NEW JERSEY STATE CANCER REGISTRY

SEER Summary Stage 2000/SEER Summary Stage 2018

Comparison Guide

Updated 5-16-18

SEER Summary Stage 2000/SEER Summary Stage 2018 Comparison
Developed by the New Jersey State Cancer Registry

Beginning with cases diagnosed in 2018, SEER Summary Stage 2018 must be documented for all cancer diagnoses. This Comparison Guide was developed by the NJSCR as a resource to highlight the changes from the SEER Summary Stage 2000 schema. Both SEER Summary Stage manuals as well as other resources can be found at https://seer.cancer.gov. Additional resources for the 2018 stage transition can be found at www.nj.gov/health/ces.

Topic **Page**

Updated 5-16-2018

General Guidelines

2000	2018
1. For each site, summary stage is based on a combined clinical and operative/pathological assessment. Gross observations at surgery are particularly important when all malignant tissue is not removed. In the event of a discrepancy between pathology and operative reports concerning excised tissue, priority is given to the pathology report. **(SS 2018 #4- Revised)**	***NEW*** 1. Updates to the Summary Stage 2018 manual were based on the AJCC 8th edition. Although the two systems are similar, there are many differences between them. For example, something that is regional in AJCC (recorded in T or N) may be distant in Summary Stage. If a structure or lymph node cannot be found in localized (code 1) or regional (codes 2-4), then review distant (code 7).
2. Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within four months of diagnosis in the absence of disease progression, whichever is longer. (SS 2018 #5)	2. Summary Stage chapters apply to ALL primary sites and histologies. Most chapters are based on primary site, while some are based on histology alone, or both primary site and histology.
3. Summary stage information obtained after treatment with radiotherapy, chemotherapy, hormonal therapy, or immunotherapy has begun may be included unless it is beyond the time frame given in guideline 2 above. **(SS 2018 #8)**	3. Chapter-specific guidelines take precedence over general guidelines. Always read the information pertaining to a specific primary site or histology chapter.
4. Exclude any metastasis known to have developed after the diagnosis was established. **(SS 2018 #9- Revised)**	4. For ALL primary sites and histologies, Summary Stage 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
5. Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the stage. Be sure to review the clinical information carefully to assure accurate summary stage. If the operative/pathology information disproves the clinical information, code the operative/pathology information. **(SS 2018 #6)**	5. Summary Stage 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.
6. All schemes apply to all histologies unless otherwise noted. Exceptions to this, for example, include all lymphomas and Kaposi sarcoma which should be staged using the histology schemes regardless of the primary site. **(SS 2018 #2- Revised)**	6. Clinical information, such as description of skin involvement for breast cancer and distant lymph nodes for any site, can change the Summary 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.
7. Autopsy reports are used in coding summary stage just as are pathology reports, applying the same rules for inclusion and exclusion. **(SS 2018 #10)**	***NEW*** 7. When multiple tumors are reported as a single primary, assign the greatest Summary Stage from any tumor.

Updated 5-16-18

2000	2018
8. Death Certificate Only cases and unknown primaries are coded '9' for summary stage. **(SS 0218 #14- Revised)**	8. Information for Summary Stage 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.
9. The summary stage may be described only in terms of T (tumor), N (node) and M (metastasis) characteristics. In such cases, record the summary stage code that corresponds to the TNM information. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM. **(SS 2018 #11/#12)**	9. Disease progression, including metastatic involvement, known to have developed after the initial stage workup, should be excluded when assigning Summary Stage.
10. Site-specific guidelines take precedence over general guidelines. Always consider the information pertaining to a specific site. **(SS 2018 #3)**	***NEW*** 10. Autopsy reports are used in Summary Stage just as are pathology reports, applying the same rules for inclusion and exclusion.
	11. T, N, M information may be used to assign Summary Stage when it is the only information available.
	12. Use the medical record documentation to assign Summary Stage 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, assign Summary Stage corresponding to the physician staging
	NEW 13. It is strongly recommended that the assessment of the Summary Stage be documented, as well as the choice of the Summary Stage assignment in a related STAGE text field on the abstract.
	14. Death Certificate Only (DCO) cases and unknown primaries are assigned '9' for Summary Stage; however, assign the appropriate Summary Stage when specific staging information is available on a DCO.

General Guidelines for Stage

2000	2018
In situ 1. Rule out in situ stage disease. Carcinomas and melanomas are the only types of cancer that can be classified as in situ. Only carcinomas have a basement membrane. Sarcomas are never described as in situ. A pathologist must examine the primary organ and state that the tumor is in situ. If the cancer is anything except a carcinoma or melanoma, it cannot be in situ. 2. If there is any evidence of invasion (or extension to), nodal involvement or metastatic spread, the case is not in situ even if the pathology report so states. This is a common error in staging cervical cancer where the path report states that the cancer is "in situ with microinvasion"- such a case would be staged as localized.	***In situ*** 1. Rule out in situ stage disease. Carcinomas and melanomas are the only types of cancer that can be classified as in situ, since they arise only in organs with a basement membrane. Sarcomas are never described as in situ. A pathologist must examine the primary tissue and state that the tumor is in situ. If the cancer is anything except a carcinoma or melanoma, it cannot be in situ. 2. If there is any evidence of invasion (or extension beyond the basement membrane), nodal involvement or metastatic spread, the case is not in situ even if the pathology report so states.
Distant 3. Rule out distant disease. If metastases can be documented, there is no need to spend a great deal of time identifying local or regional spread. If distant metastases are recorded on x-ray or needle biopsy, the stage is already determined and the patient does not need to undergo a lot of other tests. 4. Hematopoietic diseases, such as leukemia and multiple myeloma, are considered disseminated or distant at time of diagnosis. 5. Rule out distant spread by reading the operative report for comments about seeding, implants, liver nodules, or other indications of metastases. Read diagnostic reports for references to distant disease. 6. If nodes, organs, or adjacent tissues are not specifically mentioned in the description of the various categories, attempt to cross-reference the term you have with those outlined. If there is no match, assume the site in question represents distant disease.	***Distant*** 3. Rule out distant disease. If distant metastases can be documented, there is no need to spend a great deal of time identifying local or regional spread. If distant metastases are recorded on imaging or needle biopsy, the stage is already determined and the patient does not need to undergo a lot of other tests. 4. Hematopoietic diseases, such as leukemia and multiple myeloma, are disseminated or distant at time of diagnosis. 5. Determine distant spread by reading the operative report for comments about seeding, implants, liver nodules, or other indications of metastases to determine if they are indicators of distant disease for a particular chapter. Read diagnostic reports for references to distant disease. 6. If nodes, organs, or adjacent tissues are not specifically mentioned for the primary site of the cancer in the description of the various staging categories, approximate the location and assign Summary Stage based on the stage listed for organs or tissues in the same anatomic area. If there is no match, assume the involved organ/tissues, nodes in question represents distant disease.
Localized 7. Rule out that the cancer is "confined to the organ of origin." In order for a lesion to be classified as localized, it must not extend beyond the outer limits of the organ and there must be no evidence of metastases anywhere else. 8. Terms such as "blood vessel invasion" or "perineural lymphatic invasion" do not necessarily indicate that the cancer has spread beyond the primary organ. If tumor at the primary site has invaded lymph or blood vessels, there	***Localized if not in Situ or Distant above*** 7. Rule out that the cancer is "confined to the organ of origin." In order for a lesion to be classified as localized, it must not extend beyond the outer limits of the organ, and there must be no evidence of metastases anywhere else. 8. Terms such as "blood vessel invasion" or "perineural lymphatic invasion" do not necessarily indicate that the cancer has spread beyond the primary organ – see specific chapter. If tumor at the primary site has invaded lymph

2000	2018
is the potential for malignant cells to be transported throughout the body. Step 1 (invasion), has occurred, but not necessarily steps 2 (transport of cancer cells) and 3 (growth at the secondary site). The case may still be localized. (Removed from SS 2018) 9. Vascular invasion within the primary is not a determining factor in changing the stage unless there is definite evidence of tumor at distant sites.	or blood vessels, there is the potential for malignant cells to be transported throughout the body. Minor vessel or lymph-vascular invasion within the primary site is not a determining factor in changing Summary Stage unless there is definite evidence of tumor at distant sites.
Regional 10. If in situ, local and distant categories have been ruled out, the stage is regional. 11. For carcinomas, if there are lymph nodes involved with the tumor, the stage is at least regional. **(#11 SS 2018)** 12. For tissues, structures, and lymph nodes, assume ipsilateral unless stated to be contralateral or bilateral**. (#10 SS 2018)**	***Regional*** 9. If in situ, distant, and localized categories have been ruled out, the stage is regional. 10. For tissues, structures, and lymph nodes, assume ipsilateral unless stated to be contralateral or bilateral. 11. For solid tumors, if there are lymph nodes involved with the tumor, the stage is at least regional. ***NEW*** 12. Determine whether it is regional by direct extension, regional nodes, or both.
Unknown if Extension or Metastasis 13. If there is not enough information in the record to categorize a case, it must be recorded as unstageable.	***Unknown if Extension or Metastasis*** 13. If there is not enough information in the record to categorize a case, and contacting the physician is not possible or has not resulted in additional information, the case must be recorded as unknown.

2000		2018	
There are five main categories in Summary Stage, each of which is discussed in detail. In addition, the regional stage is subcategorized by the method of spread. The code structure is:		**There are six main categories in Summary Stage, each of which is discussed in detail. In addition, the main category of Regional stage is subcategorized by the method of spread. The code structure is:**	
Code	**Definition**	**Code**	**Definition**
0	In situ	**0**	In situ
1	Localized only	**1**	Localized only
2	Regional by direct extension only	**2**	Regional by direct extension only
3	Regional lymph nodes only	**3**	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement	**4**	Regional by BOTH direct extension AND lymph node involvement
5	Regional, NOS (Not Otherwise Specified)	**7**	Distant site(s)/node(s) involved
7	Distant site(s)/node(s) involved	**8 *NEW***	Benign/borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified)	**9**	Unknown if extension or metastasis (unstaged, unknown, or unspecified)

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland

Note: For SS2018, code 5 for “Regional, NOS” can no longer be coded. Code 5 (Regional, NOS) is still applicable for SS2000.

Guidelines by Stage

Code 0: In Situ

2000	2018
In situ means “in place.” The technical definition of in situ is the presence of malignant cells within the cell group from which they arose. There is no penetration of the basement membrane of the tissue and no stromal invasion. Generally, a cancer begins in the rapidly dividing cells of the epithelium or lining of an organ and grows from the inside to the outside of the organ. An in situ cancer fulfills all pathologic criteria for malignancy except that it has not invaded the supporting structure of organ on which it arose.	1. In situ means “in place”. The technical definition of in situ is the presence of malignant cells within the cell group from which they arose. There is no penetration of the basement membrane of the tissue and no stromal invasion. Generally, a cancer begins in the rapidly dividing cells of the epithelium or lining of an organ and grows from the inside to the outside of the organ. An in situ cancer fulfills all pathological criteria for malignancy except that it has not invaded the supporting structure of the organ or tissue in which it arose. ***NEW*** Note: If the pathology report indicates an in situ tumor but there is evidence of positive lymph nodes or distant metastases, code to the regional nodes/distant metastases.
An in situ diagnosis can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated. If the basement membrane has been disrupted (in other words, the pathologist describes the tumor as microinvasive), the case is no longer in situ and is at least localized. Pathologists have many ways of describing in situ cancer, such as non-invasive, pre-invasive, non-infiltrating, intra-epithelial, Stage 0, intraductal, intracystic, no stromal invasion, and no penetration below the basement membrane. Organs and tissues that have no epithelial layer cannot be staged as in situ, since they do not have a basement membrane. Therefore, there cannot be a diagnosis of “sarcoma in situ.”	2. An in situ diagnosis can only be made microscopically, because a pathologist must identify the basement membrane and determine that it has not been penetrated. If the basement membrane has been disrupted (in other words, the pathologist describes the tumor as microinvasive, microinvasion), the case is no longer in situ and is at least localized (code 1). 3. Pathologists have many ways of describing in situ cancer • Intracystic • Intra-epithelial • No penetration below the basement membrane • No stromal invasion • Non-infiltrating • Noninvasive • Pre-invasive 4. Organs and tissues that have no epithelial layer cannot be staged as in situ, since they do not have a basement membrane.
	NEW 5. Code 0 is not applicable for the following Summary Stage chapters Bone • Brain • Cervical Lymph Nodes, Occult Head and Neck • CNS Other • Corpus Sarcoma • Heart, Mediastinum and Pleura

2000	2018
	• HemeRetic • Ill-defined other • Kaposi Sarcoma • Lymphoma • Lymphoma Ocular Adnexa • Mycosis Fungoides • Myeloma Plasma Cell Disorder • Pleural Mesothelioma • Primary Cutaneous Lymphoma (non-MF and SS) • Retinoblastoma • Retroperitoneum • Soft Tissue

Code 1: Localized

2000	2018
A localized cancer is a malignancy limited to the organ of origin; it has spread no farther than the organ in which it started. There is infiltration past the basement membrane of the epithelium into the functional part of the organ, but there is no spread beyond the boundaries of the organ. A tumor can be widely invasive or even show metastases within the organ itself and still be considered "confined to organ of origin" or localized in summary stage. **(SS 2018 #1)**	1. A localized cancer is defined as a. Malignancy limited to the site of origin b. Spread no farther than the site of origin in which it started c. Infiltration past the basement membrane of the epithelium into parenchyma (the functional part of the organ), but there is no spread beyond the boundaries of the organ Note: A tumor can be widely invasive or show metastases within the organ itself and still be "confined to organ of origin" or localized in Summary Stage.
For organs that have definite boundaries (such as prostate, testis, or stomach) or sites where there is a clear line between the organ of origin and the surrounding region (such as breast or bladder), it is usually straightforward to determine whether the cancer is localized. An exception is skin, because it is sometimes difficult to determine where the dermis ends and subcutaneous tissue begins. For most internal organs, it is not possible to determine whether tumor is localized without exploratory surgery. However, the increasing sophistication of many imaging techniques is predicted to eventually make exploratory surgery obsolete. **(SS 2018 #2)**	2. For organs that have definite boundaries (such as prostate, testis, or stomach) or sites where there is a clear line between the organ of origin and the surrounding region (such as breast or bladder), it is usually straightforward to determine if the cancer is localized. a. An exception is skin, because it is sometimes difficult to determine where the dermis ends and subcutaneous tissue begins. b. For many internal organs, it is difficult to determine whether the tumor is localized without surgery; however, with the increasing sophistication of imaging, it may be possible to determine whether a cancer is localized or regional without surgery.
It is important to know and recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so that a description of invasion or involvement of these structures will not be interpreted as regional spread. **(SS 2018 #3)**	3. It is important to know and recognize the names of different structures within the organ (such as lamina propria, myometrium, muscularis) so that a description of invasion or involvement of these structures will not be interpreted inappropriately, which may lead to over-staging.
Because summary stage uses both clinical and pathologic information, it is important to read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as diagnostic imaging reports for mention of distant disease. If any of these reports provides evidence that the cancer has spread beyond the boundaries of the organ of origin, the case is not localized. On the other hand, if the pathology report, operative report and other investigations show no evidence of spread, the tumor may be assumed to be localized. **(SS 2018 #4)**	4. Because Summary Stage uses both clinical and pathological information, it is important to review and read the pathology and operative report(s) for comments on gross evidence of spread, microscopic extension and metastases, as well as physical exam and diagnostic imaging reports for mention of regional or distant disease. a. If any of these reports provides evidence that the cancer has spread beyond the boundaries of the organ of origin, the case is not localized. b. If the pathology report, operative report and other investigations show no evidence of spread, the tumor may be assumed to be localized.
	NEW 5. Code 1 is not applicable for the following Summary Stage chapters: • Cervical Lymph Nodes and Unknown Primary • Ill-defined other

Code 2: Regional By Direct Extension

2000	2018
Regional stage is perhaps the broadest category as well as the most difficult to properly identify. The brief definition of regional stage is tumor extension beyond the limits of the organ of origin. Although the boundary between localized and regional tumor extension is usually well-identified, the boundary between regional and distant spread is not always clear and can be defined differently by physicians in various specialties. **(SS 2018 #1)**	1. Regional stage by direct extension is perhaps the broadest category as well as the most difficult to properly identify. The brief definition is direct tumor extension beyond the limits of the site of origin. Although the boundary between localized and regional tumor extension is usually well-identified, the boundary between regional and distant spread is not always clear and can be defined differently by physicians in various specialties.
Cancer becomes regional when there is the potential for spread by more than one lymphatic or vascular supply route. For example, the tumor in the hepatic flexure of the colon with extension along the lumen to the ascending colon is staged as localized because both areas drain to same lymph nodes. On the other hand, a sigmoid tumor extending into the rectum is staged as regional because the tumor now has potential for the tumor cell drainage to both iliac and mesenteric nodes. **(SS 2018 #2)**	2. Cancer becomes regional by direct extension when there is potential for spread by more than one vascular supply route. For example, if the tumor goes outside of the wall and invades another organ, it regional by direct extension.
The formal (scientific) definition used by surgeons is that area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of— or an entire— organ with outer limits to include at least the first level nodal basin. However, en bloc resection (removal of multiple organs or tissues in one piece at the same time) is not always feasible or may have been shown not to be necessary. For example, a number of clinical trials have shown that lumpectomy or modified radical mastectomy has equivalent survival to the very disfiguring radical mastectomy for treatment of breast cancer. In contrast, radiation oncologists define the term regional as including any organs or tissues encompassed in the radiation field used to treat the primary site and regional lymph nodes. **(SS 2018 #3/#4)**	3. The formal (scientific) definition of regional used by surgeons is that area extending from the periphery of an involved organ that lends itself to removal en bloc with a portion of, or an entire organ with outer limits to include at least the first level nodal basin. However, en bloc resection (removal of multiple organs or tissues in one piece at the same time) is not always feasible or may have been shown not to be necessary. For example, many clinical trials have shown that lumpectomy or modified radical mastectomy has equivalent survival to the very disfiguring radical mastectomy for treatment of breast cancer. 4. In contrast, radiation oncologists define the term regional as including any organs or tissues encompassed in the radiation field used to treat the primary site and regional lymph nodes.
Regional stage has several subcategories, each of which is described in detail below. 2 Regional by direct extension only 3 Regional lymph nodes involved only 4 Regional by BOTH direct extension AND lymph node involvement 5 Regional, NOS (Not Otherwise Specified)	5. For primary sites that have “walls” (e.g. colon, rectum), regional by direct extension is invasion through entire wall of organ into surrounding organs and/or adjacent tissues, direct extension or contiguous spread. For those primary sites without defined walls, regional by direct extension is when the tumor has spread beyond the primary site or capsule into adjacent structures. 6. Do NOT use code 2 if there is direct extension and also regional nodes positive (see code 4).

2000	2018
These codes and subcategories describe different methods of regional spread of tumor: A. Invasion through entire wall of organ into surrounding organs and/or adjacent tissues (code 2, regional by direct extension or contiguous spread) B. Tumor invasion of walls of lymphatics where cells can travel through lymphatic vessels to nearby lymph nodes where they are "filtered" out and begin to grow in the nodes (code 3, regional to lymph nodes) C. A combination of direct extension and lymph node involvement (code 4, regional by direct **(SS 2018 #5/#6)**	
A fourth category of regional stage is code 5, regional not otherwise specified. This category may be used when it is unclear whether the tissues are involved by direct extension or lymph nodes, or when the other categories are not applicable, such as for staging Non-Hodgkin and Hodgkin lymphoma of more than one lymph node chain. (removed from SS 2018, Reg by Direct Ext)	**CODE 5 (REGIONAL NOS) REMOVED**
Clinicians may use some terms differently than cancer registrars. Therefore, it is important to understand the words used to describe the spread of the cancer and how they are used in staging. For example: 1) "Local" as in "carcinoma of the stomach with involvement of the local lymph nodes." Local nodes are the first group of nodes to drain the primary. Unless evidence of distant spread is present, such a case should be staged as regional, not local. 2) "Metastases" as in "carcinoma of lung with peribronchial lymph node metastases." Metastases in this sense means involvement by tumor. Such a case would still be regional. Learn the names of regional nodes for each primary site (removed from SS 2018, Reg by Direct Ext)	Notes removed from SS 2018
	NEW 7. Code 2 is not applicable for the following Summary Stage chapters: • Cervical Lymph Nodes and Unknown Primary • HemeRetic • Ill-defined other • Myeloma Plasma Cell Disorder

Code 3: Regional lymph nodes only

2000	2018
1. Consider the farthest specific lymph node chain that is involved by tumor. (removed from SS 2018, Regional- LN)	***NEW*** 1. Regional lymph nodes are listed for each chapter/site. a. If a lymph node chain is not listed in code 3, then the following resources can be used to help identify regional lymph nodes: i. Appendix I ii. Anatomy textbook iii. ICD-O manual iv. Medical dictionary (synonym)
2. For lymphomas, any mention of lymph nodes is indicative of involvement and is used to determine the number and location of lymph node chains involved (see lymphoma scheme). (removed from SS 2018, Regional- LN)	***NEW*** 2. If no preoperative treatment was administered and there is a discrepancy between clinical information and pathological information about the same lymph nodes, pathological information takes precedence. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement. Use the following priority order: a. Pathology report b. Imaging i. If nodes are determined positive based on imaging and then confirmed to be negative on pathological exam, treat the regional nodes as negative when assigning Summary Stage c. Physical exam i. If nodes are determined positive based on physical exam and then confirmed to be negative on pathological exam, treat the regional nodes as negative when assigning Summary Stage
3. For solid tumors, the terms “fixed” or “matted” and “mass in the mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes. **(SS 2018 #4)**	***NEW*** 3. 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.
4. Terms such as “palpable”, “visible swelling”, and “shotty” should be ignored. Look for a statement of involvement, either clinical or pathological. The terms “enlarged” and “lymphadenopathy” should be ignored for all sites except lung. For lung primaries, these terms are interpreted as regional lymph node involvement. (removed from SS 2018, Regional- LN) **(SS 2018 #4a-Revised)**	4. 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. If these terms are used and there is no treatment to indicate lymph node involvement, treat the case as having no lymph node involvement.

2000	2018
5. The terms “homolateral” and “ipsilateral” are used interchangeably. Any unidentified nodes included with the resected primary site specimen are to be considered as “Regional Lymph Nodes, NOS.”	5. The terms “homolateral,” “ipsilateral,” and “same side” are used interchangeably.
6. If the only indication of lymph node involvement in the record is the physician’s statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes’ C, consider that information in considering regional lymph node involvement. **(SS 2018 #13)**	***NEW*** 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 determine negative regional lymph nodes.
7. If there is a discrepancy between documentation in the medical record and the physician’s assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM (see General Guideline 9). (removed from SS 2018, Regional- LN)	***NEW*** 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 the tumor is Localized and standard treatment for a localized site is done, it is sufficient to determine negative regional lymph nodes.
8. If a specific chain of lymph nodes is named, but not listed as regional, first determine if the name is synonymous with a listed lymph node. Otherwise, assume distant lymph node(s) are involved. **(SS 2018 #14)**	***NEW*** 8. 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
Note: Regional lymph nodes are not palpable for inaccessible sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be the surgeon’s evaluation at the time of exploratory surgery or definitive surgery. (removed from SS 2018, Regional- LN)	***NEW*** 9. For some chapters, ITCs are counted as positive regional nodes, while other chapters count them as negative. See the individual chapters to determine how to count ITCs.
	NEW 10. Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum can occur WITH or WITHOUT regional lymph node involvement. Assign the appropriate code according to guidelines in individual chapters. Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with

2000	2018
	extravascular spread, or a totally replaced lymph node. If there are Tumor Deposits AND node involvement, code only the information on node involvement in Summary Stage.
	NEW 11. If direct extension of the primary tumor into a regional lymph node is shown, code as involved regional nodes.
	NEW 12. Any positive unidentified nodes included with the resected primary site specimen are to be coded as "Regional Lymph Nodes, NOS".
	13. If the only indication of positive regional lymph node involvement in the record is the physician's statement of a positive N category from the TNM staging system or a stage from a site-specific staging system, use that information to code regional lymph node involvement.
	14. If a specific chain of lymph nodes is named, but not listed as regional, first determine if the name is synonymous with a listed lymph node. Otherwise, assume distant lymph node(s) are involved.
	NEW 15. Code 3 is not applicable for the following Summary Stage chapters: • Brain • CNS Other • HemeRetic • Ill-defined other (includes unknown primary site, C809) • Intracranial Gland • Lymphoma o Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate chapters from Lymphoma and regional lymph node involvement is assigned in these chapters.
	NEW 16. Do NOT use code 3 if there are regional nodes positive AND also direct extension (see code 4).

Code 4: Regional by BOTH direct extension AND regional lymph node(s) involved

2000	2018
No instruction	***NEW*** 1. For tumors that are regional (see definition of code 2) and have regional lymph node involvement (see definition of code 3), use code 4.
	NEW 2. If there is only localized involvement (see definition of code 1) with regional lymph node involvement, assign code 3.
	NEW 3. Code 4 is not applicable for the following Summary Stage chapters: • Brain • Cervical Lymph Nodes and Unknown Primary • CNS Other • HemeRetic • Ill-defined other (includes unknown primary site) • Intracranial Gland • Lymphoma o Primary Cutaneous Lymphoma and Ocular Adnexal Lymphoma have separate chapters from Lymphoma and regional lymph node involvement is assigned in these chapters. • Myeloma Plasma Cell Disorder

Code 7: Distant

2000	2018
Distant metastases are tumor cells that have broken away from the primary tumor, have travelled to other parts of the body, and have begun to grow at the new location. Distant stage is also called remote, diffuse, disseminated, metastatic, or secondary disease. The point is that in most cases there is no continuous trail of tumor cells between the primary site and the distant site. **(SS 2018 #1)** Cancer cells can travel from the primary site in any of four ways: 1) Extension from primary organ beyond adjacent tissue into next organ; for example, from the lung through the pleura into bone or nerve. 2) Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body. 3) Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary or arteriole. At that point the tumor penetrates the vessel wall and grows back into the surrounding tissue. (Please see the scientific illustration on the next page.) 4) Spread through fluids in a body cavity. Example: malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land on and begin to grow on any tissue reached by the fluid. This type of spread is also called implantation or seeding metastases. Some tumors form large quantities of fluid called ascites that can be removed, but the fluid rapidly re-accumulates. However, the presence of fluid or ascites does not automatically indicate dissemination. There must be cytologic evidence of malignant cells. **(SS 2018 #2)**	1. Distant metastases are tumor cells that have broken away from the primary tumor, have travelled to other parts of the body, and have begun to grow at the new location. Distant stage is also called remote, diffuse, disseminated, metastatic, or secondary disease. The point is that in most cases there is no visible continuous trail of tumor cells involving only the primary site and the distant site. 2. Cancer cells can travel from the primary site in any of four ways. a. Extension from primary organ beyond adjacent tissue into next organ; for example, from the lung through the pleura into bone or nerve b. Travel in lymph channels beyond the first (regional) drainage area. Tumor cells can be filtered, trapped and begin to grow in any lymph nodes in the body. c. Hematogenous or blood-borne metastases. Invasion of blood vessels within the primary tumor (veins are more susceptible to invasion than thicker-walled arteries) allows escape of tumor cells or tumor emboli which are transported through the blood stream to another part of the body where it lodges in a capillary or arteriole. At that point, the tumor penetrates the vessel wall and grows back into the surrounding tissue. d. Spread through fluids in a body cavity. i. Example: malignant cells rupture the surface of the primary tumor and are released into the thoracic or peritoneal cavity. They float in the fluid and can land and grow on any tissue reached by the fluid. ii. This type of spread is also called implantation or seeding metastases. Some tumors form large quantities of fluid called ascites that can be removed, but the fluid rapidly re-accumulates. However, the presence of fluid or ascites does not automatically indicate dissemination. There must be cytologic evidence of malignant cells. A subsequent clinical diagnosis should be able to override a negative cytology. Malignant cells in ascites or peritoneal washings may not be distant involvement in some schemas.
Common sites of distant spread are liver, lung, brain, and bones, but they are not listed specifically for each scheme. These organs receive blood flow from all parts of body and thus are a target for distant metastases. However, if the primary site is adjacent to the liver, lung, brain or bone, it is important to review the summary staging scheme for the primary site to assure that the stage is not regional by direct extension. An example would be liver	3. Common sites of distant spread are liver, lung, brain, and bones, but they are not listed specifically for each chapter. These organs receive blood flow from all parts of body and thus are a target for distant metastases. However, if the primary site is adjacent to the liver, lung, brain or bone, it is important to review the Summary Stage chapter for the primary site to assure that the stage is not regional by direct extension.

2000	2018
involvement from a primary in the gallbladder. It is likely that this is regional by direct extension rather than distant stage, since the gallbladder is adjacent to liver. Read the diagnostic imaging reports to determine whether the cancer involves the surface of the secondary organ, which would be regional by direct extension, or whether the cancer is inside the secondary organ. If the latter is the case, the only way it could have developed in the secondary organ is if the tumor cells arrived there via the blood stream (distant hematogenous metastases). Another way to remember the difference between regional direct extension and distant metastases is whether the secondary site has tumor on the surface (most likely direct extension) or in the organ (blood-borne metastases). Hematopoietic, reticuloendothelial, immunoproliferative, and myeloproliferative neoplasms are considered distant except as noted in the staging scheme. **(SS 2018 #3/#4/#5)**	a. Example: Liver involvement from a primary in the gallbladder. It is likely that this is regional by direct extension rather than distant stage, since the gallbladder is adjacent to the liver. 4. Read the diagnostic imaging reports to determine whether the cancer involves the surface of the secondary organ, which could either be regional by direct (contiguous) extension or distant (if determined to be a discontiguous surface implant). If the tumor is identified growing from one organ onto/through the surface of the secondary organ, then it is contiguous extension. But if the tumor is only found in the parenchyma of the secondary organ well away from the primary organ, then it is discontinuous mets. 5. Hematopoietic, immunoproliferative, and myeloproliferative neoplasms are distant except as noted in the Summary Stage chapter.
	NEW 6. Code 7 is not applicable for the following Summary Stage chapters: • Ill-defined other

Code 8: Benign/Borderline

2000	2018
No instruction	***NEW*** 1. Code 8 is for Benign/borderline neoplasms. Benign/borderline neoplasms are collected ONLY for the following chapters: • Brain • CNS Other • Intracranial Gland
	NEW 2. If a registry collects other benign/borderline tumors that are not reportable, use code 9 for Summary Stage 2018. Code 8, at this time, will not be allowed for other sites.

Code 9: Unknown if extension or metastasis (unstaged, unknown or unspecified)

2000	2018
If the primary site is unknown (C80.9), then the summary stage must be unknown. **(SS 2018 #1)**	1. If the primary site is unknown (C809), then Summary Stage must be unknown.
There will be cases for which sufficient evidence is not available to adequately assign a stage. Examples include occasions when the patient expires before workup is completed, when a patient refuses a diagnostic or treatment procedure, and when there is limited workup due to the patient's age or a simultaneous contraindicating condition. If sufficient information does not exist, the case is unstageable. **(SS 2018 #3)**	2. Assign 9 very sparingly. If possible, contact the physician to see if there is more information about the case which is not in the record, such as diagnostic studies performed prior to admission or documentation in the physician's office record.
This code should be assigned very sparingly. If at all possible, contact the physician to see if there is more information about the case which is not in the record, such as diagnostic studies performed prior to admission or documentation in the physician's office record. **(SS 2018 #2)**	3. There will be cases for which sufficient evidence is not available to adequately assign a stage. Examples include: a. The patient expires before workup is completed b. A patient refuses a diagnostic or treatment procedure c. There is limited workup due to the patient's age or a simultaneous comorbid or contraindicating condition d. Only a biopsy is done and does not provide enough information to assign stage
Death certificate only cases are coded to '9', unknown. **(SS 2018 #4)**	4. Code 9 is to be used by default for Death Certificate Only (DCO) cases; however, assign the appropriate Summary Stage when specific staging information is available on a DCO.