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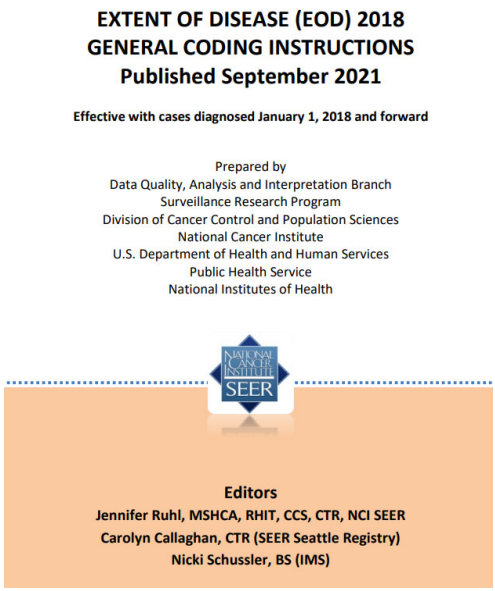

2018 Extent of Disease [SEER EOD] 2018 Summary Stage

Manual Mania
Iowa Cancer Registry
Lori Somers, RN

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Introduction

Extent of Disease (EOD) 2018 is the **newest** version of EOD with significant differences from previous versions.

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

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

2

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Major Updates

- EOD has “Schemas”
  - General instructions online 35 page pdf
    - Published Sept 2021
    - Change Log v2.1 https://seer.cancer.gov/tools/staging/eod/change-log.pdf
  - Schemas found at SEER*RSA
    - EOD_PUBLIC v2.1 (NAACCR 2022) use this version until all 2022 dx complete
- Summary Stage has “Chapters”

3

4

Main data items

There are 3 main data items in EOD, each of which will be 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.

4

5

Definitions Used in the Manual

Pages 7-8

Terms used in the manual and their meaning

Example:

Discontinuous

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

Regional

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

5

6

Ambiguous Terminology

Extent of involvement terms

- Look at documentation
- Make informed decision on how patient treated
- Use the following lists to interpret the intent of the clinician **ONLY** when further documentation is not available

- Note 1 Terminology in schema
- Note 2 List is ONLY for EOD 2018 or SUMM Stage 2018
- Note 3 **NOT** same list as ambiguous reportable terms. **NOT** same list as Solid Tumor rules.

KNOW YOUR LISTS…

6

7

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

7

8

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

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EOD Schemas

EOD 2018 Schemas

The EOD site-specific schemas are based on historical schemas, Summary Stage 2000 and the AJCC 8th Edition. 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.

EOD Schema	SS Chapter	AJCC – Chap. No	AJCC Chapter Name
Adnexa Uterine Other	Adnexa Uterine Other	N/A	N/A
Adrenal Gland	Adrenal Gland (including NET)	76	Adrenal Cortical Carcinoma
Ampulla Vater	Ampulla Vater (including NET)	27	Ampulla of Vater
Anus	Anus	21	Anus
Appendix	Appendix (including NET)	19	Appendix-Carcinoma
Bile Ducts Distal	Extrahepatic Bile Ducts	26	Distal Bile Duct
Bile Ducts Intrahepatic	Intrahepatic Bile Ducts	23	Intrahepatic Bile Duct
Bile Ducts Perihilar	Extrahepatic Bile Ducts	25	Perihilar Bile Ducts
Biliary Other	Biliary Other	N/A	N/A
Bladder	Bladder	62	Urinary Bladder

General Coding Instructions

- 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.**

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

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General Coding Guidelines

2. All sites, EOD based on combined clinical and operative/pathological
   - Gross observations at surgery
     - Discrepancy between OP vs Path re excised tissue, priority goes to Path.
3. The 4 month rule
4. Clinical info can change EOD
   - a. If the operative/pathology information disproves the clinical information, use the operative/pathology information.

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General Guidelines

5. Surgery info after neoadjuvant may be used but only if EOD greater than pre treatment clinical findings

6. Exclude disease progression or metastatic involvement if developed after initial workup

9. TNM (by MD) may be used to code EOD when it is only info available

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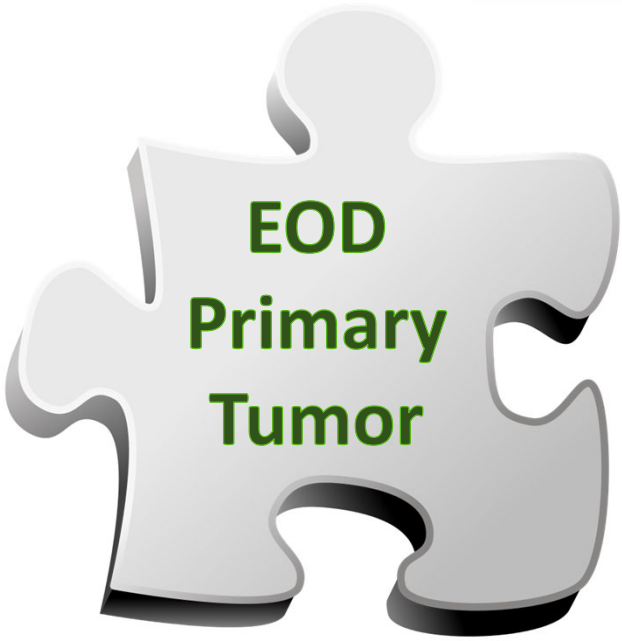
General Guidelines

10. Use medical record documentation to assign EOD when there is discrepancy between TNM and medical record.

11. EOD schema-specific guidelines take precedence over general guidelines.

    a. Always read schema-specific guidelines

13



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Primary Tumor Coding Instructions

1. **Assign farthest documented contiguous extension of primary tumor**.
2. Clinical vs Path codes
   a. Clin assessment only and no surgical resection of pri tumor or site (exam, imaging, biopsy)
   b. Path assessment codes used when surgical resection of pri tumor or site
3. Localized NOS only used after exhaustive search for more info.

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Primary Tumor Coding Instructions

4. **Path findings take priority over clinical findings.**
   a. assign highest code, greatest extension pathologically when available
   b. if no pathology, greatest extension clinically [imaging then physical exam]
   c. if pos clinically but path neg, code based on path findings.
5. **Neoadjuvant (preoperative) therapy**: code worst finding (farthest documented extension) either before or after post-neoadjuv surgery; if same code based on clinical info

6. **In situ tumors**: Assign code 000 for in situ tumors
   - *Exception look for multiple in situ codes (breast)

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Primary Tumor Coding Instructions

7. ***In situ tumors with nodal or metastatic involvement.**
a. Assign EOD primary tumor as IN SITU
b. Assign EOD Reg Nodes and/or EOD mets appropriately
c. Behavior code /3 for these tumors. Primary tumor is in situ however, evidence of invasive component due to pos LNs or mets.

***This is a change from prior versions of EOD.**

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Primary Tumor Coding Instructions

8. Multiple tumors reported as single primary
a. Code furthest direct extension from any tumor.

9. **Discontinuous or distant mets**
a. Usually coded in EOD mets
b. Some Exceptions. See manual.

If the specific structure involved by direct extension is not listed in either data item, assign the highest known contiguous extension code in EOD Primary Tumor.

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Primary Tumor Coding Instructions

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

a. This code does not apply where bx removes all tumor and no residual tumor on surgical resection

11. **Code 999**

- No info on primary tumor extent
- By default on DCO; however if extension available, code it

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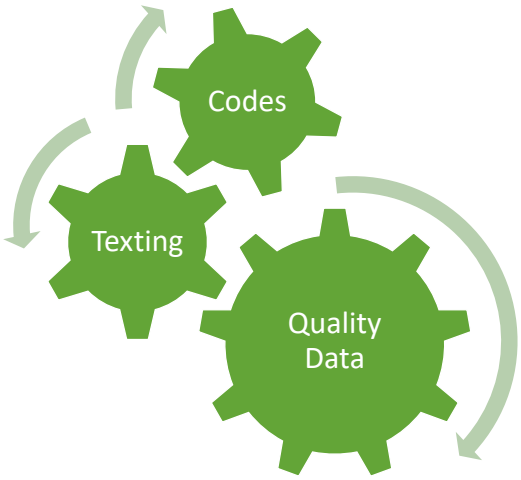
Primary Tumor & Text



11. Document choice of EOD primary tumor in text

- assessment of primary tumor

- Most commonly found in pathology and/or operative report

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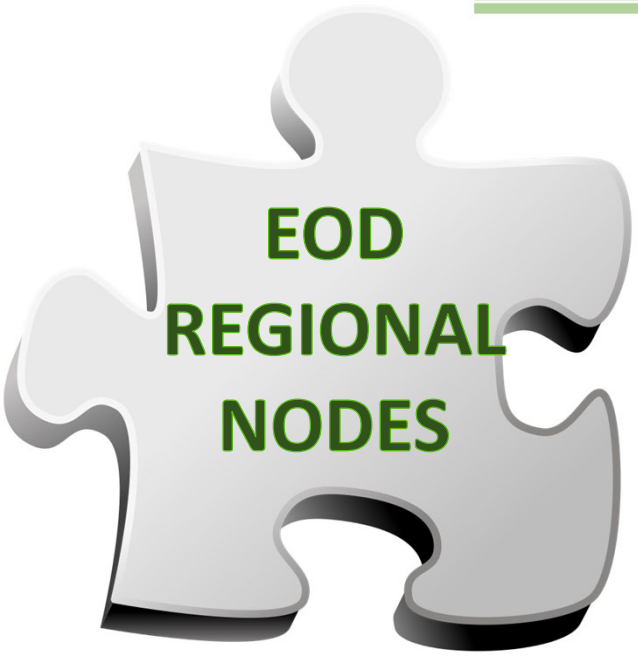

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Regional Nodes Coding Instructions

1. **Record the specific involved regional lymph node chain(s) farthest from the primary site.**
   a. Reg LNs in chain closest to primary site have lower codes; while Reg LNs farther away or in farther LN chains have higher codes. (Exceptions due to drainage patterns)
   b. If LN chain not listed, check notes in SEER*RSA, Appendix C of H-L manual, anatomy text book, lymphoma man, AJCC Manual, or Summ Stage.

***If the 'named' lymph node chain or its synonym are not listed in regional lymph nodes, code the involved node(s) in EOD Mets.**

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Regional Nodes Coding Instructions

2. Clinical vs Path codes

a. Some schemas have codes noted “clinical assessment only” or “path assessment only”

i. Clinical assessment only: clinical workup only, no surgical resection of primary tumor or site. Includes: exam, FNA, needle core bx, SLN bx, LN excision. EXCEPTION: If neoadjuvant therapy given, clinical assessment greater than path, use clinical assessment code as priority

ii. Path assessment codes: surgical resection of primary tumor or site plus FNA, SLN bx, LN dissection. Example: FNA or SLN bx during clinical workup followed by negative LN dissection

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Regional Nodes Coding Instructions

3. Path findings take priority over clinical findings

a. Code LN involvement at dx pathologically (from path report)

b. If no histology, assign LN involvement based on clinical findings Imaging takes precedence over physical exam

c. If nodes pos on imaging and neg on path exam, code EOD Nodes based on negative path findings.

Not necessary to biopsy every LN in suspicious area to disprove involvement.

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Question: 2018 Breast Primary

- A core needle biopsy of a lymph node was pathologically neg. MRI shows indeterminate LN. The treating physician assigns an N1. Patient goes on to have neoadjuvant chemotherapy. How do we code Regional Nodes EOD since the rules tell us to take pathologic findings over clinical. The doctor felt they 'didn't get the cancer' with the needle biopsy of the LN.
- Answer: Code EOD Regional Nodes to 150, for a clinical N1. Even though the pathology was negative, the physician is still calling this positive and will base the treatment on that.

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Regional Nodes Coding Instructions

4. **Neoadjuvant (preoperative) systemic therapy**

- Code the clinical information if that is the most extensive LN involvement
- If the post-neoadjuvant surgery shows more extensive lymph node involvement, code the regional nodes based on the post-neoadjuvant information.
- If clinical and path the same, code Reg LNs based on clinical

Systemic neoadjuvant (preoperative) therapy includes:
Chemotherapy, immunotherapy or radiation therapy

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Regional Nodes Coding Instructions

4. **Lymph Node Involvement terminology**

SOLID tumors:

- Record as involved: Terms "fixed" or "matted" and "mass in the hilum, mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved)

a. Ignore: palpable, enlarged, visible swelling, shotty or lymphadenopathy UNLESS statement of involvement by clinician or pt was treated as though regional LNs were involved.

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

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Example of Lymph Node terminology

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.

- a. Ignore: palpable, enlarged, visibile swelling, shotty or lymphadenopathy UNLESS…stated as involved.

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Regional Nodes Coding Instructions

6. Accessible Lymph Nodes

- **Observed, palpated, examined without instruments**
- A statement such as "remainder of examination negative" is sufficient to code 000 negative regional lymph nodes. NEED Description in text.
  - **NOTE: If there is mention of a clinical evaluation but no mention of positive lymph nodes, assign code 000.**

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Regional Nodes Coding Instructions

7. Inaccessible Lymph Nodes: within body cavities

- **Not easily examined by palpation, observation, exam**

- When EOD Primary Tumor is low stage/Localized and standard treatment is done, it is sufficient to code 000 for negative regional lymph nodes.

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Regional Nodes Coding Instructions

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.

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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.

Code 999 for unknown lymph node involvement in the absence of any specific information regarding regional nodes.

32

33

Regional Nodes Coding Instructions

9. Pure Insitu tumors (/2) cannot have LN mets, code 000.

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.**

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Regional Nodes Coding Instructions

11. **Direct tumor extension into lymph node:** Code the involved node(s) in EOD Regional Nodes.

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Regional Nodes Coding Instructions

12. **Sentinel lymph nodes**

- classified as positive regional nodes

a. first lymph node to receive lymphatic drainage from a primary tumor.

b. If positive, this indicates that other lymph nodes may contain tumor. If negative, other lymph nodes are not likely to contain tumor. Occasionally there is more than one sentinel lymph node removed.

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Regional Nodes Coding Instructions

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.**

14. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum**

- Can occur WITH or WITHOUT regional lymph node involvement.
- See individual schemas for appropriate code.

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Regional Nodes Coding Instructions

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

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Regional Nodes Coding Instructions

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

- i. Brain
- ii. CNS Other
- iii. HemeRetic
- iv. Ill-Defined Other (includes unknown primary site)
- v. Intracranial Gland
- vi. Lymphoma
  - a) Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate schemas from Lymphoma. **EOD Regional Nodes must be coded for those two schemas (888 is not valid)**
- vii. Lymphoma-CLL/SLL
- viii. Plasma Cell Myeloma

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Regional Nodes Coding Instructions

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: however, assign the appropriate EOD Regional Nodes code when specific regional lymph node involvement information is available for a DCO.

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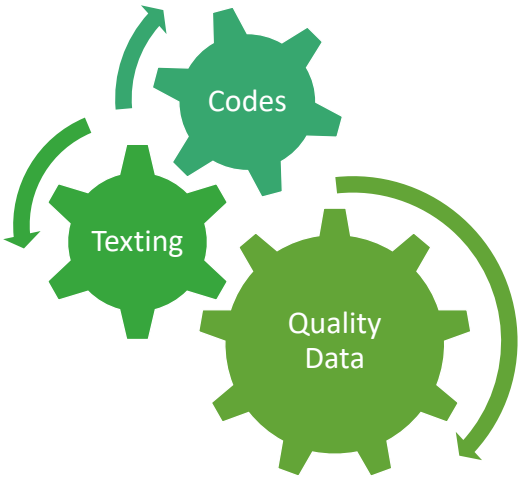
Regional Nodes & Text



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

- Can be found on physical exam, scans, path reports

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EOD METS Coding Instructions

1. **Determination of EOD Mets requires only history and physical examination**.
   - Imaging distant organs not required
   - Infer no distant mets when case lacks any extensive workup

   a. Assign 00 for no distant mets determined by clinical, radiographic and/or path methods
   b. A case is classified clinically free of mets (code 00) UNLESS there is documented evidence of mets by clinical, cyto or path exam of metastatic site.
   c. Assign appropriate EOD Mets 10-70 one or more distant mets identified clinically, imaging or path methods.

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EOD METS Coding Instructions

3. **Discontinuous or hematogenous metastases**

- Distant mets at time of diagnosis coded in EOD Mets. (At diagnosis tumor already spread to distant site or nodes from primary site.
- Refer to individual schemas for details

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EOD METS Coding Instructions

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

a. Assign highest code for mets at diagnosis pathologically (based on path report) when available.

b. No path or path does not show mets, code EOD Mets based on clinical findings.

- Imaging takes precedence over physical exam

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EOD METS Coding Instructions

5. Not all possible metastatic sites listed in schemas

If confirmed mets of a site not listed, assign highest code:

a. Schemas with only Codes 10 (distant LNs) and 70 (all other mets), code 70 is to be used for all mets
b. Schemas with additional codes, use highest code before 70, mets present but not specified in codes. Code 70 only used for distant mets NOS.
   i. Schemas where multiple distant site codes and specific mets not described, use code "other specific mets"
   ii. Example: history only cases or cases with minimal info.

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EOD METS Coding Instructions

6. **Neoadjuvant (preoperative) therapy:**

a. Code the clinical info that identifies the most extensive metastasis.

b. Code post-neoadjuvant therapy **if** more extensive metastasis than clinical

- If clinical and path info same, code mets based on clinical info

Systemic therapy includes preop (chemotherapy, immunotherapy) or radiation therapy.

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EOD METS Coding Instructions

7. Isolated Tumor Cells (ITCs), Circulating Tumor Cells (CTCs), and Disseminated Tumor Cells (DTCs)

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.

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EOD METS Coding Instructions

7. **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).

Behavior would be /3 for these tumors because there is evidence of invasive component due to metastatic involvement.

*****This is a change from prior versions of EOD.**

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EOD METS Coding Instructions

9. **Code 88 for the following schemas**

- i. HemeRetic
- ii. Ill-Defined Other (includes unknown primary site)
- iii. Kaposi Sarcoma
- iv. Lymphoma a) Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate schemas from Lymphoma. **EOD Mets must be coded for those two schemas (88 is not valid)**
- v. Lymphoma-CLL/SLL
- vi. Plasma Cell Myeloma
- vii. Plasmacytomas

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EOD METS Coding Instructions

9. **Code 99**

- **used ONLY for death certificate only (DCO) cases**
- assign the appropriate EOD Mets code when specific metastatic information is available on a DCO.
  - a. When it is unknown if there are distant metastases, code 00 (see rule 1b).

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Lymphoma – Mets at Dx

- Stage I, II, III -> **Code 0** for all

- Stage IV
  - At least (1) of the Mets at Dx – Bone, Brain, Liver, Lung, Other = **Code 1**
  - Mets at Dx – Distant lymph nodes -> Always **Code 0**
  - Mets at Dx – Other -> **Code 1** for bone marrow involvement or if multiple extra-lymphatic organ involvement

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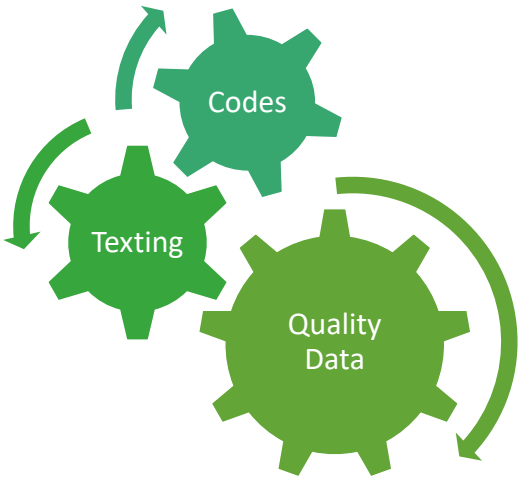
EOD METS & Text



10. **Document choice of EOD Mets code in text**

- positive and negative assessment of distant lymph nodes and/or distant metastasis
- Most commonly found in physical exam and scans

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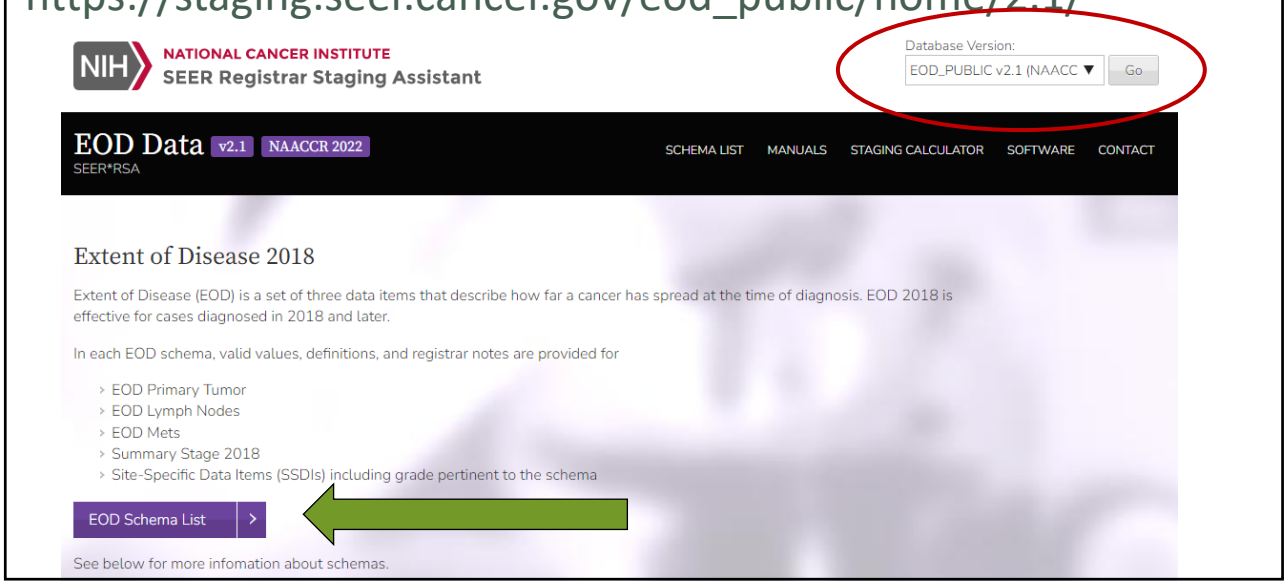
SEER*RSA

https://staging.seer.cancer.gov/eod_public/home/2.1/



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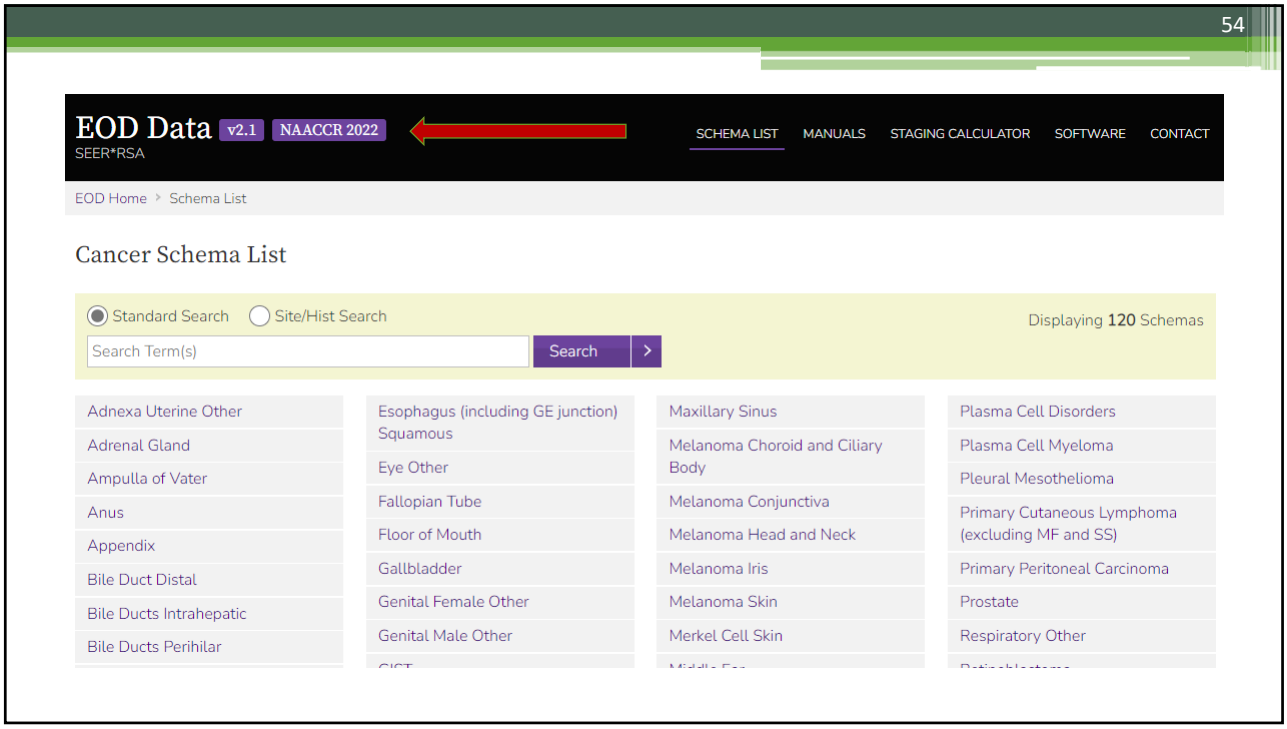

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Colon and Rectum

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Primary Site	Histology
C180, C182-C189, C199, C209	8000-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790, 9700-9701

Notes

8000-8149, 8154, 8157, 8160-8231, 8243-8248, 8250-8682, 8690-8700, 8720-8790, 9700-9701

C180 Cecum
C182 Ascending colon
C183 Hepatic flexure of colon
C184 Transverse colon
C185 Splenic flexure of colon
C186 Descending colon
C187 Sigmoid colon
C188 Overlapping lesion of colon
C189 Colon, NOS
C199 Rectosigmoid junction
C209 Rectum, NOS

Note 1: The following sources were used in the development of this schema

- SEER Extent of Disease 1988: Codes and Coding Instructions (3rd Edition, 1998) (https://seer.cancer.gov/archive/manuals/EOD10Dig.3rd.pdf)
- SEER Summary Staging Manual-2000: Codes and Coding Instructions (https://seer.cancer.gov/tools/ssm/ssm2000/)
- Collaborative Stage Data Collection System, version 02.05: https://cancerstaging.org/cstage/Pages/default.aspx
- Chapter 20 *Colon and Rectum*, in the AJCC Cancer Staging Manual, Eighth Edition (2017) published by Springer International Publishing. Used with permission of the American College of Surgeons, Chicago, Illinois.

Note 2: See the following schemas for the listed histologies

- 8150-8153, 8155-8156, 8158, 8240-8242, 8249, 8683: *NET Colon and Rectum*

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EOD Primary Tumor	999	Yes	NAACCR #772 eodPrimaryTumor		None
EOD Regional Nodes	999	Yes	NAACCR #774 eodRegionalNodes		None
EOD Mets	00	Yes	NAACCR #776 eodMets		None
SS2018	<BLANK>	No	NAACCR #764 summaryStage2018		None
Grade Clinical	9	No	NAACCR #3843 gradeClinical	CCCR/Canada COC NPCR SEER	SSDI
Grade Pathological	9	No	NAACCR #3844 gradePathological	CCCR/Canada COC NPCR SEER	SSDI
Grade Post Therapy Clin (yc)	<BLANK>	No	NAACCR #1068 gradePostTherapyClin	COC NPCR SEER	SSDI
Grade Post Therapy Path (yp)	<BLANK>	No	NAACCR #3845 gradePostTherapy	CCCR/Canada COC NPCR SEER	SSDI
CEA PreTX Lab Value	XXXX.8	No	NAACCR #3820 ceaPretreatmentLabValue	COC SEER	SSDI
CEA PreTX Interpretation	8	No	NAACCR #3819 ceaPretreatmentInterpretation	CCCR/Canada COC SEER	SSDI

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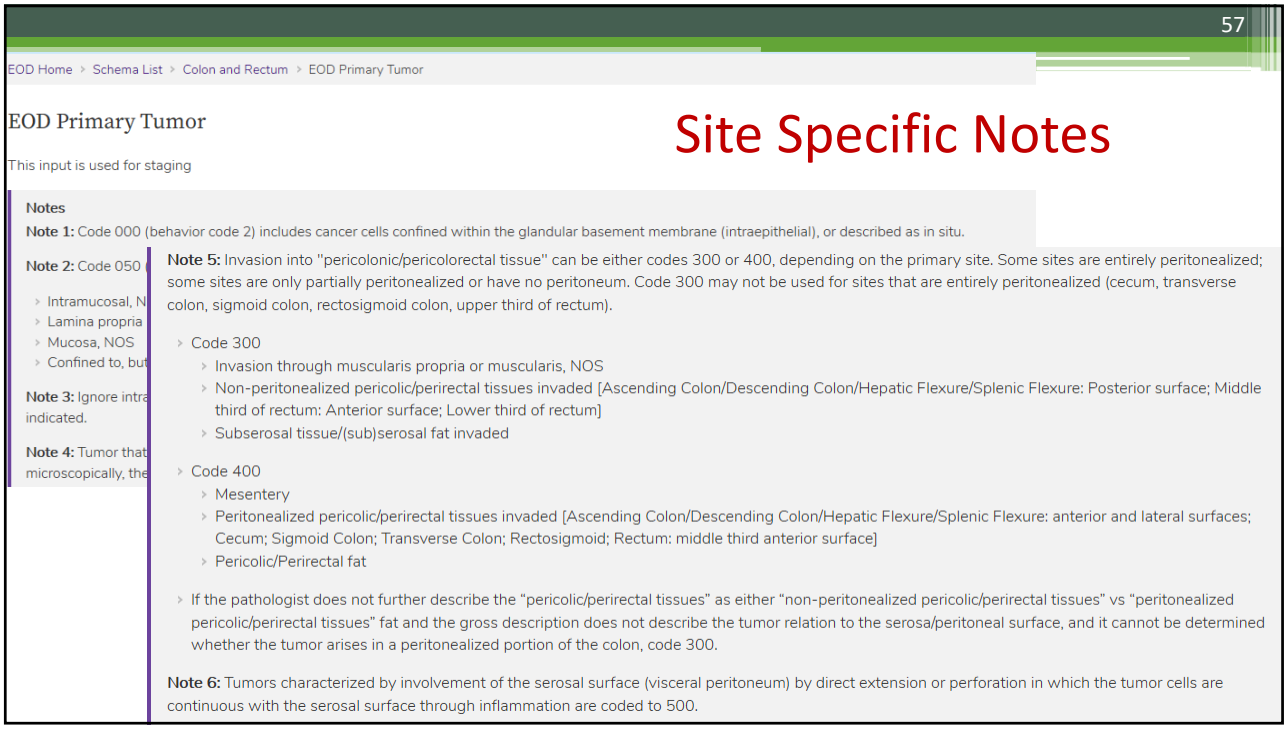

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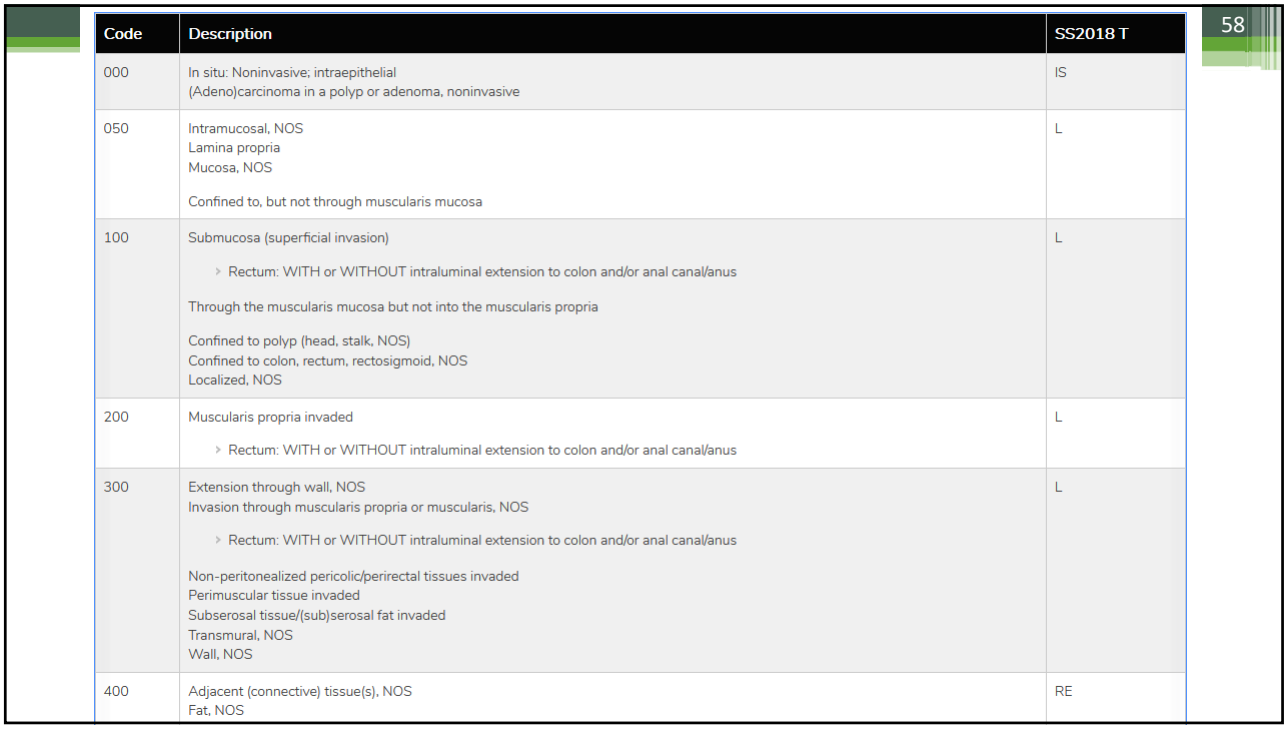

Code	Description	SS2018 T
000	In situ: Noninvasive; intraepithelial (Adeno)carcinoma in a polyp or adenoma, noninvasive	IS
050	Intramucosal, NOS Lamina propria Mucosa, NOS Confined to, but not through muscularis mucosa	L
100	Submucosa (superficial invasion) › Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Through the muscularis mucosa but not into the muscularis propria Confined to polyp (head, stalk, NOS) Confined to colon, rectum, rectosigmoid, NOS Localized, NOS	L
200	Muscularis propria invaded › Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus	L
300	Extension through wall, NOS Invasion through muscularis propria or muscularis, NOS › Rectum: WITH or WITHOUT intraluminal extension to colon and/or anal canal/anus Non-peritonealized pericolic/perirectal tissues invaded Perimuscular tissue invaded Subserosal tissue/(sub)serosal fat invaded Transmural, NOS Wall, NOS	L
400	Adjacent (connective) tissue(s), NOS Fat, NOS	RE

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Site Specific Notes

EOD Regional Nodes

This input is used for staging

Notes

Note 1: Code only regional nodes and nodes, NOS in this field. Distant nodes are coded in EOD Mets.

Note 2: For Colon and Rectum ONLY, any unnamed nodes that are removed with a colon or rectal resection are presumed to be regional pericolic or perirectal lymph nodes and are included in the EOD Regional Nodes code 300 (pericolic for sites C180 - C189, C199 and perirectal for sites C199 or C209). This site-specific instruction applies only to colon and rectum tumors and was verified with subject matter experts.

Note 3: Code 200 is defined as "PATHOLOGICAL assessment only." This is used when

- Primary tumor or site surgically resected with
  - Any positive microscopic examination of tumor deposits WITHOUT positive lymph nodes
    - If there are also positive lymph nodes, code 300

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EOD Mets

This input is used for staging

Notes

Note 1: Use code 70 when the only information is

- Distant lymph nodes are involved, but not stated as single or multiple lymph node chains
- Distant metastasis is present, but not stated as single or multiple organ involvement

Note 2: Peritoneal involvement, WITH or WITHOUT any other involvement, is code 50.

Note 3: Distant lymph node(s) for Colon, Rectum and Rectosigmoid include

Colon

- Iliac (common, external, hypogastric, internal, obturator, NOS)
- Inferior mesenteric (cecum, ascending colon, hepatic flexure, transverse colon)
- Para-aortic
- Retroperitoneal
- Superior mesenteric

Rectosigmoid

- Hemorrhoidal, inferior (rectosigmoid)
- Iliac (common, external, hypogastric, internal, obturator)
- Rectal, inferior
- Superior mesenteric

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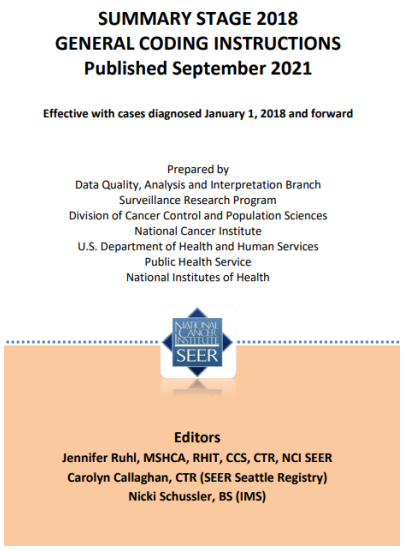
Intro to Summ Stage 2018

- Most basic way to categorize how far cancer has spread
- Provides standardized and stable measure of stage for population based registries like NPCR and SEER
- Applies to ALL primary site/histology combinations
  - *Reminder: AJCC 8th Ed does not cover every primary site and/or histology combination



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Summary Stage 2018

- Derived effective 1/1/2018 and forward
- CoC directly coding summ stage
- Online manual only https://seer.cancer.gov/tools/ssm/
- See guidelines by stage in manual

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Quiz

- Locate the online MS Forms Quiz that matches the name of this presentation.
- Complete prior to moving to the next presentation.

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