VERSION 3.0 CHANGES FOR EOD AND SUMMARY STAGE

This document shows the changes that were made to EOD and Summary Stage 2018 for the SEER*RSA version 3.0 release

Table 1.1: Updated Schemas due to AJCC Version 9 rolling updates, Version 3.0

Schema	Applicable Years	Comments
Anus Version 9	2023+	AJCC's Anus, Version 9, will be used with 2023+ diagnosis. There are now two EOD Anus schemas in SEER*RSA • EOD Anus 8th: 2018-2022 (Schema ID: 00210) • EOD Anus V9: 2023+ (Schema ID: 09210) Software will automatically take you to the correct Anus schema based on the date of diagnosis Note: For Schema ID 09210 only (2023+), new SSDI: p16 • p16 is not applicable for cases diagnosed 2018-2022
Appendix Version 9	2023+	AJCC's Appendix, Version 9, will be used with 2023+ diagnosis. There are now two EOD Appendix schemas in SEER*RSA • EOD Appendix 8th: 2018-2022 (Schema ID: 00190) • EOD Appendix V9: 2023+ (Schema ID: 09190) Software will automatically take you to the correct Appendix schema based on the date of diagnosis Note: For Schema ID 09190 only (2023+), new SSDI: Histologic Subtype • Histologic subtype is not applicable for cases diagnosed 2018-2022
Brain Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two EOD Brain schemas in SEER*RSA • EOD Brain 8th: 2018-2022 (Schema ID: 00721) • EOD Brain V9: 2023+ (Schema ID: 09721) Software will automatically take you to the correct Brain schema based on the date of diagnosis

Schema	Applicable Years	Comments
CNS Other Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two Brain schemas in SEER*RSA • EOD CNS Other 8th: 2018-2022 (Schema ID: 00722) • EOD CNS Other: 2023+ (Schema ID: 09722) Software will automatically take you to the correct CNS Other schema based on the date of diagnosis
Intracranial Gland Version 9	2023+	AJCC's Brain and Spinal Cord, Version 9, will be used with 2023+ diagnosis. There are now two EOD Intracranial Gland schemas in SEER*RSA • EOD Intracranial Gland 8th: 2018-2022 (Schema ID: 00723) • EOD Intracranial Gland V9: 2023+ (Schema ID: 09723) Software will automatically take you to the correct CNS Other schema based on the date of diagnosis
Medulloblastoma Version 9	2023+	Brain and Spinal Cord, Version 9, will be used with 2023+ diagnoses and covers the following: • C700-C729: 9362, 9740-9472, 9474-9478, 9501-9504, 9508 • C700-C722, C724-C729: 9473 • C753: C751 For cases diagnosed prior to 2023+, use the appropriate Schema based on primary site 1. Schema ID: 00721: EOD Brain (Primary Sites: C700, C710-C719) 2. Schema ID: 00722: EOD CNS Other (Primary Sites: C701, C709, C720-C729) 3. Schema ID: 00723: EOD Intracranial Gland (Primary Site: C753) Software will automatically take you to the correct schema based on the date of diagnosis

Table 1.2: Updated Summary Stage chapters due to AJCC, Version 9 rolling updates, Version 3.0

Summary Stage Chapter	Applicable Years	Comments
Medulloblastoma New for 2023+	2023+	Brain and Spinal Cord, Version 9, will be used with 2023+ diagnoses and covers the following: • C700-C729: 9362, 9740-9472, 9474-9478, 9501-9504, 9508 • C700-C722, C724-C729: 9473 • C753: C751 New Summary Stage chapter for diagnosis years 2023+ For cases diagnosed prior to 2023+, use the appropriate Summary Stage chapter based on primary site 1. Summary Stage Chapter Brain (Primary Sites: C700, C710-C719) 2. Summary Stage Chapter CNS Other (Primary Sites: C701, C709, C720-C729) 3. Summary Stage Chapter Intracranial Gland (Primary Site: C753)

Table 2: Changes to EOD Schemas, Version 3.0

Schema	Data Item	Code	Original Text	Updated/New Text
Appendix	EOD Mets	10	Intraperitoneal metastasis • WITHOUT peritoneal mucinous deposits containing tumor cells or UNKNOWN	Intraperitoneal metastasis (peritoneal carcinomatosis) • WITHOUT peritoneal mucinous deposits containing tumor cells or UNKNOWN
Appendix	EOD Mets	50	Carcinomatosis	Carcinomatosis • Excludes peritoneal carcinomatosis (see EOD Mets code 30)
Bile Ducts Intrahepatic	EOD Primary Tumor	400		**New Code** 400: Invasion into, but not through the visceral peritoneum
Bone Pelvis	EOD Primary Tumor	Notes		**Note 2:** The number of pelvic segments involved by the primary tumor determines the appropriate EOD Primary Tumor (codes 100 through 550). The four pelvic segments used in these codes are • Acetbulum • Iliac wing • Public ramus/Symphysis/Ischium • Sacrum
Brain (2018-2022)	EOD Primary Tumor	Notes	**Note 3:** Discontiguous spread, including circulating cells in cerebrospinal fluid (CSF), is coded in EOD Mets	**Note 3:** Discontiguous spread, or "drop metastasis" are coded in EOD mets
Breast	EOD Primary Tumor	300	Invasion of (or fixation to) • Chest wall • Intercostal or serratus anterior muscle(s) • Rib(s)	• Chest wall • Intercostal or serratus anterior muscle(s) • Ipsilateral rib(s) (contiguous extension only, for discontiguous extension, see EOD Mets)

Schema	Data Item	Code	Original Text	Updated/New Text
Breast	EOD Mets	70	Distant metastasis • Adrenal (suprarenal) gland • Bone other than adjacent rib • Contralateral (opposite) breast-if stated as metastatic • Lung • Ovary • Satellite nodule(s) in skin other than primary breast	Distant metastasis • Adrenal (suprarenal) gland • Bone, including contralateral ribs • Contralateral (opposite) breast-if stated as metastatic • Ipsilateral rib(s) (discontiguous extension only, see EOD Primary Tumor for contiguous extension) • Lung • Ovary • Satellite nodule(s) in skin other than primary breast

Colon and Rectum	EOD Primary Tumor	Notes	**Note 5:** Invasion into "pericolonic/pericolorectal tissue" can be either codes 300 or 400, depending on the primary site. Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Code 300 may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).
			• Code 300
			  ○ Invasion through muscularis propria or muscularis, NOS
			  ○ Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper two thirds of rectum: Posterior surface; Lower third of rectum]
				Note 5: The colon and rectum may be entirely peritonealized, partially peritonealized, or non-peritonealized. Use this list to help distinguish between EOD Primary Tumor codes 300 and 400 (See Note 6).
				
				• Entirely peritonealized segments: Cecum, Transverse colon, Sigmoid colon, Rectosigmoid colon
				• Segmental surfaces that are peritonealized: Anterior and lateral surfaces of: Ascending colon, Descending colon, Hepatic flexure, Splenic flexure, Upper third of rectum. Anterior surface: Middle third of rectum.
				• Entirely non-peritonealized segment: Lower third of rectum

Schema	Data Item	Code	Original Text	Updated/New Text
Colon and Rectum	EOD Primary Tumor	Notes (cont)	○ Subserosal tissue/(sub)serosal fat invaded • Code 400 ○ Mesentery ○ Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper third of rectum: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface] ○ Pericolic/Perirectal fat • If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code 300.	• Segmental surfaces that are non-peritonealized: Posterior surface of: Ascending colon, Descending colon, Hepatic flexure, Splenic flexure, Upper two-thirds of rectum **Note 6:** Invasion into "pericolonic/pericolorectal tissue" can be either code 300 or 400, depending on the primary site and whether it is peritonealized (fully or partially) or not. When extension is described as "pericolonic/pericolorectal tissue." • Code 300 may NOT be used for entirely peritonealized sites (cecum, transverse colon, sigmoid colon, rectosigmoid colon), as this would be equivalent to peritonealized pericolic/perirectal tissue invasion (code 400) • Code 300 may ONLY be used for peritonealized sites (See Note 5) when the extension is described using other terms listed under code 300 (ex. subserosal fat). If there are no other terms used to describe the extension, other than invasion of "pericolorectal tissue", then assign code 400

Schema	Data Item	Code	Original Text	Updated/New Text
Colon and Rectum	EOD Primary Tumor	Notes (cont)		• For partially peritonealized sites (See Note 5), "pericolonic/pericolorectal tissue" may indicate invasion of either non-peritonealized (code 300) or peritonealized tissue (code 400) ○ Check for mention of serosa/peritoneum in the operative report and/or pathology report final diagnosis or gross description to determine the correct code. Again, if other descriptions besides "pericolonic/pericolorectal tissue" are used, assign code 300 or 400 based on the terminology used • If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" and the operative report and/or gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code 300.

Schema	Data Item	Code	Original Text	Updated/New Text
Colon and Rectum	EOD Primary Tumor	300	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS • Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Non-peritonealized pericolic/perirectal tissues invaded (see Code 400 for peritonealized pericolic/perirectal tissues invaded. See Note 5) Pericolic/perirectal tissues invaded, NOS (unknown whether non-peritonealized or peritonealized. See Note 5) Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS Wall, NOS	All Sites • Extension through wall, NOS • Invasion through muscularis propria or muscularis, NOS ○ Rectum (C209): WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus • Perimuscular tissue invaded • Subserosal tissue/(sub)serosal fat invaded • Transmural, NOS • Wall, NOS For non-peritonealized sites (See Notes 5 and 6) or UNKNOWN if peritonealized (for peritonealized sites, see code 400) • Pericolic fat/tissues • Perirectal fat/tissues

Schema	Data Item	Code	Original Text	Updated/New Text
Colon and Rectum	EOD Primary Tumor	400	Adjacent (connective) tissue(s), NOS Fat, NOS Gastrocolic ligament (transverse colon and flexures) Greater omentum (transverse colon and flexures) Mesentery (including mesenteric fat, mesocolon) Pericolic fat Perirectal fat Peritonealized pericolic/perirectal tissues invaded (see code 300 for non-peritonealized pericolic/perirectal tissues invaded. See Note 5) Rectovaginal septum (rectum) Retroperitoneal fat (ascending and descending colon only)	All Sites • Adjacent (connective) tissue(s), NOS • Fat, NOS • Gastrocolic ligament (transverse colon and flexures) • Greater omentum (transverse colon and flexures) • Mesentery (including mesenteric fat, mesocolon) • Rectovaginal septum (rectum) • Retroperitoneal fat (ascending and descending colon only) For peritonealized sites (See Notes 5 and 6) (for non-peritonealized sites or UNKNOWN if peritonealized, see code 300) • Pericolic fat/tissues • Perirectal fat/tissue
Liver	EOD Primary Tumor	150	Code 100 with vascular invasion	Summary Stage Derivation changed from RE to L
Liver	EOD Primary Tumor	200	Multiple (satellite) nodules/tumors confined to one lobe • WITH or WITHOUT vascular invasion	Summary Stage Derivation changed from RE to L

Schema	Data Item	Code	Original Text	Updated/New Text
Lung	EOD Primary Tumor	Notes	**Note 2:** Code 100 is to be used only when the following criteria are met • Minimally invasive adenocarcinoma (less than or equal to 3 cm) • **WITH** predominantly **lepidic pattern AND** • less than or equal to 5 mm invasion in greatest dimension • If predominantly **lepidic pattern** is present and the size of the invasive component is unknown, see code 300	**Note 2:** Ground glass opacities (GGO), ground glass nodules (GGN), and ground/glass lepidic (GG/L) are frequently observed on CT and are increasingly detected with the advancements in imaging and are described as an area of hazy increased lung opacity. GGO, GGN, and GG/L can be observed in both benign and malignant lung conditions along with pre-invasive lesions (adenocarcinoma in situ, minimally invasive adenocarcinoma, and lepidic carcinoma). They are often associated with early stage lung cancer but not necessarily malignancies themselves. • For staging purposes, these are not to be counted as separate tumor nodules Rest of notes renumbered

Schema	Data Item	Code	Original Text	Updated/New Text
Lung	EOD Primary Tumor	Notes (cont)		New Note 9: **Note 9:** "Vocal cord paralysis," "superior vena cava syndrome," and "compression of the trachea or the esophagus" are classified as either direct extension from the primary tumor or mediastinal lymph node involvement • If these manifestations are caused by direct extension of the primary tumor, code as primary tumor involvement (EOD Primary Tumor, code 650) • If the primary tumor is peripheral and clearly unrelated to vocal cord paralysis, SVC obstruction, or compression of the trachea, or the esophagus, these manifestations are secondary to lymph node involvement; code as mediastinal lymph node involvement (EOD Lymph Nodes, code 400) • If unable to determine if these manifestations are due to direct extension or mediastinal lymph node involvement, record as mediastinal lymph node involvement (EOD Lymph Nodes, code 400) Original notes 8 and 9 are now 9 and 10

Schema	Data Item	Code	Original Text	Updated/New Text
Lung	EOD Regional Nodes	Notes	Note 2: “Vocal cord paralysis,” “superior vena cava,” and “compression of the trachea or the esophagus” are classified as mediastinal lymph node involvement (code 400) unless there is a statement of involvement by direct extension from the primary tumor	**Note 2:** "Vocal cord paralysis," "superior vena cava syndrome," and "compression of the trachea or the esophagus" are classified as either direct extension from the primary tumor or mediastinal lymph node involvement • If these manifestations are caused by direct extension of the primary tumor, code as primary tumor involvement (EOD Primary Tumor, code 650) • If the primary tumor is peripheral and clearly unrelated to vocal cord paralysis, SVC obstruction, or compression of the trachea, or the esophagus, these manifestations are secondary to lymph node involvement; code as mediastinal lymph node involvement (EOD Lymph Nodes, code 400) • If unable to determine if these manifestations are due to direct extension or mediastinal lymph node involvement, record as mediastinal lymph node involvement (EOD Lymph Nodes, code 400)
Lymphoma, Lymphoma-CLL/SLL	EOD Primary Tumor	575	Not applicable	New code: Code 600 separated into codes 575 and 600 Nodal and Extranodal lymphomas • Involvement of lymph node regions on BOTH sides of the diaphragm ○ WITHOUT or UNKNOWN spleen involvement

Schema	Data Item	Code	Original Text	Updated/New Text
Lymphoma, Lymphoma-CLL/SLL	EOD Primary Tumor	600	Nodal lymphomas • Involvement of lymph node regions on BOTH sides of the diaphragm ○ OR nodes ABOVE the diaphragm involved ▪ WITH spleen involvement	Nodal and Extranodal lymphomas • Involvement of lymph node regions on BOTH sides of the diaphragm WITH spleen involvement ○ Includes involvement of lymph nodes ABOVE the diaphragm WITH spleen involvement
NET Colon and Rectum	EOD Primary Tumor	600	Colon subsites • Abdominal wall • Adrenal (suprarenal) gland • Bladder • Diaphragm • Fallopian tube • Fistula to skin • Gallbladder • Other segment(s) of colon via serosa • Ovary(ies) • Retroperitoneum (excluding fat) • Small intestine • Uterus	Colon subsites • Abdominal wall • Adrenal (suprarenal) gland • Bladder • Diaphragm • Fallopian tube • Fistula to skin • Gallbladder • Other segment(s) of colon via serosa • Retroperitoneum (excluding fat) • Small intestine Note: Ovary(ies) and Uterus removed from code 600 under “Colon Subsites”. Is correctly documented in code 700
Oropharynx HPV-Mediated (p16+)	EOD Primary Tumor	700	Pharyngeal Tonsil (C111) • Paranasal Sinus	Deleted: Also included in code 600, which is correct (derives a Summary Stage RE)
Oropharynx (p16-)	EOD Primary Tumor	550	Pharyngeal Tonsil (C111) • Paranasal Sinus	Deleted: Also included in code 500, which is correct (derives a Summary Stage RE)
Pleura Mesothelioma	EOD Primary Tumor	000	None	**New code:** Code 000: In situ, intraepithelial, noninvasive

Schema	Data Item	Code	Original Text	Updated/New Text
Pleura Mesothelioma	EOD Mets	Notes	**Note 1:** A physician's statement of positive (malignant) pleural effusion or a positive cytology confirming a malignant pleural effusion must be used to code 05. • If the physician feels the pleural effusion is due to tumor, despite negative cytology, the physician's assessment can be used to code EOD Mets • If pleural fluid cytology is described as suspicious/suspicious for mesothelioma, code 05 **Note 2:** In addition to EOD Mets, the following data item is also collected to determine the results of the Pleural Effusion, which include negative, atypical, or Pleural effusion, NOS • Pleural effusion [NAACCR Data Item #3913] **Note 3:** If there is a malignant pleural effusion WITH other mets, code 70.	**Note 1:** A physician's statement of positive (malignant) pleural effusion or a positive cytology confirming a malignant pleural effusion must be used to code 05. • If the physician feels the pleural effusion is due to tumor, despite negative cytology, the physician's assessment can be used to code EOD Mets • If pleural fluid cytology is described as suspicious/suspicious for mesothelioma, code 05 • A positive pleural effusion (code 05) should not be coded as present under the Mets at Dx-Other field. Code 0 for Mets at Dx-Other when code 05 is coded in EOD Mets. **Note 2:** In addition to EOD Mets, the following data item is also collected to determine the results of the Pleural Effusion, which include negative, atypical, or Pleural effusion, NOS • Pleural effusion [NAACCR Data Item #3913] **Note 3:** If there is a malignant pleural effusion WITH other mets, code 70.

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	EOD Primary Tumor	Notes	**Note 1:** This field and Prostate Pathological Extension, must both be coded, whether or not a prostatectomy was performed. Information from prostatectomy and autopsy is excluded from this field and coded only in Prostate Pathological Extension. **Note 2:** Code this data item based on findings from the DRE, needle core biopsy, trans rectal ultrasound (TRUS) guided biopsy, transurethral resection of prostate (TURP) and/or simple prostatectomy. **Note 3:** Code 100 or 110 with a TURP only. **Note 4:** Clinically inapparent and apparent tumor. When clinical apparency cannot be determined, code 300. • Clinically inapparent tumors are not palpable. Physician documentation of a DRE that does not mention a palpable "tumor", "mass", or "nodule" can be inferred as inapparent. This would include findings limited to benign prostate enlargement/hypertrophy. • 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.	Notes totally redone **Note 1:** For this schema, the EOD Primary Tumor field captures a clinical extent of disease only. The guidelines for assigning Clinical Extension for AJCC and EOD are different. Per AJCC, a digital rectal exam (DRE) is required to assign a clinical T (cT). For EOD, a code can be assigned if there is no DRE information. (See Note 7). **Note 2:** Information from radical prostatectomy and autopsy are recorded in EOD Prostate Pathologic Extension • ***Note:*** A simple prostatectomy (Surgery code 30) does not qualify for a radical prostatectomy. Results from a simple prostatectomy are recorded in EOD Primary Tumor **Note 3:** Imaging is **not** used to determine the clinical extension. If a physician incorporates imaging findings into their evaluation (including the clinical T category), **do not** use this information. • If it cannot be determined if the physician is using imaging, assume they are not and code the clinical extension based on the physician's statement **Note 4:** Codes 100, 110, or 150 are used when there is a TURP only during the clinical workup and there was no clinically apparent tumor (DRE negative or unknown) (See Note 6 if positive DRE).

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	EOD Primary Tumor	Notes (cont)	• Imaging is not used to determine the clinical extension. If a physician incorporates imaging findings into their evaluation (including the clinical T category), do not use this information • Do not infer inapparent or apparent tumor based on the registrar's interpretation of other terms in the DRE or imaging reports. • Code 300 for localized cancer when it is unknown if the tumor is clinically apparent. This would include cases with elevated PSA and positive needle core biopsy but no documentation regarding tumor apparency (inapparent versus apparent). Another example would be a diagnosis made prior to admission for a prostatectomy with no details provided on the initial clinical findings. **Note 5:** This field is based on the DRE whether or not the tumor is clinically apparent or inapparent. Do not use biopsy results to code this field UNLESS they prove extraprostatic extension. **Note 6:** 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.	• Code 150 if only a TURP is done, and the percentage of cells is not noted in the pathology report **Note 5:** Code 120 when the tumor is clinically inapparent (DRE negative). • Do not use this code when there is no information about the DRE results (see Note 7 for code 300). • **Clinically inapparent tumors** are not palpable. Physician documentation of a DRE that does not mention a palpable “tumor”, “mass”, or “nodule” can be inferred as inapparent. This would include DRE findings of only benign prostate enlargement/hypertrophy • Do not use ICD-10-CM code R97.20 (Elevated prostate specific antigen [PSA]) alone to code 120 **Note 6:** Codes 200-250 are for clinically apparent tumors (DRE positive). • **Clinically apparent tumors** are palpable. If a clinician documents a “tumor”, “mass”, or “nodule” by physical examination, this can be inferred as apparent • Do not infer inapparent or apparent tumor based on the registrar’s interpretation of other terms

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	EOD Primary Tumor	Notes (cont)	• *Example*: DRE reveals prostate is "firm." Physician stages the patient as a cT2a. The T2a can be used since the physician has documented this. **Note 7:** Involvement of the prostatic urethra does not alter the EOD code. **Note 8:** "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign a description of frozen pelvis to code 700. **Note 9:** When an incidental finding of prostate cancer is found during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), code 800 (no evidence of primary tumor) in this field. If there is no documentation regarding a normal prostate evaluation (physical examination or imaging) prior to prostatectomy/autopsy, code 999 (unknown; extension not stated) in this field.	**Note 7:** Code 300 for localized cancers when the DRE result is not documented, or DRE not done and there is no clinical evidence of extraprostatic extension, or the physician incorporates imaging findings into their evaluation • ***Example 1:*** Patient with elevated PSA and positive needle core biopsy, but no documentation regarding tumor apparency (inapparent versus apparent), and there is no evidence of extraprostatic extension • ***Example 2:*** Pathology report from a needle core biopsy done confirming cancer. No information on PSA, DRE or physician statement regarding clinical extension • ***Example 3:*** Pathology report from a needle core biopsy done confirming cancer. No information on PSA, DRE or physician statement regarding clinical extension. Physician states imaging shows extraprostatic extension and assigns cT3a **Note 8:** Codes 350-700 are for when there is positive extraprostatic extension, which can be determined by DRE, clinical exam, or needle core biopsy • If a needle core biopsy confirms extraprostatic extension, that information can be used for EOD

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	EOD Primary Tumor	Notes (cont)		**Note 9:** If there is no information from the DRE, or the terminology used is not documented in Note 5, but the physician assigns a clinical extent of disease, the registrar can use that. • ***Example:*** DRE reveals prostate is "firm." Physician states the patient as a cT2a. The T2a can be used in the physician has documented this. Code 200 ○ ***Exception:*** If the physician is clearly using imaging findings to determine clinical stage or extension of disease, do not use this information and code as 300 (Localized, NOS) (See Note 7) **Note 10:** Involvement of the prostatic urethra does not alter the EOD code. Extraprostatic urethra involved is captured in code 600. **Note 11:** "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign a description of frozen pelvis to code 700. **Note 12:** Code 800 when an incidental finding of prostate cancer is found during a prostatectomy performed for other reasons (i.e., prostate cancer not suspected). • ***Example 1:*** Cystoprostatectomy done for bladder cancer and prostate cancer found incidentally

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	EOD Primary Tumor	Notes (cont)		• ***Example 2:*** Patient found to have prostate cancer during autopsy **Note 13:** Code 999 when there is no documentation regarding a prostate evaluation (PSA, physical exam or physician's statement) prior to prostatectomy/autopsy. ***Example:*** Patient presents for prostatectomy for known prostate cancer. No information on clinical evaluation
Prostate	Prostate Path Extension	Notes	**Note 1:** Only use histologic information from a radical prostatectomy and/or autopsy in this field. Information from biopsy of extraprostatic sites is coded in EOD Primary Tumor. • Code results from a transurethral resection of prostate (TURP) or simple prostatectomy in EOD Primary Tumor **Note 2:** Code 900 if there is no prostatectomy performed within the first course of treatment. **Note 3:** Limit information in this field to first course of treatment in the absence of disease progression. **Note 4:** When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found.	Notes totally redone **Note 1:** Only use histologic information from a radical prostatectomy and/or autopsy in this field. Information from biopsy of extraprostatic sites is coded in EOD Primary Tumor. • Code results from a transurethral resection of prostate (TURP) or simple prostatectomy in EOD Primary Tumor **Note 2:** Code 900 if there is no radical prostatectomy or autopsy performed within first course of treatment. (See also Note 7) • A radical prostatectomy is defined as Surgery of Primary Site codes 50-70 • If Surgery of primary site is 00-30, 90, then code 900 ○ *Note:* Surgery of primary site can be 00 if an autopsy is done

Schema	Data Item	Code	Original Text	Updated/New Text
Prostate	Prostate Path Extension	Notes (cont)	**Note 5:** Involvement of the prostatic urethra does not alter the extension code. **Note 6:** "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 700. **Note 7:** Code 950 is used when first course of treatment is active surveillance, but a prostatectomy is done at a later date due to disease progression or the patient changed their mind. When code 950 is used, code the following SSDIs as X9: Gleason Patterns Pathological, Gleason Score Pathological, and Gleason Tertiary	**Note 3:** Limit information in this field to first course of treatment in the absence of disease progression. **Note 4:** When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), or an autopsy, use the appropriate code for the extent of disease found. **Note 5:** Involvement of the prostatic urethra does not alter the extension code. **Note 6:** "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 700. **Note 7:** Code 950 is used when first course of treatment is active surveillance, but a radical prostatectomy is done at a later date due to disease progression or the patient changed their mind. • When code 950 is used, code the following SSDIs as X9: Gleason Patterns Pathological, Gleason Score Pathological, and Gleason Tertiary **Note 8:** Code 999 when • Radical prostatectomy is performed, but there is no information on the extension • Surgery of Primary Site is Prostatectomy, NOS (Surgery of Primary Site is 80) Unknown if surgery is done (Surgery of Primary Site is 99)

Table 3: Changes to Summary Stage 2018 Chapters, Version 3.0

Schema	Code	Original Text	Updated/New Text
Bone	Note	**Note 3:** Code 0 is not applicable for this chapter. **Note 4:** The cortex of a bone is the dense outer shell that provides strength to the bone; the spongy center of a bone is the cancellous portion. The periosteum of the bone is the fibrous membrane covering of a bone that contains the blood vessels and nerves; the periosteum is similar to the capsule on a visceral organ. **Note 5:** Regional lymph nodes are defined as those in the vicinity of the primary tumor.	**Note 3:** Code 0 is not applicable for this chapter. **Note 4:** The cortex of a bone is the dense outer shell that provides strength to the bone; the spongy center of a bone is the cancellous portion. The periosteum of the bone is the fibrous membrane covering of a bone that contains the blood vessels and nerves; the periosteum is similar to the capsule on a visceral organ. **Note 5:** For the spinal tumors (C412), if only the number of adjacent vertebral segments below are involved, this would be localized (code 1). Any other vertebral segments involved (non-adjacent) would be regional (code 2). • Body (left) • Body (right) • Pedicle (left) • Pedicle (right) • Posterior element **Note 6:** For the pelvic tumors (C414), both the number of pelvic segments involved by the primary tumor and the presence or absence of extraosseous extension determine the correct Summary Stage 2018 for localized and regional pelvic bone primaries. The four pelvic segments used in these codes are: • Acetabulum • Iliac wing • Pubic ramus/Symphysis/Ischium • Sacrum **Note 7:** Regional lymph nodes are defined as those in the vicinity of the primary tumor.

Schema	Code	Original Text	Updated/New Text
Bone	2	Spine (C412) • One to two pelvic segments involved WITH extraosseous extension	Pelvis (C412) • One to four pelvic segments involved WITH extraosseous extension
Bone	1	Pelvis (C414) • Confined to pelvis, NOS (number of segments involved not known) • One to two pelvic segments involved WITHOUT or UNKNOWN if extraosseous extension	Pelvis (C414) • Confined to pelvis, NOS (number of segments involved not known and WITHOUT or UNKNOWN if extraosseous extension) • One to four pelvic segments involved WITHOUT or UNKNOWN if extraosseous extension
Breast	2	• Pectoral fascia or muscle(s) • Rib(s) • Subcutaneous tissue • Skin infiltration of primary breast including skin of nipple and/or areola	• Ipsilateral rib(s) (contiguous extension only, for discontiguous extension, see code 7) • Pectoral fascia or muscle(s) • Subcutaneous tissue • Skin infiltration of primary breast including skin of nipple and/or areola
Breast	7	Distant site(s) (including further contiguous extension) • Adrenal (suprarenal) gland • Bone other than adjacent rib • Contralateral (opposite) breast-if stated as metastatic • Lung • Ovary	Distant site(s) (including further contiguous extension) • Adrenal (suprarenal) gland • Bone, including contralateral ribs • Contralateral (opposite) breast-if stated as metastatic • Ipsilateral rib(s) (discontiguous extension only, see code 2 for contiguous extension) • Lung • Ovary

Schema	Code	Original Text	Updated/New Text

Colon and Rectum	Notes	**Note 6:** Invasion into "pericolonic/pericolorectal tissue" can be either Localized or Regional, depending on the primary site. Some sites are entirely peritonealized; some sites are only partially peritonealized or have no peritoneum. Localized may not be used for sites that are entirely peritonealized (cecum, transverse colon, sigmoid colon, rectosigmoid colon, upper third of rectum).
		• Localized
		  ○ Invasion through muscularis propria or muscularis, NOS
		  ○ Non-peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper two thirds of rectum: Posterior surface; Lower third of rectum]
		  ○ Subserosal tissue/(sub)serosal fat invaded
		• Regional
		  ○ Mesentery
		  ○ Peritonealized pericolic/perirectal tissues invaded [Ascending Colon/Descending Colon/Hepatic Flexure/Splenic Flexure/Upper third of rectum: anterior and lateral surfaces; Cecum; Sigmoid Colon; Transverse Colon; Rectosigmoid; Rectum: middle third anterior surface]
			Note 6: The colon and rectum may be entirely peritonealized, partially peritonealized, or non-peritonealized. Use this list to help distinguish between Localized and Regional Tumors (See Note 7).
			• Entirely peritonealized segments: Cecum, Transverse colon, Sigmoid colon, Rectosigmoid colon
			• Segmental surfaces that are peritonealized: Anterior and lateral surfaces of: Ascending colon, Descending colon, Hepatic flexure, Splenic flexure, Upper third of rectum. Anterior surface: Middle third of rectum.
			• Entirely non-peritonealized segment: Lower third of rectum
			• Segmental surfaces that are non-peritonealized: Posterior surface of: Ascending colon, Descending colon, Hepatic flexure, Splenic flexure, Upper two-thirds of rectum
			
			Note 7: Invasion into "pericolonic/pericolorectal tissue" can be either Localized or Regional, depending on the primary site and whether it is peritonealized (fully or partially) or not. When extension is described as "pericolonic/pericolorectal tissue"
			• Localized (code 1) may NOT be used for entirely peritonealized sites (cecum, transverse colon, sigmoid colon, rectosigmoid colon), as this would be equivalent to peritonealized pericolic/perirectal tissue invasion (regional, code 2).
			  ○ Localized (code 1) may be used for these peritonealized sites when the extension is described using other terms listed under localized (code 1) (ex. subserosal fat).

Schema	Code	Original Text	Updated/New Text
Colon and Rectum	Notes (cont)	○ Pericolic/Perirectal fat • If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" fat and the gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, code Localized.	• For partially peritonealized sites (See Note 6), "pericolonic/pericolorectal tissue" may indicate invasion of either non-peritonealized (localized, code 1) or peritonealized tissue (regional, code 2). ○ Check for mention of serosa/peritoneum in the operative report and/or pathology report to determine the correct code. Again, if other descriptions besides "pericolonic/pericolorectal tissue" are used, assign code localized (code 1) or regional (code 2) based on the terminology used. • If the pathologist does not further describe the "pericolic/perirectal tissues" as either "non-peritonealized pericolic/perirectal tissues" vs "peritonealized pericolic/perirectal tissues" and the operative report and/or gross description does not describe the tumor relation to the serosa/peritoneal surface, and it cannot be determined whether the tumor arises in a peritonealized portion of the colon, coded to localized (code 1.)

Schema	Code	Original Text	Updated/New Text

Colon and Rectum	1	Localized only (localized, NOS)
		
		• Confined to colon, rectum, rectosigmoid, NOS
		• Extension through wall, NOS
		• Intraluminal extension to colon and/or anal canal/anus (rectum only)
		• Invasion of
		  ○ Intramucosal, NOS
		  ○ Lamina propria
		  ○ Mucosa, NOS
		  ○ Muscularis mucosae
		  ○ Muscularis, NOS
		  ○ Muscularis propria
		  ○ Submucosa (superficial invasion)
		• Non-peritonealized pericolic/perirectal tissues invaded (see Regional for peritonealized pericolic/perirectal tissues invaded. See Note 6)
		• Pericolic/perirectal tissues invaded, NOS (unknown whether non-peritonealized or peritonealized. See Note 6)
		• Perimuscular tissue invaded
		• Polyp (head, stalk, NOS)
		• Subserosal tissue/(sub)serosal fat invaded
		• Transmural, NOS
		• Wall, NOS
			Localized only (localized, NOS)
			
			All Sites
			
			• Confined to colon, rectum, rectosigmoid, NOS
			• Confined to polyp (head, stalk, NOS)
			• Extension through wall, NOS
			• Intraluminal extension to colon and/or anal canal/anus (rectum only)
			• Invasion of
			  ○ Intramucosal, NOS
			  ○ Lamina propria
			  ○ Mucosa, NOS
			  ○ Muscularis mucosae
			  ○ Muscularis, NOS
			  ○ Muscularis propria
			  ▪ Rectum (C209): WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus
			• Perimuscular tissue invaded
			• Submucosa (superficial invasion)
			• Subserosal tissue/(sub)serosal fat invaded
			• Transmural, NOS
			• Wall, NOS
			
			Non-peritonealized sites (See Notes 6 and 7) or UNKNOWN if peritonealized (for peritonealized sites, see code 2)
			
			• Pericolic fat/tissues
			• Perirectal fat/tissues

Schema	Code	Original Text	Updated/New Text
Colon and Rectum	2	Regional by direct extension only • All sites ○ Abdominal wall ○ Adherent to other organs or structures clinically with no microscopic examination ○ Adjacent (connective) tissue(s), NOS ○ Fat, NOS ○ Mesentery (including mesenteric fat, mesocolon) ○ Mesothelium ○ Pericolic fat ○ Perirectal fat ○ Peritonealized pericolic/perirectal tissues invaded (see Localized for non-peritonealized pericolic/perirectal tissues invaded. See Note 6) ○ Retroperitoneum (excluding fat) ○ Serosa ○ Small intestine ○ Tumor found in adhesion(s) if microscopic examination performed ○ Tunica serosa ○ Visceral peritoneum	Regional by direct extension only All sites • Abdominal wall • Adherent to other organs or structures clinically with no microscopic examination • Adjacent (connective) tissue(s), NOS • Fat, NOS • Mesentery (including mesenteric fat, mesocolon) • Mesothelium • Retroperitoneum (excluding fat) • Serosa • Small intestine • Tumor found in adhesion(s) if microscopic examination performed • Tunica serosa • Visceral peritoneum Peritonealized sites (See Notes 6 and 7) (for non-peritonealized sites or UNKNOWN if peritonealized, see code 1) • Pericolic fat/tissues • Perirectal fat/tissues

Schema	Code	Original Text	Updated/New Text
Liver	Notes		New Note **Note 3:** The liver is divided into several lobes as defined below. In the absence of other tumor involvement (lymph node involvement or distant metastasis), code the lobe or segment involvement as follows: If multiple lobes (such as the Caudate lobe and the Left Lobe) are involved, code 2 (Regional). If multiple segments (such as 5 and 6 in the right lobe) in the same lobe are involved, this would be multiple tumors within one lobe, code 1 (Localized). • Caudate lobe: Segment 1 • Quadrate lobe: Segment 4b • Left lobe: Segments 2, 3, 4a • Right lobe: Segments 5, 6, 7, 8
Liver	1	Localized only (localized, NOS) • Confined to liver, NOS • Single tumor (one lobe) WITH or UNKNOWN vascular invasion	Localized only (localized, NOS) • Confined to liver, NOS • Single tumor (one lobe) WITH or WITHOUT vascular invasion • Multiple (satellite) nodules/tumor confined to one lobe WITH or WITHOUT vascular invasion

Schema	Code	Original Text	Updated/New Text

Liver	2	Regional by direct extension only
		…..
		• Major vascular invasion, NOS
		• More than one lobe involved by contiguous growth (single lesion)
		  ○ WITH or WITHOUT vascular invasion
		• Multiple (satellite) nodules/tumor (one lobe)
		  ○ WITHOUT or UNKNOWN vascular invasion
		• Multiple (satellite) nodules/ tumors in more than one lobe of liver or on surface of parenchyma
		  ○ WITH or WITHOUT vascular invasion
		• Single lesion (one lobe) WITH vascular invasion
			Regional by direct extension only
			…..
			• Major vascular invasion, NOS
			• More than one lobe involved by contiguous growth (single lesion)
			  ○ WITH or WITHOUT vascular invasion
			• Multiple (satellite) nodules/ tumors in more than one lobe of liver or on surface of parenchyma
			  ○ WITH or WITHOUT vascular invasion

Lung	Notes	**Note 3:** "Bronchopneumonia" is not the same thing as "obstructive pneumonitis" and should not be coded as such.	**Note 3:** Ground glass opacities (GGO), ground glass nodules (GGN), and ground/glass lepidic (GG/L) are frequently observed on CT and are increasingly detected with the advancements in imaging and are described as an area of hazy increased lung opacity. GGO, GGN, and GG/L can be observed in both benign and malignant lung conditions along with pre-invasive lesions (adenocarcinoma in situ, minimally invasive adenocarcinoma, and lepidic carcinoma). They are often associated with early stage lung cancer but not necessarily malignancies themselves. • For staging purposes, these are not to be counted as separate tumor nodules **Rest of notes renumbered**

Schema	Code	Original Text	Updated/New Text
Lung	Notes	**Note 7:** "Vocal cord paralysis," "superior vena cava syndrome," and "compression of the trachea or the esophagus" are classified as mediastinal lymph node involvement (code 3) unless there is a statement of involvement by direct extension from the primary tumor	**Note 8:** "Vocal cord paralysis," "superior vena cava syndrome," and "compression of the trachea or the esophagus" are classified as either direct extension from the primary tumor or mediastinal lymph node involvement • If these manifestations are caused by direct extension of the primary tumor, code as primary tumor involvement (code 2) • If the primary tumor is peripheral and clearly unrelated to vocal cord paralysis, SVC obstruction, or compression of the trachea, or the esophagus, these manifestations are secondary to lymph node involvement; code as mediastinal lymph node involvement (code 3) • If unable to determine if these manifestations are due to direct extension or mediastinal lymph node involvement, record as mediastinal lymph node involvement (code 3)
Lymphoma	7	• Involvement of lymph node regions on BOTH sides of the diaphragm ○ OR nodes ABOVE the diaphragm involved WITH spleen involvement	• Involvement of lymph node regions on BOTH sides of the diaphragm WITH or WITHOUT spleen involvement • Involvement of lymph node regions ABOVE the diaphragm WITH spleen involvement
Oropharynx	7	Pharyngeal Tonsil (C111) • Paranasal Sinus	Deleted: Also included in code 2, which is correct (derives a Summary Stage RE)
Pleura Mesothelioma	0	None	**New code:** **Code 0: In situ, intraepithelial, noninvasive**

Schema	Code	Original Text	Updated/New Text
Prostate	Notes	**Note 5:** Imaging is not used to determine the clinical extension. If a physician incorporates imaging findings into their evaluation (including the clinical T category), do not use this information. **Note 6:** If there is no information from the DRE, but the physician assigns a clinical extent of disease, the registrar can use that. • *Example*: DRE reveals prostate is "firm." Physician stages the patient as a cT2a. The T2a (localized) can be used since the physician has documented this.	**Note 5:** Imaging is not used to determine clinical extension. If a physician incorporates imaging findings into their evaluation, do not use this information. • If it cannot be determined if the physician is using imaging, assume they are not and code the Summary Stage based on the physician's statement **Note 6:** If there is no information from the DRE, but the physician assigns an extent of disease, the registrar can use that. • ***Example:*** DRE reveals prostate is "firm." Physician stages the patient as a cT2a. ○ The T2a (localized) can be used since the physician has documented this **Note 7:** Localized (code 1) can be assigned when the DRE result is not documented, or DRE not done and there is no evidence of extraprostatic extension • ***Example 1:*** Patient with elevated PSA and positive needle core biopsy, but no documentation regarding tumor apparency (inapparent versus apparent), and there is no evidence of extraprostatic extension. No prostatectomy done • ***Example 2:*** Pathology report from a needle core biopsy done confirming cancer. No information on PSA, DRE, Radical prostatectomy, or physician statement regarding clinical extension • ***Example 3:*** Pathology report from a needle core biopsy done confirming cancer. No information on PSA, DRE or physician statement regarding clinical extension. Physician states imaging shows extraprostatic extension and assigns cT3a Rest of notes renumbered