



Directly Coded Summary Stage Is Back

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Outline

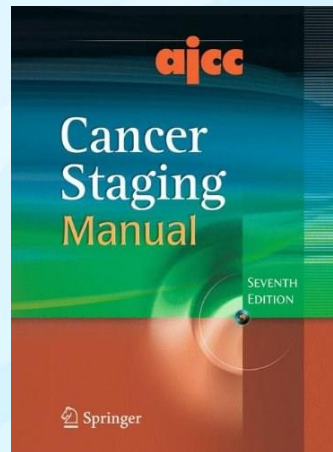
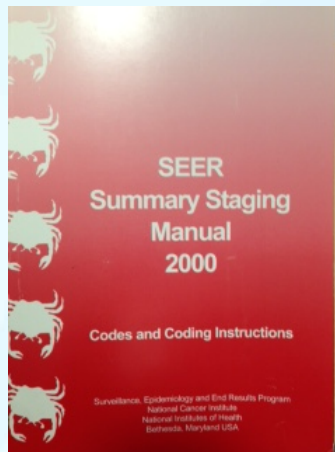
- ❑ **What is SEER Summary Stage 2000 (SS2000)?**
- ❑ **Summary Stage Housekeeping**
- ❑ **Summary Stage Manual Organization**
- ❑ **Summary Stage Code Review**
- ❑ **How to Stage**
- ❑ **About Lymph nodes**
- ❑ **Abstractor Tips**
- ❑ **Staging Exercises**

What is SEER Summary Staging?

- ❑ The most **basic way to categorize how far a cancer has spread** from its point of origin to other parts of the body
 - Anatomic Staging
- ❑ **Applies to every anatomic site**, including the lymphomas and leukemia's
 - *Can be used for pediatric cancers*
- ❑ Uses all information available in the medical record
- ❑ **Is a combination of the most precise *clinical and pathologic* documentation** of the extent of disease.
- ❑ Efficient staging tool
 - Provides a standardized measure of anatomic extent of disease for cancer surveillance.
 - Staging categories are broad enough to measure the success of cancer control and other epidemiologic efforts
 - Epidemiologists/Researchers use Summary Stage **NOT Physicians.**

Summary Stage & AJCC TNM Stage

- ❑ Two Different Staging Systems with Different Rules
- ❑ Often don't align-cannot convert TNM to Summary Stage



SEER Summary Staging

- ◆ Epidemiologic Purposes
- ◆ (Population Information)

AJCC TNM System

- ◆ Individual Patient Assessment/Treatment
 - T=Tumor
 - N=Nodes
 - M=Metastasis

What is Summary Stage

Summary Stage Groups

- ❑ 0 In Situ
- ❑ 1 Local
- ❑ 2 Regional by Direct Extension (D.E.)
- ❑ 3 Regional Lymph Nodes only involved
- ❑ 4 Regional by *both* D.E. and to Regional Nodes
- ❑ 5 Regional, NOS
- ❑ 7 Distant Sites and/or Distant Nodes
- ❑ 8 Brain/CNS (benign or borderline), Not applicable
- ❑ 9 Unknown

The Summary Stage 2000 Manual

Housekeeping:

❑ Paper Manual - Needs updating with Errata

Updates and Errata

- [Updates to Manual and Files \(12/2012\)](#) [105 KB]
- [Errata \(8/20/2002\)](#) [30 KB]
- [Errata \(6/14/2001\)](#) [21 KB]

<http://seer.cancer.gov/tools/ssm>

- Stage Group 8 - added in 2003
- Histology codes added to some schema
- Clarifications to notes in some schema
- **TNM references not current**; they are from the AJCC 5th Edition
 - ✓ Check AJCC 7th Ed definitions to compare definitions; especially important for PROSTATE
- **FIGO stage references are from 2000; FIGO was updated in 2010**

Summary Stage Manual

Housekeeping:

- ❑ **Online Manual Recommended:** <http://seer.cancer.gov/tools/ssm>

Updates and Errata

- [Updates to Manual and Files \(12/2012\)](#) [105 KB]
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Manual Sections

- [Introduction to Summary Staging](#) [552KB]
- [Head and Neck](#) [403 KB]
- [Digestive System](#) [769 KB]
- [Respiratory Tract and Thorax](#) [371 KB]
- [Musculoskeletal System](#) [173 KB]
- [Breast and Female Genital System](#) [274 KB]
- [Male Genital System](#) [195 KB]
- [Urinary System](#) [322 KB]
- [Eye](#) [108 KB]
- [Brain and Central Nervous System](#) [391 KB]
- [Endocrine System](#) [41 KB]
- [Other Sites](#) [90 KB – updated 12/2012]
- [Appendices and Index](#) [108 KB]

[Complete SEER Summary Staging Manual – 2000](#) [3.5 MB – updated 12/2012]

- **Online manual contains all updates with the exception of code 8**
 - Remember Code 8 does exist

Summary Stage Manual

- ❑ Review SS2000 Manual: **Know how to use the manual before you start**
- ❑ Read first chapters carefully-lots of good info!

TABLE OF CONTENTS

NOTE: The site-specific schemes in this manual are in ICD-O-3 order, with a few exceptions. If a site or subsite is not found in the table of contents or index, determine the ICD-O-3 code and locate the site sequentially.

Foreword and Acknowledgments	1
Summary Staging	2
Guidelines by Stage	3
General Instructions for Using the SEER Summary Staging Manual - 2000	10
Guidelines for Summary Staging	11
How to Assign Summary Stage	12
Abbreviations, Acronyms, and Symbols	13
Definitions of Terms Used in this Manual	14
Interpreting Ambiguous Terminology for Summary Stage	15

Summary Stage Manual

General Instructions for Using the SEER Summary Staging Manual - 2000

The SEER Summary Staging Manual - 2000 schemes consist of a one-digit hierarchical code for each and every site. In the United States, these staging schemes will apply to January 1, 2001 diagnoses and later.

General Guidelines

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.
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.
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.
4. Exclude any metastasis known to have developed after the diagnosis was established.
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.
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.
7. Autopsy reports are used in coding summary stage just as are pathology reports, applying the same rules for inclusion and exclusion.
8. Death Certificate Only cases and unknown primaries are coded '9' for summary stage.
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.
10. Site-specific guidelines take precedence over general guidelines. Always consider the information pertaining to a specific site.

Include

Review
Carefully

Caution
TNM references out
of date

Exclude

Site Specific Rules

Summary Stage Manual

- ❑ **Instructions & guidelines are all in the first 15 pages!**
 - Includes description and overview of the Summary Stage codes 0-9
 - Includes definitions of terms used in manual

- ❑ **Site specific chapters are in ICD-O-3 primary/site order**
 - Exception: Lymphoma/Leukemia/Kaposi sarcoma & other hematopoietic cancers are based on histology specific scheme.
 - Many anatomic drawings included and tables for reference.

- ❑ **Each site specific schema provides:**
 - Definitions, names organ structures, tissues, regional and distant lymph nodes and metastatic sites.
 - Anatomic drawings and Notes for coding consideration.

Summary Stage Manual - Scheme example

COLON

C18.0-C18.9
 C18.0 Cecum
 C18.1 Appendix
 C18.2 Ascending (right) colon
 C18.3 Hepatic flexure of colon
 C18.4 Transverse colon
 C18.5 Splenic flexure of colon
 C18.6 Descending (left) colon
 C18.7 Sigmoid colon
 C18.8 Overlapping lesion of colon
 C18.9 Colon, NOS

SUMMARY STAGE

0 In situ: Noninvasive; intraepithelial
 (Adeno)carcinoma in a polyp or adenc

1 Localized only

Invasive tumor confined to:

- Intramucosa, NOS
- Lamina propria
- Mucosa, NOS
- Muscularis mucosae
- Muscularis propria
- Perimuscular tissue invaded
- Polyp, NOS:
 - Head of polyp
 - Stalk of polyp
- Submucosa (superficial invasion)
- Subserosal tissue/(sub)serosal fat
- Transmural, NOS
- Wall, NOS

Confined to colon, NOS
 Extension through wall, NOS
 Invasion through muscularis propria or mu

Localized, NOS

2 Regional by direct extension only

Extension to:
All colon sites:
 Invasion of/through serosa (mesothelium) (visceral perit
 Extension into/through:
 Abdominal wall^{###}
 Adjacent tissue(s), NOS
 Connective tissue
 Fat, NOS
 Greater omentum
 Mesenteric fat
 Mesentery
 Mesocolon
 Pericolonic fat
 Retroperitoneum (excluding fat)^{###}
 Small intestine

Ascending colon:
 Kidney, right^{###}
 Liver, right lobe
 Retroperitoneal fat^{###}
 Ureter, right^{###}

Transverse colon and flexures:
 Bile ducts^{###}
 Gallbladder^{###}
 Gastrocolic ligament
 Kidney
 Liver
 Pancreas
 Spleen
 Stomach^{###}

Descending colon:
 Kidney, left^{###}
 Pelvic wall^{###}
 Retroperitoneal fat^{###}
 Spleen
 Ureter, left

Sigmoid colon:
 Pelvic wall^{###}

3 Regional lymph node(s) involved only

REGIONAL Lymph Nodes

All colon subsites:
 Colic, NOS
 Epicolic (adjacent to bowel wall)
 Mesenteric, NOS
 Paracolic/pericolic

Nodule(s) in pericolic fat

Cecum and Appendix:
 Cecal, NOS
 Anterior (prececal)
 Posterior (retrocecal)
 Ileocolic
 Right colic

Ascending colon:
 Ileocolic
 Middle colic
 Right colic

Transverse colon and flexures:
 Inferior mesenteric for splenic flexure only
 Left colic for splenic flexure only
 Middle colic[‡]
 Right colic for hepatic flexure only

Descending colon:
 Inferior mesenteric
 Left colic
 Sigmoid^{###}

Sigmoid:
 Inferior mesenteric
 Sigmoidal (sigmoid mesenteric)
 Superior hemorrhoidal^{###}
 Superior rectal^{###}

Regional lymph node(s), NOS

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

Codes (2) + (3)

Note: Ignore intraluminal extension to adjacent segment(s) of colon/rectum or to the ileum from the cecum.



Summary Stage Code Review

Stage 0 - IN SITU

- **In-situ is defined as malignancy without invasion.**
- **No potential to metastasize**
- No invasion of the basement membrane
- No lymph-vascular invasion
- No foci of invasion present
- No micro-invasion present
- No evidence of nodal involvement
- **Can only be determined pathologically - can never be a clinical diagnosis**

IN SITU- Is it really ?

Be careful when reading pathology report

Example 1:

Large in situ carcinoma of breast with 3 of 15 axillary nodes positive for cancer

Example 2:

Final diagnosis of carcinoma in situ with focus of microinvasion on the lateral margin.

Would you stage either of these in situ?

No

Stage 1 - LOCAL

- ❑ There is infiltration past the basement membrane into functional part of organ-*but not beyond*.
- ❑ Cancer must be confined to the organ of origin
- ❑ A tumor can show metastases *within* the organ itself and still be confined to the organ of origin-localized
- ❑ Rule out any nodal involvement
- ❑ Rule out extension to regional organ(s) or tissues
- ❑ Rule out distant disease

Example: 1.2 cm adenoca sigmoid colon with focal invasion of muscularis propria; 0/13 regional LNs positive. CT Ab/Pelvis no evidence of disease.
Code as Stage 1 Local disease

Stage 1- LOCALIZED – Special notes

□ If still within the organ of origin

- Blood vessel invasion
- Perineural lymphatic invasion
- Vascular invasion

OR

- Multiple tumors, same cell type
- Metastases within the organ of origin
- Multifocal disease

Does not change the stage
“Indicates - *Potential* for Spread”

Regional Disease Stages 2 , 3, 4 or 5

- ❑ Regional tumors may demonstrate metastases via direct extension, via regional lymphatics or *both*.
- ❑ Regional Disease is the Broadest Category
- ❑ **Subdivided into Stages 2-5**
 - Stage 2- Regional by Direct Extension
 - Tumor through entire wall of organ into surrounding organ or adjacent tissues
 - Tumor has demonstrated it can metastasize by direct extension.
- ❑ **Example: Descending colon adenoca with extension completely through bowel wall extending to and adherent to pelvic side wall.**
 - **Code as Stage 2 Regional by direct extension**

Regional Disease Stages 3 & 4

- ❑ **Stage 3- Invasion of Regional Lymph Nodes only**
 - **Example: Infiltrating ductal breast carcinoma with 1/2 sentinel lymph nodes positive for mets.**
 - Tumor is confined to the breast and regional LNs are involved.

- ❑ **Stage 4- Both Direct Extension & Positive Lymph Nodes**
 - **Example: Endometrial ca extending into vagina with 6/17 pelvic LNs positive**
 - Tumor directly extends out of the organ of origin to adjacent tissues or structure AND involvement of regional lymph nodes.

Stage 5- Regional, NOS

- ❑ **Unclear whether tissues are involved by direct extension or if lymph nodes involved**
 - ❑ Insufficient workup
 - ❑ Evidence of disease is more than local but less than distant
 - ❑ LNs status unknown
 - ❑ Clinical diagnosis only
 - ❑ MD statement only of “regional disease”
 - ❑ Other categories not applicable
- ❑ **Example: Invasive colon cancer without metastatic workup or surgical resection.**
- ❑ **NOTE: Regional NOS / Stage 5 is used for Lymphoma’s with 2 or more lymph node chains involved (same side of diaphragm).**

Stage 7 - DISTANT

Diffuse disease and/or advanced spread:

- to distant organs or tissues
- to distant nodes
- seeding in a body cavity
 - Peritoneal cavity or pleural cavity

Systemic cancers:

- Leukemia/Hematopoietic
- Multiple Myeloma

Always distant – Stage 7

Stage 8

Benign & Borderline CNS & Not Applicable

- ❑ **Benign & Borderline CNS**
 - Never use for malignant tumors

- ❑ **“Not applicable”**
 - Other benign/borderline reportable tumors

- ❑ **Code added in 2003**
 - Not in Manual (paper OR online)
 - Remember Code 8 exists!



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Stage 9 - Unknown

- Insufficient information to stage
- Patient expired before workup
- Patient refused workup
- Limited workup due to age, or comorbid conditions
- No MD statement regarding extent of disease
- Primary Site is Unknown -
- Death certificate only case
- Assign unknown stage sparingly
- ✓ Document the reason case is unknown stage in the text.

NOTE: If you have enough information to determine the case is not in situ and not distant, but somewhere in between, you should be able to stage the case!

Hodgkins & Non-Hodgkin Lymphoma—all sites

- ❑ **Site based on histology**
 - Can never be in situ - there is no basement membrane
- ❑ **Only Stages 1, 5, 7 or 9 apply**
 - **No stage 2, 3 or 4**
 - Stage 1- involvement of single lymph node region
 - Single extralymphatic organ/site
 - Multifocal involvement of one extralymphatic organ/site
 - Stage 5 – Involvement of 2 or more LN region on same side of diaphragm
- ❑ **Any mention of lymphadenopathy is considered involvement of nodes**

Malignant Brain and Meninges

Malignant brain and meninges

- ❑ Only Stages 1, 5, 7 or 9 possible

- ❑ Disease spread split between Stage 1 Local and Stage 5 Regional NOS
 - Read manual for involved tissues/spread.

- ❑ **Stage 3 & 4 not possible**
 - No anatomic lymph nodes nor nodal drainage area in these sites



Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative neoplasms

Leukemia, Multiple Myeloma and other hematopoietic diseases are “systemic” conditions

- Always Summary Stage 7 – Distant
- Localized Stage 1 allowable only for these histologies:
 - 9731/3 *Plasmacytoma of bone, solitary* (or Stage 7 or 9 as applicable)
 - 9734/3 *Plasmacytoma, extramedullary* (or Stage 7 or 9 as applicable)
 - 9750/3 *Malignant histiocytosis* (or Stage 7 or 9 as applicable)
 - 9751/3 *Langerhans cell histiocytosis NOS* (Stage 1 or 9 only)
 - 9752/3 *Langerhans cell histiocytosis, unifocal* (Stage 1 or 9 only)

Summary Stage – How To



Summary Stage - How to

Summary Stage Should Answer 4 basic Questions

1. Where did the cancer start? (primary site)
2. Where did the cancer go? (extent of disease)
3. How did the cancer get to the other organ or structure?
4. What is the correct stage / code for this cancer?

Summary Stage - How to

Understand How Cancer Spreads

Methods of spread:

- Local Invasion
- By direct extension beyond local organ
- Via lymphatic system
- Via blood-borne metastases
- Intracavitary metastatic seeding

How did the cancer get to the other organ or structure?

- Continuous line of cancer cells from the primary site
 - *Probably direct extension*
- Cancer cells break away from primary cancer and traveled through blood stream or body fluids?
 - *Probably distant*

Summary Stage - How to

- ❑ **Summary Stage Uses Ambiguous Terminology**
 - 2 lists of terms clarify whether or not a finding is part of the malignant process.
 - Instruct registrar to either
 - **Consider as Involvement, or...**
 - **Do Not Consider as Involvement**
- ❑ **Review terms to interpret tumor involvement & select correct stage.**

Summary Stage - How to

Summary Stage –Timing Rule

Should include all information through completion of surgery(s) in the first course of treatment

OR

Within four months of diagnosis in the absence of disease progression

--Whichever is longer—

- Disease progression is defined as further direct extension, regional node involvement, or distant metastasis known to have *developed after the diagnosis was established.*

Summary Stage – How To

Timing Rule Example:

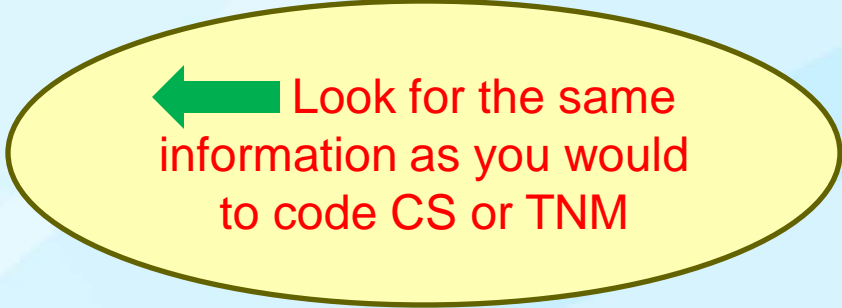
- ❑ 2/10 Prostate biopsy c/w Adenocarcinoma, Gleason 4+4
- ❑ 3/15 Radical Prostatectomy
- ❑ 7/01 Patient complains of hip pain
- ❑ 7/04 Bone scan reveals metastatic disease from prostate cancer

- ❑ Would you include all of this information to determine stage?
 - No - the bone scan is disease progression

Summary Stage- How To

Where to find information for staging:

- Admitting Notes
- History and Physical Exam
- Consultation Reports
- MD Progress Notes
- Discharge Summary
- Diagnostic Imaging Report(s)
- Endoscopy report(s)
- Operative Report(s)
- Pathology Report(s)
- Laboratory and Specialty Tumor markers
- Any records relevant to case



Look for the same information as you would to code CS or TNM

Reminders:

- ❑ **Summary Stages uses all clinical and pathologic info to code the highest applicable stage**
- ❑ **Clinicians do *not* document Summary Stage**



Summary Stage- How To

Determine the Extent of Disease

After you have reviewed the medical record:

- ❑ **Determine the primary site**
 - Select appropriate Summary Stage Schema
 - ICD-O-3 solid tumor scheme
 - Histology specific scheme

- ❑ **Review schema & match names of structures and organs involved**
 - Important: Carefully review the “NOTES” at the end of staging scheme for special rules.
 - If more than one structure or organ is involved, select the highest category that includes an involved structure.

Summary Stage - How to

COLON

- C18.0-C18.9
- C18.0 Cecum
- C18.1 Appendix
- C18.2 Ascending (right) colon
- C18.3 Hepatic flexure of colon
- C18.4 Transverse colon
- C18.5 Splenic flexure of colon
- C18.6 Descending (left) colon
- C18.7 Sigmoid colon
- C18.8 Overlapping lesion of colon
- C18.9 Colon, NOS

SUMMARY STAGE

0 In situ: Noninvasive; intraepithelial
(Adeno)carcinoma in a polyp or adenoma

1 Localized only

Invasive tumor confined to:

- Intramucosa, NOS
- Lamina propria
- Mucosa, NOS
- Muscularis mucosae
- Muscularis propria
- Perimuscular tissue invaded
- Polyp, NOS:
 - Head of polyp
 - Stalk of polyp
- Submucosa (superficial invasion)
- Subserosal tissue/(sub)serosal fat
- Transmural, NOS
- Wall, NOS

- Confined to colon, NOS
- Extension through wall, NOS
- Invasion through muscularis propria or mu

Localized, NOS

Note: Ignore intraluminal extension to adjacent segment(s) of

2 Regional by direct extension only

Extension to:

All colon sites:

- Invasion of/through serosa (mesothelium) (visceral perit
- Extension into/through:
 - Abdominal wall###
 - Adjacent tissue(s), NOS
 - Connective tissue
 - Fat, NOS
 - Greater omentum
 - Mesenteric fat
 - Mesentery
 - Mesocolon
 - Pericolic fat
 - Retroperitoneum (excluding fat)###
 - Small intestine

Ascending colon:

- Kidney, right###
- Liver, right lobe
- Retroperitoneal fat###
- Ureter, right###

Transverse colon and flexures:

- Bile ducts###
- Gallbladder###
- Gastrocolic ligament
- Kidney
- Liver
- Pancreas
- Spleen
- Stomach###

Descending colon:

- Kidney, left###
- Pelvic wall###
- Retroperitoneal fat###
- Spleen
- Ureter, left

Sigmoid colon:

- Pelvic wall###

3 Regional lymph node(s) involved only

REGIONAL Lymph Nodes

All colon subsites:

- Colic, NOS
- Epicolic (adjacent to bowel wall)
- Mesenteric, NOS
- Paracolic/pericolic

Nodule(s) in pericolic fat

Cecum and Appendix:

- Cecal, NOS
 - Anterior (prececal)
 - Posterior (retrocecal)
- Ileocolic
- Right colic

Ascending colon:

- Ileocolic
- Middle colic
- Right colic

Transverse colon and flexures:

- Inferior mesenteric for splenic flexure only
- Left colic for splenic flexure only
- Middle colic[¥]
- Right colic for hepatic flexure only

Descending colon:

- Inferior mesenteric
- Left colic
- Sigmoid###

Sigmoid:

- Inferior mesenteric
- Sigmoidal (sigmoid mesenteric)
- Superior hemorrhoidal###
- Superior rectal###

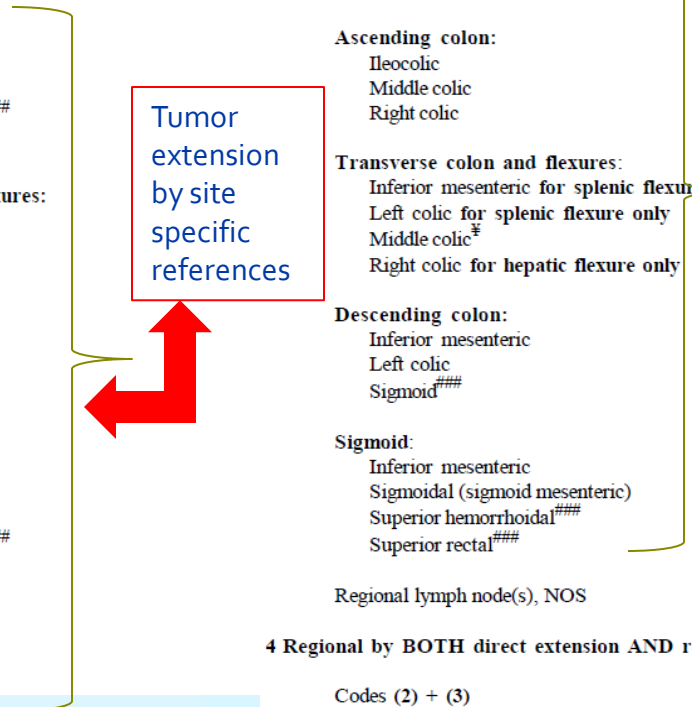
Regional lymph node(s), NOS

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

Codes (2) + (3)

Tumor extension by site specific references

Site Specific Lymph Nodes by tumor location



Summary Stage – How To Determining Stage - Process of Elimination

What Can Be Ruled Out?

- ❑ ***First Rule out In situ or distant disease, or benign reportable disease.***
 - These are the easiest to quickly identify and rule out

- ❑ ***Then Rule out Localized disease***
 - Has the disease spread outside the outer limits of the organ or origin?
 - Remember vascular invasion, perineural invasion, blood vessel invasion – does not change stage

- ❑ ***Determine if it's Regional disease:***
 - If other stages have been ruled out - then the stage is regional
 - Lymph node involvement NOS – stage is “at least” regional nodes
 - Assume ipsilateral, unless stated otherwise

- ❑ ***Is Stage Unknown:***
 - Unknown primary site or Not enough Information

About Lymph Nodes - Site Specific

- ❑ **Each Site Specific scheme/chapter lists:**
 - Regional Lymph Nodes
 - Distant Lymph Nodes
- ❑ **If LN chain is not listed as regional or distant in SS2000**
 - Determine if LN in medical record is a synonym for one listed in SS*
 - If term not synonymous, can assume LNs are distant
 - If MD refers to “*local nodal involvement*” **Summary Stage is still regional per rules** so code accordingly. (See slide 39)
- ❑ ***Review Appendix III in SS2000 Manual for LN synonyms**
 - Example: Superficial axillary (low axillary) (Level 1 axillary)
- ❑ **Excellent additional reference for LN names is the AJCC Staging Manual**
 - ✓ ***DOCUMENT / NAME “INVOLVED” NODES IN TEXT!***

About Lymph Nodes – Solid Tumors

- ❑ ***Don't Overstage:***
 - Palpable, visible, swelling or shotty lymph nodes are not considered involved
 - Enlarged nodes or lymphadenopathy should be ignored **EXCEPT** for lung.
- ❑ Terms “fixed or matted lymph nodes” or “mass in the mediastinum, retroperitoneum, and/or mesentery are considered involvement of lymph nodes (With no specific information [stated] as to tissue involved)
- ❑ **Any unidentified nodes included with resected primary site specimen are to be considered as *regional LNS***

About Lymph Nodes & Terms

Ambiguous Lymph Node Terms Table

TUMOR	INVOLVED	TUMOR	NO INVOLVEMENT
SOLID TUMORS	Fixed, matted mass in the mediastinum, retroperitoneum and/or mesentery	SOLID TUMORS	Palpable, visible, swelling, shotty (without clinical or path statement)
LUNG	Enlarged, Lymphadenopathy	SOLID TUMORS (Except Lung)	Enlarged, Lymphadenopathy
LYMPHOMAS	Any mention of lymph nodes		

- **However: MD/clinical statement of involvement takes precedence over terms**

About Lymph Nodes – Inaccessible Sites

SITES

Lung

Esophagus

Kidney

Prostate

Corpus Uteri

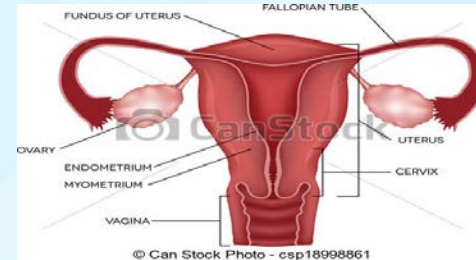
Liver

Stomach

Bladder

Ovary

- ❑ Review CT's/PET
- ❑ Surgical Observations by MD



About Lymph Nodes

TNM Stage and Summary Stage Differences


- ❑ Some lymph nodes in Summary stage schemes may be regional but distant per TNM *and vice versa*.
- ❑ **Prostate Example**
 - 71-year old male
 - Negative metastatic imaging workup
 - Pathology reveals Adenoca of prostate bilaterally
 - 2 of 8 pelvic LNs positive
 - Summary Stage = Regional LNs involved, Stage 3
 - AJCC TNM = T2c N1 M0 Stage IV
- ❑ **Remember you cannot convert TNM to Summary Stage**

Abstractor Tips

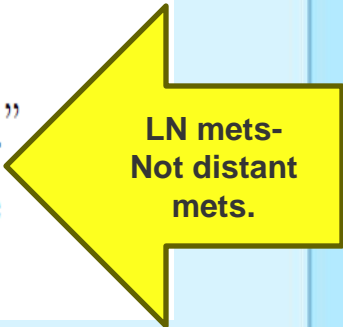
➤ Physicians may use words differently than registrars

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.



If LNs are involved it's not local



LN mets-
Not distant
mets.

Abstractor Tips

- ❑ **If all malignant tissue is not removed**
 - Include information from gross surgical observation about any observed tumor involvement.
- ❑ **Disagreement concerning excised tissue**
 - Pathology report has precedence over operative report
- ❑ **Operative/pathology disproves clinical information**
 - Operative/pathology has precedence over clinical information

Abstractor Tips

- ❑ If pathology reports contain **statements of invasion, nodal-involvement or metastatic spread-** the case cannot be staged **as *in situ*** even if the pathology of the tumor states it.
- ❑ If there are **nodes involved**, the **stage** must be **at least regional**.
- ❑ If there are nodes involved but the chain is not named in the medical record or path report, ***assume the nodes are regional***.
- ❑ For regional tissues, structures, and LNs, ***assume ipsilateral unless stated to be contralateral or bilateral***.

Abstractor Tips

- A 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 (lymphatic or blood-borne metastases).**
- If the record does not contain enough information to assign a stage, it must be recorded as unstageable.

Abstractor Tip- Accuracy of Text/Data

❑ Review your case/text

- Does your text support the summary stage coded?
- Name the involved LNs in text.
- If disease is Regional NOS, does text document situation, MD statement, limited info, etc.
- If stage is unknown, did you document situation, unknown primary, insufficient info, etc.

❑ Any staging conflicts?

- In situ stage with only a clinical diagnosis **is impossible**

❑ **Text review is important for quality abstracting and future data usage**

Staging Exercises

Prostate – How would you stage this case?

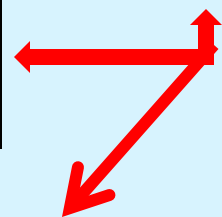
- ❑ 68 year old male admitted through ER with right hip fracture
- ❑ X-rays suggested pathologic fracture and bone scan confirmed metastatic disease in pelvis and femurs.
- ❑ PSA was elevated to over 600.
- ❑ Prostate biopsies were done with the findings of poorly differentiated adenocarcinoma.
- ❑ **Answer: Summary Stage 7- Distant bone metastases**

Important!

TNM definitions in Summary Stage 2000 from AJCC 5th Edition

PROSTATE CANCER SUMMARY STAGE VS AJCC T,N,M Definitions						
<p>NOTICE: SEER Summary Stage 2000 Manual has explanations of extension which refer to the <u>AJCC 5th Edition</u> TNM "codes"</p> <ul style="list-style-type: none"> In some cases the <u>T, N or M definitions changed from the AJCC 5th to 6th to 7th Edition TNM staging Manual and are incorrect in SS2000.</u> Example below: Note T, N, M definitions that have changed (highlighted in pink). 						
AJCC EDITION	5 th Edition		6 th Edition		7 th Edition	
	CLINICAL	PATHOLOGIC	CLINICAL	PATHOLOGIC	CLINICAL	PATHOLOGIC
T2a	Involves one lobe	Unilateral	Involves one-half of one lobe or less	Unilateral, one-half of one lobe or less	Involved one-half or one lobe or less	Unilateral, one-half of one side or less
T2b	Involves both lobes	Bilateral	Involves more than one-half of one lobe but not both lobes	Unilateral, involving more than one-half of lobe but not both lobes	Involved more than one-half of one lobe but not both lobes	Unilateral, involving more than one-half of side but not both sides
T2, NOS	Confined within prostate	Organ Confined	Confined within prostate	Organ confined	Confined within prostate	Organ confined

Caution when selecting stage based only on TNM statement



T4, NOS in SS2000 Manual = Code 2 / Regional by direct extension
 T4 in AJCC 7th Edition = Stage IV disease (any T4 tumor is automatically stage IV disease)

Colon #1 – How would you stage this case?

- ❑ Patient presented with history of bloody stool. Colonoscopy confirmed tumor in the transverse colon.
- ❑ Patient underwent surgery with findings of poorly differentiated adenocarcinoma.
- ❑ Path report noted extension through the serosa.
- ❑ 5 nodes were removed with 4 positive for tumor.
- ❑ A liver biopsy at time of surgery was negative for mets.
- ❑ **Answer- Summary Stage 4 -regional by both direct extension (through serosa) and regional Lymph nodes positive for involvement (Codes 2 +3)**

Colon #2 – How would you stage this case?

- ❑ Patient found to have large mass in the hepatic flexure of colon on colonoscopy.
- ❑ CT scan revealed 7cm section of hepatic flexure/transverse colon adherent to the right lobe of liver with likely tumor infiltration c/w metastatic disease to the liver. Suspicious enlarged regional LNs likely indicative of metastatic involvement.
- ❑ Patient underwent hemicolectomy and partial liver wedge resection. Path revealed 5cm adenocarcinoma extending through bowel wall with direct invasion into the liver. 0/15 regional LNs positive.
- ❑ **Answer: Summary Stage 2- regional by direct extension only**

Breast #1– How would you stage this case?

- ❑ Patient presented after noting a mass in her left breast. Physical exam stated there was no discharge or retraction of the nipple.
- ❑ Physical exam revealed enlarged axillary lymph nodes.
- ❑ Needle biopsy identified infiltrating ductal carcinoma, moderately differentiated.
- ❑ A modified radical mastectomy identified tumor had infiltrated the dermis. Ten axillary nodes were examined and three were found to be involved.
- ❑ **Answer: Summary Stage 4 - Direct extension to dermis *and* regional nodal involvement (codes 2+3)**

Breast #2– How would you stage this case?

- ❑ Patient presented after noting a mass in her left breast. Physical exam stated there was no discharge or retraction of the nipple.
- ❑ Physical exam revealed enlarged axillary lymph nodes which MD considered likely involved.
- ❑ Needle biopsy identified infiltrating ductal carcinoma, moderately differentiated
- ❑ A modified radical mastectomy revealed 1.8 cm invasive ductal carcinoma. Ten axillary nodes were examined and found negative
- ❑ **Answer: Summary Stage 1 – Localized disease only**

Breast #3– How would you stage this case?

- ❑ 81-year old patient presented with a hard nodule in her right breast with biopsy positive for infiltrating ductal carcinoma.
- ❑ She subsequently had work up and opted for a modified radical mastectomy results of which are not available
- ❑ Per MD following surgery she elected not to undergo any further workup or treatment for her regional disease.
- ❑ **Answer: Summary Stage 5 - Regional Disease not otherwise specified**

Lung – How would you stage this case?

- ❑ Patient found to have a solitary mass in the LUL on CXR.
- ❑ Biopsy is positive for Adenocarcinoma.
- ❑ CT Scan reveals 3cm LUL mass with bilateral mediastinal lymphadenopathy.
- ❑ Bone Scan is Negative
- ❑ **Answer: Distant LNs Stage 7- positive *bilateral* mediastinal lymph nodes**

SUMMARY

SUMMARY

- ❑ **Know how to use the SS2000 Manual**
 - Download SS2000 Errata for paper manual- Online Manual preferred
 - Stage 8 for benign/borderline brain added in 2003
 - First 15 pages contain most of the Guidelines and Instructions- READ!
 - Review notes about lymph nodes

- ❑ **Use list of Ambiguous Terms for determining involvement**
 - Instruct to “Consider as involvement”
 - Or “Do Not Consider as involvement”

SUMMARY

- ❑ **Site Specific chapters (organized by ICD-O-3 primary site)**
 - ✓ Exception: Lymphoma/Leukemia/Kaposi sarcoma have histology specific schemes
 - Regional tissues and nodes are listed for each site
 - Anatomy diagrams and tables available
 - **Pay attention to any special notes at end of scheme**

- ❑ **Site Specific rules (relatively few)**
 - Most Hematopoietic disease coded as distant code 7
 - Any mention of lymph nodes is indicative of involvement
 - Unknown Primary / Death Certificate cases always code 9

Summary

- ❑ **Summary Stage can be used for pediatric cancers**
 - No specific pediatric scheme-stage as you would an adult.
- ❑ **Cannot convert TNM to Summary Stage & vice versa**
- ❑ **References to TNM and FIGO stage are out of date**
 - Use caution

SUMMARY

❑ **Staging Strategy - Process of Elimination**

- Four of the summary stage categories can be ruled out quickly:
 - Benign, In-situ, Localized and Distant.
 - If review of records documents distant mets, the registrar can avoid reviewing further because all other categories are surpassed.

❑ **Always assign highest code associated with involved structures**

SUMMARY

- ❑ **SEER Summary Stage 2000 bases staging of solid tumors solely on how far a cancer has spread from its point of origin.**
- ❑ **It is an efficient tool to categorize how far the cancer has spread from the original site as the staging categories are broad enough to measure the success of cancer control and other epidemiologic efforts**
- ❑ **Uses Information within four (4) months of diagnosis**
- ❑ **Summary Stage is a combination of the most precise *clinical and pathologic* documentation of the extent of disease**
- ❑ **Summary Stage applies to every anatomic site.**

Excellent Resources for Summary Staging

SEER Summary Stage 2000 Manual:

- http://seer.cancer.gov/manuals/2013/SPCSM_2013_maindoc.pdf

SEER Summary Stage 2000, SEER Training modules:

- <http://training.seer.cancer.gov>
- http://training.seer.cancer.gov/modules_site_spec.html

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- ❑ **Mary Lewis, CTR “Guidelines for Assign SS2000”**
- ❑ **Steve Peace, CTR “Summary Stage 2000 Introduction and General Rules”**

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