled during the sentinel node biopsy procedure; i.e., record the total number of nodes from the procedure regardless of sentinel node status</p> <ul style="list-style-type: none"> Code 02
Melanoma Skin	EOD Mets	00 (94.8%)	00 (94.8%)	<p>PET CT and MRI brain showed no evidence of metastatic disease</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Melanoma Skin	SS2018	3 (70.9%)	3 (70.9%)	<p>Melanoma confined to the skin with positive regional lymph nodes</p> <ul style="list-style-type: none"> Code 3: Localized tumor with positive regional nodes
Melanoma Skin	Grade Clinical	9 (99.4%)	9 (99.4%)	<p>Clinical grade not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Pathological	9 (99.4%)	9 (99.4%)	<p>Pathological grade not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Post Therapy	Blank (78.5%)	Blank (78.5%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Melanoma Skin	Sentinel Lymph Nodes Examined	01 (24.4%)	03 (57.0%)	<p>Surgical pathology report: Re-excisional biopsy and SLN biopsy: 1 R axillary SLN & 1/2 L axillary LN excision; both showed metastatic malignant melanoma</p> <p>Per the SEER Manual, Sentinel Nodes Examined, #1: Document the total number of nodes sampled during the sentinel node procedure in this data item when both sentinel and non-sentinel nodes are sampled during the sentinel node biopsy procedure; i.e., record the total number of nodes from the procedure regardless of sentinel node status</p>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 03
Melanoma Skin	Sentinel Lymph Nodes Positive	01 (27.3%)	02 (60.5%)	<p>Surgical pathology report: Re-excisional biopsy and SLN biopsy: 1 R axillary SLN & 1/2 L axillary LN excision; both showed metastatic malignant melanoma</p> <p>Per the SEER manual, Sentinel Nodes Positive, #1: Document the total number of positive nodes identified during the sentinel node procedure in this data item when, during a sentinel node biopsy procedure a few non-sentinel node happen to be sampled and are positive; i.e., record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer)</p> <ul style="list-style-type: none"> Code 02
Melanoma Skin	Breslow Thickness	2.9 (79.1%)	2.9 (79.1%)	<p>Surgical pathology report: Shave biopsy, 2.9 mm Breslow thickness depth</p> <ul style="list-style-type: none"> Code 2.9
Melanoma Skin	Ulceration	0 (98.3%)	0 (98.3%)	<p>Surgical pathology report: Shave biopsy, no Ulceration</p> <ul style="list-style-type: none"> Code 0: Ulceration not identified/not present
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Lab Value	XXXXX.9 (94.2%)	XXXXX.9 (94.2%)	<p>LDH not documented in patient record Physician states "normal labs," but cannot use this to assume that LDH is normal</p> <ul style="list-style-type: none"> Code XXXXX.9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Level	9 (99.4%)	9 (99.4%)	<p>LDH not documented in patient record Physician states "normal labs," but cannot use this to assume that LDH is normal</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Level not assessed or unknown if assessed
Melanoma Skin	LDH Upper Limits of Normal	XX9 (93.0%)	XX9 (93.0%)	LDH not documented in patient record

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Physician states “normal labs,” but cannot use this to assume that LDH is normal <ul style="list-style-type: none"> Code XX9: Not documented in patient record, LDH Upper Limit not assessed or unknown if assessed
Melanoma Skin	Mitotic Rate Melanoma	01 (92.4%)	01 (92.4%)	Surgical pathology report: Shave biopsy, Mitotic rate 1/mm ² <ul style="list-style-type: none"> Code 01
Ovary	Primary Site	C569 (100.0%)	C569 (100.0%)	Surgical pathology report: Bilateral ovaries <ul style="list-style-type: none"> Code C569: Ovary
Ovary	Histology	8380 (86.1%)	8380 (86.1%)	Surgical pathology report: Endometrioid adenocarcinoma <ul style="list-style-type: none"> Code 8380: Endometrioid adenocarcinoma, NOS
Ovary	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Ovary	Tumor Size Clinical	110 (79.5%)	110 (79.5%)	CT Abdomen/Pelvis: Mass 11 cm x 10 cm x 11 cm Per the SEER Manual, Tumor Size Clinical, #10: Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis. However, when the tumor is described as a “cystic mass or polypoid mass,” and only the size of the entire mass is given, code the size of the entire mass, since the cysts or polyps are part of the tumor itself. <ul style="list-style-type: none"> Code 110
Ovary	Tumor Size Pathologic	105 (86.1%)	105 (86.1%)	Surgical pathology report: Right ovary 10.5 cm, left ovary 8 cm Code the size of the larger tumor <ul style="list-style-type: none"> Code 105
Ovary	EOD Primary Tumor	700 (63.3%)	700 (63.3%)	Surgical pathology report: both ovaries and fallopian tubes involved with diffuse peritoneal implants throughout the abdomen Physician assigns FIGO Stage IIIC <ul style="list-style-type: none"> Code 700: Macroscopic peritoneal implants or macroscopic peritoneal carcinomatosis beyond pelvis, Greater than 2 cm in diameter, FIGO Stage IIIC IIIB (Note: Code 700 was updated in SEER*RSA Version 1.7 in September 2020: now specifies “peritoneal carcinomatosis)

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Ovary	EOD Regional Nodes	400 (33.7%)	999 (32.5%)	<p>CT A/P 4/1/2018: retroperitoneal lymphadenopathy up to 2 cm Per EOD Coding instructions: cannot use “lymphadenopathy”</p> <p>Clinical Stage: 3c (with or without lymph node involvement) No regional nodes examined during surgery. Due to extensive involvement and the description of “lymphadenopathy,” better to code lymph node status as unknown</p> <ul style="list-style-type: none"> Code 999: Unknown; regional lymph node(s) not stated, Regional lymph node(s) cannot be assessed, Not documented in patient record
Ovary	Regional Nodes Positive	98 (80.7%)	98 (80.7%)	<p>No regional lymph nodes examined</p> <ul style="list-style-type: none"> Code 98: No nodes examined
Ovary	EOD Mets	00 (25.9%)	00 (25.9%)	<p>Surgical pathology report: Diffuse adenocarcinoma with omental caking and <i>carcinomatosis</i></p> <p>For SEER*RSA Version 1.6 (which was used in the study), Carcinomatosis in the peritoneum was not specified as being collected in EOD Primary Tumor. For SEER*RSA Version 1.7 (Released September 2019), EOD Primary Tumor has clear instructions that peritoneal carcinomatosis is included (see codes 600, 650, 700, 750 and Note 4) and EOD Mets code 50 has a new note stating “excludes peritoneal carcinomatosis [see EOD Primary Tumor]”. This change is now in line with AJCC.</p> <p>Follow up CT Scan (4 weeks post-surgery) mentions “liver metastasis” and that they have progressed from the previous scan done prior to surgery; however, the findings from the previous scan do not mention any liver metastasis. The liver metastasis would not be included in the original stage (managing physician also signed out as Stage 3C).</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Ovary	SS2018	7 (89.2%)	7 (89.2%)	<p>Both ovaries and fallopian tubes involved with diffuse peritoneal implants throughout the abdomen</p> <ul style="list-style-type: none"> Code 7: Distant

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Ovary	Grade Clinical	9 (89.2%)	9 (89.2%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Ovary	Grade Pathological	3 (90.4%)	3 (90.4%)	Surgical pathology report: WHO grade 2-3, go with the higher grade <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated, undifferentiated
Ovary	Grade Post Therapy	Blank (81.3%)	Blank (81.3%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Ovary	CA-125 PreTX Lab Value	9 (97.0%)	9 (97.0%)	CA-125 not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, CA-125 not assessed or unknown if assessed
Ovary	FIGO Stage	37 (75.3%)	37 (75.3%)	Surgical pathology report: FIGO Stage IIIC <ul style="list-style-type: none"> Code 37: FIGO Stage IIIC
Ovary	Residual Tumor Volume Post Cytoreduction	99 (43.4%)	97 (19.3%)	Surgical operative report: Exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, appendectomy and proctosigmoidoscopy. No mention of cytoreduction or debulking. <ul style="list-style-type: none"> Code 97: No cytoreductive surgery performed
Prostate	Primary Site	C619 (100%)	C619 (100%)	Surgical pathology report: Prostate <ul style="list-style-type: none"> Code C619: Prostate
Prostate	Histology	8140 (93.6%)	8140 (93.6%)	Surgical pathology report: Adenocarcinoma; per Synoptic Report: Acinar Adenocarcinoma Per Solid Tumor Rules for "Other Sites," Rule H10: Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Prostate	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Prostate	Tumor Size Clinical	999 (98.3%)	999 (98.3%)	Tumor size clinical not documented in patient record Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	Tumor Size Pathologic	999 (70.9%)	020 (21.5%)	<p>Per #4b: Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available</p> <p>Gross description: Sectioning reveals a 2 x 1.5 x 0.8 cm yellow-tan, firm mass within the posterior right, apical aspect of the prostate</p> <ul style="list-style-type: none"> • Code 020
Prostate	EOD Primary Tumor	200 (25.0%)	200 (25.0%)	<p>H&P: Prostate nodule at right base</p> <p>Per Note 3, 2nd bullet: Clinically apparent tumors are palpable. If a clinician documents a "tumor," "mass," or "nodule" by physical examination, this can be inferred as apparent. "Tumor," "mass," or "nodule" on imaging can only be used by the registrar if the managing clinician/urologist uses it.</p> <p>Note: Know that only one side is involved and that it is at the base. Code 200 is the lower of the two codes that deal with one side involved.</p> <ul style="list-style-type: none"> • Code 200: Involves one-half of one side or less, (clinically apparent/palpable)
Prostate	Prostate Path Exten	350 (73.8%)	350 (73.8%)	<p>Surgical pathology report: Focal extraprostatic extension present (right postero-lateral)</p> <ul style="list-style-type: none"> • Code 350: Extraprostatic extension (beyond prostatic capsule), unilateral, bilateral, or NOS
Prostate	EOD Regional Nodes	000 (98.8%)	000 (98.8%)	<p>Surgical pathology report: 0/10 lymph nodes</p> <ul style="list-style-type: none"> • Code 000: No regional lymph node involvement
Prostate	Regional Nodes Positive	00 (98.8%)	00 (98.8%)	<p>Surgical pathology report: 0/10 lymph nodes</p> <ul style="list-style-type: none"> • Code 00: All nodes examined negative
Prostate	EOD Mets	00 (98.8%)	00 (98.8%)	<p>No clinical evidence of metastasis</p> <ul style="list-style-type: none"> • Code 00: No distant metastasis, Unknown if distant metastasis
Prostate	SS2018	2 (75.0%)	2 (75.0%)	<p>Extraprostatic extension (regional), negative lymph nodes and metastasis</p> <ul style="list-style-type: none"> • Code 2: Regional
Prostate	Grade Clinical	2 (96.5%)	2 (96.5%)	<p>Biopsy pathology report: Clinical Gleason pattern 3+4=7</p> <ul style="list-style-type: none"> • Code 2: Grade Group 2: Gleason score 7, Gleason pattern 3+4

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	Grade Pathological	2 (96.5%)	2 (96.5%)	Surgical pathology report: Pathological Gleason pattern 3+4=7 <ul style="list-style-type: none"> Code 2: Grade Group 2: Gleason score 7, Gleason pattern 3+4
Prostate	Grade Post Therapy	Blank (79.1%)	Blank (79.1%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Prostate	PSA Lab Value	13.6 (91.3%)	13.6 (91.3%)	Labs: PSA 13.6 (No leading zeros are needed) <ul style="list-style-type: none"> Code 13.6
Prostate	Gleason Patterns Clinical	34 (97.7%)	34 (97.7%)	Biopsy pathology report: Clinical Gleason pattern 3+4=7 <ul style="list-style-type: none"> Code 34
Prostate	Gleason Score Clinical	07 (96.5%)	07 (96.5%)	Biopsy pathology report: Clinical Gleason pattern 3+4=7 <ul style="list-style-type: none"> Code 07: Gleason score 7
Prostate	Gleason Patterns Pathological	34 (98.3%)	34 (98.3%)	Surgical pathology report: Pathological Gleason pattern 3+4=7 <ul style="list-style-type: none"> Code 34
Prostate	Gleason Score Pathological	07 (97.7%)	07 (97.7%)	Surgical pathology report: Pathological Gleason pattern 3+4=7 <ul style="list-style-type: none"> Code 07: Gleason score 7
Prostate	Gleason Tertiary Pattern	X9 (86.0%)	X9 (86.0%)	Surgical pathology report: Tertiary Gleason pattern not documented <ul style="list-style-type: none"> Code X9: Not documented in medical record, Gleason Tertiary Pattern not assessed or unknown if assessed
Prostate	Number of Cores Examined	20 (12.8%)	X6 (31.4%)	Biopsy pathology report: Per the Gross Description: The number of “cores” counted are described as “pieces” Per Note 3: Second bullet: Information from the gross description of the core biopsy pathology report can be used to code this data item when the gross findings provide the actual number of cores and <i>not pieces, chips, fragments, etc.</i> <ul style="list-style-type: none"> Code X6: Biopsy cores examined, number unknown
Prostate	Number of Cores Positive	04 (51.2%)	X6 (2.9%)	Biopsy pathology report: Positive cores reported as “fragments” Per Note 3: Second bullet: Information from the gross description of the core biopsy pathology report can be used to code this data item when the gross findings provide the actual number of cores and <i>not pieces, chips, fragments, etc.</i>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> • Code X6: Biopsy cores positive, number unknown
Soft Tissue Abd/Thor	Primary Site	C495 (46.0%)	C495 (46.0%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site</p> <p><i>Note:</i> There are no specific primary site instructions for Soft Tissue</p> <p>Surgical pathology report, Synoptic report: Tumor Site: Left anterior pelvis soft tissue</p> <p>The biopsy report refers to a lower abdomen lesion (C494, which almost half of the registrars coded to), which would be a different primary site. Surgical findings take priority.</p> <ul style="list-style-type: none"> • Code C495: Connective, subcutaneous and other soft tissues of pelvis
Soft Tissue Abd/Thor	Histology	8811 (83.4%)	8811 (83.4%)	<p>Surgical pathology report: Histologic Type (WHO): High grade myxofibrosarcoma</p> <ul style="list-style-type: none"> • Code 8811: Fibromyosarcoma
Soft Tissue Abd/Thor	Behavior	3 (98.8%)	3 (98.8%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Soft Tissue Abd/Thor	Tumor Size Clinical	100 (46.0%)	100 (46.0%)	<p>Outside CT states 10 cm size (as noted by physician in consulting note). MRI report stated 9.8 cm mass</p> <p>Per the SEER manual for Tumor Size Clinical, #7: Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, <i>and over a physical exam.</i></p> <ul style="list-style-type: none"> • Code 100
Soft Tissue Abd/Thor	Tumor Size Pathologic	130 (83.4%)	130 (83.4%)	<p>Surgical pathology report: 13.0 cm</p> <ul style="list-style-type: none"> • Code 130

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	EOD Primary Tumor	500 (11.0%)	500 (11.0%)	Surgical pathology report: 13.0 cm in greatest dimension Macroscopic Extent of Tumor: Tumor involves the deep dermis and subcutaneous tissue. Deep dermis is part of the skin, which is an “organ.” <ul style="list-style-type: none"> Code 500: ONE adjacent organ/structure invaded, Adjacent organ(s)/structure(s), NOS
Soft Tissue Abd/Thor	EOD Regional Nodes	000 (87.1%)	000 (87.1%)	Surgical pathology report: Regional Lymph Nodes: No lymph nodes submitted or identified. <p>Per Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative. Code unknown (999) only when there is no available information on the extent of the patient's disease, for example when a lab-only case is abstracted from a biopsy report and no clinical history is available.</p> <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Soft Tissue Abd/Thor	Regional Nodes Positive	98 (80.4%)	98 (80.4%)	Surgical pathology report: No lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Soft Tissue Abd/Thor	EOD Mets	00 (99.4%)	00 (99.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Soft Tissue Abd/Thor	SS2018	2 (39.9%)	2 (39.9%)	Involvement of adjacent connective tissue with no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 2: Regional
Soft Tissue Abd/Thor	Grade Clinical	9 (41.1%)	D (10.4%)	Biopsy pathology report: High-grade myxofibrosarcoma Preferred grading system: FNCLCC. “High-grade” is not part of FNCLCC Soft Tissue has generic grade codes of A-D available, can use the table for converting grade descriptions, “High-grade” equal to D <ul style="list-style-type: none"> Code D: High grade
Soft Tissue Abd/Thor	Grade Pathological	3 (86.5%)	3 (86.5%)	Surgical pathology report: Histologic Grade (FNCLCC): 3 of 3 <ul style="list-style-type: none"> Code 3: G3: Sum of differentiation score, mitotic count score and necrosis score of 6, 7, or 8
Soft Tissue Abd/Thor	Grade Post Therapy	Blank (85.3%)	Blank (85.3%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	Bone Invasion	0 (97.5%)	0 (97.5%)	No mention of bone invasion in imaging reports Per Note 3: Code 0 if relevant imaging is performed and there is no mention of bone invasion. <ul style="list-style-type: none"> Code 0: Bone invasion not present/not identified on imaging
Tongue Anterior	Primary Site	C022 (57.4%)	C023 (20.4%)	<p>Per the 2018 Solid Tumor Rules for Head and Neck, the priority order for assigning primary site is:</p> <ol style="list-style-type: none"> Tumor Board: No information from Tumor Board Tissue/pathology from tumor resection or biopsy: Scans Physician documentation <p>Per operative report: Right lateral tongue</p> <p>Per clarification from SEER: Assign C023 for lateral tongue without further information. The tongue has a midline on the dorsal surface and the frenulum on the ventral surface which divide the tongue into left and right halves. Anything on the left half or on the right half can be referred to as "lateral." A lesion arising on the left or right lateral tongue could be on the dorsal surface, the ventral surface, or on the border. See SEER Inquiry 20041032.</p> <ul style="list-style-type: none"> Code C023: Anterior 2/3 of tongue, NOS
Tongue Anterior	Histology	8071 (56.8%)	8070 (40.1%)	<p>Surgical pathology report: Squamous cell carcinoma, well differentiated, keratinizing</p> <p>Cancer case summary: Squamous cell carcinoma, conventional type</p> <p>Per clarification from SEER: The 4th Ed WHO tumors of H&N no longer includes keratinizing SCC and non-keratinizing SCC in the chapter. The histology tables in the Solid Tumor Rules are based on the 4th Ed which is why these two histologies are not listed. Pathologists are discouraged from using these terms, however it</p>

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				takes a while for this to happen in the real world. Since both histologies have different codes from SCC, NOS they are subtypes/variants. <ul style="list-style-type: none"> Code 8070: Squamous cell carcinoma, NOS
Tongue Anterior	Behavior	3 (98.8%)	3 (98.8%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Tongue Anterior	Tumor Size Clinical	050 (61.7%)	025 (26.5%)	Primary site changed to C023 for right lateral tongue. The 4 x 5 cm description was based on “tongue 4x5 cm plaque-like protrusion right ventral mobile tongue,” which is not necessarily describing a mass. There is no imaging available, so tumor size clinical is based on physician’s statement of “tongue lesion measuring 1 x 2.5 cm” <ul style="list-style-type: none"> Code 025
Tongue Anterior	Tumor Size Pathologic	014 (87.0%)	014 (87.0%)	Surgical Pathology Report: 1.4 cm <ul style="list-style-type: none"> Code 014
Tongue Anterior	EOD Primary Tumor	100 (89.5%)	100 (89.5%)	Surgical Pathology Report: Confined to organ, tumor invades to a depth of .5 cm (5 mm) <ul style="list-style-type: none"> Code 100: Group 1 (localized lesion) WITH depth of invasion (DOI) less than or equal to 5 mm OR unknown depth of invasion
Tongue Anterior	EOD Regional Nodes	000 (85.8%)	000 (85.8%)	Surgical pathology Report: 0/41 LNs involved <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Tongue Anterior	Regional Nodes Positive	00 (84.0%)	00 (84.0%)	Surgical pathology Report: 0/41 LNs involved <ul style="list-style-type: none"> Code 00: All nodes examined negative
Tongue Anterior	EOD Mets	00 (100%)	00 (100%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Tongue Anterior	SS2018	1 (90.1%)	1 (90.1%)	Mass confined to site of origin, no evidence lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized
Tongue Anterior	Grade Clinical	9 (61.1%)	1 (36.4%)	Biopsy pathology report: Well differentiated <ul style="list-style-type: none"> Code 1: Well differentiated
Tongue Anterior	Grade Pathological	3 (50.0%)	3 (50.0%)	Surgical pathology report: Poorly differentiated <ul style="list-style-type: none"> Code 3: Poorly differentiated

Group 2 Case	Group 2 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Tongue Anterior	Grade Post Therapy	Blank (83.3%)	Blank (83.3%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Tongue Anterior	Extranodal Exten H & N Clin	0 (45.7%)	7 (23.5%)	MRI mildly prominent L lymph node measuring 1.2 X 0.8 cm, likely reactive Likely reactive is not diagnostic of lymph node involvement <ul style="list-style-type: none"> Code 7: No lymph node involvement during diagnostic workup (cN0)
Tongue Anterior	Extranodal Exten H & N Path	X.7 (72.2%)	X.7 (72.2%)	Surgical pathology report: 0/41 No LNs involved <ul style="list-style-type: none"> Code X.7-surgically resected regional lymph node(s) negative for cancer (pN0)
Tongue Anterior	Human Papilloma Virus (HPV) Status	9 (85.8%)	9 (85.8%)	HPV not documented in patient record <ul style="list-style-type: none"> Code 9: Unknown if HPV test detecting viral DNA and or RNA was performed
Tongue Anterior	LN Size	0.0 (81.5%)	0.0 (81.5%)	Surgical pathology report: 0/41 LNs involved <ul style="list-style-type: none"> Code 0.0: No involved regional nodes

Group 3 Cases

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Primary Site	C714 (96.5%)	C714 (96.5%)	<p>Per the 2018 Solid Tumor Rules for Malignant CNS and Peripheral Nerves, the priority order for assigning primary site is</p> <ol style="list-style-type: none"> 1. Resection <ul style="list-style-type: none"> • Operative report • Pathology report 2. Biopsy <ul style="list-style-type: none"> • Operative report • Pathology report 3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information) <ul style="list-style-type: none"> • Tumor Board • Code from physician's documentation of original diagnosis from operative report or pathology report OR • Physician's documentation of primary site in the medical record 4. For cases diagnosed by imaging (no pathology/resection or biopsy), use information from scans in the following priority order: MRI, CT, PET, Angiogram <p>Resection, operative report takes priority: Left occipital tumor</p> <ul style="list-style-type: none"> • Code C714: Occipital lobe
Brain	Histology	9440 (98.2%)	9440 (98.2%)	<p>Surgery pathology report: Glioblastoma, wild-type (WHO Grade IV)</p> <ul style="list-style-type: none"> • Code 9440: Glioblastoma, NOS
Brain	Behavior	3 (98.8%)	3 (98.8%)	<p>Invasive histology histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Brain	Tumor Size Clinical	048 (93.6%)	048 (93.6%)	<p>MRI Brain describes 4.8 cm mass</p> <ul style="list-style-type: none"> • Code 048

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Tumor Size Pathologic	999 (91.2%)	999 (91.2%)	Pathological tumor size not available. Gross description states: "Occipital tumor, 10 cm aggregate of friable, hemorrhagic soft tissue fragments received in two separate containers." This is the size of the specimen, not the size of the actual tumor <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Brain	EOD Primary Tumor	100 (91.2%)	100 (91.2%)	Surgical pathology report: Left occipital lobe tumor confined to the brain and does not cross the midline CT scan shows possible right midline shift: Midline shift does not affect extension. It must state "crosses the midline" to be coded to 500 <ul style="list-style-type: none"> Code 100: Confined to brain
Brain	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value (no lymph nodes in the brain) Code 888: Not applicable
Brain	Regional Nodes Positive	99 (84.8%)	99 (84.8%)	Not applicable: Default value (no lymph nodes in the brain) <ul style="list-style-type: none"> Code 99: Not applicable
Brain	EOD Mets	00 (97,1%)	00 (97,1%)	No clinical evidence of mets <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Brain	SS2018	1 (87.1%)	1 (87.1%)	Left occipital lobe tumor confined to the brain and does not cross the midline, no evidence of mets CT scan shows possible right midline shift: Midline shift does not affect extension. It must state "crosses the midline" to be coded to 2 <ul style="list-style-type: none"> Code 1: Localized
Brain	Grade Clinical	9 (77.8%)	9 (77.8%)	MRI showed a contrast-enhancing lesion in the left occipital lobe concerning for high grade tumor. Concerning is not definitive for diagnosis <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Brain	Grade Pathological	4 (91.2%)	4 (91.2%)	Surgical pathology report: Glioblastoma, wild-type (WHO Grade IV)

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination
Brain	Grade Post Therapy	Blank (86.0%)	Blank (86.0%)	Patient did not have neoadjuvant therapy Per Note 1, leave blank when there is no neoadjuvant therapy
Brain	Brain Molecular Markers	05 (84.2%)	05 (84.2%)	Surgical pathology report: Glioblastoma, wild-type (WHO Grade IV) <ul style="list-style-type: none"> Code 05: Glioblastoma, IDH-wildtype (9440/3)
Brain	Chromosome 1p Status	9 (93.0%)	9 (93.0%)	Chromosome 1p not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 1p deletion/LOH not assessed or unknown if assessed
Brain	Chromosome 19q Status	9 (93.6%)	9 (93.6%)	Chromosome 19q not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 19q: LOH not assessed or unknown if assessed
Brain	MGMT	0 (93.6%)	0 (93.6%)	MGMT Tumor report: Negative for MGMT methylation <ul style="list-style-type: none"> Code 0: MGMT methylation absent/not present, unmethylated MGMT
Breast	Primary Site	C501 (71.1%)	C501 (71.1%)	Per Appendix C of the SEER manual, Breast Coding Guidelines, the following priority order is used when there is conflicting information <ol style="list-style-type: none"> Operative Report Pathology Report Mammogram, ultrasound (ultrasound becoming more frequently used) Physical examination <p>Operative report takes priority, states central portion of right breast</p> <ul style="list-style-type: none"> Code C501: Central portion of breast
Breast	Histology	8500 (99.4%)	8500 (99.4%)	Surgical pathology report: Invasive ductal carcinoma <ul style="list-style-type: none"> Code 8500: Infiltrating duct carcinoma, NOS
Breast	Behavior	3 (97.7%)	3 (97.7%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	Tumor Size Clinical	013 (90.2%)	013 (90.2%)	Mammogram, 10 mm x 10 mm x 13 mm <ul style="list-style-type: none"> Code 013
Breast	Tumor Size Pathologic	027 (96.5%)	027 (96.5%)	Surgical pathology report: 2.7 cm <ul style="list-style-type: none"> Code 027
Breast	EOD Primary Tumor	100 (96.5%)	100 (96.5%)	Surgical pathology report: 2.7 cm tumor confined to breast <ul style="list-style-type: none"> Code 100: Any size tumor; Confined to breast tissue and fat including nipple and/or areola, Localized, NOS; EXCLUDES: skin invasion of breast, nipple and areola (see code 200)
Breast	EOD Regional Nodes	070 (35.8%)	070 (35.8%)	Surgical pathology report: 0/4 SLNs, no evidence of micrometastasis; no mention of ITCs Note: Preferred answer was noted as "000" on the website; however, it was really 070 in the master document for preferred answers/rationale. <ul style="list-style-type: none"> Code 070: No regional lymph node involvement pathologically, (lymph nodes removed and pathologically negative), WITHOUT ITCs or ITC testing unknown
Breast	Regional Nodes Positive	00 (96.5%)	00 (96.5%)	Surgical pathology report: 0/4 SLNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Breast	EOD Mets	00 (98.3%)	00 (98.3%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Breast	SS2018	1 (96.0%)	1 (96.0%)	Mass confined to breast, no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized, confined to breast
Breast	Grade Clinical	3 (87.9%)	3 (87.9%)	Biopsy pathology report: Modified Bloom-Richardson 3/3 <ul style="list-style-type: none"> Code 3: G3: High combined histologic grade (unfavorable); SBR score of 8-9 points
Breast	Grade Pathological	3 (94.2%)	3 (94.2%)	Surgical pathology report: Nottingham grade 3 <ul style="list-style-type: none"> Code 3: G3: High combined histologic grade (unfavorable); SBR score of 8-9 points
Breast	Grade Post Therapy	Blank (87.9%)	Blank (87.9%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Breast	Sentinel Lymph Nodes Examined	04 (93.6%)	04 (93.6%)	Surgical pathology report: 0/4 SLNs

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 04: Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
Breast	Sentinel Lymph Nodes Positive	00 (99.4%)	00 (99.4%)	Surgical pathology report: 0/4 SLNs <ul style="list-style-type: none"> Code 00: All sentinel nodes examined are negative
Breast	ER Summary	1 (98.3%)	1 (98.3%)	Biopsy pathology report: ER report: Counted cells:1561, Positives: 99.6%, Intensity:2.9, Allred: 8 <ul style="list-style-type: none"> Code 1: ER positive
Breast	ER Percent Positive	100 (45.1%)	100 (45.1%)	Biopsy pathology report: ER percent positive reported as 99.6%. Since this data item does not have a decimal, need to round up. Per general rules for rounding, 0-4 (round down), 5-9 (round up). Rounding up makes this 100% <ul style="list-style-type: none"> Code 100
Breast	ER Allred Score	08 (87.3%)	08 (87.3%)	Biopsy pathology report: ER report: Counted cells:1561, Positives: 99.6%, Intensity:2.9, Allred: 8 <ul style="list-style-type: none"> Code 08: Total ER Allred score of 8
Breast	PR Summary	1 (98.8%)	1 (98.8%)	Biopsy pathology report: PR report: Counted cells:1823, Positives: 62.9%. Intensity:2.9, Allred: 7 <ul style="list-style-type: none"> Code 1: PR positive
Breast	PR Percent Positive	063 (52.0%)	063 (52.0%)	Biopsy pathology report: PR percent positive reported as 62.9%. Since this data item does not have a decimal, need to round up. Per general rules for rounding, 0-4 (round down), 5-9 (round up). Rounding up makes this 63% (Code 063) <ul style="list-style-type: none"> Code: 063
Breast	PR Allred Score	07 (85.5%)	07 (85.5%)	Biopsy pathology report: PR report: Counted cells:1823, Positives: 62.9%. Intensity:2.9, Allred: 7 <ul style="list-style-type: none"> Code 07: Total PR Allred score of 7
Breast	HER2 IHC Summary	2 (80.3%)	2 (80.3%)	Biopsy pathology report: HER2 Neu report (IHC): Counted cells:13250, Class 0: 16.4% (2171), Class 1: 8.0% (1058), Class 2: 66.0% (8749), Class 3: 9.6% (1272), Equivocal (2+) <ul style="list-style-type: none"> Code 2: Equivocal (Score 2+), Stated as equivocal
Breast	HER2 ISH Summary	3	3	Biopsy pathology report: HER2 FISH report: Amplified

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(71.1%)	(71.1%)	<ul style="list-style-type: none"> Code 3: Positive [amplified]
Breast	HER2 Overall Summary	1 (78.6%)	1 (78.6%)	Positive (amplified) based on HER2 ISH (IHC equivocal) <ul style="list-style-type: none"> Code 1: HER2 positive
Breast	HER2 SP Copy Number	XX.9 (72.8%)	XX.9 (72.8%)	HER2 SP Copy Number not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Copy Number	6.1 (29.5%)	6.1 (29.5%)	Biopsy pathology report: HER2 FISH report: HER2/ CEP 17 ratio: 2.5, Total# of cells manually counted: 80, Number of individuals counting: 2, Average# of HER2 signals/ nucleus: 6.1, Average # of CEP 17: 2.4. The Average HER2 signals/nucleus is for this field (6.1) <ul style="list-style-type: none"> Code: 6.1
Breast	HER2 DP Ratio	2.5 (51.4%)	2.5 (51.4%)	Biopsy pathology report: HER2 FISH report: Her2 / CEP 17 ratio: 2.5, Total# of cells manually counted: 80, Number of individuals counting: 2, Average# of Her2 signals/nucleus: 6.1, Average # of CEP 17: 2.4. The HER2/CEN17 signal ratio is for this field (2.5) Note: The Average # of CEN17 2.4 is a control variable and is not recorded <ul style="list-style-type: none"> Code: 2.5
Breast	Ki-67	25.5 (55.5%)	25.5 (55.5%)	Biopsy pathology report: Ki-67 report: Counted cells:2599, Positives: 25.5%, Intensity:2.4, Allred: 5, H Score: 62.4, M Score: 10.4, Unfavorable (Greater than 20%) Note: The additional information in this report is not needed, only the percentage positive <ul style="list-style-type: none"> Code 25.5
Breast	Lymph Nodes Positive Axillary Level I-II	00 (91.9%)	00 (91.9%)	Surgical pathology report: 0/4 SLNs <ul style="list-style-type: none"> Code 00: All ipsilateral axillary nodes examined negative
Breast	Multigene Signature Method	9 (93.1%)	9 (93.1%)	Multigene Signature Method not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Multigene Signature Method not assessed or unknown if assessed
Breast	Multigene Signature Results	X9 (93.1%)	X9 (93.1%)	Multigene Signature Results not documented in patient record

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code X9: Not documented in medical record, Multigene Signature Results not assessed or unknown if assessed
Breast	Oncotype DX Recur Score – DCIS	XX6 (65.3%)	XX6 (65.3%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> XX6: Not applicable, invasive case
Breast	Oncotype DX Recur Score	XX5 (1.2%)	XX7 (44.5%)	Oncologist states that Oncotype is High. No number given. Originally coded to XX5, for Oncotype greater than 11 (per Risk Level, High is defined recurrence score greater than 31) Based on responses from registrars and discussion with SSDI, changed answer to XX7 to indicate that the test was done, but the specific results were not in the chart <ul style="list-style-type: none"> Code XX7: Test ordered, results not in chart
Breast	Oncotype Dx Risk Level – DCIS	6 (64.2%)	6 (64.2%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> Code 6: Not applicable, invasive case
Breast	Oncotype Dx Risk Level Invasive	2 (50.9%)	2 (50.9%)	Oncologist states that Oncotype is High <ul style="list-style-type: none"> Code 2: High risk (recurrence score greater than or equal to 31)
Breast	Response to Neoadjuvant Therapy	0 (86.1%)	0 (86.1%)	No neoadjuvant therapy given <ul style="list-style-type: none"> Code 0: Neoadjuvant therapy not given
Colon and Rectum	Primary Site	C187 (64.1%)	C199 (35.3%)	Per the coding guidelines from SEER, the following priority order for assigning primary site for Colon is <ul style="list-style-type: none"> Resected cases <ul style="list-style-type: none"> Operative report with surgeon’s description Pathology report Imaging Non-resected cases <ul style="list-style-type: none"> Polypectomy or excision without resection Endoscopy report Operative report, which takes priority, states preoperative diagnosis as sigmoid colon; postoperative diagnosis as rectosigmoid colon. The operative

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>report also noted that the tumor was “way down’ into the rectosigmoid colon.</p> <ul style="list-style-type: none"> • Code C199: Rectosigmoid junction
Colon and Rectum	Histology	8140 (87.1%)	8140 (87.1%)	<p>Surgical Pathology report: Invasive adenocarcinoma in arising in a tubulovillous adenoma of the sigmoid colon</p> <p>Per the Solid Tumor Rules, Colon, under “Changes from 2007 Rules,” #7 Polyps are now disregarded when coding histology. For example, adenocarcinoma in an adenomatous polyp is coded as adenocarcinoma 8140. For the purposes of determining multiple primaries, tumors coded as adenocarcinoma in a polyp for pre-2018 cases should be treated as adenocarcinoma 8140.</p> <ul style="list-style-type: none"> • Code 8140: Adenocarcinoma, NOS
Colon and Rectum	Behavior	3 (98.2%)	3 (98.2%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Colon and Rectum	Tumor Size Clinical	060 (38.2%)	999 (58.2%)	<p>Circumferential lobulated friable irregular mass extending from rectosigmoid junction at 12 cm to approximately 18 cm</p> <p>Do not extrapolate the 6 cm measurement from this description, no other information provided</p> <ul style="list-style-type: none"> • Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Colon and Rectum	Tumor Size Pathologic	089 (98.2%)	089 (98.2%)	<p>Surgical pathology report: 8.9 cm</p> <ul style="list-style-type: none"> • Code 089
Colon and Rectum	EOD Primary Tumor	400 (42.9%)	400 (42.9%)	<p>Surgical pathology report: Invades into the pericolonic adipose tissue (i.e., pericolic fat); Microscopic extent: invades into subserosal adipose tissue or nonperitonealized soft tissues but does not extend to serosal surface</p> <p>Per updated instructions, Rectosigmoid colon is peritonealized and code 400 should be used, even though pathology states non-peritonealized tissues</p>

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 400: Non-peritonealized pericolic/perirectal tissues invaded, subserosa
Colon and Rectum	EOD Regional Nodes	000 (99.4%)	000 (99.4%)	Surgical pathology report: 0/38 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement and no tumor deposits (TD)
Colon and Rectum	Regional Nodes Positive	00 (99.4%)	00 (99.4%)	Surgical pathology report: 0/38 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Colon and Rectum	EOD Mets	00 (99.4%)	00 (99.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Colon and Rectum	SS2018	2 (53.5%)	2 (53.5%)	Invades into the pericolic adipose tissue (i.e., pericolic fat); Microscopic extent: invades into subserosal adipose tissue or nonperitonealized soft tissues but does not extend to serosal surface Per updated instructions, Rectosigmoid colon is peritonealized and code 2 should be used, even though pathology states non-peritonealized tissues <ul style="list-style-type: none"> Code 2: Regional
Colon and Rectum	Grade Clinical	9 (93.5%)	9 (93.5%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Colon and Rectum	Grade Pathological	2 (97.6%)	2 (97.6%)	Surgical Pathology Report: Moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Colon and Rectum	Grade Post Therapy	Blank (88.2%)	Blank (88.2%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Colon and Rectum	CEA PreTX Interpretation	9 (96.5%)	9 (96.5%)	CEA PreTx Interpretation not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Colon and Rectum	CEA PreTX Lab Value	XXXX.9 (95.9%)	XXXX.9 (95.9%)	CEA PreTx Lab value not documented in patient record <ul style="list-style-type: none"> Code XXXX.9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Colon and Rectum	Circumferential Resection Margin	XX.1 (90.6%)	XX.1 (90.6%)	<p>Surgical pathology report: Circumferential (Radial) or Mesenteric Margin: Uninvolved by invasive carcinoma, Distance from margin not documented</p> <p>Note: The gross description provides more information on the margins; however, these are for distal and proximal margins only (the mass is 7 cm from the proximal margin and 3.5 cm from the distal margin. No additional information on the CRM margin).</p> <ul style="list-style-type: none"> Code XX.1: Margins clear, distance from tumor not stated, Circumferential or radial resection margin negative, NOS, No residual tumor identified on specimen
Colon and Rectum	KRAS	9 (97.6%)	9 (97.6%)	<p>KRAS not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, KRAS not assessed or unknown if assessed
Colon and Rectum	Microsatellite Instability	0 (62.9%)	0 (62.9%)	<p>Surgical pathology report: No loss of nuclear expression of MMR proteins, low probability of MSI-H</p> <p>Note: Per confirmation from AJCC and CAP, a statement of “low probability of MSI-H” is equivalent to MSI-S (code 0). This test was an MMR test since “no loss of nuclear expression” was noted, which is the definition of code 0 for the MMR test.</p> <ul style="list-style-type: none"> Code 0: Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
Colon and Rectum	Perineural Invasion	0 (98.2%)	0 (98.2%)	<p>Surgical pathology report: Perineural invasion not identified</p> <ul style="list-style-type: none"> Code 0: Perineural invasion not identified/not present
Colon and Rectum	Tumor Deposits	00 (97.1%)	00 (97.1%)	<p>Surgical pathology report: Tumor Deposits not identified</p> <ul style="list-style-type: none"> Code 00: No tumor deposits
Lung	Primary Site	C341 (98.2%)	C341 (98.2%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site.</p> <p><i>Note:</i> There are no specific primary site instructions for Lung</p>

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Physician states LUL based on CT scan. Summary Cancer Data: Tumor site: Upper lobe <ul style="list-style-type: none"> Code C341: Upper lobe, lung
Lung	Histology	8230 (30.7%)	8230 (30.7%)	Surgical pathology report: Adenocarcinoma, solid predominant Per the Solid Tumor Rules for Lung, Table 3: Solid Predominant is a subtype/variant of Adenocarcinoma Under "Coding Histologies": Predominantly describes the greater amount of tumor. Predominant and majority are synonyms. Per the CAP protocol, the term predominant is acceptable for the following specific subtypes of adenocarcinoma. For these subtypes only, the word predominant is used to describe both the subtype and the grade of the tumor. See Table 3 for coding instructions and Solid Predominant (8230) is listed. <ul style="list-style-type: none"> Code 8230: Solid carcinoma, NOS (New alternate name: Adenocarcinoma, solid predominant)
Lung	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lung	Tumor Size Clinical	045 (15.7%)	045 (15.7%)	PET CT Mid Body: There is an ill-defined spiculated hypermetabolic mass lesion involving the left upper lobe, measuring 3.3 x 4.5 cm with an SUV of 4.69. <ul style="list-style-type: none"> Code 045
Lung	Tumor Size Pathologic	035 (98.8%)	035 (98.8%)	Surgical pathology report: 3.5 cm <ul style="list-style-type: none"> Code 035
Lung	EOD Primary Tumor	450 (68.7%)	450 (68.7%)	Surgical pathology report: 3.5 cm mass confined to lung with visceral pleural invasion Note: Code 450 currently states only Visceral Pleural Invasion PL1 or PL2, "NOS" being added to next version of manual <ul style="list-style-type: none"> Code 450: Visceral pleura invasion
Lung	EOD Regional Nodes	300 (84.3%)	300 (84.3%)	Surgical pathology report: 1/20 LNs, stated to be N1 nodes <ul style="list-style-type: none"> Code 300: Regional lymph nodes involved (N1)
Lung	Regional Nodes Positive	01 (98.2%)	01 (98.2%)	Surgical pathology report: 1/20 LNs <ul style="list-style-type: none"> Code 01

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lung	EOD Mets	00 (98.2%)	00 (98.2%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Lung	SS2018	4 (55.4%)	4 (55.4%)	Visceral pleural invasion (regional, code 2) plus regional lymph nodes <ul style="list-style-type: none"> Code 4: Regional tumor plus regional lymph nodes
Lung	Grade Clinical	9 (92.2%)	9 (92.2%)	Clinical grade not available in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Pathological	3 (96.4%)	3 (96.4%)	Surgical pathology report: G3 Poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Lung	Grade Post Therapy	Blank (89.2%)	Blank (89.2%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lung	Separate Tumor Nodules	0 (96.4%)	0 (96.4%)	No evidence of separate tumor nodules <ul style="list-style-type: none"> Code 0: No separate tumor nodules
Lung	Visceral and Parietal Pleural Invasion	4 (57.8%)	4 (57.8%)	Summary pathology report: Visceral pleural invasion present, not stated as P1 or P2 <ul style="list-style-type: none"> Code 4: Invasion of visceral pleura present, NOS; not stated if PL1 or PL2
Lymphoma CLL/SLL	Primary Site	C421 (95.7%)	C421 (95.7%)	Bone marrow biopsy and peripheral blood smear: CLL/SLL Per Heme Manual, Module 3: PH5: Code the primary site to bone marrow (C421) when the bone marrow is involved or when only peripheral blood is involved <ul style="list-style-type: none"> Code C421: Bone marrow
Lymphoma CLL/SLL	Histology	9823 (100%)	9823 (100%)	Bone marrow biopsy: CLL/SLL <ul style="list-style-type: none"> Code 9823: Chronic lymphocytic leukemia/small lymphocytic lymphoma
Lymphoma CLL/SLL	Behavior	3 (98.1%)	3 (98.1%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lymphoma CLL/SLL	Tumor Size Clinical	999 (97.5%)	999 (97.5%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma	Tumor Size Pathologic	999	999	Not applicable: Default value

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
CLL/SLL		(97.5%)	(97.5%)	<ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	EOD Primary Tumor	800 (79.0%)	800 (79.0%)	<p>If primary site is C421, EOD Primary Tumor is 800</p> <p>A new note will be added regarding peripheral blood involvement, also will be added to code 800 in the next release of the EOD manual</p> <p>Bone marrow included in code 800 (positive bone marrow aspirate)</p> <ul style="list-style-type: none"> Code 800: Peripheral blood involvement
Lymphoma CLL/SLL	EOD Regional Nodes	888 (100%)	888 (100%)	<p>Not applicable: Default value</p> <ul style="list-style-type: none"> Code 888: Not applicable
Lymphoma CLL/SLL	Regional Nodes Positive	99 (99.4%)	99 (99.4%)	<p>Not applicable: Default value</p> <ul style="list-style-type: none"> Code 99: Not applicable
Lymphoma CLL/SLL	EOD Mets	88 (100%)	88 (100%)	<p>Not applicable: Default value</p> <ul style="list-style-type: none"> Code 88: Not applicable
Lymphoma CLL/SLL	SS2018	7 (83.3%)	7 (83.3%)	<p>If primary site is C421, Summary Stage is 7</p> <p>A new note will be added regarding peripheral blood involvement, also will be added to code 7 in the next release of the SS2018 manual</p> <p>Bone marrow included in code 7 (positive bone marrow aspirate)</p> <ul style="list-style-type: none"> Code 7: Peripheral blood involvement
Lymphoma CLL/SLL	Grade Clinical	8 (100%)	8 (100%)	<p>Grade not applicable for this Heme schema</p> <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Pathological	8 (100%)	8 (100%)	<p>Grade not applicable for this Heme schema</p> <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Post Therapy	Blank (69.1%)	Blank (69.1%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lymphoma CLL/SLL	Adenopathy	0 (58.6%)	9 (40.1%)	<p>No mention of adenopathy in the record</p> <p>Per Note 5: If there is no mention of adenopathy (present or absent), code 9</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, Adenopathy not assessed or unknown if assessed
Lymphoma CLL/SLL	Anemia	0 (64.8%)	0 (64.8%)	<p>Labs: Hgb 11.5</p> <ul style="list-style-type: none"> Code 0: Anemia not present, Hgb >=11.0 g/dL
Lymphoma	B symptoms	0	0	Oncology consult: No fevers, no weight loss, no night sweats

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
CLL/SLL		(67.3%)	(67.3%)	<ul style="list-style-type: none"> Code 0: No B symptoms
Lymphoma CLL/SLL	HIV status	9 (85.2%)	9 (85.2%)	<p>HIV status not documented in medical record Per Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative.</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, HIV status not assessed or unknown if assessed
Lymphoma CLL/SLL	Lymphocytosis	1 (56.8%)	1 (56.8%)	<p>Labs: Absolute Lymphocytes: 5502 H (850-3900 cells/uL)</p> <ul style="list-style-type: none"> Code 1: Lymphocytosis present, Absolute lymphocyte count > 5,000 cells/μL
Lymphoma CLL/SLL	NCCN International Prognostic Index (IPI)	X9 (97.5%)	X9 (97.5%)	<p>NCCN not documented in patient record</p> <ul style="list-style-type: none"> Code X9: Not documented in medical record, NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Lymphoma CLL/SLL	Organomegaly	9 (64.2%)	9 (64.2%)	<p>No mention of organomegaly in the record Per Note 5: If there is no mention of organomegaly (present or absent), code 9.</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, Organomegaly not assessed or unknown if assessed
Lymphoma CLL/SLL	Thrombocytopenia	0 (57.4%)	0 (57.4%)	<p>Labs: Platelets: 301 X 10 (³)/mm³ Multiple 301 X 1000= 301,000</p> <ul style="list-style-type: none"> Code 0: Thrombocytopenia not present, Platelets (Plt) \geq100,000/μL
Melanoma Skin	Primary Site	C446 (98.2%)	C446 (98.2%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Melanoma Skin.</p> <p>Physician note, history and physical: Lesion left upper arm Surgical pathology report, Tumor site: Left upper arm</p> <ul style="list-style-type: none"> Code C446: Skin of upper limb and shoulder
Melanoma Skin	Histology	8720 (83.5%)	8771 (14.6%)	Surgical pathology report: Shave biopsy, Malignant melanoma, invasive, Cell type: epithelioid

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Per the 2007 Solid Tumor Rules for Cutaneous Melanoma, H9: Code the most specific histologic term when the melanoma, NOS (8720) with a single specific type.</p> <p>Note 2: The specific type for invasive lesions may be identified as type, subtype, predominantly, with features of, or with ____ differentiation.</p> <ul style="list-style-type: none"> • Code 8771: Epithelioid cell melanoma
Melanoma Skin	Behavior	3 (99.4%)	3 (99.4%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Melanoma Skin	Tumor Size Clinical	999 (79.9%)	999 (79.9%)	<p>Tumor size clinical not documented in patient record</p> <p>Note: Breslow's depth and Tumor Size are not the same thing</p> <ul style="list-style-type: none"> • Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Melanoma Skin	Tumor Size Pathologic	999 (76.8%)	999 (76.8%)	<p>Tumor Size Pathologic not documented. Tumor Size Clinical unknown.</p> <p>Tumor size pathology indicates that the incisional/excisional biopsy is considered pathological when the biopsy entirely removes the tumor. Instruction 12 states:</p> <p>12. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.</p> <p>The first biopsy removed the tumor entirely, and per SEER's instruction, any tumor size note would be the pathological tumor size</p> <p>Per Tumor Size Pathologic, #4b:</p> <p>4. Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment</p> <p>Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy.</p> <p>a. Code the size from the synoptic report (also known as CAP protocol or pathology report checklist) when there is a discrepancy among</p>

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				tumor size measurements in the various sections of the pathology report. b. Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available. <ul style="list-style-type: none"> Code 999
Melanoma Skin	EOD Primary Tumor	300 (87.8%)	300 (87.8%)	Surgical pathology report: Shave biopsy, Anatomical (Clark's) Level IV Per the "Relationship Between Thickness, Depth of Invasion, and Clark Level Table," found in the Summary Stage 2018 manual, 1.0 mm measurement is a Clark's Level III (code 200); however, the pathology report states Level IV. The pathology report takes priority. <ul style="list-style-type: none"> Code 300: Reticular dermis invaded, Clark level IV
Melanoma Skin	EOD Regional Nodes	000 (99.4%)	000 (99.4%)	Surgical pathology report: Re-excision and SLN biopsy, 0/2 SLNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Melanoma Skin	Regional Nodes Positive	00 (93.3%)	00 (93.3%)	Surgical pathology report: Re-excision and SLN biopsy, 0/2 SLNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Melanoma Skin	EOD Mets	00 (100%)	00 (100%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Melanoma Skin	SS2018	1 (97.0%)	1 (97.0%)	Clark's level IV lesion, no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized tumor
Melanoma Skin	Grade Clinical	9 (99.4%)	9 (99.4%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Pathological	9 (99.4%)	9 (99.4%)	Pathological grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Post Therapy	Blank (89.0%)	Blank (89.0%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Melanoma Skin	Sentinel Lymph Nodes Examined	02 (95.7%)	02 (95.7%)	Surgical pathology report: 0/2 SLNs <ul style="list-style-type: none"> Code 02
Melanoma Skin	Sentinel Lymph Nodes Positive	00 (98.2%)	00 (98.2%)	Surgical pathology report: 0/2 SLNs <ul style="list-style-type: none"> Code 00

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	Breslow Thickness	1.0 (78.0%)	1.0 (78.0%)	Surgical pathology report: Shave biopsy, Greatest thickness: 1.0 mm <ul style="list-style-type: none"> Code 1.0
Melanoma Skin	Ulceration	0 (94.5%)	0 (94.5%)	Surgical pathology report: Shave biopsy, Ulceration absent <ul style="list-style-type: none"> Code 0: Ulceration not identified/not present
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Lab Value	XXXXX.9 (94.5%)	XXXXX.9 (94.5%)	LDH not documented in patient record <ul style="list-style-type: none"> Code XXXXX.9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Level	9 (95.7%)	9 (95.7%)	LDH not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Level not assessed or unknown if assessed
Melanoma Skin	LDH Upper Limits of Normal	XX9 (95.7%)	XX9 (95.7%)	LDH not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in patient record, LDH Upper Limit not assessed or unknown if assessed
Melanoma Skin	Mitotic Rate Melanoma	05 (93.9%)	05 (93.9%)	Surgical pathology report: Shave biopsy, Mitosis 5 per sq. mm <ul style="list-style-type: none"> Code 05
Ovary	Primary Site	C569 (100.0%)	C569 (100.0%)	Surgical pathology report: Ovary (and fallopian tube) <ul style="list-style-type: none"> Code C569: Ovary
Ovary	Histology	8461 (17.7%)	8461 (17.7%)	Surgical pathology report: High-grade serous carcinoma Per the 2018 ICD-O-3 updates: "high grade serous carcinoma" is a new alternate name for 8461 <ul style="list-style-type: none"> Code 8461: Serous surface papillary carcinoma
Ovary	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Ovary	Tumor Size Clinical	144 (56.7%)	144 (56.7%)	Imaging shows 14.4 cm mass Per confirmation from SEER, even though there was not a confirmation of malignancy prior to surgical exploration, the size from the imaging can be used as tumor size clinical <ul style="list-style-type: none"> Code 144

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Ovary	Tumor Size Pathologic	140 (72.6%)	140 (72.6%)	Surgical Pathology Report, 14 cm <ul style="list-style-type: none"> Code 140
Ovary	EOD Primary Tumor	300 (73.2%)	300 (73.2%)	Hematology/Oncology assessment: Pathologic Stage 1C3 Surgical pathology report: Involvement of bilateral ovaries and fallopian tubes, peritoneal washings positive for malignant cells, FIGO Stage IC3 Note: Fallopian tube involvement is code 400; however, per physician this is Stage IC3 <ul style="list-style-type: none"> Code 300: Malignant cells in ascites or peritoneal washings
Ovary	EOD Regional Nodes	000 (98.8%)	000 (98.8%)	Surgical Pathology Report: 0/1 Lymph nodes <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Ovary	Regional Nodes Positive	00 (100%)	00 (100%)	Surgical Pathology Report: 0/1 Lymph nodes <ul style="list-style-type: none"> Code 00: All nodes examined negative
Ovary	EOD Mets	00 (98.8%)	00 (98.8%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Ovary	SS2018	2 (86.0%)	2 (86.0%)	Hematology/Oncology assessment: Pathologic Stage 1C3 Involvement of bilateral ovaries and fallopian tubes, peritoneal washings positive for malignant cells, no lymph nodes or metastasis <ul style="list-style-type: none"> Code 2: Regional
Ovary	Grade Clinical	9 (89.6%)	9 (89.6%)	Patient was diagnosed by imaging, no biopsy done, went straight to surgery, no clinical grade available <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Ovary	Grade Pathological	H (95.1%)	H (95.1%)	Surgical pathology report: High grade <ul style="list-style-type: none"> Code H: High grade
Ovary	Grade Post Therapy	Blank (87.8%)	Blank (87.8%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Ovary	CA-125 PreTX Lab Value	1 (91.5%)	1 (91.5%)	Labs: CEA 125 60.4 Per Note 5: Normal values may vary with patient age and from lab to lab. The typical human reference ranges are 0 to less than or equal 35 units per milliliter (U/mL). This is equivalent to kU/L. <ul style="list-style-type: none"> Code 1: Positive/elevated
Ovary	FIGO Stage	11	11	Hematology/Oncology assessment: Pathologic Stage 1C3 (pT1c3, pN0, M0)

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(65.9%)	(65.9%)	Per Note 2: If a stage group is stated but it does not specify that it is a FIGO stage, assume that it is a FIGO stage and code it. <ul style="list-style-type: none"> Code 11: FIGO Stage IC3
Ovary	Residual Tumor Volume Post Cytoreduction	00 (30.5%)	97 (50.0%)	Surgical operative report: Laparoscopic assisted vaginal hysterectomy and bilateral oophorectomy with lymph node dissection and partial omentectomy No mention of cytoreduction or debulking <ul style="list-style-type: none"> Code 97: No cytoreductive surgery performed
Prostate	Primary Site	C619 (100%)	C619 (100%)	Surgical pathology report: Prostate Code: C619: Prostate
Prostate	Histology	8140 (94.0%)	8140 (94.0%)	Surgical pathology report: Adenocarcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Prostate	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Prostate	Tumor Size Clinical	999 (91.0%)	999 (91.0%)	Tumor size clinical not documented in patient record Measurements given of the “cores” lengths, but this is not clinical tumor size <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	Tumor Size Pathologic	999 (86.2%)	999 (86.2%)	Tumor Size Pathologic not available. Surgical pathology report: Estimated volume of index tumor (in cc): 1.2. Volume is not the same thing as tumor size. <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	EOD Primary Tumor	250 (9.6%)	200 (20.4%)	Per Physician’s notes: Abnormal DRE, newly diagnosed T2a Per Note 5: If there is no information from the DRE, or the terminology used is not documented in Note 3, but the physician assigns a clinical extent of disease, the registrar can use that. Physician documented T2a: Tumor involves one-half of one side of lobe. <ul style="list-style-type: none"> Code 200: Involves one-half of one side or less (clinically apparent/palpable)
Prostate	Prostate Path Exten	300 (82.6%)	300 (82.6%)	Surgical pathology report: Extraprostatic and seminal vesicle invasion absent Disease confined to prostate

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 300: Confined to prostate, localized
Prostate	EOD Regional Nodes	000 (96.4%)	000 (96.4%)	Surgical pathology report: 0/7 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Prostate	Regional Nodes Positive	00 (94.6%)	00 (94.6%)	Surgical pathology report: 0/7 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Prostate	EOD Mets	00 (98.2%)	00 (98.2%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Prostate	SS2018	1 (94.6%)	1 (94.6%)	Confined to prostate, no lymph node or metastasis involvement <ul style="list-style-type: none"> Code 1: Localized
Prostate	Grade Clinical	4 (94.6%)	4 (94.6%)	Biopsy pathology report: Clinical Gleason pattern 3+5=8 <ul style="list-style-type: none"> Code 4: Grade Group 4: Gleason score 8
Prostate	Grade Pathological	4 (31.7%)	4 (31.7%)	Surgical pathology report: Pathological Gleason pattern 4+3=7; however, Clinical Gleason pattern 3+5=8 on biopsy Per Note 2: Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade. (This follows the AJCC rule that pathological time frame includes all the clinical time frame information plus information from the resected specimen.) Patient had one dose of Lupron. Although this is coded as hormone therapy, it does not qualify for neoadjuvant therapy. Per AJCC, a recommended 4-6 doses of hormone therapy is needed to affect the tumor and qualify for neoadjuvant therapy. <ul style="list-style-type: none"> Code 4: Grade Group 4: Gleason score 8
Prostate	Grade Post Therapy	Blank (73.7%)	Blank (73.7%)	Patient had one dose of Lupron. Although this is coded as hormone therapy, it does not qualify for neoadjuvant therapy. Per AJCC, a recommended 4-6 doses of hormone therapy is needed to affect the tumor and qualify for neoadjuvant therapy. <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Prostate	PSA Lab Value	4.0 (64.7%)	4.0 (64.7%)	Clinic Note, PSA 4.0 (No leading zeros are needed)

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Also states that PSA 4.4, but based on date information provided, this PSA was done after the prostate biopsy Per Note 3, the PSA value must be recorded prior to diagnostic biopsy of prostate <ul style="list-style-type: none"> Code 4.0
Prostate	Gleason Patterns Clinical	35 (93.4%)	35 (93.4%)	Biopsy pathology report: Clinical Gleason pattern 3+5=8 <ul style="list-style-type: none"> Code 35
Prostate	Gleason Score Clinical	08 (98.2%)	08 (98.2%)	Biopsy pathology report: Clinical Gleason pattern 3+5=8 <ul style="list-style-type: none"> Code 08: Gleason score 8
Prostate	Gleason Patterns Pathological	43 (77.2%)	43 (77.2%)	Surgical pathology report: Pathological Gleason pattern 4+3=7 Patient had one dose of Lupron. Although this is coded as hormone therapy, it does not qualify for neoadjuvant therapy. Per AJCC, a recommended 4-6 doses of hormone therapy is needed to affect the tumor and qualify for neoadjuvant therapy. <ul style="list-style-type: none"> Code 43
Prostate	Gleason Score Pathological	07 (76.0%)	07 (76.0%)	Surgical pathology report: Pathological Gleason pattern 4+3=7 Patient had one dose of Lupron. Although this is coded as hormone therapy, it does not qualify for neoadjuvant therapy. Per AJCC, a recommended 4-6 doses of hormone therapy is needed to affect the tumor and qualify for neoadjuvant therapy. <ul style="list-style-type: none"> Code 07: Gleason score 7
Prostate	Gleason Tertiary Pattern	50 (77.8%)	50 (77.8%)	Surgical pathology report: Tertiary Gleason pattern 5 Patient had one dose of Lupron. Although this is coded as hormone therapy, it does not qualify for neoadjuvant therapy. Per AJCC, a recommended 4-6 doses of hormone therapy is needed to affect the tumor and qualify for neoadjuvant therapy. <ul style="list-style-type: none"> Code 50: Tertiary pattern 5
Prostate	Number of Cores Examined	12 (58.7%)	26 (10.2%)	Biopsy pathology report: Per the Gross Description: A-F, 26 cores were examined

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Note 3 (Bullet 2): Information from the gross description of the core biopsy pathology report can be used to code this data item when the <i>gross findings provide the actual number of cores</i> and not pieces, chips, fragments, etc.</p> <ul style="list-style-type: none"> • Code 26
Prostate	Number of Cores Positive	05 (79.0%)	05 (79.0%)	<p>Biopsy pathology report: 5/8 cores positive, Clinic note, physician documents 5 of 12 cores positive; (as noted above, gross description showed 26 cores examined)</p> <ul style="list-style-type: none"> • Code 05
Soft Tissue Abd/Thor	Primary Site	C493 (98.2%)	C493 (98.2%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site</p> <p><i>Note:</i> There are no specific primary site instructions for Soft Tissue</p> <p>Surgical pathology report: Tumor site: Thorax, right chest wall</p> <ul style="list-style-type: none"> • C493: Connective, subcutaneous and other soft tissues of thorax
Soft Tissue Abd/Thor	Histology	8801 (79.9%)	8801 (79.9%)	<p>Surgical pathology report: Histologic type: Fibroblastic-type spindle cell sarcoma</p> <p><i>Note:</i> Spindle cell sarcoma is the histology, the fibroblastic-type is not a recognized variant of spindle cell sarcoma and should be ignored.</p> <ul style="list-style-type: none"> • Code 8801: Spindle cell sarcoma
Soft Tissue Abd/Thor	Behavior	3 (100%)	3 (100%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Soft Tissue Abd/Thor	Tumor Size Clinical	036 (84.8%)	036 (84.8%)	<p>Clinic Note: Imaging MRI, 3.6 cm</p> <p>Per SEER manual, clinical classification is composed of diagnostic workup prior to first treatment, including physical examination. Per confirmation from SEER, even though there was not a confirmation of cancer prior to surgical exploration, the size from the imaging can be used as tumor size clinical</p> <ul style="list-style-type: none"> • Code 036
Soft Tissue Abd/Thor	Tumor Size Pathologic	025 (93.9%)	025 (93.9%)	<p>Surgical pathology report: Tumor size: 2.5cm</p> <ul style="list-style-type: none"> • Code 025

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	EOD Primary Tumor	100 (75.6%)	100 (75.6%)	Surgical pathology report: Deep intramuscular invasion, positive margins, involvement of skeletal muscle Primary site: Thorax, chest wall (C493), Unclear whether skeletal muscle would be an adjacent organ, Staged as pT1, indicating organ confined <ul style="list-style-type: none"> Code 100: Confined to organ
Soft Tissue Abd/Thor	EOD Regional Nodes	000 (84.8%)	000 (84.8%)	Surgical pathology report: Regional Lymph Nodes: No lymph nodes submitted or identified Per Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative. Code unknown (999) only when there is no available information on the extent of the patient's disease, for example when a lab-only case is abstracted from a biopsy report and no clinical history is available. <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Soft Tissue Abd/Thor	Regional Nodes Positive	98 (70.7%)	98 (70.7%)	Surgical pathology report: No lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Soft Tissue Abd/Thor	EOD Mets	00 (99.4%)	00 (99.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Soft Tissue Abd/Thor	SS2018	1 (81.1%)	1 (81.1%)	Confined to organ (pT1 per physician assignment), no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized
Soft Tissue Abd/Thor	Grade Clinical	9 (83.5%)	9 (83.5%)	Clinical grade not documented in patient record First two biopsies, done during clinical work up, were negative for malignancy First grade reported was on surgical resection (pathology) <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Grade Pathological	1 (28.0%)	1 (28.0%)	Surgical pathology report: Histologic grade: Differentiation: 2 Mitoses: 1 Necrosis: 0 Grade, (FNCLCC): 3; grade = 1 First two biopsies, done during clinical work up, were negative for malignancy First grade reported was on surgical resection (excision), which qualifies for pathological grade

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 1: G1: Sum of differentiation score, mitotic count score and necrosis score equals 2 or 3
Soft Tissue Abd/Thor	Grade Post Therapy	Blank (78.0%)	Blank (78.0%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Soft Tissue Abd/Thor	Bone Invasion	0 (95.1%)	0 (95.1%)	No mention of bone invasion in imaging reports Per Note 3: Code 0 if relevant imaging is performed and there is no mention of bone invasion <ul style="list-style-type: none"> Code 0: Bone invasion not present/not identified on imaging
Tongue Anterior	Primary Site	C022 (28.8%)	C020 (57.7%)	Per the 2018 Solid Tumor Rules for Head and Neck, the priority order for assigning primary site is: <ol style="list-style-type: none"> Tumor Board: No information from Tumor Board Tissue/pathology from tumor resection or biopsy Scans Physician documentation Operative report: Dorsal surface of tongue <ul style="list-style-type: none"> Code C020: Dorsal surface of tongue, NOS
Tongue Anterior	Histology	8070 (95.1%)	8070 (95.1%)	Surgical pathology report: Histology: Squamous cell carcinoma <ul style="list-style-type: none"> Code 8070
Tongue Anterior	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Tongue Anterior	Tumor Size Clinical	024 (69.3%)	024 (69.3%)	CT Neck Soft Tissue, 2.4 x 2.4 x 1.8 cm tongue lesion. Physician states 2.5 cm. Per the SEER manual for Tumor Size Clinical, #7: Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, <i>and over a physical exam</i> . This states that imaging takes priority over physical exam. <ul style="list-style-type: none"> Code 024

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Tongue Anterior	Tumor Size Pathologic	025 (98.2%)	025 (98.2%)	Surgical pathology report: 2.5 cm <ul style="list-style-type: none"> Code 025
Tongue Anterior	EOD Primary Tumor	150 (65.6%)	150 (65.6%)	Surgical pathology report: 2.5 cm tumor, depth of invasion 8 mm Per operative report, floor of mouth involved, operative procedure included resection of floor of mouth. Pathology report does not document floor of mouth as being positive; however, there are positive margins. Per EOD General Instructions 3. Pathological findings take priority over clinical findings. a. Assign the highest code representing the greatest extension pathologically (based on pathology report), when available In this situation, the pathology report findings would be based on the tumor confined to the tongue <ul style="list-style-type: none"> Code 150: Group 1 WITH depth of invasion (DOI) greater than 5 mm and less than or equal to 10 mm
Tongue Anterior	EOD Regional Nodes	600 (62.6%)	600 (62.6%)	Surgical pathology report: 2/36 lymph nodes positive, ENE present <ul style="list-style-type: none"> Code 600: PATHOLOGICAL ONLY: Metastasis in MULTIPLE ipsilateral, contralateral, or bilateral nodes, Extranodal extension (ENE) positive for any node
Tongue Anterior	Regional Nodes Positive	02 (98.8%)	02 (98.8%)	Surgical pathology report: 2/36 lymph nodes positive <ul style="list-style-type: none"> Code 02
Tongue Anterior	EOD Mets	00 (98.8%)	00 (98.8%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Tongue Anterior	SS2018	3 (68.1%)	3 (68.1%)	Confined to site of origin, positive regional lymph nodes, no evidence metastasis Per operative report, floor of mouth involved, operative procedure included resection of floor of mouth. Pathology report does not document floor of mouth as being positive; however, there are positive margins. Per Summary Stage 2018 General Instructions, #4

Group 3 Case	Group 3 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are important when all malignant tissue cannot be, or was not, removed. <ul style="list-style-type: none"> In the event of a discrepancy between pathology and operative reports concerning excised tissue, <i>priority is given to the pathology report</i> Code 3: Localized tumor with positive regional lymph nodes
Tongue Anterior	Grade Clinical	3 (87.1%)	3 (87.1%)	Biopsy pathology report: Poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Tongue Anterior	Grade Pathological	3 (36.2%)	3 (36.2%)	Surgical pathology report: G2 Per Note 2: Assign the highest grade from the primary tumor. If the clinical grade is the highest grade identified, use the grade that was identified during the clinical time frame for both the clinical grade and the pathological grade. (This follows the AJCC rule that pathological time frame includes all of the clinical time frame information plus information from the resected specimen). <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Tongue Anterior	Grade Post Therapy	Blank (89.6%)	Blank (89.6%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Tongue Anterior	Extranodal Exten H & N Clin	0 (51.5%)	0 (51.5%)	Clinic note: Noted to have 1 cm mobile lymph node in right cervical chain; physician also assigned N1 for clinical stage. No evidence of ENE. <ul style="list-style-type: none"> Code 0: Regional lymph node(s) involved, ENE not present/not identified during diagnostic workup
Tongue Anterior	Extranodal Exten H & N Path	X.2 (54.6%)	X.2 (54.6%)	Surgical pathology report: Extranodal Extension (ENE): Present, ENEmi (<= 2 mm). <i>Note: The <=2mm is the definition of ENE mi.</i> <ul style="list-style-type: none"> Code X.2: ENE microscopic, size unknown, Stated as ENE (mi)
Tongue Anterior	Human Papilloma Virus (HPV) Status	9 (93.3%)	9 (93.3%)	HPV not documented in patient record <ul style="list-style-type: none"> Code 9: Unknown if HPV test detecting viral DNA and or RNA was performed
Tongue Anterior	LN Size	0.4 (40.5%)	4.0 (31.9%)	Surgical pathology report: Size of Largest Metastatic Deposit in Centimeters 0.4, equal to 4 mm <ul style="list-style-type: none"> Code 4.0

Group 4 Cases

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Primary Site	C713 (62.4%)	C713 (62.4%)	<p>Per the 2018 Solid Tumor Rules for Malignant CNS and Peripheral Nerves, the priority order for assigning primary site is</p> <ol style="list-style-type: none"> 1. Resection <ul style="list-style-type: none"> • Operative report • Pathology report 2. Biopsy <ul style="list-style-type: none"> • Operative report • Pathology report 3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information) <ul style="list-style-type: none"> • Tumor Board • Code from physician’s documentation of original diagnosis from operative report or pathology report OR • Physician’s documentation of primary site in the medical record 4. For cases diagnosed by imaging (no pathology/resection or biopsy), use information from scans in the following priority order: MRI, CT, PET, Angiogram <p>Resection, operative report, takes priority: Right parietal occipital region of his head</p> <ul style="list-style-type: none"> • Code C713: Parietal lobe
Brain	Histology	9440 (97.0%)	9440 (97.0%)	<p>Surgical pathology report: Glioblastoma, IDH-wildtype</p> <ul style="list-style-type: none"> • Code 9440: Glioblastoma, NOS
Brain	Behavior	3 (100%)	3 (100%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Brain	Tumor Size Clinical	075 (89.1%)	075 (89.1%)	<p>MRI Brain: 3.0 x 7.5 cm mass</p> <ul style="list-style-type: none"> • Code 075

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Tumor Size Pathologic	999 (93.3%)	999 (93.3%)	Size not stated in record, operative report also states that about 10% of tumor left behind <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Brain	EOD Primary Tumor	100 (84.2%)	100 (84.2%)	Surgical pathology report: Confined to the brain CT scan shows right midline shift: Midline shift does not affect extension. It must state "crosses the midline" to be coded to 500 <ul style="list-style-type: none"> Code 100: Confined to the brain
Brain	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value (no lymph nodes in the brain) <ul style="list-style-type: none"> Code 888: Not applicable
Brain	Regional Nodes Positive	99 (82.4%)	99 (82.4%)	Not applicable: Default value (no lymph nodes in the brain) <ul style="list-style-type: none"> Code 99: Not applicable
Brain	EOD Mets	00 (97.6%)	00 (97.6%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Brain	SS2018	1 (87.3%)	1 (87.3%)	Confined to the brain, no evidence of metastasis CT scan shows right midline shift: Midline shift does not affect extension. It must state "crosses the midline" to be coded to 2 <ul style="list-style-type: none"> Code 1: Localized
Brain	Grade Clinical	9 (77.6%)	9 (77.6%)	Operative procedure: working diagnosis neoplasm of unspecified behavior of brain; clinical grade cannot be assigned, no confirmed diagnosis until resection <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Brain	Grade Pathological	4 (86.7%)	4 (86.7%)	Glioblastoma, WHO Grade IV, IDH Wildtype <ul style="list-style-type: none"> Code 4: WHO Grade IV: Tumors that are cytologically malignant, mitotically active, and associated with rapid clinical progression and potential for dissemination
Brain	Grade Post Therapy	Blank (74.5%)	Blank (74.5%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Brain	Brain Molecular Markers	05 (80.0%)	05 (80.0%)	Surgical pathology report: Glioblastoma, IDH-wildtype (9440/3) <ul style="list-style-type: none"> Code 05: Glioblastoma, IDH-wildtype (9440/3)

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Chromosome 1p Status	9 (93.3%)	9 (93.3%)	Chromosome 1p not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 1p deletion/LOH not assessed or unknown if assessed
Brain	Chromosome 19q Status	9 (93.9%)	9 (93.9%)	Chromosome 19q not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist, Chromosome 19q: LOH not assessed or unknown if assessed
Brain	MGMT	9 (92.7%)	9 (92.7%)	MGMT not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist MGMT not assessed or unknown if assessed
Breast	Primary Site	C508 (90.9%)	C508 (90.9%)	Per Appendix C of the SEER manual, Breast Coding Guidelines, the following priority order is used when there is conflicting information <ol style="list-style-type: none"> Operative Report Pathology Report Mammogram, ultrasound (ultrasound becoming more frequently used) Physical examination <p>No operative report available. Pathology report only states "right breast." Mammogram and ultrasound state mass at 9 o'clock position, which physician confirms in general surgery consult</p> <p>Per SEER manual, Breast coding guidelines, code the primary site to 508 when stated as 12, 3, 6, or 9 o'clock position in breast</p> <ul style="list-style-type: none"> Code C508: Overlapping lesion of breast
Breast	Histology	8520 (90.2%)	8520 (90.2%)	Surgical pathology report: Infiltrating lobular carcinoma <ul style="list-style-type: none"> Code 8520: Lobular carcinoma, NOS
Breast	Behavior	3 (98.2%)	3 (98.2%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	Tumor Size Clinical	028 (51.8%)	030 (25.6%)	<p>Per SEER manual, Tumor Size Clinical, #7: Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, and over a physical exam</p> <p>Per #8: Tumor size discrepancies among imaging and radiographic reports: Record the largest size in the record regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies the imaging that is most accurate Physician references the mammogram, which takes priority</p> <ul style="list-style-type: none"> Code 030: 3 cm
Breast	Tumor Size Pathologic	035 (96.3%)	035 (96.3%)	<p>Surgical pathology report: Tumor size at least 3.5 cm</p> <ul style="list-style-type: none"> Code 035
Breast	EOD Primary Tumor	100 (94.5%)	100 (94.5%)	<p>Surgical pathology report: 3.5 cm mass, confined to breast, no mention of any other involvement</p> <ul style="list-style-type: none"> Code 100: Localized, confined to breast
Breast	EOD Regional Nodes	070 (37.8%)	070 (37.8%)	<p>Surgical pathology report: 0/5 SLNs, no evidence of isolated tumor cells Note: Code 000 for is negative nodes-clinical evaluation only. Since there was a sentinel lymph node biopsy done, a pathological code must be used.</p> <ul style="list-style-type: none"> Code 070: No regional lymph node involvement pathologically, (lymph nodes removed and pathologically negative), WITHOUT ITCs or ITC testing unknown
Breast	Regional Nodes Positive	00 (95.7%)	00 (95.7%)	<p>Surgical pathology report: 0/5 SLNs</p> <ul style="list-style-type: none"> Code 00: All nodes examined negative
Breast	EOD Mets	00 (97.6%)	00 (97.6%)	<p>No clinical evidence of metastasis</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Breast	SS2018	1	1	Mass confined to breast, no evidence of lymph nodes or metastasis

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(95.1%)	(95.1%)	<ul style="list-style-type: none"> Code 1: Localized, confined to breast
Breast	Grade Clinical	2 (76.2%)	2 (76.2%)	<p>Biopsy pathology report: Grade 2. Although Nottingham is not mentioned, the "G2" fits the format for the preferred grading system</p> <ul style="list-style-type: none"> Code 2: G2: Intermediate combined histologic grade (moderately favorable); SBR score of 6-7 points
Breast	Grade Pathological	3 (93.9%)	3 (93.9%)	<p>Surgical pathology report: Nottingham Grade 3</p> <ul style="list-style-type: none"> Code 3: G3: High combined histologic grade (unfavorable); SBR score of 8-9 points
Breast	Grade Post Therapy	Blank (81.7%)	Blank (81.7%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Breast	Sentinel Lymph Nodes Examined	05 (95.7%)	05 (95.7%)	<p>Surgical pathology report: 0/5 SLNs</p> <ul style="list-style-type: none"> Code 05
Breast	Sentinel Lymph Nodes Positive	00 (98.2%)	00 (98.2%)	<p>Surgical pathology report: 0/5 SLNs</p> <ul style="list-style-type: none"> Code 00: All sentinel nodes examined are negative
Breast	ER Summary	1 (97.6%)	1 (97.6%)	<p>Biopsy pathology report: ER Report: Estrogen Receptor (ER) Status Positive Percentage of cells with nuclear positivity 91-100% Average Intensity of Staining Strong</p> <ul style="list-style-type: none"> Code 1: ER Positive
Breast	ER Percent Positive	R99 (82.3%)	R99 (82.3%)	<p>Biopsy pathology report: Percent positive stated as 91-100%</p> <ul style="list-style-type: none"> Code R99: Stated as 91-100%
Breast	ER Allred Score	08 (49.4%)	08 (49.4%)	<p>Biopsy pathology report: Proportion score of 91-100%. Per the "Allred Score* for Estrogen and Progesterone Receptor Evaluation" in the SSDI manual, a percent positive of 91-100 is equal to a proportion score of 5. A strong intensity is equal to a 3-intensity score. To get Allred Score, add the two together: 5 + 3 = 8.</p> <ul style="list-style-type: none"> Code 08: Total ER Allred score of 8
Breast	PR Summary	1 (96.3%)	1 (96.3%)	<p>Biopsy pathology report: Progesterone Receptor (PgR) Status Positive Percentage of cells with nuclear positivity 91-100% Average Intensity of Staining Strong</p> <ul style="list-style-type: none"> Code 1: PR Positive
Breast	PR Percent Positive	R99	R99	Biopsy pathology report: Percent positive stated as 91-100%

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(79.3%)	(79.3%)	<ul style="list-style-type: none"> R99: Stated as 91-100%
Breast	PR Allred Score	08 (45.7%)	08 (45.7%)	<p>Biopsy pathology report: Proportion score of 91-100%. Per the “Allred Score* for Estrogen and Progesterone Receptor Evaluation” in the SSDI manual, a percent positive of 91-100 is equal to a proportion score of 5. A strong intensity is equal to a 3-intensity score. To get Allred Score, add the two together: 5 + 3 = 8.</p> <ul style="list-style-type: none"> Code 08: Total PR Allred score of 8
Breast	HER2 IHC Summary	1 (72.0%)	1 (72.0%)	<p>Biopsy pathology report: HER2 by immunohistochemistry (IHC) Negative (Score "1 +)</p> <ul style="list-style-type: none"> Code 1: Negative (Score 1+)
Breast	HER2 ISH Summary	9 (81.1%)	9 (81.1%)	<p>HER2 ISH Summary not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Not documented in medical record, Results cannot be determined (indeterminate), HER2 ISH Summary not assessed or unknown if assessed
Breast	HER2 Overall Summary	0 (87.2%)	0 (87.2%)	<p>HER2 IHC negative, HER2 FISH not done, overall HER2 score is negative</p> <ul style="list-style-type: none"> Code 0: HER2 negative; equivocal
Breast	HER2 SP Copy Number	XX.9 (90.9%)	XX.9 (90.9%)	<p>HER2 SP Copy Number not documented in patient record</p> <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Copy Number	XX.9 (93.3%)	XX.9 (93.3%)	<p>HER2 ISH not documented in patient record</p> <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Dual Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Ratio	XX.9 (93.9%)	XX.9 (93.9%)	<p>HER2 ISH not documented in patient record</p> <ul style="list-style-type: none"> Code XX.9: Not documented in patient record, Results cannot be determined (indeterminate), HER2 ISH dual probe ratio not assessed or unknown if assessed
Breast	Ki-67	0.4 (32.3%)	0.4 (32.3%)	<p>Biopsy pathology report: KI67 index 0.38. Following general rounding rules, round up for hundredths .5 to .9, 0.4</p> <ul style="list-style-type: none"> Code 0.4

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	Lymph Nodes Positive Axillary Level I-II	00 (87.2%)	00 (87.2%)	Surgical pathology report: 0/5 SLNs <ul style="list-style-type: none"> Code 00: All ipsilateral axillary nodes examined negative
Breast	Multigene Signature Method	9 (86.0%)	9 (86.0%)	Multigene Signature Method not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Multigene Signature Method not assessed or unknown if assessed
Breast	Multigene Signature Results	X9 (82.9%)	X9 (82.9%)	Multigene Signature Results not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, Multigene Signature Results not assessed or unknown if assessed
Breast	Oncotype DX Recur Score – DCIS	XX6 (68.9%)	XX6 (68.9%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> Code XX6: Not applicable, invasive case
Breast	Oncotype DX Recur Score	025 (86.6%)	025 (86.6%)	Oncotype Dx Report: Breast Cancer Node Negative: 025 <ul style="list-style-type: none"> Code 025
Breast	Oncotype Dx Risk Level – DCIS	6 (64.6%)	6 (64.6%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> Code 6: Not applicable, invasive case
Breast	Oncotype Dx Risk Level Invasive	1 (80.5%)	1 (80.5%)	Oncotype Dx Report: Breast Cancer Node Negative: 025 <ul style="list-style-type: none"> Code 1: Intermediate risk (recurrence score 18-30)
Breast	Response to Neoadjuvant Therapy	0 (86.0%)	0 (86.0%)	No neoadjuvant therapy given <ul style="list-style-type: none"> Code 0: Neoadjuvant therapy not given
Colon and Rectum	Primary Site	C187 (96.3%)	C187 (96.3%)	Per the coding guidelines from SEER, the following priority order for assigning primary site for Colon is <ul style="list-style-type: none"> Resected cases <ul style="list-style-type: none"> Operative report with surgeon’s description Pathology report Imaging Non-resected cases <ul style="list-style-type: none"> Polypectomy or excision without resection Endoscopy report <p>Operative report, which takes priority, states descending colon obstruction</p>

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Operative notes state colon dilation and stenosis at the junction of the descending colon/sigmoid colon, pathology report confirms sigmoid colon <ul style="list-style-type: none"> Code C187: Sigmoid colon
Colon and Rectum	Histology	8140 (100%)	8140 (100%)	Surgical pathology report: Adenocarcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma
Colon and Rectum	Behavior	3 (98.8%)	3 (98.8%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Colon and Rectum	Tumor Size Clinical	999 (95.1%)	999 (95.1%)	Clinical tumor size not documented in patient record <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Colon and Rectum	Tumor Size Pathologic	025 (96.3%)	025 (96.3%)	Surgical pathology report: 2.5 cm <ul style="list-style-type: none"> Code 025
Colon and Rectum	EOD Primary Tumor	400 (61.1%)	400 (61.1%)	Surgical pathology report: Tumor invades through the muscularis propria into peri-colorectal fat. No further information regarding invasion of other structures/tissues. Per updated instructions, Sigmoid colon is peritonealized and code 400 should be used for extension into pericolic fat <ul style="list-style-type: none"> Code 400: Tumor invades into pericolic fat
Colon and Rectum	EOD Regional Nodes	000 (98.8%)	000 (98.8%)	Surgical pathology report: 0/12 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement and no tumor deposits (TD)
Colon and Rectum	Regional Nodes Positive	00 (98.8%)	00 (98.8%)	Surgical pathology report: 0/12 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Colon and Rectum	EOD Mets	00 (98.8%)	00 (98.8%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Colon and Rectum	SS2018	2 (71.0%)	2 (71.0%)	Tumor invades through the muscularis propria into peri-colorectal fat. No further information regarding invasion of other structures/tissues. Code based on the invasion through the muscularis propria, no evidence lymph nodes or metastasis

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Per updated instructions, Sigmoid colon is peritonealized and code 2 should be used for extension into pericolic fat <ul style="list-style-type: none"> Code 2: Regional
Colon and Rectum	Grade Clinical	9 (95.1%)	9 (95.1%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Colon and Rectum	Grade Pathological	1 (96.3%)	1 (96.3%)	Surgical pathology report: Well differentiated <ul style="list-style-type: none"> Code 1: G1: Well differentiated
Colon and Rectum	Grade Post Therapy	Blank (79.0%)	Blank (79.0%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Colon and Rectum	CEA PreTx Interpretation	9 (96.3%)	9 (96.3%)	CEA PreTx Interpretation not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Colon and Rectum	CEA PreTx Lab Value	XXXX.9 (94.4%)	XXXX.9 (94.4%)	CEA PreTx Lab value not documented in patient record <ul style="list-style-type: none"> Code XXXX.9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed
Colon and Rectum	Circumferential Resection Margin	XX.1 (27.2%)	XX.9 (48.8%)	Surgical specimen: All margins clear, proximal/distal distance from margin given, but not for radial/circumferential Per Note 8: Use code XX.9 (CRM not mentioned) if the pathology report describes only distal and proximal margins, or margins, NOS. To use code XX.1, must have statement that radial/circumferential margins are clear. <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Circumferential or radial resection margin not assessed or unknown if assessed
Colon and Rectum	KRAS	9 (96.9%)	9 (96.9%)	KRAS not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, KRAS not assessed or unknown if assessed
Colon and Rectum	Microsatellite Instability	0 (44.4%)	0 (44.4%)	Surgical pathology report: IHC Testing for MMR: Intact nuclear expression, low probability for MSI-H

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Note: Per confirmation from AJCC and CAP, a statement of “low probability of MSI-H” is equivalent to a MSI-S (code 0). This test was a MMR test since “intact nuclear expression” was noted, which is the definition of code 0 for the MMR test.</p> <ul style="list-style-type: none"> Code 0: Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins <p>Further follow up, oncologist states patient is not MSI-H. Further notes state that patient is MMR proficient, which is not terminology used in the SSDI</p> <p>Based on the MMR results, go with the 0, which show that there is intact protein expression on all microsatellites tested</p>
Colon and Rectum	Perineural Invasion	0 (94.4%)	0 (94.4%)	<p>Surgical pathology report: Perineural invasion not identified</p> <ul style="list-style-type: none"> Code 0: Perineural invasion not identified/not present
Colon and Rectum	Tumor Deposits	00 (95.7%)	00 (95.7%)	<p>Surgical pathology report: Tumor deposits not identified</p> <ul style="list-style-type: none"> Code 00: No tumor deposits
Lung	Primary Site	C341 (98.1%)	C341 (98.1%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site</p> <p><i>Note:</i> There are no specific primary site instructions for Lung.</p> <p>CT Scan: Right upper lobe mass. Pulmonary consult: Physician refers to "right upper lobe" based on CT scan</p> <ul style="list-style-type: none"> Code 341: Upper lobe, lung
Lung	Histology	8140 (89.5%)	8140 (89.5%)	<p>Biopsy pathology report: non-small cell carcinoma consistent with adenocarcinoma</p> <p>Per the Solid Tumor Rules, Lung, H3: Code the specific histology when the diagnosis is non-small cell lung carcinoma (NSCLC) consistent with (or any other ambiguous term) a specific carcinoma (such as adenocarcinoma, squamous cell carcinoma,</p>

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				etc.) when: The histology is clinically confirmed by a physician (attending, pathologist, oncologist, pulmonologist, etc. <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Lung	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lung	Tumor Size Clinical	110 (58.0%)	110 (58.0%)	Chest Xray notes 10.8 cm mass in the right and upper lobe PET Scan: Large mass in right upper lobe contiguous with right hilum and mediastinum, 11. 0 x 7. 7 cm Per SEER Manual, Tumor Size Clinical, #8: Record the largest size in the record regardless of the imaging technique, when there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies the imaging that is most accurate <ul style="list-style-type: none"> Code 110
Lung	Tumor Size Pathologic	999 (96.9%)	999 (96.9%)	Pathological tumor size not document in patient record, no surgical resection <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Lung	EOD Primary Tumor	700 (12.3%)	650 (42.6%)	Pulmonary consult: RUL mass, with possible separate tumor nodule in right apex (possible is not an ambiguous term that indicates involvement; pulmonary consult states spiculated nodular opacities c/w mets noted in radiology report; however, does not factor this insto staging [considered them negative]; staged clinically as IIIB, T4N3M0; imaging showed invades parietal pleura, paratracheal region, compresses SVC; confluent with right hilum <ul style="list-style-type: none"> Code 650: Based on compression of the SVC (SVC syndrome)
Lung	EOD Regional Nodes	600 (58.0%)	600 (58.0%)	Pulmonary consult: Noted to have supraclavicular nodal metastases. PET showed involvement of paratracheal "region." No definitive statement of involvement of paratracheal nodes (code 700). <ul style="list-style-type: none"> Code 600: Supraclavicular lymph nodes
Lung	Regional Nodes Positive	98 (77.8%)	98 (77.8%)	No regional lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Lung	EOD Mets	00	00	Pulmonary consult: No evidence of metastatic disease

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(77.8%)	(77.8%)	<ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Lung	SS2018	7 (47.5%)	7 (47.5%)	Supraclavicular lymph nodes (N3) involved <ul style="list-style-type: none"> Code 7: Distant lymph nodes
Lung	Grade Clinical	9 (98.8%)	9 (98.8%)	Clinical grade not documented <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Pathological	9 (98.1%)	9 (98.1%)	Per Note 6, 2 nd bullet: Code 9 when there is no resection of the primary site <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Post Therapy	Blank (79.6%)	Blank (79.6%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lung	Separate Tumor Nodules	1 (16.7%)	0 (41.4%)	<p>Per PET Scan: possible metastasis to the right lung apex. Possible is not an ambiguous term that indicates involvement.</p> <p>Pulmonary consult: Spiculated nodular opacities consistent with metastases in both lungs (per radiology); however, final stage does not indicate separate tumor nodules (signed out as M0)</p> <p>Oncology consult: A PET CT scan was performed on 5/14/2018 revealing a large metabolic right upper lobe mass with right supraclavicular metastases and question of metastatic disease in the right lung apex (question of second small focus of disease). No definitive diagnosis of a separate tumor nodule</p> <ul style="list-style-type: none"> Code 0: No separate tumor nodules; single tumor only
Lung	Visceral and Parietal Pleural Invasion	9 (44.4%)	9 (44.4%)	No surgical resection of primary tumor is done <ul style="list-style-type: none"> Code 9: Not documented in medical record, No surgical resection of primary site is performed, Visceral Pleural Invasion not assessed or unknown if assessed or cannot be determined
Lymphoma CLL/SLL	Primary Site	C778 (40.6%)	C421 (32.5%)	<p>Per Record: peripheral blood flow cytometry demonstrated 90% lymphocytes demonstrating CD5, CD19, dim CD20 and CD23 positivity. These are lambda restricted. The ZAP70 was positive in 80% of cells. IGHV unmutated. CLL FISH panel was normal.</p> <ul style="list-style-type: none"> Per the documentation available, the peripheral blood smear was not a definitive diagnosis of CLL/SLL

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Physician later confirmed diagnosis based on peripheral blood <p>Per Heme Manual, Module 3: PH5: Code the primary site to bone marrow (C421) when the bone marrow is involved or when only peripheral blood is involved</p> <ul style="list-style-type: none"> Code C421: Bone marrow
Lymphoma CLL/SLL	Histology	9823 (100%)	9823 (100%)	Lymph node biopsy: CLL/SLL <ul style="list-style-type: none"> Code 9823: Chronic lymphocytic leukemia/small lymphocytic lymphoma
Lymphoma CLL/SLL	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lymphoma CLL/SLL	Tumor Size Clinical	999 (92.5%)	999 (92.5%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	Tumor Size Pathologic	999 (95.6%)	999 (95.6%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	EOD Primary Tumor	600 (67.5%)	800 (12.5%)	<p>If primary site is C421, EOD Primary Tumor is 800</p> <p>A new note will be added regarding peripheral blood involvement, also will be added to code 800 in the next release of the EOD manual</p> <p>Bone marrow included in code 800 (positive bone marrow aspirate)</p> <ul style="list-style-type: none"> Code 800: Peripheral blood involvement
Lymphoma CLL/SLL	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 888: Not applicable
Lymphoma CLL/SLL	Regional Nodes Positive	99 (97.5%)	99 (97.5%)	Not applicable: Default value <ul style="list-style-type: none"> Code 99: Not applicable
Lymphoma CLL/SLL	EOD Mets	88 (100%)	88 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 88: Not applicable
Lymphoma CLL/SLL	SS2018	7 (86.9%)	7 (86.9%)	<p>If primary site is C421, Summary Stage is 7</p> <p>A new note will be added regarding peripheral blood involvement, also will be added to code 7 in the next release of the SS2018 manual</p> <p>Bone marrow included in code 7 (positive bone marrow aspirate)</p> <ul style="list-style-type: none"> Code 7: Peripheral blood involvement

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lymphoma CLL/SLL	Grade Clinical	8 (100%)	8 (100%)	Grade not applicable for this Heme schema <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Pathological	8 (100%)	8 (100%)	Grade not applicable for this Heme schema <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Post Therapy	Blank (55.6%)	Blank (55.6%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lymphoma CLL/SLL	Adenopathy	1 (95.0%)	1 (95.0%)	Clinic note: Supraclavicular node 5.1 cm, Level 3-3.6 cm node, Level 2A, 3.1 cm node <ul style="list-style-type: none"> Code 1: Adenopathy present, Presence of lymph nodes > 1.5 cm
Lymphoma CLL/SLL	Anemia	0 (66.9%)	0 (66.9%)	Lab: Hgb 13.1 <ul style="list-style-type: none"> Code 0: Anemia not present, Hgb >=11.0 g/dL
Lymphoma CLL/SLL	B symptoms	0 (81.9%)	0 (81.9%)	Clinic Note: No weight loss, fevers, chills. <ul style="list-style-type: none"> Code 0: No B symptoms
Lymphoma CLL/SLL	HIV status	9 (90%)	9 (90%)	HIV status not documented in medical record Per Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative. <ul style="list-style-type: none"> Code 9: Not documented in medical record, HIV status not assessed or unknown if assessed
Lymphoma CLL/SLL	Lymphocytosis	9 (73.8%)	6 (5.0%)	Patient noted to have an elevated white blood count (WBC). This is not enough to determine lymphocytosis. <ul style="list-style-type: none"> Monocytes. They have a longer lifespan than many white blood cells and help to break down bacteria. Lymphocytes. They create antibodies to fight against bacteria, viruses, and other potentially harmful invaders. Neutrophils. They kill and digest bacteria and fungi. They are the most numerous type of white blood cell and your first line of defense when infection strikes. Basophils. These small cells seem to sound an alarm when infectious agents invade your blood. They secrete chemicals such as histamine, a

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>marker of allergic disease, that help control the body's immune response.</p> <ul style="list-style-type: none"> Eosinophils. They attack and kill parasites and cancer cells, and help with allergic responses. <p>Reasons for a high WBC: extreme physical stress caused by an injury or emotional stress can also trigger high white blood cell levels, inflammation, smoking, extreme exercise, some medications raise the WBC</p> <ul style="list-style-type: none"> So, based on a WBC result only, this data item cannot be coded <p>Physician also stated this patient had a RAI Stage I CLL. Per the definition for Stage I RAI Stage (see AJCC 8th edition, Chapter 79: Table 79.7): There must be evidence of lymphocytosis and adenopathy</p> <ul style="list-style-type: none"> Code 6: Lab value unknown, physician states lymphocytosis is present
Lymphoma CLL/SLL	NCCN International Prognostic Index (IPI)	X9 (95.0%)	X9 (95.0%)	<p>NCCN not documented in patient record</p> <ul style="list-style-type: none"> Code X9: Not documented in medical record, NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Lymphoma CLL/SLL	Organomegaly	0 (76.3%)	0 (76.3%)	<p>Clinic Note: Abdomen, soft, nontender, nondistended with normoactive bowel sounds. No hepatosplenomegaly</p> <ul style="list-style-type: none"> Code 0: Organomegaly of liver and/or spleen not present
Lymphoma CLL/SLL	Thrombocytopenia	0 (33.1%)	0 (33.1%)	<p>Clinic Oncology Note: Platelets 106. Multiple 106 X1000= 106,000</p> <ul style="list-style-type: none"> Code 0: Thrombocytopenia not present, Platelets (Plt) >=100,000/μL
Melanoma Skin	Primary Site	C446 (96.9%)	C446 (96.9%)	<p>Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site</p> <p>Note: There are no specific primary site instructions for Melanoma Skin</p> <p>History and Physical: Left arm melanoma</p> <ul style="list-style-type: none"> Code C446: Skin of upper limb and shoulder
Melanoma Skin	Histology	8720 (100%)	8720 (100%)	<p>Melanoma, NOS</p> <ul style="list-style-type: none"> 8720: Malignant melanoma, NOS

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	Behavior	3 (98.8%)	3 (98.8%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Melanoma Skin	Tumor Size Clinical	008 (48.8%)	008 (48.8%)	History and Physical states shave biopsy of left arm with 0.8 cm by 1.65 mm deep melanoma <ul style="list-style-type: none"> Code 008
Melanoma Skin	Tumor Size Pathologic	999 (67.3%)	999 (67.3%)	Wide excision done; however, results of the wide excision not available in patient record. <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Melanoma Skin	EOD Primary Tumor	400 (32.7%)	300 (10.5%)	Biopsy of lesion reported as 1.65 mm Breslow thickness. No mention of papillary or reticular surface involvement. Per the “Relationship Between Thickness, Depth of Invasion, and Clark Level Table,” found in the Summary Stage 2018 manual, this is a Level IV lesion based on the 1.65 mm measurement and no other mention of invasion into adjacent structures <ul style="list-style-type: none"> Code 300: Reticular dermis invaded, Clark level IV
Melanoma Skin	EOD Regional Nodes	000 (42.0%)	000 (42.0%)	Physical exam, no adenopathy (based on clinical evaluation only). Sentinel lymph node biopsy done, but results not documented in chart. Since only clinical information is available, which did not indicate lymph node involvement, go with no lymph node involvement Clinical impression: Stage I melanoma, which implies no clinical lymph node involvement <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Melanoma Skin	Regional Nodes Positive	99 (61.1%)	99 (61.1%)	Record documents sentinel node biopsy to be done, but results not in chart <ul style="list-style-type: none"> Code 99: Unknown if nodes are positive; not applicable, Not documented in patient record
Melanoma Skin	EOD Mets	00 (98.1%)	00 (98.1%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	SS2018	1 (61.7%)	1 (61.7%)	<p>Biopsy of lesion showed 1.65 mm Breslow’s depth. No mention of papillary or reticular surface involvement.</p> <p>Per the “Relationship Between Thickness, Depth of Invasion, and Clark Level Table,” found in the Summary Stage 2018 manual, this is a Level IV lesion based on the 1.65 mm measurement and no other mention of invasion into adjacent structures</p> <p>Per clinical assessment, there is no evidence of lymph node involvement</p> <p>Per physician’s assessment, clinically Stage I, indicating no evidence of lymph node involvement</p> <p>Even though the results of the sentinel lymph node procedure are not known, record what is known for this case</p> <ul style="list-style-type: none"> Code 1: Localized lesion, confined to site of origin
Melanoma Skin	Grade Clinical	9 (98.8%)	9 (98.8%)	<p>Clinical grade not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Pathological	9 (98.8%)	9 (98.8%)	<p>Pathological grade not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Post Therapy	Blank (83.3%)	Blank (83.3%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Melanoma Skin	Sentinel Lymph Nodes Examined	98 (13.6%)	02 (48.1%)	<p>Per the Operative report, 2 radioactive nodes were encountered and excised</p> <p>No pathology report is available for the sentinel lymph node procedure. Based on the operative report, 2 sentinel lymph nodes were removed.</p> <ul style="list-style-type: none"> Code 02
Melanoma Skin	Sentinel Lymph Nodes Positive	97 (1.9%)	99 (65.4%)	<p>Per the Operative report, 2 radioactive nodes were encountered and excised</p> <p>No pathology report is available for the sentinel lymph node procedure, so unknown if sentinel nodes were positive or negative</p> <ul style="list-style-type: none"> Code 99: Unknown if sentinel nodes are positive; Not documented in patient record

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	Breslow Thickness	1.7 (62.3%)	1.7 (62.3%)	1.65 mm depth; Only measured in tenths, round up last number. General rounding .05-.09, round up <ul style="list-style-type: none"> Code 1.7
Melanoma Skin	Ulceration	0 (64.2%)	0 (64.2%)	Physician statement of no evidence of ulceration when referencing shave biopsy <p>Per Note 1: Physician statement of microscopically confirmed ulceration (e.g., based on biopsy or surgical resection) can be used to code this data item</p> <ul style="list-style-type: none"> Code 0: Ulceration not identified/not present
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Lab Value	216.0 (53.1%)	216.0 (53.1%)	Lactate Dehydrogenase (LDH)-final result: 216 <p>LDH done after the shave biopsy. LDH is usually not tested until after a confirmation of melanoma, which means that it is done after the shave/punch/excisional biopsy which makes the diagnosis. LDH should be done prior to re-excision, or adjuvant therapy. LDH done prior to the re-excision and sentinel lymph node biopsy.</p> <ul style="list-style-type: none"> Code 216.0; lab result is documented
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Level	0 (66.7%)	0 (66.7%)	LDH value 216; range 119-226; is WNL (within normal limits) <p>See note in LDH (Lactate Dehydrogenase) Pretreatment Lab Value</p> <ul style="list-style-type: none"> Code 0: Normal LDH level
Melanoma Skin	LDH Upper Limits of Normal	226 (42.6%)	226 (42.6%)	LDH value 216; range 119-226 <p>See note in LDH (Lactate Dehydrogenase) Pretreatment Lab Value</p> <ul style="list-style-type: none"> Code 226 (exact upper limit of normal)
Melanoma Skin	Mitotic Rate Melanoma	02 (65.4%)	02 (65.4%)	Physician cites mitotic index of 2 <p>Per Note 1: Physician statement of the Mitotic Rate Melanoma can be used to code this data item when no other information is available</p> <ul style="list-style-type: none"> Code 02
Ovary	Primary Site	C569	C569	Surgical pathology report: Left ovary

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
		(100.0%)	(100.0%)	<ul style="list-style-type: none"> Code C569: Ovary
Ovary	Histology	8310 (96.2%)	8310 (96.2%)	Surgical pathology report: Clear cell carcinoma <ul style="list-style-type: none"> Code 8310: Clear cell adenocarcinoma, NOS
Ovary	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Ovary	Tumor Size Clinical	126 (44.9%)	126 (44.9%)	Imaging shows 12.6 cm mass Per confirmation from SEER, even though there was not a confirmation of malignancy prior to surgical exploration, the size from the imaging can be used as tumor size clinical <ul style="list-style-type: none"> Code 126
Ovary	Tumor Size Pathologic	135 (92.3%)	135 (92.3%)	Surgical pathology report: 13.5 x 10.6 x 8.8 <ul style="list-style-type: none"> Code 135
Ovary	EOD Primary Tumor	100 (95.5%)	100 (95.5%)	Surgical pathology report: Left ovary involved, surface involvement on ovary and fallopian tube absent, peritoneal washings negative <ul style="list-style-type: none"> Code 100: Limited to one ovary (capsule intact) AND No tumor on ovarian surface AND No malignant cells in ascites or peritoneal washings
Ovary	EOD Regional Nodes	000 (99.4%)	000 (99.4%)	Surgical pathology report: 0/47 Lymph nodes <ul style="list-style-type: none"> Code 000: Code 000: No regional lymph node involvement
Ovary	Regional Nodes Positive	00 (96.8%)	00 (96.8%)	Surgical pathology report: 0/47 Lymph nodes <ul style="list-style-type: none"> Code 00: All nodes examined negative
Ovary	EOD Mets	00 (98.7%)	00 (98.7%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Ovary	SS2018	1 (98.1%)	1 (98.1%)	Left ovary involved, surface involvement on ovary and fallopian tube absent, peritoneal washings negative <ul style="list-style-type: none"> Code 1: Localized
Ovary	Grade Clinical	9 (91.7%)	9 (91.7%)	Patient was diagnosed by imaging, no biopsy done, went straight to surgery, no clinical grade available. Physician notes state this is a grade 3; however, since there was no biopsy done (clinical), this would be a pathological grade and clinical grade would be unknown.

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Ovary	Grade Pathological	9 (55.1%)	3 (43.6%)	<p>Surgical pathology report: Histologic grade: not applicable; however, physician notes states this is a grade 3. Since no biopsy was done (patient went straight to surgery), this grade would be based on the surgical pathology.</p> <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated, undifferentiated
Ovary	Grade Post Therapy	Blank (80.8%)	Blank (80.8%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Ovary	CA-125 PreTX Lab Value	1 (79.5%)	1 (79.5%)	<p>Operative procedure section-patient had a slightly elevated CA-125</p> <ul style="list-style-type: none"> Code 1: Positive/elevated
Ovary	FIGO Stage	02 (80.1%)	02 (80.1%)	<p>Discharge Summary: Stage 1a</p> <ul style="list-style-type: none"> Code 02: FIGO Stage IA
Ovary	Residual Tumor Volume Post Cytoreduction	00 (50.0%)	97 (26.9%)	<p>Surgical operative report: Localized disease, no disease left behind</p> <p>No mention of cytoreduction or debulking</p> <ul style="list-style-type: none"> Code 97: No cytoreductive surgery performed
Prostate	Primary Site	C619 (100%)	C619 (100%)	<p>Biopsy pathology report: Prostate</p> <ul style="list-style-type: none"> Code C619: Prostate
Prostate	Histology	8140 (88.1%)	8140 (88.1%)	<p>Biopsy pathology report: Acinar adenocarcinoma</p> <p>Per Solid Tumor Rules for "Other Sites," Rule H10: Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma</p> <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Prostate	Behavior	3 (100%)	3 (100%)	<p>Invasive histology</p> <ul style="list-style-type: none"> Code 3: Malignant
Prostate	Tumor Size Clinical	999 (91.8%)	999 (91.8%)	<p>Tumor size clinical not documented in patient record</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	Tumor Size Pathologic	999 (96.9%)	999 (96.9%)	<p>Tumor Size Pathologic not available</p> <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	EOD Primary Tumor	120 (75.5%)	120 (75.5%)	Clinic Note, Prostate moderate sized, symmetric, benign and smooth with no nodules Elevated PSA <ul style="list-style-type: none"> Code 120: Tumor identified by needle biopsy (clinically inapparent/not palpable)
Prostate	Prostate Path Exten	900 (85.5%)	900 (85.5%)	No prostatectomy done <ul style="list-style-type: none"> Code 900: No prostatectomy or autopsy performed
Prostate	EOD Regional Nodes	000 (88.7%)	000 (88.7%)	CT Chest Abdomen Pelvis: No evidence of lymphadenopathy <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Prostate	Regional Nodes Positive	98 (79.2%)	98 (79.2%)	No regional lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Prostate	EOD Mets	30 (86.2%)	30 (86.2%)	CT Chest Abdomen Pelvis: Diffuse osseous metastases from prostate carcinoma <ul style="list-style-type: none"> Code 30: Bone WITH or WITHOUT distant lymph node(s)
Prostate	SS2018	7 (89.9%)	7 (89.9%)	Bone metastasis <ul style="list-style-type: none"> Code 7: Distant metastasis (bone metastasis)
Prostate	Grade Clinical	3 (92.5%)	3 (92.5%)	Biopsy pathology report: Clinical Gleason pattern 4+3=7 <ul style="list-style-type: none"> Code 3: Grade Group 3: Gleason score 7, Gleason pattern 4+3
Prostate	Grade Pathological	9 (86.8%)	9 (86.8%)	Per Note 5, 2 nd bullet: Code 9 when there is no resection of the primary site <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Prostate	Grade Post Therapy	Blank (83.0%)	Blank (83.0%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Prostate	PSA Lab Value	XXXX.1 (83.6%)	XXXX.1 (83.6%)	Clinic note, PSA 4076 <ul style="list-style-type: none"> Code XXXX.1: 1,000 ng/ml or greater
Prostate	Gleason Patterns Clinical	43 (95.6%)	43 (95.6%)	Biopsy pathology report: Clinical Gleason pattern 4+3=7 <ul style="list-style-type: none"> Code 43
Prostate	Gleason Score Clinical	07 (97.5%)	07 (97.5%)	Biopsy pathology report: Clinical Gleason pattern 4+3=7 <ul style="list-style-type: none"> Code 07: Gleason score 7
Prostate	Gleason Patterns Pathological	X7 (84.3%)	X7 (84.3%)	No prostatectomy done <ul style="list-style-type: none"> Code X7: No prostatectomy done

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	Gleason Score Pathological	X7 (84.9%)	X7 (84.9%)	No prostatectomy done <ul style="list-style-type: none"> Code X7: No prostatectomy done
Prostate	Gleason Tertiary Pattern	X7 (85.5%)	X7 (85.5%)	No prostatectomy done <ul style="list-style-type: none"> Code X7: No prostatectomy done
Prostate	Number of Cores Examined	15 (47.8%)	15 (47.8%)	Biopsy pathology report: 15 cores examined per gross description <ul style="list-style-type: none"> Code 15
Prostate	Number of Cores Positive	02 (93.1%)	02 (93.1%)	Biopsy pathology report: 2 cores positive <ul style="list-style-type: none"> Code 02
Soft Tissue Abd/Thor	Primary Site	C494 (96.1%)	C494 (96.1%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site Note: There are no specific primary site instructions for Soft Tissue Surgical Pathology: Abdominal wall tumor <ul style="list-style-type: none"> Code C494: Connective, subcutaneous and other soft tissues of abdomen
Soft Tissue Abd/Thor	Histology	8803 (80.0%)	8803 (80.0%)	Surgical pathology report: CIC-DUY4 Positive Round Cell Sarcoma <ul style="list-style-type: none"> Code 8803: Small cell sarcoma
Soft Tissue Abd/Thor	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Soft Tissue Abd/Thor	Tumor Size Clinical	185 (64.5%)	185 (64.5%)	CT Scan: Largest mass prior to biopsy: 16 x 18.5 x 15 cm. Per the radiologist's note, this was thought to be a large hematoma; however, after biopsy, it was determined to be a sarcoma. Since there was a confirmation that this was indeed a sarcoma and not a hematoma, the tumor size can be used from the imaging. <ul style="list-style-type: none"> Code 185
Soft Tissue Abd/Thor	Tumor Size Pathologic	999 (53.5%)	999 (53.5%)	Per the pathology report, a tumor size could not be measured for the residual. A 9.0 cm measurement was given; however, this was noted as both "sarcoma and associated tissue with treatment effect." The instructions for Tumor Size Pathologic state:

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>4. Code the largest size of the primary tumor measured on the surgical resection specimen when surgery is administered as part of the first definitive treatment</p> <p>Note: This includes pathologic tumor size from surgery when there is neoadjuvant therapy</p> <ol style="list-style-type: none"> a. Code the size from the synoptic report (also known as CAP protocol or pathology report checklist) when there is a discrepancy among tumor size measurements in the various sections of the pathology report b. Use final diagnosis, microscopic, or gross examination, in that order, when no synoptic report is available <p>The instructions give priority to the synoptic report (even after neoadjuvant treatment) when there is a discrepancy. The synoptic report section of the pathology report states, "Tumor Size: Cannot be determined (see note)." The note states, "The main abdominal wall excision shows a tumor mass consisting of both residual, viable sarcoma and treatment associated changes. The component of residual, viable sarcoma represents 15-20% of the overall tissue with treatment associated changes. Given the patchy nature of the viable neoplasm, a gross measurement of the sarcoma cannot be determined."</p> <p>The pathologist's final diagnosis does not have priority over the synoptic per the priority order in Rule 4. Since the pathologist stated the post-therapy size cannot be determined, 999 is the most defensible answer and 090 (9 cm) really is just the gross description of viable tumor plus necrotic changes plus surrounding tissue that probably represents the treated primary tumor.</p> <ul style="list-style-type: none"> • Code 999

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	EOD Primary Tumor	500 (6.5%)	700 (4.5%)	<p>Multifocal involvement, NOS: Tumor was multifocal at diagnosis; confirmed involvement included the peritoneum, omentum and mesentery</p> <p>Patient had neoadjuvant therapy; however, the post-therapy resection did not prove more extensive involvement than the clinical information. Per the operative report, the tumor was wrapped around colon, artery and jejunum; however, the tumor was freed without evidence of involvement of those sites.</p> <ul style="list-style-type: none"> • Code 700: Multifocal involvement, NOS, Unknown how many structures involved
Soft Tissue Abd/Thor	EOD Regional Nodes	000 (52.9%)	000 (52.9%)	<p>CT Abdomen/Pelvis: Abdominal and pelvic lymph nodes: no discrete lymphadenopathy</p> <p>PET/CT scan shows lymph nodes suspicious for involvement (left supraclavicular, left retroclavicular, left internal mammary, right axillary and left external iliac regions); however, these would be distant based on the primary site</p> <ul style="list-style-type: none"> • Code 000
Soft Tissue Abd/Thor	Regional Nodes Positive	98 (80.0%)	98 (80.0%)	<p>Surgical pathology report: No lymph nodes examined</p> <ul style="list-style-type: none"> • Code 98: No nodes examined
Soft Tissue Abd/Thor	EOD Mets	00 (51.6%)	10 (17.4%)	<p>PET/CT scan shows lymph nodes suspicious for involvement (left supraclavicular, left retroclavicular, left internal mammary, right axillary and left external iliac regions). Based on primary site, these would be distant lymph nodes.</p> <ul style="list-style-type: none"> • Code 10: Distant lymph nodes
Soft Tissue Abd/Thor	SS2018	2 (26.5%)	7 (39.4%)	<p>Distant based on involvement of distant lymph nodes</p> <ul style="list-style-type: none"> • Code 7: Distant
Soft Tissue Abd/Thor	Grade Clinical	C (40.0%)	C (40.0%)	<p>Biopsy pathology report: "The specimen shows a poorly differentiated malignant neoplasm." Preferred grading system not used, A-D codes available, so use description for nuclear grade: poorly differentiated.</p> <ul style="list-style-type: none"> • Code C: Poorly differentiated

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	Grade Pathological	9 (76.1%)	9 (76.1%)	Per Note 4, 3 rd bullet: Code 9 when Neo-adjuvant therapy is followed by a resection (see post therapy grade). Chemo done prior to resection. <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Grade Post Therapy	9 (62.6%)	9 (62.6%)	Post-neoadjuvant surgery: Grade post therapy not documented in patient record Note: Cannot use information from clinical grade for post-therapy grade <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Bone Invasion	0 (95.5%)	0 (95.5%)	No mention of bone invasion in imaging reports Per Note 3: Code 0 if relevant imaging is performed and there is no mention of bone invasion <ul style="list-style-type: none"> Code 0: Bone invasion not present/not identified on imaging
Tongue Anterior	Primary Site	C021 (51.3%)	C021 (51.3%)	Per the 2018 Solid Tumor Rules for Head and Neck, the priority order for assigning primary site is: <ol style="list-style-type: none"> Tumor Board: No information from Tumor Board Tissue/pathology from tumor resection or biopsy Scans Physician documentation Resection: Left lateral border of tongue Per SEER clarification, if “lateral” is used and there is no further information, then code C023; however, for this case, we have “border of tongue” as part of the description <ul style="list-style-type: none"> Code 021: Border of tongue
Tongue Anterior	Histology	8070 (98.1%)	8070 (98.1%)	Surgical pathology report: Squamous cell carcinoma <ul style="list-style-type: none"> Code 8070: Squamous cell carcinoma
Tongue Anterior	Behavior	3 (98.7%)	3 (98.7%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Tongue Anterior	Tumor Size Clinical	013 (2.6%)	015 (10.9%)	Per CT scan: CT Neck Soft Tissue: Asymmetric enhancement involving the L ventricle tongue/floor of mouth measuring 1.3cm x 0.7 cm x 1.5 cm

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p><i>(inadvertently recorded the wrong measurement, should be the highest measurement of 1.5 cm)</i></p> <p>Per the SEER manual for Tumor Size Clinical, #7: Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, <i>and over a physical exam</i>. This states that imaging takes priority over physical exam.</p> <ul style="list-style-type: none"> • Code 015
Tongue Anterior	Tumor Size Pathologic	041 (92.3%)	041 (92.3%)	<p>Surgical pathology report: 4.1 cm</p> <ul style="list-style-type: none"> • Code 041
Tongue Anterior	EOD Primary Tumor	200 (37.8%)	200 (37.8%)	<p>Surgical pathology report: 4.1 cm tumor with depth of invasion 12 mm, per operative report, floor of mouth also involved</p> <p>Per EOD General Instructions 3. Pathological findings take priority over clinical findings. a. Assign the highest code representing the greatest extension pathologically (based on pathology report), when available</p> <p>In this situation, the pathology report findings would be based on the tumor confined to the tongue</p> <ul style="list-style-type: none"> • Code 200: Group 1 WITH depth of invasion (DOI) greater than 10 mm
Tongue Anterior	EOD Regional Nodes	600 (77.6%)	600 (77.6%)	<p>Surgical pathology report: At least 10 lymph nodes involved, ENE present, at least 3 mm</p> <ul style="list-style-type: none"> • Code 600: PATHOLOGICAL ONLY: Metastasis in MULTIPLE ipsilateral, contralateral, or bilateral nodes, Extranodal extension (ENE) positive for any node
Tongue Anterior	Regional Nodes Positive	10 (87.2%)	10 (87.2%)	<p>Surgical pathology report: At least 10 lymph nodes involved</p> <p>Note: There are no specific instructions on how to code when “at least” is documented. Code as 10 lymph nodes positive</p>

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 10
Tongue Anterior	EOD Mets	00 (94.9%)	00 (94.9%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Tongue Anterior	SS2018	3 (44.9%)	3 (44.9%)	4.1 cm tumor with depth of invasion 12 mm confined to site of origin, per operative report, floor of mouth also involved, 10 positive lymph nodes, no evidence of metastasis Per Summary Stage 2018 General Instructions, #4 For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are important when all malignant tissue cannot be, or was not, removed. <ul style="list-style-type: none"> In the event of a discrepancy between pathology and operative reports concerning excised tissue, <i>priority is given to the pathology report</i> Code 3: Localized tumor with positive regional lymph nodes
Tongue Anterior	Grade Clinical	2 (60.9%)	2 (60.9%)	Biopsy pathology report: Moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Tongue Anterior	Grade Pathological	3 (93.6%)	3 (93.6%)	Surgical pathology report: Poorly differentiated <ul style="list-style-type: none"> Code 3: G3: Poorly differentiated
Tongue Anterior	Grade Post Therapy	Blank (80.1%)	Blank (80.1%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Tongue Anterior	Extranodal Exten H & N Clin	0 (37.2%)	1 (32.7%)	Based on clinical exam, patient has positive nodes, noted to be “matted” Per Note 5, Bullet 3: Code 1 when “the terms ‘fixed’ or ‘matted’ are used to describe lymph nodes <ul style="list-style-type: none"> Code 1: Regional lymph node(s) involved, ENE present/identified during diagnostic workup, based on physical exam WITH or WITHOUT imaging
Tongue Anterior	Extranodal Exten H & N Path	3.0 (41.7%)	3.0 (41.7%)	Surgical pathology report: ENE at least 3mm, Defined as: Present: ENE (ma) (> 2 mm) There are currently no rules regarding “at least,” so code to the measurement that is known (3 mm)

Group 4 Case	Group 4 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 3.0
Tongue Anterior	Human Papilloma Virus (HPV) Status	9 (94.9%)	9 (94.9%)	HPV not documented in patient record <ul style="list-style-type: none"> Code 9: Unknown if HPV test detecting viral DNA and or RNA was performed
Tongue Anterior	LN Size	XX.9 (18.6%)	XX.9 (18.6%)	Surgical pathology report: "There are matted lymph nodes in level II area (3.1 cm)." This is not the size of the LN metastasis, this is just stating that there are matted nodes. Path report also states: Size of Largest Metastatic Deposit in Centimeters: Cannot be determined. <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Regional lymph node(s) involved, size not stated, Lymph Nodes Size not assessed, or unknown if assessed

Group 5 Cases

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Primary Site	C711 (95.9%)	C711 (95.9%)	<p>Per the 2018 Solid Tumor Rules for Malignant CNS and Peripheral Nerves, the priority order for assigning primary site is</p> <ol style="list-style-type: none"> 1. Resection <ul style="list-style-type: none"> • Operative report • Pathology report 2. Biopsy <ul style="list-style-type: none"> • Operative report • Pathology report 3. Resection and/or biopsy performed, but operative report(s) and pathology are not available (minimal information) <ul style="list-style-type: none"> • Tumor Board • Code from physician's documentation of original diagnosis from operative report or pathology report OR • Physician's documentation of primary site in the medical record 4. For cases diagnosed by imaging (no pathology/resection or biopsy), use information from scans in the following priority order: MRI, CT, PET, Angiogram <p>Resection, operative report, takes priority: Left frontal mass</p> <ul style="list-style-type: none"> • Code C711: Frontal lobe
Brain	Histology	9451 (89.9%)	9451 (89.9%)	<p>Surgical pathology report: Anaplastic Oligodendroglioma</p> <ul style="list-style-type: none"> • Code 9451: Oligodendroglioma, NOS
Brain	Behavior	3 (99.4%)	3 (99.4%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Brain	Tumor Size Clinical	045 (56.8%)	045 (56.8%)	<p>MRI: 4.5 x 2.4 x 2.1 cm mass</p> <p>Note: In the intraoperative documentation prior to surgery, physician states "4.7 cm T2-hyperintense, non-enhancing mass in the left frontal lobe"</p>

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				There is only documentation of one MRI, which stated size as 4.5 cm. There is also documentation from two other physicians of 4.5 cm size. The 4.7 cm was probably entered incorrectly. <ul style="list-style-type: none"> Code 045
Brain	Tumor Size Pathologic	999 (90.5%)	999 (90.5%)	Pathological tumor size not available, submitted in sections <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Brain	EOD Primary Tumor	100 (88.2%)	100 (88.2%)	MRI Brain: 4.5 x 2.4 x 2.1 cm mass, no midline shift, confined to frontal lobe Pathology report does not indicate extent of disease, go with clinical evaluation Patient follows up and found to have 4 th nerve palsy; however, this does not indicate that the 4 th nerve is involved with tumor <ul style="list-style-type: none"> Code 100: Confined to brain
Brain	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value (no lymph nodes in the brain) <ul style="list-style-type: none"> Code 888: Not applicable
Brain	Regional Nodes Positive	99 (89.9%)	99 (89.9%)	Not applicable: Default value (no lymph nodes in the brain) <ul style="list-style-type: none"> Code 99: Not applicable
Brain	EOD Mets	00 (96.4%)	00 (96.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Brain	SS2018	1 (93.5%)	1 (93.5%)	Confined to brain, no evidence metastasis Pathology report does not indicate extent of disease, go with clinical evaluation Patient follows up and found to have 4 th nerve palsy; however, this does not indicate that the 4 th nerve is involved with tumor <ul style="list-style-type: none"> Code 1: Localized
Brain	Grade Clinical	H (25.4%)	9 (63.3%)	MRI Brain: Findings suggest a high-grade intra-axial glial neoplasm Suggests is not definitive for diagnosis and the high grade cannot be used <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Brain	Grade Pathological	3 (84.0%)	3 (84.0%)	Surgical pathology report: WHO Grade III <ul style="list-style-type: none"> Grade 3: WHO Grade III: Tumors with histologic evidence of malignancy, including nuclear atypia and mitotic activity, associated with an aggressive clinical course

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Brain	Grade Post Therapy	Blank (82.2%)	Blank (82.2%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Brain	Brain Molecular Markers	07 (73.4%)	07 (73.4%)	Surgical pathology report: IDH-Mutant and 1p/19q-Codeleted <ul style="list-style-type: none"> Code 07: Anaplastic oligodendroglioma, IDH-mutant and 1p/19q co-deleted (9451/3)
Brain	Chromosome 1p Status	1 (66.3%)	1 (66.3%)	Surgical pathology report: IDH-Mutant and 1p/19q-Codeleted <ul style="list-style-type: none"> Code 1: Chromosome 1p deletion/LOH identified/present
Brain	Chromosome 19q Status	1 (65.1%)	1 (65.1%)	Surgical pathology report: IDH-Mutant and 1p/19q-Codeleted <ul style="list-style-type: none"> Code 1: Chromosome 19q deletion/LOH present
Brain	MGMT	9 (88.8%)	9 (88.8%)	MGMT not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in patient record, Cannot be determined by the pathologist MGMT not assessed or unknown if assessed
Breast	Primary Site	C504 (98.2%)	C504 (98.2%)	Per Appendix C of the SEER manual, Breast Coding Guidelines, the following priority order is used when there is conflicting information <ol style="list-style-type: none"> Operative Report Pathology Report Mammogram, ultrasound (ultrasound becoming more frequently used) Physical examination No operative report available. Pathology report states upper outer quadrant (which mammogram also states) <ul style="list-style-type: none"> Code C504: Upper-outer quadrant of breast
Breast	Histology	8520 (88.1%)	8520 (88.1%)	Surgical pathology report; Lobular carcinoma <ul style="list-style-type: none"> Code 8520: Lobular carcinoma, NOS
Breast	Behavior	3 (98.2%)	3 (98.2%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Breast	Tumor Size Clinical	028 (56.0%)	028 (56.0%)	Per Tumor Size Clinical instructions #1: Code the largest measurement of the primary tumor from physical exam, imaging, or other diagnostic procedures before any form of treatment

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				Mammogram/US: 28 mm x 26 mm x 27 mm mass in upper outer quadrant <ul style="list-style-type: none"> Code 028
Breast	Tumor Size Pathologic	999 (91.1%)	999 (91.1%)	Path tumor size not documented in patient record <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Breast	EOD Primary Tumor	100 (86.3%)	100 (86.3%)	Consult note, mass confined to breast, no evidence of skin infiltration or inflammatory changes <ul style="list-style-type: none"> Code 100: Localized, confined to breast
Breast	EOD Regional Nodes	150 (53.0%)	150 (53.0%)	Breast Oncology note: Multiple enlarged mobile lymph nodes. Physician states patient is a N1. Lymph node, right axillary, core biopsy: - Metastatic carcinoma (1.4 cm). Clinical evaluation only. <ul style="list-style-type: none"> Code 150: CLINICAL assessment only, Clinically positive movable axillary (level I and II) lymph node(s), ipsilateral, Positive needle core biopsy/FNA
Breast	Regional Nodes Positive	95 (57.7%)	95 (57.7%)	Lymph node biopsy pathology report: right axillary, core biopsy <ul style="list-style-type: none"> Code 95: Positive aspiration or core biopsy of lymph node(s)
Breast	EOD Mets	70 (92.3%)	70 (92.3%)	Bone Scan Total Body: Widespread osseous metastatic disease involving the axial and appendicular skeleton <ul style="list-style-type: none"> Code 70: Includes Bone metastasis
Breast	SS2018	7 (88.1%)	7 (88.1%)	Clinical evidence of bone metastasis <ul style="list-style-type: none"> Code 7: Distant, bone metastasis
Breast	Grade Clinical	2 (92.9%)	2 (92.9%)	Biopsy pathology report: Nottingham grade: Grade II: 6-7 points <ul style="list-style-type: none"> Code 2: G2: Intermediate combined histologic grade (moderately favorable); SBR score of 6-7 points
Breast	Grade Pathological	9 (79.8%)	9 (79.8%)	Per Note 6, 2 nd bullet: Code 9 when there is no resection of the primary site <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Breast	Grade Post Therapy	Blank (82.1%)	Blank (82.1%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Breast	Sentinel Lymph Nodes Examined	00 (51.2%)	00 (51.2%)	Lymph node, right axillary, core biopsy, this is not a sentinel node lymph node biopsy

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 00: No sentinel nodes were examined
Breast	Sentinel Lymph Nodes Positive	98 (33.9%)	98 (33.9%)	<p>Lymph node, right axillary, core biopsy, this is not a sentinel node lymph node biopsy</p> <ul style="list-style-type: none"> Code 98: No sentinel nodes were biopsied
Breast	ER Summary	1 (98.2%)	1 (98.2%)	<p>Biopsy pathology report: ER Report: Estrogen Receptor [SP1], Quantitative Evaluation, 95% positive cells, Intensity strong</p> <ul style="list-style-type: none"> Code 1: ER Positive
Breast	ER Percent Positive	095 (69.0%)	095 (69.0%)	<p>Biopsy pathology report: ER Report: Estrogen Receptor [SP1], Quantitative Evaluation, 95% positive cells, Intensity strong</p> <ul style="list-style-type: none"> Code 095: 95%
Breast	ER Allred Score	08 (91.1%)	08 (91.1%)	<p>Biopsy pathology report: Proportion score of 95%. Per the “Allred Score* for Estrogen and Progesterone Receptor Evaluation” in the SSDI manual, a percent positive of 95% is equal to a proportion score of 5. A strong intensity is equal to a 3-intensity score. To get Allred Score, add the two together: 5 + 3 = 8.</p> <ul style="list-style-type: none"> Code 08: Total ER Allred score of 8
Breast	PR Summary	1 (95.8%)	1 (95.8%)	<p>Biopsy pathology report: PR Report: Progesterone Receptor [PR88], Quantitative Evaluation, 35% positive cells, Intensity strong</p> <ul style="list-style-type: none"> Code 1: PR positive
Breast	PR Percent Positive	035 (70.2%)	035 (70.2%)	<p>Biopsy pathology report: PR Report: Progesterone Receptor [PR88], Quantitative Evaluation, 35% positive cells, Intensity strong</p> <ul style="list-style-type: none"> Code 035
Breast	PR Allred Score	07 (87.5%)	07 (87.5%)	<p>Biopsy pathology report: Proportion score of 35%. Per the “Allred Score* for Estrogen and Progesterone Receptor Evaluation” in the SSDI manual, a percent positive of 35% is equal to a proportion score of 4. A strong intensity is equal to a 3-intensity score. To get Allred Score, add the two together: 4 + 3 = 7.</p> <ul style="list-style-type: none"> Code 07: Total ER Allred score of 7
Breast	HER2 IHC Summary	0 (85.1%)	0 (85.1%)	<p>Immunohistochemistry report: HER2 (polyclonal), Quantitative Evaluation, No over-expression (0)</p> <ul style="list-style-type: none"> Code 0: Negative (Score 0)
Breast	HER2 ISH Summary	9 (79.8%)	9 (79.8%)	HER2 ISH Summary not documented in patient record

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 9: Not documented in medical record, Results cannot be determined (indeterminate), HER2 ISH Summary not assessed or unknown if assessed
Breast	HER2 Overall Summary	0 (94.0%)	0 (94.0%)	HER2 IHC negative, HER2 FISH not gone, overall HER2 score is negative <ul style="list-style-type: none"> Code 0: HER2 negative; equivocal
Breast	HER2 SP Copy Number	XX.9 (87.5%)	XX.9 (87.5%)	HER2 SP Copy Number not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Single Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Copy Number	XX.9 (86.3%)	XX.9 (86.3%)	HER2 ISH not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in medical record, Cannot be determined (indeterminate), HER2 ISH Dual Probe Copy Number not assessed or unknown if assessed
Breast	HER2 DP Ratio	XX.9 (87.5%)	XX.9 (87.5%)	HER2 ISH not documented in patient record <ul style="list-style-type: none"> Code XX.9: Not documented in patient record, Results cannot be determined (indeterminate), HER2 ISH dual probe ratio not assessed or unknown if assessed
Breast	Ki-67	15.0 (86.3%)	15.0 (86.3%)	Biopsy pathology report: Ki-67 [MIB-1], Quantitative Evaluation, 15% positive cells <ul style="list-style-type: none"> Code: 15.0
Breast	Lymph Nodes Positive Axillary Level I-II	X6 (54.2%)	X6 (54.2%)	Lymph node, right axillary, core biopsy <ul style="list-style-type: none"> Code X6: Positive aspiration or needle core biopsy of lymph node(s)
Breast	Multigene Signature Method	9 (92.3%)	9 (92.3%)	Multigene Signature Method not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Multigene Signature Method not assessed or unknown if assessed
Breast	Multigene Signature Results	X9 (88.1%)	X9 (88.1%)	Multigene Signature Results not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, Multigene Signature Results not assessed or unknown if assessed
Breast	Oncotype DX Recur Score – DCIS	XX6 (63.1%)	XX6 (63.1%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> XX6: Not applicable, invasive case

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Breast	Oncotype DX Recur Score	XX9 (95.8%)	XX9 (95.8%)	Oncotype Dx Recurrence Score not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in medical record, Oncotype Dx Recurrence Score-Invasive not assessed or unknown if assessed
Breast	Oncotype Dx Risk Level – DCIS	6 (58.3%)	6 (58.3%)	Invasive case. Information for DCIS would not be collected <ul style="list-style-type: none"> Code 6: Not applicable, invasive case
Breast	Oncotype Dx Risk Level Invasive	9 (92.9%)	9 (92.9%)	Oncotype Dx Risk Level not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, Oncotype Dx Risk Level-Invasive not assessed or unknown if assessed
Breast	Response to Neoadjuvant Therapy	0 (78.0%)	0 (78.0%)	No neoadjuvant therapy given <ul style="list-style-type: none"> Code 0: Neoadjuvant therapy not given
Colon and Rectum	Primary Site	C186 (97.6%)	C186 (97.6%)	Per the coding guidelines from SEER, the following priority order for assigning primary site for Colon is <ul style="list-style-type: none"> Resected cases <ul style="list-style-type: none"> Operative report with surgeon’s description Pathology report Imaging Non-resected cases <ul style="list-style-type: none"> Polypectomy or excision without resection Endoscopy report <p>Operative report not available Pathology report, which is next priority, states descending colon, left</p> <ul style="list-style-type: none"> Code C186: Descending colon
Colon and Rectum	Histology	8140 (98.2%)	8140 (98.2%)	Surgical pathology report: Adenocarcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma
Colon and Rectum	Behavior	3 (98.2%)	3 (98.2%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Colon and Rectum	Tumor Size Clinical	038 (85.7%)	038 (85.7%)	CT scan: Mass measures 2.7 x 3.8 cm mass <ul style="list-style-type: none"> Code 038

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Colon and Rectum	Tumor Size Pathologic	045 (97.6%)	045 (97.6%)	Surgical pathology report: 4.5 cm <ul style="list-style-type: none"> Code 045
Colon and Rectum	EOD Primary Tumor	500 (75.6%)	500 (75.6%)	Surgical pathology report: Extension through colon wall and invades visceral peritoneum Note 5: Tumors characterized by <i>involvement of the serosal surface (visceral peritoneum)</i> by direct extension or perforation in which the tumor cells are continuous with the serosal surface through inflammation are coded to 500 <ul style="list-style-type: none"> Code 500: Mesothelium, Serosa, Tunica serosa, Invasion through the visceral peritoneum
Colon and Rectum	EOD Regional Nodes	300 (76.2%)	300 (76.2%)	Surgical pathology report: 3/24 LNs Per Note 2: For Colon and Rectum ONLY, any unnamed nodes that are removed with a colon or rectal resection are presumed to be regional pericolic or perirectal lymph nodes and are included in the EOD Regional Nodes code 300 (pericolic for sites C180 - C189, C199 and perirectal for sites C199 or C209). This site-specific instruction applies only to colon and rectum tumors and was verified with subject matter experts. <ul style="list-style-type: none"> Code 300: Includes all regional for Colon and Rectum
Colon and Rectum	Regional Nodes Positive	03 (99.4%)	03 (99.4%)	Surgical Pathology: 3/24 LNs <ul style="list-style-type: none"> Code 03
Colon and Rectum	EOD Mets	50 (44.0%)	20 (26.8%)	Surgical pathology report: Tumor nodule in attached portion of omentum. Per Gross description of pathology report: probably involved. Documented as M1 disease in the pathology report. Physician follow up also documents M1 disease and notes that treatment plan is based on M1 disease. <ul style="list-style-type: none"> Code 20: SINGLE distant organ (except peritoneum) for omentum involvement
Colon and Rectum	SS2018	7 (76.8%)	7 (76.8%)	Tumor nodule in attached portion of omentum; stated as M1 <ul style="list-style-type: none"> Code 7: Distant
Colon and Rectum	Grade Clinical	2 (91.1%)	2 (91.1%)	Biopsy pathology report: Moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Colon and Rectum	Grade Pathological	2 (99.4%)	2 (99.4%)	Surgical pathology report: Moderately differentiated <ul style="list-style-type: none"> Code 2: G2: Moderately differentiated
Colon and Rectum	Grade Post Therapy	Blank (82.1%)	Blank (82.1%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Colon and Rectum	CEA PreTX Interpretation	9 (76.2%)	9 (76.2%)	CEA 2.8, but not checked prior to surgery Per Note 2: Record the interpretation of the highest CEA test result documented in the medical record prior to treatment or polypectomy. <ul style="list-style-type: none"> Code 9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Interpretation not assessed or unknown if assessed
Colon and Rectum	CEA PreTX Lab Value	XXXX.9 (73.2%)	XXXX.9 (73.2%)	CEA 2.8, but not checked prior to surgery Per Note 2: Record the lab value of the highest CEA test result documented in the medical record prior to treatment or polypectomy. <ul style="list-style-type: none"> Code XXXX.9: Not documented in medical record, CEA (Carcinoembryonic Antigen) Pretreatment Lab Value not assessed or unknown if assessed
Colon and Rectum	Circumferential Resection Margin	XX.1 (51.2%)	20.0 (12.5%)	Surgical pathology report: All margins uninvolved by invasive carcinoma Closest margin: mesocolonic pedicle margin 2 cm Per clarification from AJCC and CAP, a “mesocolonic” margin is a CRM margin. <ul style="list-style-type: none"> Code 20.0 (2 cm equal to 20 mm). CRM is coded in millimeters
Colon and Rectum	KRAS	0 (76.8%)	0 (76.8%)	Oncology note, KRAS came back with no alterations <ul style="list-style-type: none"> Code 0: Normal (wild type), Negative for mutations
Colon and Rectum	Microsatellite Instability	0 (97.0%)	0 (97.0%)	Surgical pathology report: MSI: No loss of expression of DNA MMR <ul style="list-style-type: none"> Code 0: Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins
Colon and Rectum	Perineural Invasion	0 (96.4%)	0 (96.4%)	Surgical pathology report: Perineural invasion not identified <ul style="list-style-type: none"> Code 0: Perineural invasion not identified/not present

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Colon and Rectum	Tumor Deposits	00 (94.0%)	00 (94.0%)	Surgical pathology report: Tumor Deposits: not identified <ul style="list-style-type: none"> Code 00: No tumor deposits
Lung	Primary Site	C341 (98.8%)	C341 (98.8%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Lung Surgical pathology report: Left upper lobe <ul style="list-style-type: none"> Code C341: Upper lobe, lung
Lung	Histology	8255 (8.4%)	8551 (46.1%)	Surgical pathology report: Invasive adenocarcinoma, acinar predominant Per the Solid Tumor Rules for Lung, Table 3: Acinar Predominant is a subtype/variant of Adenocarcinoma Under “Coding Histologies”: Predominantly describes the greater amount of tumor. Predominant and majority are synonyms. Per the CAP protocol, the term predominant is acceptable for the following specific subtypes of adenocarcinoma. For these subtypes only, the word predominant is used to describe both the subtype and the grade of the tumor. See Table 3 for coding instructions and Acinar Solid Predominant (8551) is listed. <ul style="list-style-type: none"> Code 8551: Acinar cell cystadenocarcinoma (New alternate name: Adenocarcinoma, acinar predominant)
Lung	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lung	Tumor Size Clinical	028 (93.4%)	028 (93.4%)	PET CT: 2.8 x 2.5 cm lung mass <ul style="list-style-type: none"> Code 028
Lung	Tumor Size Pathologic	025 (95.2%)	025 (95.2%)	Surgical pathology report: Surgical: 2.5 cm mass <ul style="list-style-type: none"> Code 025
Lung	EOD Primary Tumor	450 (64.1%)	450 (64.1%)	Surgical pathology report: 2.5 cm mass, pleural invasion present (not documented as PL1 or PL2), no adjacent structures involved

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Note: The operative report indicated invasion of the pulmonary artery. Per the Gross description of the pathology report, the tumor is “adherent” to the pulmonary artery, but the final diagnosis does not indicate involvement.</p> <p>Per EOD General Instructions 3. Pathological findings take priority over clinical findings a. Assign the highest code representing the greatest extension pathologically (based on pathology report), when available In this situation, the pathology report findings would be based on involvement of the visceral pleural</p> <ul style="list-style-type: none"> • Code 450: Visceral pleural invasion
Lung	EOD Regional Nodes	400 (64.1%)	400 (64.1%)	<p>Surgical pathology report: 4/19 LNs, (hilar [N1] and mediastinal [N2]). Staged as N2</p> <ul style="list-style-type: none"> • Code 400: Includes mediastinal
Lung	Regional Nodes Positive	04 (84.4%)	04 (84.4%)	<p>Surgical pathology report: 4/19 LNs</p> <ul style="list-style-type: none"> • Code 04
Lung	EOD Mets	00 (94.6%)	00 (94.6%)	<p>No clinical evidence of metastasis</p> <ul style="list-style-type: none"> • Code 00: No distant metastasis, Unknown if distant metastasis
Lung	SS2018	4 (64.7%)	4 (64.7%)	<p>Tumor with visceral pleural invasion (regional) and positive lymph nodes</p> <p>Note: The operative report indicated invasion of the pulmonary artery. Per the Gross description of the pathology report, the tumor is “adherent” to the pulmonary artery, but the final diagnosis does not indicate involvement.</p> <p>Per Summary Stage 2018 General Instructions, #4 For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are important when all malignant tissue cannot be, or was not, removed.</p> <ul style="list-style-type: none"> • In the event of a discrepancy between pathology and operative reports concerning excised tissue, <i>priority is given to the pathology report</i> • Code 4: Regional with positive lymph nodes

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lung	Grade Clinical	9 (98.2%)	9 (98.2%)	Clinical grade not documented <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Pathological	9 (97.6%)	9 (97.6%)	Pathological grade not documented <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Lung	Grade Post Therapy	Blank (85.6%)	Blank (85.6%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lung	Separate Tumor Nodules	0 (97.0%)	0 (97.0%)	No evidence of separate tumor nodules <ul style="list-style-type: none"> Code 0: No separate tumor nodules
Lung	Visceral and Parietal Pleural Invasion	4 (63.5%)	4 (63.5%)	Surgical pathology report: Visceral pleura invasion, not stated as PL1 or PL2 <ul style="list-style-type: none"> Code 4: Invasion of visceral pleura present, NOS; not stated if PL1 or PL2
Lymphoma CLL/SLL	Primary Site	C770 (75.6%)	C770 (75.6%)	Consult Note: physician states “disease” limited to area of cervical nodes; PET scan showed no other evidence of disease, no evidence of peripheral blood or bone marrow involvement <ul style="list-style-type: none"> Flow cytometry report consistent with CLL/SLL. Although flow cytometry is usually associated with peripheral blood, the flow cytometry done was on the lymph node No peripheral blood smear done <p>Per Heme Manual, Module 3: PH6: Code the primary site to the involved lymph nodes and/or organs</p> <p>Per Rule PH19: Code the primary site to the specific lymph node region when only one lymph node or one lymph node region is involved</p> <ul style="list-style-type: none"> C770: Lymph nodes of head, face and neck
Lymphoma CLL/SLL	Histology	9823 (100%)	9823 (100%)	Lymph node biopsy: CLL/SLL <ul style="list-style-type: none"> Code 9823: Chronic lymphocytic leukemia/small lymphocytic lymphoma
Lymphoma CLL/SLL	Behavior	3 (100%)	3 (100%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Lymphoma CLL/SLL	Tumor Size Clinical	999 (92.7%)	999 (92.7%)	Not applicable: Default value <ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma	Tumor Size Pathologic	999	999	Not applicable: Default value

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
CLL/SLL		96.3%	96.3%	<ul style="list-style-type: none"> Code 999: Not applicable
Lymphoma CLL/SLL	EOD Primary Tumor	100 (82.9%)	100 (82.9%)	Consult note: Disease limited to area of cervical nodes <ul style="list-style-type: none"> Code 100: Single lymph node region involved
Lymphoma CLL/SLL	EOD Regional Nodes	888 (100%)	888 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 888: Not applicable
Lymphoma CLL/SLL	Regional Nodes Positive	99 (95.1%)	99 (95.1%)	Not applicable: Default value <ul style="list-style-type: none"> Code 99: Not applicable
Lymphoma CLL/SLL	EOD Mets	88 (100%)	88 (100%)	Not applicable: Default value <ul style="list-style-type: none"> Code 88: Not applicable
Lymphoma CLL/SLL	SS2018	1 (79.3%)	1 (79.3%)	Limited to area of cervical nodes (single lymph node area) <ul style="list-style-type: none"> Code 1: Localized
Lymphoma CLL/SLL	Grade Clinical	8 (100%)	8 (100%)	Grade not applicable for this Heme schema <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Pathological	8 (100%)	8 (100%)	Grade not applicable for this Heme schema <ul style="list-style-type: none"> Code 8: Not applicable
Lymphoma CLL/SLL	Grade Post Therapy	Blank (61.6%)	Blank (61.6%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Lymphoma CLL/SLL	Adenopathy	1 (90.2%)	1 (90.2%)	Consult note: Left cervical adenopathy with nodes ~ 2.5 cm. Per oncologist, there is palpable left cervical lymph node adenopathy <ul style="list-style-type: none"> Code 1: Adenopathy present, Presence of lymph nodes > 1.5 cm
Lymphoma CLL/SLL	Anemia	0 (66.5%)	9 (31.1%)	Per Note 3: Record this data item based on a blood test (CBC, hemoglobin & hematocrit, H&H) performed at diagnosis (pre-treatment). In the absence of the lab test, a physician's statement can be used. The only documentation of the Hemoglobin is 4 months after diagnosis <ul style="list-style-type: none"> Code 9: Not documented in medical record, Anemia not assessed or unknown if assessed
Lymphoma CLL/SLL	B symptoms	0 (88.4%)	0 (88.4%)	Otolaryngology consult note: No night sweats, fever or weight loss <ul style="list-style-type: none"> Code 0: No B symptoms

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Lymphoma CLL/SLL	HIV status	9 (49.4%)	9 (49.4%)	Otolaryngology consult note: No recent exposure to HIV, but does not document that HIV is negative Per Note 4: Code 9 if there is no mention of HIV/AIDS in the medical record. Do not assume that the patient is HIV negative <ul style="list-style-type: none"> Code 9: Not documented in medical record, HIV status not assessed or unknown if assessed
Lymphoma CLL/SLL	Lymphocytosis	0 (51.2%)	9 (43.9%)	Per Note 3: Record this data item based on a blood test (CBC and differential) performed at diagnosis (pre-treatment). In the absence of the lab test, a physician's statement can be used. The only documentation of Lymphocytosis is 4 months after diagnosis <ul style="list-style-type: none"> Code 9: Not documented in medical record, Lymphocytosis not assessed or unknown if assessed
Lymphoma CLL/SLL	NCCN International Prognostic Index (IPI)	X9 (93.3)	X9 (93.3)	NCCN not documented in patient record <ul style="list-style-type: none"> Code X9: Not documented in medical record, NCCN International Prognostic Index (IPI) not assessed or unknown if assessed
Lymphoma CLL/SLL	Organomegaly	0 (76.8%)	9 (23.2%)	No physical exam for organomegaly done at time of diagnosis; evaluation for organomegaly occurred 4 months after diagnosis <ul style="list-style-type: none"> Code 9: Not documented in medical record, Organomegaly not assessed or unknown if assessed
Lymphoma CLL/SLL	Thrombocytopenia	0 (61.6%)	9 (34.8%)	Per Note 3: Record this data item based on a blood test (CBC and differential) performed at diagnosis (pre-treatment). In the absence of the lab test, a physician's statement can be used. The only documentation of Thrombocytopenia is 4 months after diagnosis <ul style="list-style-type: none"> Code 9: Not documented in medical record, Thrombocytopenia not assessed or unknown if assessed
Melanoma Skin	Primary Site	C447 (98.8%)	C447 (98.8%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<i>Note:</i> There are no specific primary site instructions for Melanoma Skin Pathology Report: Skin, right lateral lower leg <ul style="list-style-type: none"> Code C447: Skin of lower limb and hip
Melanoma Skin	Histology	8720 (60.8%)	8743 (38.0%)	Surgical pathology report: Shave biopsy, Malignant melanoma, Histologic subtype: nevoid Sent out for consult, came back as: nevoid/superficial spreading type <ul style="list-style-type: none"> Code 8743: Superficial spreading melanoma
Melanoma Skin	Behavior	3 (100%)	3 (100%)	Invasive <ul style="list-style-type: none"> Code 3: Malignant
Melanoma Skin	Tumor Size Clinical	999 (86.1%)	999 (86.1%)	Tumor size clinical not documented in patient record <i>Note:</i> Breslow's depth and Tumor Size are not the same thing <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Melanoma Skin	Tumor Size Pathologic	999 (88.6%)	999 (88.6%)	Tumor Size Pathologic not documented in patient record <i>Note:</i> Breslow's depth and Tumor Size are not the same thing <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Melanoma Skin	EOD Primary Tumor	300 (89.8%)	300 (89.8%)	Surgical pathology report: Shave biopsy, At least Clark's Level IV. Wide excision noted 0.9 mm lesion (see Breslow's depth). <ul style="list-style-type: none"> Code 300: Reticular dermis invaded, Clark level IV
Melanoma Skin	EOD Regional Nodes	000 (96.4%)	000 (96.4%)	Surgical pathology report: Re-excision and SLN biopsy: 0/1 SLNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Melanoma Skin	Regional Nodes Positive	00 (90.4%)	00 (90.4%)	Surgical pathology report: Re-excision and SLN biopsy: 0/1 SLNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Melanoma Skin	EOD Mets	00 (99.4%)	00 (99.4%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Melanoma Skin	SS2018	1 (94.6%)	1 (94.6%)	Clark's Level IV, no evidence of lymph nodes or metastasis <ul style="list-style-type: none"> Code 1: Localized tumor, confined to site of origin
Melanoma Skin	Grade Clinical	9 (97.6%)	9 (97.6%)	Clinical grade not documented in patient record

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Pathological	9 (97.6%)	9 (97.6%)	Pathological grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Melanoma Skin	Grade Post Therapy	Blank (84.3%)	Blank (84.3%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Melanoma Skin	Sentinel Lymph Nodes Examined	01 (92.8%)	01 (92.8%)	Surgical pathology report: Re-excision and SLN biopsy: 0/1 SLNs <ul style="list-style-type: none"> Code 01
Melanoma Skin	Sentinel Lymph Nodes Positive	00 (95.8%)	00 (95.8%)	Surgical pathology report: Re-excision and SLN biopsy: 0/1 SLNs <ul style="list-style-type: none"> Code 00: All sentinel nodes examined are negative
Melanoma Skin	Breslow Thickness	A0.6 (3.6%)	0.9 (71.1%)	<p>Shave biopsy showed Breslow's depth of at least .6 mm. Re-excision stated Breslow's depth as .9 mm. Per comment, "considering the combination of prior biopsy site changes and residual atypical dermal melanocytes as highlighted by the Melan-A red stain, our best estimate for a Breslow depth is a maximum of 0.9 mm."</p> <p>Per Note 4: Do not add measurements together from different procedures (even in the rare circumstance that the pathologist adds the measurements from two specimens).</p> <p>Based on the documentation in the patient record, the pathologist appears to have added the two measurements together, which we are not to record based on Note 4</p> <p>Followed up with AJCC Melanoma experts, who said it was okay for the pathologist (but not the registrar) to add measurements together to get a final Breslow's measurement, so in this case, coding .9 mm as the Breslow thickness is acceptable (Note: SSDI manual will be updated to reflect this information)</p> <ul style="list-style-type: none"> Code 0.9
Melanoma Skin	Ulceration	0 (96.4%)	0 (96.4%)	Surgical pathology report: Shave biopsy, Ulceration not present <ul style="list-style-type: none"> Code 0: Ulceration not identified/not present

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Lab Value	XXXXX.9 (94.6%)	XXXXX.9 (94.6%)	LDH not documented in patient record <ul style="list-style-type: none"> Code XXXXX.9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Lab Value not assessed or unknown if assessed
Melanoma Skin	LDH (Lactate Dehydrogenase) Pretreatment Level	9 (98.2%)	9 (98.2%)	LDH not documented in patient record <ul style="list-style-type: none"> Code 9: Not documented in medical record, LDH (Lactate Dehydrogenase) Pretreatment Level not assessed or unknown if assessed
Melanoma Skin	LDH Upper Limits of Normal	XX9 (92.8%)	XX9 (92.8%)	LDH not documented in patient record <ul style="list-style-type: none"> Code XX9: Not documented in patient record, LDH Upper Limit not assessed or unknown if assessed
Melanoma Skin	Mitotic Rate Melanoma	01 (86.7%)	01 (86.7%)	Surgical pathology report: Shave biopsy, Mitotic rate 1/mm ² <ul style="list-style-type: none"> Code 01
Ovary	Primary Site	C569 (100.0%)	C569 (100.0%)	Surgical pathology report: Right ovary <ul style="list-style-type: none"> Code 569: Ovary
Ovary	Histology	8441 (49.4%)	8461 (30.5%)	Surgical pathology report: High grade serous carcinoma Per the 2018 ICD-O-3 updates: "high grade serous carcinoma" is a new alternate name for 8461 <ul style="list-style-type: none"> Code 8461: Serous surface papillary carcinoma
Ovary	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Ovary	Tumor Size Clinical	999 (89.6%)	999 (89.6%)	Tumor size clinical not documented in patient record <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Ovary	Tumor Size Pathologic	030 (87.2%)	030 (87.2%)	Surgical pathology report: 3 cm <ul style="list-style-type: none"> Code 030
Ovary	EOD Primary Tumor	650 (75.6%)	650 (75.6%)	Surgical pathology report: Macroscopic (less than 2 cm) peritoneal implants or peritoneal carcinomatosis FIGO Stage IIIB

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 650: Macroscopic peritoneal implants or macroscopic peritoneal carcinomatosis beyond pelvis, Less than or equal to 2 cm in diameter, FIGO Stage IIIB (Note: Code 650 has been updated for the 2020 update)
Ovary	EOD Regional Nodes	999 (47.6%)	000 (51.8%)	<p>Surgical pathology report: No lymph nodes found/examined: pNX Per HPI, based on 12/17/17 CT scan, borderline prominent celiac axis LNs, without substantial LAD</p> <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Ovary	Regional Nodes Positive	98 (80.5%)	98 (80.5%)	<p>No regional lymph nodes examined</p> <ul style="list-style-type: none"> Code 98: No nodes examined
Ovary	EOD Mets	00 (61.0%)	00 (61.0%)	<p>PET CT scan: Carcinomatosis Per operative report: Small volume carcinomatosis</p> <p>For SEER*RSA Version 1.6 (which was used in the study), Carcinomatosis in the peritoneum was not specified as being collected in EOD Primary Tumor. For SEER*RSA Version 1.7 (Released September 2019), EOD Primary Tumor has clear instructions that peritoneal carcinomatosis is included (see codes 600, 650, 700, 750 and Note 4) and EOD Mets code 50 has a new note stating “excludes peritoneal carcinomatosis [see EOD Primary Tumor]”. This change is now in line with AJCC</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Ovary	SS2018	7 (90.9%)	7 (90.9%)	<p>Macroscopic (less than 2 cm) peritoneal implants, FIGO Stage IIIB</p> <ul style="list-style-type: none"> Code 7: Distant
Ovary	Grade Clinical	9 (53.7%)	9 (53.7%)	<p>Clinical grade not documented in patient record Omentum, needle core biopsy shows low-grade serous carcinoma; however, this is not the grade from the primary site, so cannot be used</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Ovary	Grade Pathological	H (92.1%)	H (92.1%)	<p>Surgical pathology report: High grade</p> <ul style="list-style-type: none"> Code H: High grade
Ovary	Grade Post Therapy	Blank (86.0%)	Blank (86.0%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Ovary	CA-125 PreTX Lab Value	1 (92.1%)	1 (92.1%)	Labs: CA 125: 558 (elevated) <ul style="list-style-type: none"> Code 1: Positive/elevated
Ovary	FIGO Stage	36 (86.0%)	36 (86.0%)	Surgical pathology report: FIGO Stage IIIB <ul style="list-style-type: none"> Code 36: FIGO Stage IIIB
Ovary	Residual Tumor Volume Post Cytoreduction	00 (67.7%)	00 (67.7%)	Per operative report: R0 cytoreduction. No gross residual disease. <ul style="list-style-type: none"> Code 00: No gross residual tumor nodules
Prostate	Primary Site	C619 (100%)	C619 (100%)	Biopsy pathology report: Prostate <ul style="list-style-type: none"> Code C619: Prostate
Prostate	Histology	8140 (92.2%)	8140 (92.2%)	Biopsy pathology report: Adenocarcinoma (acinar, not otherwise specified) Per Solid Tumor Rules for "Other Sites", Rule H10: Code 8140 (adenocarcinoma, NOS) for prostate primaries when the diagnosis is acinar (adeno)carcinoma <ul style="list-style-type: none"> Code 8140: Adenocarcinoma, NOS
Prostate	Behavior	3 (99.4%)	3 (99.4%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Prostate	Tumor Size Clinical	999 (94.0%)	999 (94.0%)	Tumor size clinical not documented in patient record <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	Tumor Size Pathologic	999 (97.6%)	999 (97.6%)	Tumor Size Pathologic not available <ul style="list-style-type: none"> Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Prostate	EOD Primary Tumor	350 (11.4%)	120 (50.6%)	Elevated PSA. Per Urology Note: Rectal examination revealed an enlarged somewhat firm prostate without nodules that appeared palpably benign on DRE. CT Abdomen and Pelvis: Median lobe of the prostate gland protrudes into the posterior bladder wall Although the CT scan indicates "protrusion into the posterior bladder wall," and the physician documents that the patient has high risk disease (high PSA and Gleason Score), there is not enough information in the record to support a code higher than code 120 for an elevated PSA

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 120: Tumor identified by needle biopsy (clinically inapparent/not palpable) Example - for elevated PSA
Prostate	Prostate Path Exten	900 (88.0%)	900 (88.0%)	No prostatectomy done <ul style="list-style-type: none"> Code 900: No prostatectomy or autopsy performed
Prostate	EOD Regional Nodes	000 (69.3%)	000 (69.3%)	CT Abdomen and Pelvis: No bulky pelvic sidewall or retroperitoneal adenopathy Retroperitoneal nodes were described as suspicious for involvement, but these are distant nodes and not recorded in EOD regional nodes <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Prostate	Regional Nodes Positive	98 (80.7%)	98 (80.7%)	No regional lymph nodes examined <ul style="list-style-type: none"> Code 98: No nodes examined
Prostate	EOD Mets	00 (64.5%)	10 (35.5%)	Physician states metastatic disease was suspected, and they were referring to the retroperitoneal node (or nodes) that were enlarged on imaging. Generally, when multiple ambiguous terms are used, the non-reportable ambiguous terms are ignored (“concerned” in this case) and use the reportable ambiguous term (“suspect” in this case). The physician does ultimately treat this patient as though he has metastatic disease as well. <ul style="list-style-type: none"> Code 10: Distant lymph node(s) (retroperitoneal nodes)
Prostate	SS2018	2 (6.0%)	7 (34.3%)	Originally coded as regional based on extension to bladder. Extension now based on elevated PSA, which makes this a localized tumor; however, also changed distant metastasis to include the retroperitoneal lymph nodes. <ul style="list-style-type: none"> Code 7: Distant metastasis (retroperitoneal lymph nodes)
Prostate	Grade Clinical	5 (91.6%)	5 (91.6%)	Biopsy pathology report: Clinical Gleason pattern 4+5=9 <ul style="list-style-type: none"> Code 5: Grade Group 5: Gleason score 9 or 10
Prostate	Grade Pathological	9 (89.2%)	9 (89.2%)	Per Note 5, 2 nd bullet: Code 9 when there is no resection of the primary site <ul style="list-style-type: none"> Code 9: Grade cannot be assessed; Unknown
Prostate	Grade Post Therapy	Blank (85.5%)	Blank (85.5%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Prostate	PSA Lab Value	646.0 (83.7%)	646.0 (83.7%)	Lab report done one day prior to biopsy states 646.0. First Urology note from physician documents 646, but in later updates, documents 647. Since there is discrepancy from the physician, go with the lab results <ul style="list-style-type: none"> Code 646.0

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Prostate	Gleason Patterns Clinical	45 (96.4%)	45 (96.4%)	Biopsy pathology report: Clinical Gleason pattern 4+5=9 <ul style="list-style-type: none"> Code 45
Prostate	Gleason Score Clinical	09 (96.4%)	09 (96.4%)	Biopsy pathology report: Clinical Gleason pattern 4+5=9 <ul style="list-style-type: none"> Code 09: Gleason score 9
Prostate	Gleason Patterns Pathological	X7 (84.3%)	X7 (84.3%)	No prostatectomy done <ul style="list-style-type: none"> Code X7: No prostatectomy done
Prostate	Gleason Score Pathological	X7 (84.9%)	X7 (84.9%)	No prostatectomy done <ul style="list-style-type: none"> Code X7: No prostatectomy done
Prostate	Gleason Tertiary Pattern	X7 (69.9%)	X7 (69.9%)	No prostatectomy done. Tertiary pattern is documented on biopsy Per Note 3: Record the tertiary pattern documented on prostatectomy or autopsy only. Record the tertiary pattern prior to neoadjuvant treatment. If a tertiary pattern is documented on needle core biopsy or transurethral resection of prostate (TURP), it should be disregarded <ul style="list-style-type: none"> Code X7: No prostatectomy done
Prostate	Number of Cores Examined	14 (97.6%)	14 (97.6%)	Biopsy pathology report: Cores positive 14, Cores examined 14 <ul style="list-style-type: none"> Code 14
Prostate	Number of Cores Positive	14 (97.6%)	14 (97.6%)	Biopsy pathology report: Cores positive 14, Cores examined 14 <ul style="list-style-type: none"> Code 14
Soft Tissue Abd/Thor	Primary Site	C494 (96.3%)	C494 (96.3%)	Per the SEER Coding Manual, General Instructions for Primary Site, #1: Unless otherwise instructed, use all available information in the medical record to code the site <i>Note:</i> There are no specific primary site instructions for Soft Tissue Surgical pathology report: Left Abdominal Wall Mass <i>Note:</i> For the histology dermatofibrosarcoma protuberans, skin is usually the primary site; however, soft tissue can be the primary site. Per the record, this is a soft tissue tumor and the skin is not involved. <ul style="list-style-type: none"> Code C494: Connective, subcutaneous and other soft tissues of abdomen

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Soft Tissue Abd/Thor	Histology	8832 (95.7%)	8832 (95.7%)	Surgical pathology report: Dermatofibrosarcoma Protuberans Note: Although this is a histology commonly associated with skin primary sites (C440-C449), it can also have a primary site of C47_ or C49_ . The pathology clearly stated connective tissue as the primary site with this histology. <ul style="list-style-type: none"> Code 8832: Dermatofibrosarcoma, NOS
Soft Tissue Abd/Thor	Behavior	3 (98.8%)	3 (98.8%)	Invasive histology <ul style="list-style-type: none"> Code 3: Malignant
Soft Tissue Abd/Thor	Tumor Size Clinical	069 (84.0%)	069 (84.0%)	Physician palpates a 9 x 7 cm. On CT scan: There is a subcutaneous abdominal wall soft tissue density mass present directly underneath the skin measuring 6.9 x 5.7 x 5.2 cm located on the left side below the umbilicus. Per the SEER Manual, Tumor Size Clinical, #7: Priority of imaging/radiographic techniques: Information on size from imaging/radiographic techniques can be used to code clinical size when there is no more specific size information from a biopsy or operative (surgical exploration) report. It should be taken as a lower priority, and over a physical exam. CT scan size of 6.9 cm (069) takes priority over the physical exam of 9 cm (090) <ul style="list-style-type: none"> Code 069
Soft Tissue Abd/Thor	Tumor Size Pathologic	100 (83.3%)	100 (83.3%)	Surgical Pathology Report: Left Abdominal Wall Mass, 10 cm <ul style="list-style-type: none"> Code 100
Soft Tissue Abd/Thor	EOD Primary Tumor	100 (92.6%)	100 (92.6%)	Surgical pathology report: Left Abdominal Wall Mass, 10 cm <ul style="list-style-type: none"> Code 100: Confined to organ, NOS, Localized, NOS
Soft Tissue Abd/Thor	EOD Regional Nodes	000 (84.6%)	000 (84.6%)	Surgical pathology report: Regional Lymph Nodes: No lymph nodes submitted or identified. Per Note 2: Regional lymph node involvement is rare. For this schema, if there is no mention of lymph node involvement clinically, assume that lymph nodes are negative. Code unknown (999) only when there is no available information on the extent of the patient's disease, for example when a lab-only case is abstracted from a biopsy report and no clinical history is available.

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Soft Tissue Abd/Thor	Regional Nodes Positive	98 (80.2%)	98 (80.2%)	<p>Surgical pathology report: No lymph nodes examined</p> <ul style="list-style-type: none"> Code 98: No nodes examined
Soft Tissue Abd/Thor	EOD Mets	00 (98.8%)	00 (98.8%)	<p>No clinical evidence of metastasis</p> <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Soft Tissue Abd/Thor	SS2018	1 (93.8%)	1 (93.8%)	<p>10 cm tumor with no evidence of invasion of other structures (confined to site of origin), no evidence of lymph nodes of metastasis</p> <ul style="list-style-type: none"> Code 1: Localized
Soft Tissue Abd/Thor	Grade Clinical	9 (95.7%)	9 (95.7%)	<p>Clinical grade not documented in patient record</p> <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Soft Tissue Abd/Thor	Grade Pathological	B (4.9%)	B (4.9%)	<p>Surgical pathology report: "The overall tumor is considered low grade." Applying the "Coding Guidelines for Generic Grade Categories" in the 2018 Grade Manual, low grade = code B.</p> <ul style="list-style-type: none"> Code B: Moderately differentiated
Soft Tissue Abd/Thor	Grade Post Therapy	Blank (88.3%)	Blank (88.3%)	<p>Patient did not have neoadjuvant therapy</p> <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Soft Tissue Abd/Thor	Bone Invasion	0 (93.8%)	0 (93.8%)	<p>No mention of bone invasion in imaging reports</p> <p>Per Note 3: Code 0 if relevant imaging is performed and there is no mention of bone invasion</p> <ul style="list-style-type: none"> Code 0: Bone invasion not present/not identified on imaging
Tongue Anterior	Primary Site	C022 (83.9%)	C022 (83.9%)	<p>Per the 2018 Solid Tumor Rules for Head and Neck, the priority order for assigning primary site is:</p> <ol style="list-style-type: none"> Tumor Board: No information from Tumor Board Tissue/pathology from tumor resection or biopsy: Scans Physician documentation <p>Operative report does state "overlapping lesions of tongue"; however, the final pathology report does not indicate any other subsite of tongue involved</p> <ul style="list-style-type: none"> Code C022: Ventral surface of tongue, NOS
Tongue Anterior	Histology	8071 (59.0%)	8070 (37.3%)	Per Surgical Pathology report: Invasive keratinizing squamous cell carcinoma

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
				<p>Per clarification from SEER: The 4th Ed WHO tumors of H&N no longer includes keratinizing SCC and non-keratinizing SCC in the chapter. The histology tables in the Solid Tumor Rules are based on the 4th Ed which is why these two histologies are not listed. Pathologists are discouraged from using these terms, however it takes a while for this to happen in the real world. Since both histologies have different codes from SCC, NOS they are subtypes/variants.</p> <ul style="list-style-type: none"> • Code 8070: Squamous cell carcinoma, NOS
Tongue Anterior	Behavior	3 (100%)	3 (100%)	<p>Invasive histology</p> <ul style="list-style-type: none"> • Code 3: Malignant
Tongue Anterior	Tumor Size Clinical	999 (97.5%)	999 (97.5%)	<p>Tumor size clinical not documented in patient record</p> <ul style="list-style-type: none"> • Code 999: Unknown, Size not stated, Not documented in patient record, Size of tumor cannot be assessed, Not applicable
Tongue Anterior	Tumor Size Pathologic	030 (100%)	030 (100%)	<p>Surgical pathology report: 3.0 cm</p> <ul style="list-style-type: none"> • Code 030
Tongue Anterior	EOD Primary Tumor	200 (49.7%)	200 (49.7%)	<p>Surgical Pathology Report: 3.0 cm tumor confined to tongue, 1.4 cm DOI (14 mm), floor of mouth benign</p> <p>The operative report indicates that the floor of mouth is involved. In a clinic note from managing physician, they referred to this being a T4a with extension to the extrinsic muscles</p> <p>Per EOD General Instructions: 3. Pathological findings take priority over clinical findings a. Assign the highest code representing the greatest extension pathologically (based on pathology report), when available</p> <p>In this situation, the pathology report findings would be based on the tumor confined to the tongue (T2, which is documented several times in the record)</p> <ul style="list-style-type: none"> • Code 200: Group 1 (localized) WITH depth of invasion (DOI) greater than 10 mm

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Tongue Anterior	EOD Regional Nodes	000 (98.8%)	000 (98.8%)	Surgical pathology report: 0/79 LNs <ul style="list-style-type: none"> Code 000: No regional lymph node involvement
Tongue Anterior	Regional Nodes Positive	00 (100%)	00 (100%)	Surgical pathology report: 0/79 LNs <ul style="list-style-type: none"> Code 00: All nodes examined negative
Tongue Anterior	EOD Mets	00 (100%)	00 (100%)	No clinical evidence of metastasis <ul style="list-style-type: none"> Code 00: No distant metastasis, Unknown if distant metastasis
Tongue Anterior	SS2018	1 (65.2%)	1 (65.2%)	3.0 cm tumor confined to tongue, no evidence of lymph nodes or metastasis The operative report indicates that the floor of mouth is involved. In a clinic note from managing physician, they referred to this being a T4a with extension to the extrinsic muscles. Negative nodes. Per Summary Stage 2018 General Instructions, #4 For ALL primary sites and histologies, Summary Stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are 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, <i>priority is given to the pathology report</i> <ul style="list-style-type: none"> Code 1: Localized tumor, confined to site of origin
Tongue Anterior	Grade Clinical	9 (93.8%)	9 (93.8%)	Clinical grade not documented in patient record <ul style="list-style-type: none"> Code 9: Grade cannot be assessed (GX); Unknown
Tongue Anterior	Grade Pathological	1 (93.2%)	1 (93.2%)	Surgery pathology report: G1: Well differentiated <ul style="list-style-type: none"> Code 1: G1: Well differentiated
Tongue Anterior	Grade Post Therapy	Blank (88.2%)	Blank (88.2%)	Patient did not have neoadjuvant therapy <ul style="list-style-type: none"> Per Note 1, leave blank when there is no neoadjuvant therapy
Tongue Anterior	Extranodal Exten H & N Clin	9 (31.7%)	7 (37.9%)	No documentation of clinical lymph node involvement <ul style="list-style-type: none"> Code 7: No lymph node involvement during diagnostic workup (cN0)
Tongue Anterior	Extranodal Exten H & N Path	X.7 (87.6%)	X.7 (87.6%)	Surgical pathology report: 0/79 LNs <ul style="list-style-type: none"> Code X.7: Surgically resected regional lymph node(s) negative for cancer (pN0)

Group 5 Case	Group 5 Data Item	Preferred Answer (% Agree)	Final Answer (% Agree)	Rationale
Tongue Anterior	Human Papilloma Virus (HPV) Status	9 (96.3%)	9 (96.3%)	HPV not documented in patient record <ul style="list-style-type: none"> Code 9: Unknown if HPV test detecting viral DNA and or RNA was performed
Tongue Anterior	LN Size	0.0 (92.5%)	0.0 (92.5%)	Surgical pathology report: 0/79 LNs <ul style="list-style-type: none"> Code 0.0: No involved regional nodes