EXTENT OF DISEASE (EOD) 2018
GENERAL CODING INSTRUCTIONS
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Effective with cases diagnosed January 1, 2018, and forward

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Publication History

EOD was first published as part of the 1976 SEER Code Manual. The first EOD-specific coding manual was the April 1977 EOD Manual, which included a 13-digit and 2-digit coding schemas. This manual was used for diagnosis years 1977-1982. In 1983, EOD was moved to a 4-digit coding schema that provided schemas for all sites.

The next major update was the EOD 1988 10-digit, which was revised in 1992 and 1998. EOD was discontinued as of diagnosis date 12/31/2003. Collaborative Stage was implemented for diagnosis dates 1/1/2004 through 12/31/2015. Although Collaborative Stage was discontinued for the cancer registry community at that time, some SEER registries continued to collect Collaborative Stage for 2016 and 2017. As of 12/31/2017, Collaborative Stage is discontinued for those SEER registries as well, and EOD 2018 is implemented for SEER registries starting 1/1/2018.

Comparisons between EOD 2018 and earlier versions of EOD or CS are evaluated on a schema-by-schema basis, as some schemas cannot be compared and those that can be compared usually have limitations.

EOD 2018 has three main data items: EOD Primary Tumor, EOD Regional Nodes and EOD Mets. EOD 2018 is fully compatible with the AJCC TNM staging manual, 8th edition. Thorough review of EOD 2018 was done by NCI SEER staff, SEER*Educate Staff from the SEER Seattle registry, and contractors.

Table of Contents

Extent of Disease

Extent of Disease (EOD) 2018 is a new version of EOD with significant differences from previous versions. NCI SEER maintains a surveillance system for cancer identification for the following purposes:

- Supporting Department of Health and Human Services (DHHS)-wide cancer control initiatives, including Healthy People 2020
- Permitting staging of the most comprehensive set of patients for all cancer sites
- Reporting and monitoring trends in cancer incidence and outcomes
- Supporting and promoting research for all types of cancer
- Enabling and ensuring ongoing continuity of staging trends over time reflecting the combination of clinical and pathologic information (since 1994)

The 2018 version of EOD applies to every site/histology combination, including lymphomas and leukemias.

EOD uses all information available in the medical record; in other words, it is a combination of the most precise clinical and pathological documentation of the extent of disease.

There are 3 main data items in EOD, each of which is discussed in detail.

1. EOD Primary Tumor
2. EOD Regional Nodes
3. EOD Mets

This manual is effective for all cases diagnosed 1/1/2018 and after.

- Once a new version is released, that version can be used for all cases diagnosed 2018+.

Send questions, suggestions and corrections to:

Ask a SEER Registrar

Choose subject: Extent of Disease (EOD)

Definitions of Terms Used in this Manual

Adjacent connective tissue
These are unnamed tissues that immediately surround an organ or structure containing a primary cancer. Use this category when a tumor has invaded past the outer border (capsule, serosa, or other edge) of the primary organ into the organ's surrounding supportive structures but has not invaded into larger structures or adjacent organs. The structures considered in ICD-O-3 as connective tissue include the following: adipose tissue; aponeuroses; arteries; blood vessels; bursa; connective tissue, NOS; fascia; fatty tissue; fibrous tissue; ganglia; ligaments; lymphatic channels (not nodes); muscle; nerves (spinal, sympathetic and peripheral); skeletal muscle; subcutaneous tissue; synovia; tendons; tendon sheaths; veins, and vessels, NOS. In general, these tissues do not have specific names. These tissues form the framework of many organs, provide support to hold organs in place, bind tissues and organs together, and serve as storage sites for nutrients.

Adjacent organs/structures
Organs are anatomic structures with specific physiologic functions other than (or in addition to) support and storage. There are two types:

- Unnamed: Contiguous growth into an unnamed organ lying next to the primary is coded to 'adjacent organs/structures.'
- Named: Connective tissues may be large enough to be given a specific name.
    - Examples include Blood, cartilage and bone are sometimes considered connective tissues, but in this manual, they would be listed separately.
    - Contiguous growth from one organ into an adjacent named structure would be coded to 'adjacent organs/structures.' For example, the brachial artery has a name, as does the broad ligament and both are structures.

Circulating Tumor Cells (CTCs)
See Isolated Tumor Cells

Contiguous
Directly adjacent; continuously adjoining; without lapse or intervening space; used in reference to regionalized cancers and extent of disease.

Cortex (adjective: cortical)
The external or outer surface layer of an organ, as distinguished from the core, or medulla, of the organ. In some organs, such as the adrenal glands, the cortex has a different function than the medulla.

Noncontiguous/Discontinuous
Tumors that are not connected; tumors in more than one area with normal tissue between them; often a sign of metastatic disease.

Disseminated Tumor Cells (DTCs)
See Isolated Tumor Cells

Direct extension/involvement
A term used in staging to indicate contiguous growth of tumor from the primary into an adjacent organ or surrounding tissue.

Distant
Refers to cancer that has spread from the original (primary) tumor to distant organs or distant lymph nodes.

Isolated tumor cells (ITCS), Circulating tumor cells (CTCs), Disseminated tumor cells (DTCs)
Isolated tumor cells (ITC) are single tumor cells or small clusters of cells not more than 0.2 mm in greatest extent that can be detected by routine H and E stains or immunohistochemistry. An additional criterion has been proposed to include a cluster of fewer than 200 cells in a single histological cross-section. The same applies to cases with findings suggestive of tumor cells or their components by non-morphological techniques such as flow cytometry or DNA analysis.

ITCs do not typically show evidence of metastatic activity (e.g., proliferation or stromal reaction) or penetration of lymphatic sinus walls.

This definition also refers to circulating tumor cells (CTCs) and disseminated tumor cells (DTCs)

Localized
In medicine, it describes disease that is limited to a certain part of the body. For example, localized cancer is usually found only in the tissue or organ where it began and has not spread to nearby lymph nodes or to other parts of the body. Some localized cancers can be completely removed by surgery.

Medulla (adjective: medullary)
The medulla (central) portion of an organ, in contrast to the outer layer or cortex. It is sometimes called marrow. In some organs, such as bone, the medulla or marrow has a different physiologic role than the cortex.

Parenchyma
The parenchyma is the functional portion of an organ, in contrast to its framework or stroma. For example, the parenchyma of the kidney contains all the structures which filter and remove waste products from the blood. In general, malignancies tend to arise in the parenchyma of an organ.

Regional
In oncology, describes the body area right around a tumor.

Stroma
The stroma are the cells and tissues that support, store nutrients, and maintain viability within an organ. Stroma consists of connective tissue, vessels and nerves, and provides the framework of an organ. In general, spread of tumor to the stroma of an organ is still localized or confined to the organ of origin.

Ambiguous Terminology

Most of the time, registrars will find definitive statements of extension/involvement; however, for those situations where extension/involvement is described with non-definitive (ambiguous) terminology, use the guidelines below to interpret and determine the appropriate assignment of EOD Primary Tumor, EOD Regional Nodes or EOD Mets.

Determination of the cancer stage is both a subjective and objective assessment by the physician(s) of how far the cancer has spread. When it is not possible to determine the extent of involvement because terminology is ambiguous, look at the documentation that the physician used to make informed decisions on how the patient is being treated. For example, assign the EOD fields based on extension/involvement when the patient was treated as though adjacent organs or nodes were involved.

Use the following lists to interpret the intent of the clinician ONLY when further documentation is not available and/or there is no specific statement of extension/involvement in the medical record. The clinician's definitions/descriptions and choice of therapy have priority over these lists because individual clinicians may use these terms differently.

***Note 1*:** Terminology in the schema takes priority over this list. Some schemas interpret certain words as involvement, such as 'encasing' the carotid artery for a head and neck site or "abutment," "encases," or "encasement" for pancreas primaries.

Note 2: Use this list only for EOD 2018 or Summary Stage 2018.

Note 3: This is ***not*** the same list used for determining reportability as published in the SEER manual, Hematopoietic Manual or in Section 1 of the Standards for Oncology Registry Entry (STORE). This is ***not*** the same list of ambiguous terminology provided in the Solid Tumors Rules published and maintained by the SEER Program.

Use the following lists as a guide ***when no other information is available***.

Involved

Adherent
Apparent(ly)
Appears to
Comparable with
Compatible with
Consistent with
Contiguous/continuous with
Encroaching upon*
Extension to, into, onto, out onto
Features of
Fixation to a structure other than primary**
Fixed to another structure**
Impending perforation of
Impinging upon
Impose/imposing on
Incipient invasion
Induration
Infringe/infringing
Into*
Intrude
Most likely
Onto*
Overstep
Presumed
Probable
Protruding into (unless encapsulated)
Suspected
Suspicious
To*
Up to

Not Involved

Abuts
Approaching
Approximates
Attached
Cannot be excluded/ruled out
Efface/effacing/effacement
Encased/encasing
Encompass(ed)
Entrapped
Equivocal
Extension to without invasion/involvement of
Kiss/kissing
Matted (except for lymph nodes)
Possible
Questionable
Reaching
Rule out
Suggests
Very close to
Worrisome

* Interpret as involvement whether the description is clinical or operative/pathologic

** Interpret as involvement of the other organ or tissue

EOD 2018 Schemas

The EOD site-specific schemas are based on historical schemas, Summary Stage 2000, AJCC 8th Edition, and starting in 2021, the AJCC Version 9 rolling updates. Applicable years for the schemas have been added. Some of the AJCC chapters were divided to line up with historical Summary Stage chapters. See SEER*RSA for schema-specific coding guidelines, codes and code descriptions for EOD Primary Tumor, EOD Regional Nodes and EOD Mets.

Note: The individual schemas are not included in the EOD Manual.

Schema ID	EOD Schema	Applicable Years	SS Chapter
00588	Adnexa Uterine Other	2018+	Adnexa Uterine Other
00760	Adrenal Gland	2018+	Adrenal Gland (including NET)
00270	Ampulla Vater	2018+	Ampulla Vater (including NET)
00210	Anus	2018-2022	Anus
09210	Anus	2023+	Anus
00190	Appendix	2018-2022	Appendix (including NET)
09190	Appendix	2023+	Appendix (including NET)
00260	Bile Ducts Distal	2018+	Extrahepatic Bile Ducts
00230	Bile Ducts Intrahepatic	2018+	Intrahepatic Bile Ducts
00250	Bile Ducts Perihilar	2018+	Extrahepatic Bile Ducts
00278	Biliary Other	2018+	Biliary Other
00620	Bladder	2018+	Bladder
00381	Bone Appendicular Skeleton	2018+	Bone
00383	Bone Pelvis	2018+	Bone
00382	Bone Spine	2018+	Bone
00721	Brain	2018-2022	Brain
09721	Brain	2023+	Brain
00480	Breast	2018+	Breast
00076	Buccal Mucosa	2018+	Buccal Mucosa
00060	Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck	2018+	Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck
00520	Cervix	2018 - 2020	Cervix
09520	Cervix	2021+	Cervix
00528	Cervix Sarcoma	2021+	Cervix
00722	CNS Other	2018-2022	CNS Other
09722	CNS Other	2023+	CNS Other
00200	Colon and Rectum	2018+	Colon and Rectum (including NET)
00650	Conjunctiva	2018+	Conjunctiva
00542	Corpus Adenosarcoma	2018+	Corpus Sarcoma (including Adenosarcoma)

Schema ID	EOD Schema	Applicable Years	SS Chapter
00530	Corpus Carcinoma	2018+	Corpus Carcinoma and Carcinosarcoma
00541	Corpus Sarcoma	2018+	Corpus Sarcoma (including Adenosarcoma)
00150	Cutaneous Carcinoma of Head and Neck	2018+	Skin (except Eyelid)
00242	Cystic Duct	2018+	Extrahepatic Bile Ducts
00288	Digestive Other	2018+	Digestive Other
00778	Endocrine Other	2018+	Endocrine Other
00161	Esophagus (including GE junction) Squamous	2018+	Esophagus (including GE junction)
00169	Esophagus (including GE junction) (excluding Squamous)	2018+	Esophagus (including GE junction)
00718	Eye Other	2018+	Eye Other
00553	Fallopian Tube	2018+	Fallopian Tube
00074	Floor of Mouth	2018+	Floor of Mouth
00241	Gallbladder	2018+	Gallbladder
00559	Genital Female Other	2018+	Genital Female Other
00598	Genital Male Other	2018+	Genital Male Other
00430	GIST	2018+	GIST
00073	Gum	2018+	Gum
00422	Heart, Mediastinum, and Pleura	2018+	Heart, Mediastinum, and Pleura
00830	HemeRetic	2018+	HemeRetic
00112	Hypopharynx	2018+	Hypopharynx
99999	Ill-Defined Other	2018+	Ill-Defined Other
00723	Intracranial Gland	2018-2022	Intracranial Gland
09723	Intracranial Gland	2023+	Intracranial Gland
00458	Kaposi Sarcoma	2018+	Kaposi Sarcoma
00600	Kidney Parenchyma	2018+	Kidney Parenchyma
00610	Kidney Renal Pelvis	2018+	Kidney Renal Pelvis
00690	Lacrimal Gland	2018+	Lacrimal Gland/Sac
00698	Lacrimal Sac	2018+	Lacrimal Gland/Sac
00132	Larynx Glottic	2018+	Larynx Glottic
00130	Larynx Other	2018+	Larynx Other
00133	Larynx SubGlottic	2018+	Larynx SubGlottic
00132	Larynx SupraGlottic	2018+	Larynx SupraGlottic
00071	Lip	2018+	Lip
00220	Liver	2018+	Liver
00360	Lung	2018-2024	Lung
09360	Lung	2025+	Lung
00790	Lymphoma	2018+	Lymphoma
00795	Lymphoma-CLL/SLL	2018+	Lymphoma

Schema ID	EOD Schema	Applicable Years	SS Chapter
00710	Lymphoma Ocular Adnexa	2018+	Lymphoma Ocular Adnexa
00080	Major Salivary Glands	2018-2025	Major Salivary Glands
09081	Major Salivary Glands	2026+	Major Salivary Glands
00121	Maxillary Sinus	2018+	Nasal Cavity and Paranasal Sinuses
09724	Medulloblastoma	2023+	Medulloblastoma
00672	Melanoma Choroid and Ciliary Body	2018+	Melanoma Uvea
00660	Melanoma Conjunctiva	2018+	Melanoma Conjunctiva
00140	Melanoma Head and Neck	2018+	Melanoma Head and Neck
00671	Melanoma Iris	2018+	Melanoma Uvea
00470	Melanoma Skin	2018+	Melanoma Skin
00460	Merkel Cell Skin	2018+	Merkel Cell Skin
00119	Middle Ear	2018+	Middle Ear
00077	Mouth Other	2018+	Mouth Other
00811	Mycosis Fungoides and Sézary Syndrome	2018+	Mycosis Fungoides
00122	Nasal Cavity and Ethmoid Sinus	2018+	Nasal Cavity and Paranasal Sinuses
00090	Nasopharynx	2018-2024	Nasopharynx
09090	Nasopharynx	2025+	
00770	NET Adrenal Gland	2018+	Adrenal Gland (including NET)
00302	NET Ampulla of Vater	2018+	Ampulla Vater (including NET)
00320	NET Appendix	2018-2023	Appendix (including NET)
09320	NET Appendix	2024+	Appendix (including NET)
00330	NET Colon and Rectum	2018+	Colon and Rectum (including NET)
09330	NET Colon and Rectum	2024+	Colon and Rectum (including NET)
00301	NET Duodenum	2018-2023	Small Intestine (including NET)
09301	NET Duodenum	2024+	Small Intestine (including NET)
00310	NET Jejunum and Ileum	2018-2023	Small Intestine (including NET)
09310	NET Jejunum and Ileum	2024+	Small Intestine (including NET)
00340	NET Pancreas	2018-2023	Pancreas (including NET)
09340	NET Pancreas	2024+	Pancreas (including NET)
00290	NET Stomach	2018-2023	Stomach (including NET)
09290	NET Stomach	2024+	Stomach (including NET)
00700	Orbital Sarcoma	2018+	Orbit
00100	Oropharynx HPV-Associated	2018-2025	Oropharynx
09100	Oropharynx HPV-Associated	2026+	Oropharynx
00111	Oropharynx HPV-Independent	2018+	Oropharynx
00551	Ovary	2018+	Ovary and Primary Peritoneal Carcinoma
00075	Palate Hard	2018+	Palate Hard
00280	Pancreas	2018+	Pancreas (including NET)

Schema ID	EOD Schema	Applicable Years	SS Chapter
00750	Parathyroid	2018+	Parathyroid
00570	Penis	2018+	Penis
00118	Pharynx Other	2018+	Pharynx Other
00560	Placenta	2018+	Placenta
00822	Plasma Cell Disorders	2018+	Myeloma Plasma Cell Disorder
00821	Plasma Cell Myeloma	2018+	Myeloma Plasma Cell Disorder
00370	Pleura Mesothelioma	2018-2024	Pleura Mesothelioma
09370	Pleura Mesothelioma	2025+	Pleura Mesothelioma
00812	Primary Cutaneous Lymphomas (excluding Mycosis Fungoides)	2018+	Primary Cutaneous Lymphomas (excluding Mycosis Fungoides)
00552	Primary Peritoneal Carcinoma	2018+	Ovary and Primary Peritoneal Carcinoma
00580	Prostate	2018+	Prostate
00378	Respiratory Other	2018+	Respiratory Other
00680	Retinoblastoma	2018+	Retinoblastoma
00440	Retroperitoneum	2018+	Retroperitoneum
00128	Sinus Other	2018+	Sinus Other
00640	Skin Eyelid	2018+	Skin Eyelid
00478	Skin Other	2018+	Skin (except Eyelid)
00180	Small Intestine	2018+	Small Intestine (including NET)
00421	Soft Tissue Abdomen and Thoracic (excluding Heart, Mediastinum, Pleura)	2018+	Soft Tissue
00400	Soft Tissue Head and Neck	2018+	Soft Tissue
00450	Soft Tissue Rare	2018+	Soft Tissue
00459	Soft Tissue Other	2018+	Soft Tissue
00410	Soft Tissue Trunk and Extremities	2018+	Soft Tissue
00170	Stomach	2018+	Stomach (including NET)
00590	Testis	2018+	Testis
00350	Thymus	2018-2024	Thymus
09350	Thymus	2025+	Thymus
00730	Thyroid	2018+	Thyroid (including Medullary)
00740	Thyroid Medullary	2018+	Thyroid (including Medullary)
00072	Tongue Anterior	2018+	Tongue Anterior
00358	Trachea	2018+	Trachea
00631	Urethra	2018+	Urethra (including prostatic)
00633	Urethra-Prostatic	2018+	Urethra (including prostatic)
00638	Urinary Other	2018+	Urinary Other
00510	Vagina	2018+	Vagina
00500	Vulva	2018-2023+	Vulva
09500	Vulva	2024+	Vulva

General Coding Instructions

Extent of Disease (EOD) 2018 is a data collection system which has three data items: EOD Primary Tumor, EOD Regional Nodes, and EOD Mets. These items may be combined with other data to derive different types of stage. EOD 2018 is collected for **every site and histology combination** for cases diagnosed 1/1/2018 and forward.

Do not use this system for any cases diagnosed prior to 1/1/2018.

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

General Guidelines

1. EOD schemas apply to ALL primary sites and specified histologies. Most schemas are based on primary site, while some are based on histology alone.

2. For ALL sites, EOD is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue cannot be or was not removed.
    a. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report

3. EOD should include all information available within **four months of diagnosis** in the absence of disease progression or upon completion **of surgery(ies)** in first course of treatment, whichever is longer.

4. Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the EOD stage. Be sure to review the clinical information carefully to accurately determine the extent of disease.
    a. If the operative/pathology information disproves the clinical information, use the operative/pathology information

5. 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.

6. Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when coding the EOD fields.

7. Autopsy reports are used in coding EOD just as are pathology reports, applying the same rules for inclusion and exclusion.

8. Death Certificate only (DCO) cases
    a. Code the following for DCO's. Do not use any other code, even for those that may have a default value.
        i) EOD Primary Tumor: 999
        ii) EOD Regional Nodes: 999

iii) EOD Mets: 99

9. T, N, M information may be used to code EOD 2018 when it is the **only** information available.

10. Use the medical record documentation to assign EOD when there is a discrepancy between the T, N, M information and the documentation in the medical record. If you have access to the physician, please query to resolve the discrepancy.
    a. When there is doubt that documentation in the medical record is complete, code the EOD corresponding to the physician staging

       Example: Patient diagnosed at community hospital with limited workup. Staging note from medical oncologist suggesting missing results from further outside test

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

EOD DATA ITEMS

EOD PRIMARY TUMOR

Item Length: 3
NAACCR Item #: 772
NAACCR Name: EOD Primary Tumor

Description

EOD Primary Tumor is part of the EOD 2018 data collection system and is used to classify contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. See also EOD Regional Nodes **[NAACCR Data item #774]** and EOD Mets **[NAACCR Data item #776]**. **Effective for cases diagnosed 1/1/2018 and forward.**

Rationale

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

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

See the most current version of SEER*RSA for rules and site-specific codes and coding structures.

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

Coding Instructions

1. **Assign the farthest documented contiguous involvement of the primary tumor**. Code the farthest documented contiguous direct extension/involvement of tumor away from the primary site. If an involved organ or tissue is not specifically mentioned in the code descriptions, approximate the location from listed structures in the same anatomic area and assign the appropriate code based on that information. EOD Primary Tumor codes are hierarchical except for code 800.
2. CLINICAL vs PATHOLOGICAL codes
    a. Some schemas have EOD extension/involvement codes that are noted as “clinical assessment only” or “pathological assessment only.”
        i. Clinical assessment codes should be used when there is a clinical work up only and there is no surgical resection of the primary tumor or site. This includes physical exam, imaging and biopsy

1. *Exception:* If patient has neoadjuvant therapy, and the clinical assessment is equal to or greater than the pathological assessment, then the clinical assessment code would take priority

ii. Pathological assessment codes can be used when there is a surgical resection of the primary tumor or site

3. A "localized, NOS" code is provided for those cases in which the only description is "localized with no further information." "NOS" codes should be used only after an exhaustive search for more specific information.

4. **Pathological findings take priority over clinical findings.**

    a. Assign the highest code representing the greatest extension/involvement pathologically (based on pathology report), when available

    b. If there is no applicable pathology, assign the highest code representing the greatest extension/involvement clinically. Imaging takes precedence over physical examination

    c. If extension/involvement is positive based on imaging and/or physical exam, but is confirmed to be negative on pathological exam, then code EOD Primary Tumor based on the pathological findings

5. **Neoadjuvant (preoperative) therapy**: If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the farthest extension/involvement documented. If the post-neoadjuvant surgery shows more extensive disease, code the extension/involvement based on the post-neoadjuvant information. If the clinical and pathological information are the same, code the extension/involvement based on the clinical information.

6. **In situ tumors:** Assign code 000 for in situ tumors.

    a. ***Exception***: For some schemas, e.g., Breast, there may be multiple categories of in situ codes. Use schema-specific instructions and codes.

7. **In situ tumors with nodal or metastatic involvement:** In the event of an in-situ tumor with nodal or metastatic involvement, assign EOD Primary Tumor as in situ and code the EOD Regional Nodes and/or EOD Mets appropriately. **This is a change from previous versions of EOD and Summary Stage.**

    a. **Note:** Behavior would be /3 for these tumors. The primary tumor is in situ; however, there is evidence of an invasive component due to the positive lymph nodes or metastatic involvement

8. When multiple tumors are reported as a single primary, code the furthest direct extension/involvement from any tumor.

9. **Noncontiguous/Discontinuous or distant metastases:** Noncontiguous/discontiguous metastases are usually coded in the EOD Mets field. Some exceptions include mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where

noncontiguous/discontinuous metastases in the pelvis or abdomen are coded in EOD Primary Tumor.

   a. For some schemas, e.g., Breast, Lung, and Kidney, direct (contiguous) extension/involvement to certain specific sites is listed under EOD Mets. If the structure involved by direct extension/involvement is not listed in EOD Primary Tumor categories, look for it in EOD Mets. **If the specific structure involved by direct extension/involvement is not listed in either data item, assign the highest known contiguous extension/involvement code in EOD Primary Tumor.**

10. **Code 800** when there is no evidence of the primary tumor (occult primary).

    a. Use code 800 when clinically and/or pathologically there is no evidence of the primary tumor. This code does **not** apply to those cases where a biopsy removes all the tumor and there is no residual tumor on the surgical resection

    b. When EOD Primary Tumor is coded 800

        i. Tumor Size Clinical should be coded to 000 when there is no surgical resection for the primary tumor or site, but clinically no primary tumor was identified

        ii. Tumor Size Pathological should be coded to 000 when the suspected primary tumor or site is resected, but no tumor is found. If no surgical resection is done, code 999

11. **Code '888' for the following schemas:**

    a. Ill-Defined Other (includes unknown primary site) (99999)

12. **Code 999**

    a. Assign code 999 when there is no information on primary tumor extent.

    b. Code 999 is to be used by default for death certificate only (DCO) cases.
        i. Do not use any other code, even for those that may have a default value. ***Example*:** HemeRetic schema, EOD Primary Tumor for Acute Myeloid Leukemia is always coded as 700. For DCO's, assign 999.

13. **Document choice of EOD Primary Tumor code in text.** It is strongly recommended that the assessment of the primary tumor extension/involvement be documented, as well as the choice of the EOD Primary Tumor code in a related STAGE text field on the abstract. While primary tumor extension/involvement can be found in a variety of places, it's most found in a pathology and/or operative report.

EOD REGIONAL NODES

Item Length: 3
NAACCR Item #: 774
NAACCR Name: EOD Regional Nodes

Description

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

Rationale

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

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

See the most current version of SEER*RSA for rules and site-specific codes and coding structures.

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

Coding Instructions

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

b. If a lymph node chain is not listed, check the abstractor notes in SEER*RSA, Appendix C of the Hematopoietic Manual, an anatomy textbook, ICD-O-3, or a medical dictionary for a synonym. **If the lymph node chain or its synonym are not listed in regional lymph nodes, code the involved node(s) in EOD Mets.**

   i. **Tip for coding lymph nodes:** If not possible to determine if a lymph node is regional or distant, check the scheme for a site that is nearby.

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

c. Make sure your EOD Lymph Node code agrees with Regional Nodes Positive

   i. If Regional Nodes Positive = 01-90, 95, 97, this indicates that regional lymph nodes are involved, and EOD Lymph Nodes should be coded appropriately

2. **CLINICAL vs PATHOLOGICAL codes**

   a. Some schemas have EOD regional node codes that are noted as "clinical assessment only" or "pathological assessment only.

      i. Clinical assessment codes should be used only when there is a clinical work up and there is no surgical resection of the primary tumor or site. This includes physical exam, FNA, needle core biopsy, sentinel node biopsy, or lymph node excision.

         a) *Exception:* If patient has neoadjuvant therapy, and the clinical assessment is equal to or greater than the pathological assessment, then the clinical assessment code would take priority

      ii. Pathological assessment codes can be used when there is a surgical resection of the primary tumor or site in conjunction with a FNA, Sentinel Lymph Node biopsy or lymph node dissection. The FNA or sentinel lymph node biopsy can be done during the clinical workup and then followed by a negative lymph node dissection

3. **Pathological findings take priority over clinical findings**: It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement. See next section for coding instructions when neo-adjuvant therapy is administered.

   a. Code the lymph node involvement at diagnosis pathologically (based on pathology report), when available.

   b. If there is no applicable histology, assign lymph node involvement based on clinical findings. Imaging takes precedence over physical examination.

   c. If nodes are determined positive based on imaging and then confirmed to be negative on pathological exam, then code EOD Regional Nodes based on the negative pathological findings.

***Exception*:** Assign code 800, "Regional lymph node(s), NOS or Lymph node(s), NOS" only when there is lymph node involvement, but no available information regarding the specific node(s) involved.

4. **Neoadjuvant (preoperative) therapy:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information if that is the most extensive lymph node involvement documented. If the post-neoadjuvant surgery shows more extensive lymph node involvement, code the regional nodes based on the post-neoadjuvant information. If the clinical and pathological information are the same, code regional lymph nodes based on the clinical information.

5. **Terms meaning lymph node involvement:** For solid tumors, the terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are recorded as involvement of lymph nodes.

    a. Other terms, such as "palpable," "enlarged," "visible swelling," "shotty," or "lymphadenopathy" should be ignored for solid tumors, unless there is a statement of involvement by the clinician, or the patient was treated as though regional nodes were involved.

    Example: Palpable axillary lymph nodes found, consistent with mets. Record as involvement of lymph nodes.

    Example: Enlarged renal hilar nodes found on CT, positive for cancer. Record as involvement of lymph nodes.

    b. The terms "homolateral," "ipsilateral," and "same side" are used interchangeably.

6. **Accessible lymph nodes:** For "accessible" lymph nodes that can be observed, palpated, or examined without instruments, such as the regional nodes for the breast, oral cavity, salivary gland, skin, thyroid, and other organs, look for some description of the regional lymph nodes. **A statement such as "remainder of examination negative" is sufficient to code 000 negative regional lymph nodes.**

    ***Note**:* If there is mention of a clinical evaluation but no mention of positive lymph nodes, assign code 000.

7. **Inaccessible lymph nodes:** For certain primary sites, regional lymph nodes are not easily examined by palpation, observation, physical examination, or other clinical methods. These are lymph nodes within body cavities that in most situations cannot be palpated, making them inaccessible. Bladder, colon, corpus uteri, esophagus, kidney, liver, lung, ovary, prostate, and stomach are examples of inaccessible sites (this is not an all-inclusive list). When EOD Primary Tumor is low stage/Localized and standard treatment is done, it is sufficient to code 000 for negative regional lymph nodes.

8. Code EOD Regional Nodes 000 (negative) instead of 999 (unknown) when **ALL** three of the following conditions are met:

    a. There is no mention of regional lymph node involvement in the physical examination, pre-treatment diagnostic testing, or surgical exploration

    b. The patient has localized disease

c. The patient receives what would be the standard treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician), or patient is offered usual treatment but refuses it

These guidelines apply only to localized cancers. Assign code 999 when there is reasonable doubt that the tumor is localized.

***Example**:* When there is evidence that a prostate cancer has penetrated through the capsule into the surrounding tissues (regional disease) and regional lymph node involvement is not mentioned, it would be correct to code 999 for unknown lymph node involvement in the absence of any specific information regarding regional nodes.

9. **In situ tumors (behavior /2):** Code 000 for lymph node involvement.
    a. **Note:** Pure in situ tumors (behavior /2) cannot have lymph node mets
        i. For Breast and Thyroid, there are multiple lymph node codes indicating no regional lymph node involvement (depending on whether lymph nodes were pathologically examined or not)
10. **In situ tumors with metastatic nodal involvement:** In the event of an in-situ tumor with metastatic nodal involvement, assign EOD Primary Tumor as in situ (code 000) and code EOD Regional Nodes appropriately (positive). **This is a change from prior versions of EOD.**
    a. **Note:** Behavior would be /3 for these tumors. The primary tumor is in situ; however, there is evidence of an invasive component due to the positive lymph nodes
11. **Direct tumor extension/involvement into lymph node:** If direct extension/involvement of the primary tumor into a regional lymph node is shown, code the involved node(s) in EOD Regional Nodes.
12. **Sentinel lymph nodes**: Involved nodes found during sentinel lymph node procedures are classified as positive regional nodes.
    a. The sentinel lymph node is the first lymph node to receive lymphatic drainage from a primary tumor.
    b. If it contains metastatic tumor, this indicates that other lymph nodes may contain tumor. If it does not contain metastatic tumor, other lymph nodes are not likely to contain tumor. Occasionally there is more than one sentinel lymph node
13. **Isolated Tumor cells (ITCs)**: For some schemas, ITCs are counted as positive regional nodes, while other schemas count them as negative. **See the individual schemas to determine how to code ITCs.**

Noncontiguous/Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum: These can occur WITH or WITHOUT regional lymph node involvement. Assign the appropriate code according to guidelines in individual schemas. Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the

primary cancer: noncontiguous/discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. If there are Tumor Deposits and node involvement, code only the information on node involvement in this field. Specific information on Tumor Deposits is coded in the data item: Tumor Deposits [NAACCR Data Item #3934].

14. **Code 800.** Use code 800 for the following situations:

    a. Lymph node assignment for the EOD schema is based on location (specifically listed lymph nodes) and the only documentation available is that lymph nodes are involved.

    b. Lymph node assignment for the EOD is based on number and/or size and the only documentation available is that lymph nodes are involved.

    c. Statement of "regional lymph nodes involved," with no further information on location, number and/or size.

    d. Unidentified nodes included with the resected primary site.

        i. Nodes may be identified in the operative or pathology report (including the final diagnosis), microscopic or gross description.

    e. Lymph nodes which are not specified as regional or distant should be assumed to be regional nodes.

15. **Code '888' for the following schemas:**

    i. Brain (00721, 09721)
    ii. CNS Other (00722, 09722)
    iii. Intracranial Gland (00723, 09723)
    iv. Medulloblastoma (09724)
    v. Lymphoma (00790)
        a) Primary Cutaneous Lymphoma (00812) and Ocular Adnexal Lymphoma (00710) have separate schemas from Lymphoma. **EOD Regional Nodes must be coded for those two schemas (888 is not valid)**
    vi. Lymphoma-CLL/SLL (00795)
    vii. Plasma Cell Myeloma (00821)
    viii. HemeRetic (00830)
    ix. Ill-Defined Other (includes unknown primary site) (99999)

16. **Code 999**

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

    b. Code 999 is to be used by default for death certificate only (DCO) case.
        i. Do not use any other code, even for those that may have a default value.
            a) *Exception*: Field is not defined for that schema.
            ***Example*:** HemeRetic schema, EOD Regional Nodes is always 888 (N/A)

17. **Document choice of EOD Regional Nodes code in text.** It is strongly recommended that the positive and negative assessment of regional lymph node(s) be documented, as well as the choice of the EOD Regional Nodes code in a related STAGE text field on the abstract. Information on regional node status can be found on physical exam, scans and pathology reports.

EOD METS

Item Length: 2
NAACCR Item #: 776
NAACCR Name: EOD Mets

Description

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

Rationale

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

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

See the most current version of SEER*RSA for rules and site-specific codes and coding structures.

Code	Description
00	No distant metastasis Unknown if distant metastasis None
	SCHEMA-SPECIFIC CODES WHERE NEEDED
70	Distant metastasis, NOS
88	Use for these sites only: HemeRetic; Ill-Defined Other (includes unknown primary site); Kaposi Sarcoma; Lymphoma; Lymphoma-CLL/SLL; Plasma Cell Myeloma, Plasmacytomas
99	Death certificate only (DCO)

Coding Instructions

1. **Determination of EOD Mets requires only history and physical examination**. Imaging of distant organs is not required. *In other words, when a case lacks any extensive workup, the registrar can infer that there are no distant metastases based solely on physical exam documentation.*

    a. Assign 00 for cases in which there are no distant metastases as determined by clinical, radiographic and/or pathologic methods.

    b. A case is classified as clinically free of metastases (code 00) unless there is documented evidence of metastasis by clinical means or by cytological/pathological examination of a metastatic site. For the following scenarios, code 00 can be used:

        i. No information is available (no PE, imaging or pathology)

ii. There is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastasis

c. Assign the appropriate EOD Mets codes 10-70 for cases in which one or more distant metastases is identified by clinical, radiographic and/or pathologic methods. EOD Mets codes are hierarchical except for code 70.

2. For a few schemas, such as Breast, Lung, Kidney, and Ovary, the EOD Mets category may include direct extension/involvement of the primary tumor into distant organs or tissues. If the structure involved by direct involvement is not listed in EOD Primary Tumor, look for the structure in EOD Mets. If the specific structure involved by contiguous involvement is not listed in either EOD Primary Tumor or EOD Mets, assign the highest available code in EOD Primary Tumor.

3. **Noncontiguous/Discontinuous or hematogenous metastases:** Distant metastasis known at the time of diagnosis is coded in EOD Mets. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to distant lymph nodes or to site(s) distant from the primary site. Refer to the individual schemas for detailed instructions.

4. **Positive pathological findings take priority over clinical findings.**

   a. Assign the highest applicable code for metastasis at diagnosis pathologically (based on pathology report), when available.

      i. Not every metastatic site may be biopsied; however, for purposes of coding this data item, each metastatic site, whether confirmed clinically or pathologically, should be included, which may mean that clinical evidence would take priority over pathological.

      Example: Colon cancer with microscopically confirmed metastases to Liver (code 10 for involvement of one organ); however, per imaging, mets also noted in the peritoneum and distant lymph nodes. EOD Mets would be coded to 50 (peritoneum involved with or without distant lymph nodes/organs) based on the clinical evidence of mets.

   b. If there is no applicable pathology or the pathology does not show metastasis, code EOD Mets based on clinical findings. Imaging takes precedence over physical examination.

5. Not all possible metastatic sites are listed in each of the schemas. If there is confirmed metastasis of a site that is not listed, assign the highest code as described below.

   a. For schemas that have only codes 10 (distant lymph nodes) and 70 (all other mets), code 70 is to be used for all mets (except distant lymph nodes only)

   b. For schemas where there are additional codes, use the highest code before code 70 when mets are present that are not specified in any of the other codes. Code 70 in these cases should only be used when the only information is “distant metastasis, NOS,” and there is no documentation regarding the specific metastases

      i. For schemas where there are multiple distant site codes and the specific mets is not described, use the code that includes “other specific metastasis.”

      ii. For example, history only cases or cases with minimal information available.

iii. There will be enough information to code the numerically lower, but more specific, EOD Mets code when the location of the metastases is documented in the chart or abstract.

6. **Neoadjuvant (preoperative) therapy:** If the patient receives neoadjuvant (preoperative) systemic therapy (chemotherapy, immunotherapy) or radiation therapy, code the clinical information description that identifies the most extensive metastasis. If the post-neoadjuvant surgery shows additional or more extensive metastasis, code EOD Mets based on the post-neoadjuvant information. If the clinical and pathological information are the same, code mets based on the clinical information.

7. **Isolated Tumor Cells (ITCs), Circulating Tumor Cells (CTCs), and Disseminated Tumor Cells (DTCs):** small clusters of tumor cells not greater than 0.2 mm in largest dimension found in distant sites such as bone, circulating blood, or bone marrow and having uncertain prognostic significance.

   a. For breast, code 05 when a biopsy of a distant site shows ITCs, CTCs or DTCs detected by IHC or molecular techniques.

   b. For other sites, CTCs, DTCs, and ITCs are coded 00.

8. **In situ tumors with metastatic involvement:** In the event of an in-situ tumor with metastatic involvement, assign EOD Primary Tumor as in situ (code 000) and code EOD Mets appropriately (positive). **This is a change from prior versions of EOD.**

   a. **Note:** Behavior would be /3 for these tumors. The primary tumor is in situ; however, there is evidence of an invasive component due to the metastatic involvement

9. **Code 88 for the following schemas/Schema IDs**
   i. Kaposi Sarcoma (00458)
   ii. Lymphoma (00790)
      a) Primary Cutaneous Lymphoma (00812) and Ocular Adnexal Lymphoma (00710) have separate schemas from Lymphoma. **EOD Mets must be coded for those two schemas (88 is not valid)**
   iii. Lymphoma-CLL/SLL (00795)
   iv. HemeRetic (00830)
   v. Plasma Cell Disorders (00822)
   vi. Plasma Cell Myeloma (00821)
   vii. Ill-Defined Other (includes unknown primary site) (99999)

10. **Code 99:** Code 99 is to be **used ONLY for death certificate only (DCO) cases.**

    a. Do not use any other code, even for those that may have a default value.
       i. *Exception*: Field is not defined for that schema.
       ***Example*:** HemeRetic schema, EOD Mets is always 88 (N/A)

    b. When it is unknown if there are distant metastases, code 00 (see rule 1b).

11. **Document choice of EOD Mets code in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis be documented, as well as the choice of the EOD Mets code in a related STAGE text field on the abstract. Information on distant mets can be found mostly in Physical Exam and Scans.

DERIVED EOD 2018 T

Item Length: 15
NAACCR Item #: 785
NAACCR Name: Derived EOD 2018 T

New Data Item for Diagnosis Year 2018 and forward. Derived in Central registry only.

Description

This item stores the derived EOD 2018 T value derived from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

Derived EOD 2018 T can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Derived EOD 2018 T is only available at the central registry level.

DERIVED EOD 2018 N

Item Length: 15
NAACCR Item #: 815
NAACCR Name: Derived EOD 2018 N

New Data Item for Diagnosis Year 2018 and forward. Derived in Central registry only.

Description

This item stores the derived EOD 2018 N staging element from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

Derived EOD 2018 N can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Derived EOD 2018 N is only available at the central registry level.

DERIVED EOD 2018 M

Item Length: 15
NAACCR Item #: 795
NAACCR Name: Derived EOD 2018 M

New Data Item for Diagnosis Year 2018 and forward. Derived in Central registry only.

Description

This item stores the derived EOD 2018 M staging element from coded fields using the EOD algorithm. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

Derived EOD 2018 M can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Derived EOD 2018 M is only available at the central registry level.

DERIVED EOD 2018 STAGE GROUP

Item Length: 15
NAACCR Item #: 818
NAACCR Name: Derived EOD 2018 Stage Group

New Data Item for Diagnosis Year 2018 and forward. Derived in Central registry only.

Description

Derived EOD 2018 Stage Group is derived using the EOD data collection system (EOD Primary Tumor [**NAACCR Data item #772]**, EOD Regional Nodes **[NAACCR Data item #774]** and EOD Mets **[NAACCR Data item #776]**) algorithm. Other data items may be included in the derivation process. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

Derived EOD 2018 Stage Group can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Derived EOD 2018 Stage Group is only available at the central registry level.

DERIVED SUMMARY STAGE 2018

Item Length: 1
NAACCR Item #: 762
NAACCR Name: Derived Summary Stage 2018

New Data Item for Diagnosis Year 2018 and forward. Derived in Central registry only.

Description

Derived Summary Stage 2018 is derived using the EOD data collection system (EOD Primary Tumor **[NAACCR Data item #772],** EOD Regional Nodes **[NAACCR Data item #774]**, and EOD Mets [**NAACCR Data item #776]**) algorithm. Effective for cases diagnosed 1/1/2018 and forward.

Rationale

The SEER program has collected staging information on cases since its inception in 1973. For many cancer sites, the different versions of AJCC stage over time have made the analyses of long-term trends in stage very difficult. Therefore, for long-term staging trends, SEER has relied on a more simplified summary stage. When Collaborative Stage (CS) information is no longer available, SEER will need to derive summary stage via computer algorithm based on T, N, or M (clinical, pathologic, Derived SEER combined) or EOD Primary Tumor, EOD Regional Nodes, and EOD Mets and other information as needed. Directly Assigned SS2018 data item is provided for those wishing to collect summary stage but are not collecting all the fields needed by the computer algorithm to derive SS2018.

Code	Description
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
7	Distant
8	Benign, borderline
9	Unstaged

Note: Code 5 (Regional, NOS) has been removed for Summary Stage 2018.