Supplemental Table 1. Results of Delphi Round One Surveys

Principle Statement	No. Responses	Percent Agreement*	Median Score (IQR)[%]
Cancer registries should routinely collect disease stage data for cases of pediatric cancer.	**25**	**100**	**1 (1-2)**
A primary reason for collecting disease stage in cancer registries is to allow stratified comparison of outcomes between groups or over time.	**25**	**96**	**2 (1-2)**
A primary reason for collecting disease stage in cancer registries is to identify trends in late presentation through the proxy of advanced stage at diagnosis.	**25**	**84**	**2 (1-2)**
Stage should reflect the extent of disease.	**25**	**96**	**1 (1-2)**
Stage data in cancer registries do not need to be as detailed as stage data for the purposes of clinical decision-making.	25	48	3 (2-4)
Staging systems used in pediatric cancer registries should be as simple yet informative as possible.	**25**	**96**	**1 (1-2)**
TNM based staging systems used in adult patients are of limited use for pediatric cases.	24	71	2 (1.75-3)
Cancer registries should routinely use pediatric specific staging systems for childhood cancer cases.	**25**	**96**	**2 (1-2)**
For malignancies common in both pediatric and adult populations (e.g. Hodgkin lymphoma, testicular cancer), staging systems should be the same across both populations.	**25**	**80**	**2 (1-2)**
Stage should be measured uniformly across all pediatric cancer registries globally to ensure comparability.	**25**	**92**	**1 (1-2)**
Different pediatric staging systems for the same disease have been developed by different clinical trial organizations; any staging system that is adopted for pediatric cancer registration needs to reconcile these differences.	**25**	**76**	**2 (1-2)**
When staging pediatric malignancies, clinical staging (i.e. staging at the time of diagnosis) is important and should be collected.	**25**	**92**	**1 (1-2)**
When staging pediatric malignancies, pathologic staging (i.e. staging at the time of surgery/resection) is important and should be collected.	25	68	2 (1-3)
Clinical and pathologic staging classification systems should be identical, and differ only in the time point of collection.	23	35	3 (2-4)
Cancer registries should collect the methods of evaluation by which stage was determined (e.g. diagnostic modalities).	25	56	2 (1-3)
Given significant differences in diagnostic capabilities, staging systems appropriate to settings with limited diagnostic and evaluation capabilities are needed.	**25**	**84**	**1 (1-2)**
Staging systems designed for resource-limited settings with few diagnostic capabilities should be, when possible, based on collapsing traditional stages used in resource-rich settings, thus preserving a degree of comparability.	**24**	**83**	**1 (1-2)**
Online tools and/or algorithms that assign stage based on inputted data (e.g. involved sites of disease) are helpful when staging pediatric malignancies.**	**25**	**80**	**2 (1-2)**

IQR – interquartile range; No. – number

*Agreement was defined as scores of 1 or 2; [%]1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree, 5=strongly disagree

**This statement was removed after the face-to-face meeting as it pertained to dissemination methods and not a core guiding principle.

Bolded principles indicate those achieving consensus by definitions outlined in text