2026Updates: EOD Grade SSDI

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Iowa Cancer Registry
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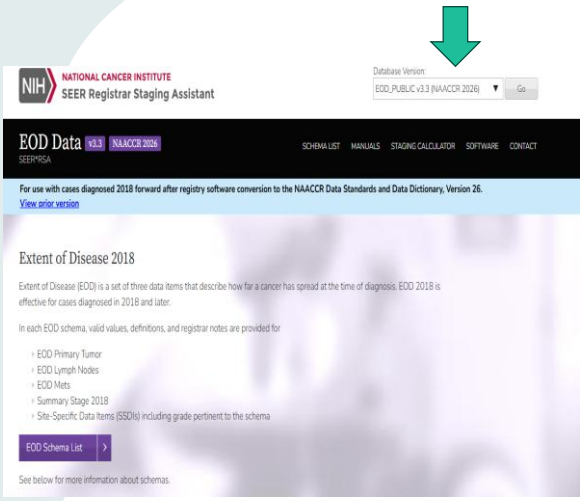
1

EOD v3.3

- General Instructions:
  - https://seer.cancer.gov/tools/staging/eod/EOD.General%20Instructions.Version3.3.pdf
- Site-Specific Codes – SEER*RSA
  - https://staging.seer.cancer.gov/eod_public/home/3.3/



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Schema Updates due to AJCC v9

Major Salivary Gland

- EOD Major Salivary Glands 8th: 2018-2025
- EOD Major Salivary Glands v9: 2026+

Oropharynx HPV-Associated

- EOD Oropharynx HPV-Associated 8th: 2018-2025
- EOD Oropharynx HPV-Associated v9: 2026+

Oropharynx HPV-Independent

- Name change – previously Oropharynx (p16-) effective 2018+

3

3

Schema Discriminator 1

- **Schema Discriminator 1**: Nasopharynx/Pharyngeal Tonsil
  - ***No longer applicable 2026+***
  - Still required 2018-2025

4

4

Oropharynx HPV-associated/HPV-independent

- **Schema Discriminator 2**: p16/HPV Status
  - Most frequent and preferred test is IHC for p16 expression
  - Other tests may be used in addition to p16 or when p16 is unavailable:
    - **High-risk HPV RNA ISH**
    - **High-risk HPV DNA ISH**
    - **High-risk HPV DNA PCR**
      - High-risk HPV types include: 16, 18, 26, 31, 33, 34, 35, 39, 45, 51, 52, 53, 56, 58, 66, 68, 70, 73, and 82
      - Low-risk HPV types (**NOT** used to determine HPV status): 6, 11, 42, 43, and 44

5

5

Oropharynx Schema Discriminator 2

Description	Notes	Codes
p16 neg; Nonreactive	Only test performed is p16 and is negative; p16 is limited (<50%) distribution only; p16 positive but subsequent reliable high-risk HPV test is negative; Stated Oropharynx-Independent	**1**
P16 positive; Extensive (>70%) moderate to strong reactivity	Only test performed is p16 and positive; p16 positive and subsequent high-risk HPV test is positive; p16 equivocal (50-70%) when subsequent high-risk HPV is positive; p16 NOT performed but high-risk HPC test is positive; Stated HPV-associated or High-risk HPV	**2**
No p16 testing; Unknown	Stated as HPV-positive and no indication it is p16 (low risk or high risk); Stated low risk HPV	**9**

6

6

Multiple Schemas – EOD Regional Node

- Several schemas were updated for EOD Regional Node
  - **Clinical vs. Pathological Notes**
    - Lymph node codes are defined as clinical or pathological assessment only
      - **No surgical resection**
        - Use **clinical assessment only codes** where is a clinical workup only and NO surgical resections of primary tumor with any microscopic exam of regional LN (FNA, core bx, SLN, LND, etc.) done during clinical work up
      - **Surgical resection without neoadjuvant therapy**
        - Use **pathologic assessment only codes** when there is a surgical resection of primary tumor with any microscopic exam of regional LN (FNA, core bx, SLN, LND, etc.)
      - **Surgical resection after neoadjuvant therapy**
        - Patient has neoadjuvant therapy, and clinical assessment is equal to or greater than pathologic assessment, then **clinical codes take priority**
        - Otherwise, code **pathologic assessment codes**

7

7

Breast – EOD Primary Tumor

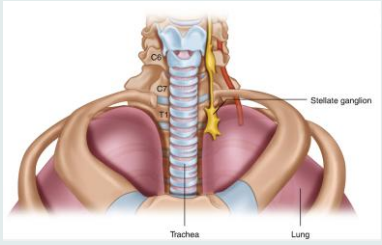
- **Note 2: Clinical evidence ONLY descriptions**
  - Adherence, attachment, fixation, induration, and thickening are clinical evidence of extension to skin or subcutaneous tissue – assign **code 200**
    - Do **NOT** use these descriptions for ***pathological assessment*** of the breast

- **Codes 450 & 700 made obsolete**
  - **450**: Diagnosis inflammatory carcinoma WITH clinical description involve less than or equal to 33%
    - **Use code 400**
  - **700**: Stated as inflammatory carcinoma
    - **Use code 600**

8

8

Lung, Version 9 – EOD Primary Tumor



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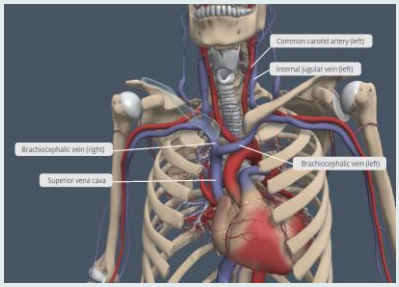


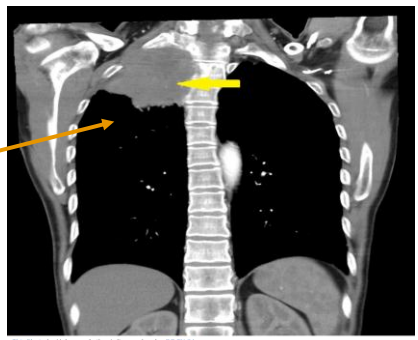
- **Code 500 updates**:
  - Involvement of **azygos vein** moved to code 500
  - Involvement of **stellate ganglion** and **thoracic nerve roots** moved to code 500
- **Code 650 updates**:
  - Involvement of **brachiocephalic vein**, **supra-aortic arteries**, and **brachial plexus** moved to code 650
  - **Subclavian vessels** and **Thymus** involvement moved to code 650

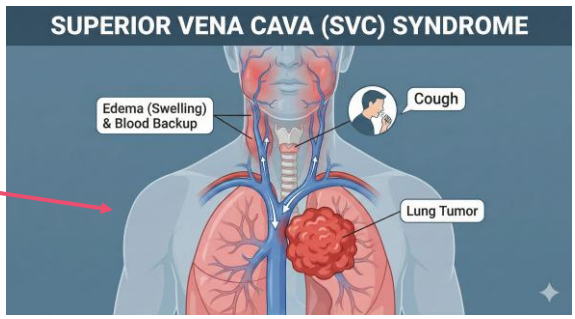
9

9

Lung, v9

- **Code 500**
  - Pancoast Tumor
    - AKA Superior Sulcus Tumor
      - Arises in the apex of the lung
- **Code 650**
  - Superior Vena Cava Syndrome
    - Caused by direct tumor extension
    - If due to LN involvement code as EOD Regional Nodes





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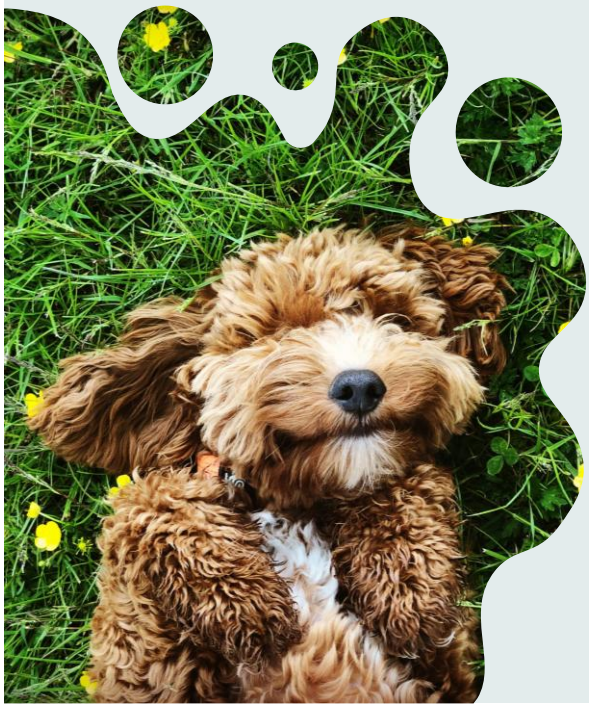


Summary Stage

No Updates for 2026!!!!

11

11

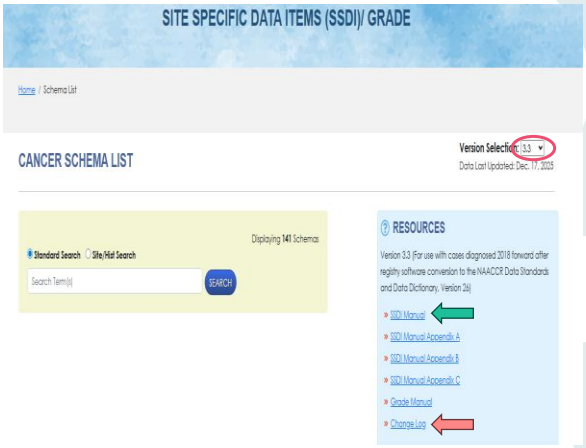
Site-Specific Data Items

New SSDIs

Changes to schemas and current SSDIs

12

12



Site-Specific Data Items v3.3

NAACCR Website

https://apps.naaccr.org/ssdi/list/3.3

SSDI Manual v3.3

https://www.naaccr.org/wp-content/uploads/2025/12/SSDI-Manual-v3.3_printed.pdf?v=1767366347

13

13

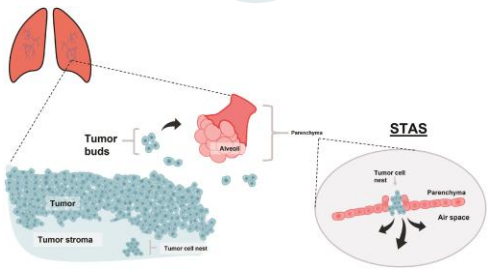
NEW SSDIs

- **Spread through Air Spaces** (STAS) – Lung
- **Residual Cancer Burden and Residual Cancer Burden Class** – Breast
- **Microsatellite Instability** (MSI) *not new SSDI*
  - NEW schema added: Corpus Carcinoma and Carcinosarcoma (2026+)

14

14

Spread Through Air Spaces (STAS)



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- **What is STAS?**
  - It is micropapillary clusters, solid nests, or single cells of tumor extend beyond the edge of the tumor into the air spaces surrounding lung parenchyma
  - Associated with increased incidence of recurrence in tumors that have limited resection
- **Applies to cases 2026+**
  - 2018-2025 leave blank

15

15

STAS – Lung

- A **surgical resection must be done** to determine STAS
  - *EXCEPTION*: in situ tumors can be **coded 0** based on biopsy or resection
  - If no surgical resection, **code 9**
    - Physician statement may be used if there is no other information available
  - Only record the information from the CAP protocol or synoptic path report

16

16

STAS – Lung

Description	Notes	Code
Not identified	No STAS on resection; in situ (/2) tumor	**0**
Present	STAS is identified on resection	**1**
No surgical resection; STAS not documented	Surgical resection performed but STAS not documented in CAP or synoptic report; Surgical pathology report not available	**9**

17

17

Breast – Residual Cancer Burden & Class

- **Residual Cancer Burden** (RCB)
  - Score that measures the amount of cancer remaining in the breast and regional LN after neoadjuvant therapy and surgical resection
  - Based on 4 independent prognostic factors measuring the primary tumor bed:
    1. Primary tumor bed area (measure in mm)
    2. Overall cancer cellularity (percentage of area)
    3. Percentage of cancer is invasive
    4. Percentage of cancer that is in situ
  - Based on 2 independent prognostic factors measuring the lymph nodes:
    1. Number of positive LN
    2. Diameter of largest mets

18

18

Breast – RCB

- Effective for cases 2026+
- Neoadjuvant therapy **AND** surgical resection must be done
- Only record the information from the CAP protocol or synoptic report

Any questions on this SSDI are to be posted in

AJCC CAnswer Forum

19

19

Breast – RCB

Description	Notes	Code
Actual RCB score: 0.000-9.999	Code actual RCB score to the nearest one thousandth; All three digits beyond the decimal point must be filled in	**0.000-9.999**
No neoadjuvant therapy OR No surgical resection	No neoadjuvant therapy, but surgical resection done; Neoadjuvant therapy given, but no surgical resection	**X.777**
No documented RCB score; Unknown/not documented	Post-neoadjuvant therapy surgery complete and RCB not documented; No information on CAP or Synoptic report; Surgical path report not available	**X.999**

20

20

Breast – RCB Class

- Based on the RCB Score, patients are divided into 4 different classes:
  - **RCB-0** No residual invasive cancer
  - **RCB-1** Very little residual invasive cancer
  - **RCB-2** Moderate amount of residual invasive cancer
  - **RCB-3** Large amount of residual invasive cancer
- Effective for cases 2026+
- Neoadjuvant therapy AND surgical resection must be done to determine class
- Only record information from CAP protocol or synoptic report

Any questions on this SSDI are to be posted in

AJCC CAnswer Forum

21

21

Breast – RCB Class

Description	Notes	Code
RCB-0	RCB-0 (pCR) class	**0**
RCB-1	RCB- I class	**1**
RCB-2	RCB-II class	**2**
RCB-3	RCB-III class	**3**
No neoadjuvant therapy OR No surgical resection	Patient had no neoadjuvant therapy, but surgical resection done; Patient had neoadjuvant therapy, but surgical resection not done	**7**
Not documented on CAP or synoptic report; Unknown	No documented RCB Class on CAP or synoptic after neoadjuvant therapy and surgical resection; Surgical path report not available	**9**

22

22

Changes to Schemas

Major Salivary Gland	**Oropharynx HPV-Associated** (previously HPV-mediated, p16+)	Name change: **Oropharynx HPV-Independent**
• Major Salivary Gland 8th: 2018-2025 • Major Salivary Gland 9th: 2026+	• Oropharynx HPV-Associated 8th: 2018-2025 • Oropharynx HPV-Associated 9th: 2026+	• Previously Oropharynx, p16-

23

23

Current SSDI Updates

- **Head/Neck Schemas**
  - **Extranodal Extension Clinical**
    - *Note 2*: **Clinical Assessment Criteria**
      - ENE may include imaging and/or physical examination
        - Biopsy of regional LN or surrounding tissue can be used to confirm metastatic disease, but cannot be used in isolation to determine ENE during clinical staging
        - Fixed nodes and/or frank skin involvement **ARE** indications of cENE
        - Matted LN are indications of iENE
        - iENE identified exclusively on imaging

ENE preferred terminology:
cENE – clinical ENE
iENE – imaging-detected ENE
pENE – pathological ENE

24

24

Head & Neck ENE – Clinical

Description	Notes	Codes
Regional LN involved; ENE **not** present	Clinically positive LN and no clinical evidence of ENE **based on physical exam**	**0**
Regional LN involved, ENE present	Definitive (unquestionable) evidence by physical exam and/or imaging	**1**
Regional LN involved, ENE present	Definitive (unquestionable) evidence by physical exam and/or imaging **AND** nodal involvement microscopically confirmed by biopsy	**2**
Regional LN involved, ENE present	Definitive (unquestionable) evidence of ENE but unknown how or identification is not known	**4**
No LN involvement	Clinically negative LN	**7**
Unknown; Not documented	ENE not assessed/unknown if assessed; Clinical assessment of LN not performed, not done, or unknown	**9**

25

25

Head & Neck ENE – Pathological

- *Note 2*: **Pathological assessment criteria**
  - Code the status of ENE assessed on histopathologic exam of surgically resected involved regional LN
    - Includes presence of ENE in a sentinel LN
    - Do **NOT** code ENE from a LN biopsy (FNA, core, incisional, or absence of ENE from a sentinel)
- *Note 3*: **Regional vs Distant nodes**
  - Do **NOT** code ENE for any distant LN
- *Note 4*: **Minor and Major ENE**
  - Minor ENE: ≤2mm
  - Major ENE: >2mm
    - Matted LN and soft tissue mets are considered major ENE

26

26

Head & Neck – LN Size

Note 2: Criteria for Coding LN Size

Metric is the size of the **largest tumor deposit** (in mm) in the LN

- **NOT** the size of the overall LN

For larger nodes however, the size of the deposit becomes essentially the size of overall LN as the nodes becomes almost replaced with tumor

Note 3: Clinical vs Pathologic Size

Code **clinical size** when the largest involved node is **NOT** examined pathologically

Code **pathologic size** when the largest involved node is examined clinically and pathologically, even if pathologic size is smaller

- Code the size of the largest tumor deposit

27

27

Lung – PD-L1

- *Note 5*: **Combined Proportion Score** (CPS)
  - Do **NOT** record the CPS Score in this data item
    - If you have a CPS score with an interpretation, **record the interpretation**
    - If you have a CPS score **WITHOUT** an interpretation, **record unknown**

28

28

Breast – HER2 Summary

- *Note 7*: **HER Positive and Oncotype**
  - Oncotype DX report may include a **quantitative HER2 result**
    - This should **NOT** be used for this data item
  - HER2 result recorded should be from the **combination or IHC and ISH** as described on the Oncotype Dx

29

29

Prostate – PSA Lab Value

- *Note 3*: **PSA Criteria**
  - **Diagnostic biopsy** done – record the last PSA prior to **AND** within 3mo of diagnostic biopsy
  - **No diagnostic biopsy** done – record the last PSA done within 3mo of the date of diagnosis or additional confirmatory testing
  - This change **can be applied for cases diagnosed 2018+**

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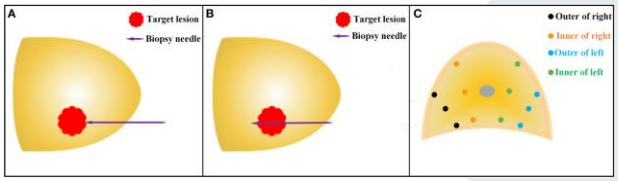


New

- *Note 4*: **Targeted biopsy or region of Interest (ROI)**
  - Count 1 core positive & 1 core examined
    - No matter how many cores were taken from the location
    - **Example**:
      - Standard biopsy (systematic) done: 3/8 cores positive
      - Targeted biopsy (#1): 5/11 cores positive
      - Targeted biopsy (#2): 7/10 cores positive
        - Record **Total Cores Positive**: 5 (3 + 2)
        - Record **Total Cores Examined**: 10 (8+2)

Prostate – Number of cores positive/examined

31

31

Plasma Cell Myeloma

High Risk Cytogenetics

New

- *Note 2*: **Component of R-ISS Stage**
  - **Code 0** if physician states RISS Stage 1 or 2 and no other information

LDH Level

- *Note 3*: **Component of R-ISS Stage**
  - **Code 0** is physician states RISS Stage 1 or 2 and no other information

32

32

Plasma Cell Myeloma

- **Serum Albumin Pretreatment Level**
  - **Source Documents**:
    - Albumin blood test; Preoperative blood work; total Protein and Albumin/Globulin (A/G) Ratio Test; comprehensive metabolic profile (CMP); Liver function test (LFT)/Hepatic panel; Nutritional assessment panels; Renal function panel
  - *Note 2*: **Pretreatment results only**
    - Record based on a blood test performed at diagnosis
      - The actual test may not state serum – if the test results are based on blood, they can be used
      - Results from a urine test can **NOT** be used
  - *Note 3*: **Component of R-ISS stage**
    - **Code 1** if physician states RISS Stage 1 and no other information

33

33

Plasma Cell Myeloma

- **Serum Beta-2 Microglobulin Pretreatment Level**
  - *Note 3*: **Component of R-ISS Stage**
    - Copy/paste error in v3.2 and now reads:
      - This is a component of the R-ISS
      - Elevated is defined as ≥5.5mg/L
      - **Use the cut points in the table** regardless of the lab's reference range
        - **Code 0** if physician states RISS Stage 1 and no other information
        - **Code 2** if physician states RISS Stage 3 and no other information

Description	Code
B2-microglobulin <3.5mg/L	**0**
B2-microglobulin ≥3.5- <5.5mg/L	**1**
B2-microglobulin >5.5mg/L	**2**

34

34

Grade

Grade updates v3.3

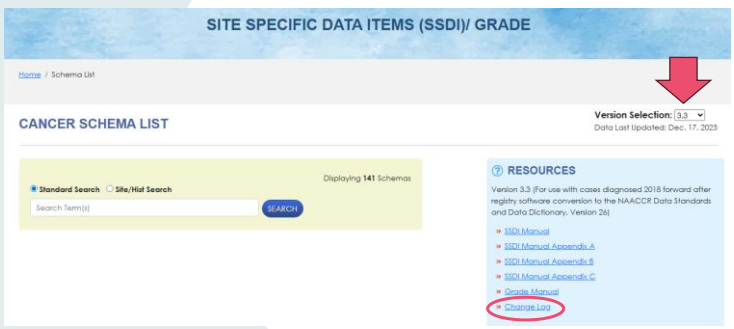
35

35

Grade Manual v3.3

NAACCR Website:

https://apps.naaccr.org/ssdi/list/3.3



36

36

Neuroendocrine Tumors (NETs)

- **Grade Table 07**: **All grade time frames**
  - *Note 4 or 5*: **Codes 1-3 take priority over codes A-D**
    - Grades A-D should only be used in the absence of a physician's statement of grade (G1, G2, G3) or no results for Ki-67 or Mitotic Count
  - *Note 5 or 6*: **Do not code grade based on the following terminology**
    - Neuroendocrine carcinoma, low grade (8240/3)
    - Neuroendocrine carcinoma, well differentiated (8240/3)
    - Neuroendocrine carcinoma, moderately differentiated (8249/3)
    - Poorly differentiated neuroendocrine carcinoma (8246/3)
  - *Note 6 or 7*: **Code grade based on physician's documentation or in the absence of this documentation, code based on Ki-67 and mitotic count**
    - **Grade 1** all you need is a Ki-67 less than 3
    - **Grades 2 and 3** are either/or for Ki-67 and Mitotic Count – you don't need both to assign grade

37

37

Grade Table 07 (NET)

Description	Notes	Code
Mitotic count (per 2mm2) less than 2 **AND** Ki-67 (%) less than 3; WHO grade 1	Only information is Ki-67 less than 3 (mitotic count not usually performed)	**1**
Mitotic count (per 2mm2) equal 2-20 **OR** Ki-67 (%) equal 3-20; WHO grade 2	Can be based on either mitotic count or Ki-67	**2**
Mitotic count (per2mm2) greater than 20 **OR** Ki-67 (%) greater than 20; WHO grade 3		**3**
Well differentiated	**Codes 1-3 take priority**; Do not base grade on term: NEC, well differentiated (8240/3)	**A**
Moderately differentiated	**Codes 1-3 take priority**; Do not base grade on term: NEC, moderately differentiated (8249/3)	**B**
Poorly differentiated	**Codes 1-3 take priority**; Do not based grade on term: poorly differentiated NEC (8246/3)	**C**
Undifferentiated; Anaplastic	**Codes 1-3 take priority**	**D**
Unknown; Can't be assessed	Grade from primary site not documented	**9**

38

38

Reminders...

- Read all change logs to know and understand every change
- Review the updated notes/coding guidelines
- After viewing all annual update training videos take the **2026 Updates Quiz**

39

Questions? Contact me.

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40