## Case Scenario 1

**History**

79 year-old white male presents with hematuria and urinary frequency.

**Imaging**

3/25/12 CT IVP: Large bladder mass causing obstruction of the left ureter. Findings are worrisome for transitional cell carcinoma.

3/30/12 CT Chest/Abdomen/Pelvis:

1. Large transitional cell carcinoma in the left side of the urinary bladder involving the trigone and possibly extending into the distal left ureter. This results in left-sided hydronephrosis. There are lymph node metastases in the left side of the pelvis.
2. No evidence of urinary obstruction on the right.
3. Mild wall and fold thickening involving loops of jejunum consistent with some form of enteritis. There is no associated obstruction or perforation.
4. Colonic diverticulosis without evidence of diverticulitis.

4/30/12 PET/CT: Widespread osseous metastases. Malignant appearing lymph nodes identified in the posterior mediastinum and retroperitoneum of the abdomen and pelvis most concentrated in the left periaortic and left external iliac lymph node chain. Right hydronephrosis.

**Procedure**

4/2/12 Cystoscopy/TUR of large (greater than 5 cm) bladder tumor: The 23-French cystoscope was passed through the urethra into the bladder, and large tumor encountered at the bladder neck immediately. There was mild prostatic hypertrophy, but it appeared the bladder tumor was causing outlet obstruction which is probably the cause of his lower urinary tract symptoms. The tumor involved most of the trigone and completely obscured the left orifice and I was unable to identify the right orifice either. The tumor extended up along the left wall of the bladder towards the dome and came up to the bladder neck. The rest of the bladder was difficult to examine and was heavily trabeculated with multiple cellules however no other lesions were readily identified. The cystoscope was removed and the 24-French resectoscope sheath and obturator were inserted. Using the Iglesias resectoscope and 24 loop the bladder tumor was resected. After all specimens had been irrigated out the bladder and the resection site cauterized for hemostasis and control of any active bleeding areas, I attempted to identify the ureteral orifices, which had been resected through. However, I was still unable to identify them, therefore retrograde pyelograms could not be performed at this time. It is my impression that this tumor probably is muscle invasive and on bimanual exam, the bladder base seems to be fixed which would be consistent with this as well.

**Pathology**

4/2/12 High grade carcinoma with features of poorly differentiated neuroendocrine carcinoma and adenocarcinoma. Extensive invasion of deep muscularis propria is identified. Extensive lymph-vascular invasion is identified.

Patient opted for no treatment and went to hospice.

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| * **How many primaries are present in this case scenario?** * **How would we code the histology of the primary you are currently abstracting?** | | | | * **What is the diagnosis date?** * **What is the sequence?** | | |
| **Stage/ Prognostic Factors** | | | | | | |
| CS Tumor Size |  | | CS SSF 9 | | 988 | |
| CS Extension |  | | CS SSF 10 | | 988 | |
| CS Tumor Size/Ext Eval |  | | CS SSF 11 | | 988 | |
| CS Lymph Nodes |  | | CS SSF 12 | | 988 | |
| CS Lymph Nodes Eval |  | | CS SSF 13 | | 988 | |
| Regional Nodes Positive |  | | CS SSF 14 | | 988 | |
| Regional Nodes Examined |  | | CS SSF 15 | | 988 | |
| CS Mets at Dx |  | | CS SSF 16 | | 988 | |
| CS Mets Eval |  | | CS SSF 17 | | 988 | |
| CS SSF 1 |  | | CS SSF 18 | | 988 | |
| CS SSF 2 |  | | CS SSF 19 | | 988 | |
| CS SSF 3 |  | | CS SSF 20 | | 988 | |
| CS SSF 4 | 988 | | CS SSF 21 | | 988 | |
| CS SSF 5 | 988 | | CS SSF 22 | | 988 | |
| CS SSF 6 | 988 | | CS SSF 23 | | 988 | |
| CS SSF 7 | 988 | | CS SSF 24 | | 988 | |
| CS SSF 8 | 988 | | CS SSF 25 | | 988 | |
| **Treatment** | | | | | | |
| Diagnostic Staging Procedure | |  |  | | |  |
| **Surgery Codes** | |  | **Radiation Codes** | | |  |
| Surgical Procedure of Primary Site | |  | Radiation Treatment Volume | | |  |
| Scope of Regional Lymph Node Surgery | |  | Regional Treatment Modality | | |  |
| Surgical Procedure/ Other Site | |  | Regional Dose | | |  |
|  | |  | Boost Treatment Modality | | |  |
| **Systemic Therapy Codes** | |  | Boost Dose | | |  |
| Chemotherapy | |  | Number of Treatments to Volume | | |  |
| Hormone Therapy | |  | Reason No Radiation | | |  |
| Immunotherapy | |  |  | | |  |
| Hematologic Transplant/Endocrine Procedure | |  |  | | |  |

## Case Scenario 2

**History**

52 year-old white female presents with hematuria, back pain, lower extremity swelling, and itching.

**Imaging**

4/25/12 CT Abdomen/Pelvis: There is a moderate bilateral hydronephrosis and ureterectasis to the lower pelvic region where the ureters cannot be followed with certainty without IV contrast. The findings are consistent w/obstructive uropathy. Given the fact that there is diffuse bladder wall thickening and also calcification and/or a focal mass in the posterolateral aspect of the bladder, this is likely the cause of the obstructive uropathy. The findings in the bladder could be inflammatory and/or neoplastic in nature. There are numerous tiny sclerotic areas seen in the visualized skeleton. This is moderately worrisome for skeletal metastases, and a bone scan would be helpful for further evaluation. 4/28/12 CT Abdomen/Pelvis:

1. A 4.8 cm heterogeneous soft tissue density involving the right bladder wall could be due to neoplasm and/or hemorrhage.
2. Few prominent inguinal lymph nodes measuring up to 1 cm.
3. Bilateral hydronephrosis, right greater than left. Left ureteral stent.
4. Colonic diverticulosis most notably in the sigmoid colon.
5. Diffuse punctate to small sclerotic osseous lesions. Differential includes a benign process such as osteopoikilosis versus metastatic disease. Comparison with prior studies, if available, and/or further evaluation with a bone scan is suggested.

**Surgical Reports**

4/26/12-Cystoscopy with biopsy

5/3/12-Pelvic exenteration

**Pathology**

4/26/12 Bladder Biopsy: Poorly differentiated malignant neoplasm

5/3/12 Final Diagnosis:

1. Small bowel mesentery biopsy: Metastatic high-grade urothelial carcinoma involving mesenteric soft tissue and lymph nodes.
2. Right ovarian vein biopsy: Involvement of vein wall and surrounding soft tissue by invasive high-grade urothelial carcinoma.
3. Left distal ureter excision: No evidence of tumor.
4. Right distal ureter excision: No evidence of tumor.
5. Pelvic exenteration: Urinary bladder with invasive high-grade urothelial carcinoma.
   1. Tumor size: 3.8 x 3.0 x 2.7 cm
   2. Extent of invasion: Tumor invades through the full-thickness of the bladder wall and extensively permeates into perivesical soft tissues.
   3. Lymph-vascular invasion: Present.
   4. Margins: Tumor is present at the inked peripheral perivesical and right periureteral soft tissue margin; urethral, distal vaginal and bilateral ureteral margins are clear.
   5. Tumor does not involve the uterine corpus, cervix, vagina, or ovaries.
   6. Bilateral periadnexal/peritubal soft tissues are extensively permeated by tumor
   7. Metastatic carcinoma involves a single right perivesical lymph node.

PATHOLOGIC STAGE: pT3b pN1 pM1 (See comment).

Diagnostic Comments: The pathologic M1 stage is based on the presence of metastatic disease within the small bowel mesenteric soft tissues and mesenteric lymph nodes. The pN1 stage is based on the identification of a single perivesical lymph node involved by metastatic carcinoma.

**Oncology**

Chemotherapy recommended; patient unable to be reached to start treatment.

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