OVARY Abstracting Tips 2023 and Beyond

THIS IS ONLY A GUIDE/TIPS – BE SURE TO USE YOUR MANUALS

Number of Primaries:

For 2023+ cases, use the Other Sites rules for cases diagnosed 1/1/2023 forward. (https://seer.cancer.gov/tools/solidtumor/)

Follow the rules in order, but here are two that apply to Ovary:

1) Rule M9: Bilateral epithelial tumors (8000-8799) of the ovary within 60 days are a single primary. Tumors must be the same histology or be an NOS and subtype/variant.

2) Rule M10: Tumors on both sides (right & left) of a site listed in Table 1 are multiple primaries.

3) Rule M17 Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3, Table 3-21 in the Equivalent Terms and Definitions. Note: The tumors may be subtypes/variants of the same or different NOS histologies: • Same NOS: Micropapillary carcinoma of stomach 8265/3 and mucinous adenocarcinoma of stomach 8480/3 are both subtypes of adenocarcinoma, NOS of stomach but are distinctly different histologies. Abstract multiple primaries. • Different NOS: Myxofibrosarcoma 8811/3 is a subtype/variant of fibrosarcoma, NOS 8810/3; myxoid liposarcoma 8852/3 is a subtype liposarcoma, NOS 8850/3. They are distinctly different histologies. Abstract multiple primaries.

For a bilateral fallopian tube primary diagnosed 2007 or later, abstract as two primaries using Rule M10. (The pathologist may stage it as T1b or T1c because AJCC staging says a T1 tumor is limited to one *or both* tubes. SS2018 code 1 also includes tumor limited to one *or both* tubes.)

Date of Diagnosis:

May be the date of imaging (possibly due to mets), physician statement of ovarian cancer, date of biopsy (would most likely be a site other than the primary), or date of surgery.

Primary Site:

If it's not clear where the tumor originated, use the following criteria to distinguish ovarian primaries from peritoneal primaries.

- The primary site is probably ovarian when it's described as a bulky mass or omental caking, unless:
  - Ovaries have been previously removed.
  - Ovaries are not involved.
  - Ovaries have no surface implants/area of involvement > 5 mm.
- The primary site is probably peritoneum when it's described as seeding, studding, or salting.

Tubo-ovarian Serous Carcinomas (per SINQ 20210025: https://seer.cancer.gov/seer-inquiry/inquiry-detail/20210025/):
Primary site when there is **conflicting** information.

- When the choice is between ovary, fallopian tube, or primary peritoneal, any indication of fallopian tube involvement indicates the primary tumor is a tubal primary.
- If there is no information about the fallopian tubes, refer to the histology and look at the treatment plans for the patient.
- If all else fails, you may have to assign C579 as a last resort.
- For additional info, see the CAP GYN protocol, Table 1: https://documents.cap.org/protocols/Ovary_FT_Perit_1.3.0.2.REL_CAPCP.pdf

Histology:

For 2023+ cases, use the Other Sites rules for cases diagnosed 1/1/2023 forward. (https://seer.cancer.gov/tools/solidtumor/)

New terms (not new codes) for 2018+:
8461/3 High-grade serous carcinoma
8460/3 Low-grade serous carcinoma

For papillary serous carcinoma:

- For cases diagnosed prior to 1/1/2021: Since this term has a corresponding ICD-O code (8460/3), use that code, regardless of whether it's high or low grade. Code the grade in the grade fields.
- For cases diagnosed 1/1/2021 forward, use 8441/3. Code the grade in the grade fields.

Code the histology diagnosed prior to neoadjuvant treatment. Code the most specific pathology from either resection or biopsy. (See the Histology Section of the Other Sites rules for more info.)

Tumor Size Summary:

May be on the path report, but if there was neoadjuvant treatment, you should look in imaging instead.

Lymph Vascular Invasion:

Cases 2021+: No longer "Not Applicable." Should now be coded like other sites.

Number of Positive Regional Nodes:

They may or may not take out regional nodes during surgery.

Number of Regional Nodes Examined:

They may or may not take out regional nodes during surgery.

Date Regional LN Dissection:

They may or may not take out regional nodes during surgery.

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Staging:

Grade:

Ovary uses Grade Table 15.
Immature teratomas and serous carcinomas: use L & H.
All other histologies: use 1, 2, & 3.
Borderline tumors: use B.
If you have a teratoma or serous carcinoma but don't have a statement of low or high, or if you have one of the other histologies but don't have a nuclear grade, use code 9.

If you <u>ONLY</u> have grade info from a peritoneal or omental biopsy, you can use that to code grade even though it's not the primary site and even if it's not contiguous extension. This is an exception they have made for ovarian/fallopian tube/primary peritoneal carcinomas <u>ONLY</u>.
(See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/92926)

Stage:

Ovary, Fallopian Tube, and Primary Peritoneal Carcinoma are now covered in the same chapter in the AJCC manual (Ch. 55).

Clinical Stage:

It's common to not be able to stage an ovarian cancer clinically. If you don't have a definitive statement that it's an ovarian cancer or at least a physician statement showing that he/she believes it's ovarian cancer, clinical stage is T(blank) N(blank) M(blank), Stage Group 99. However, if there is a statement that it's ovarian cancer, or the physician believes it to be ovarian cancer, then do assign a clinical stage.

They will rarely biopsy ovarian tumors because they could rupture the capsule, causing the malignancy to spread. However, they may biopsy an omental mass, for instance.

From AJCC ONLINE MANUAL

Clinical stage classification is based on patient history, physical examination, and any imaging done before initiation of treatment. Imaging study information may be used for clinical staging, but clinical stage may be assigned based on whatever information is available. No specific imaging is required to assign a clinical stage for any cancer site. When performed within this framework, biopsy information on regional lymph nodes and/or other sites of metastatic disease may be included in the clinical classification. The TNM is denoted by use of a lowercase *c* prefix: cT, cN, and cM0, cM1, or pM1. The M category use of cM or pM is based on method of assessment.

See General Staging Rules Table and Stage Classifications Table in Supplemental Information for additional guidance, including the time frame/staging window for determining clinical stage.

Clinical/Pathological Stage:

Pay attention to whether an organ's parenchyma is involved or just the surface of the organ. Ovarian tumors can easily float around in the peritoneal fluid and attach to the surfaces of organs and/or peritoneum (implants). This does not necessarily mean that organ is "involved." Example:

Tumor on capsule of liver or spleen = T3c
Liver or splenic parenchymal mets = M1b

T category:
Discontinuous tumors in pelvic & abdominal cavities are included in the T classification.

T1 = Confined to ovaries OR fallopian tubes
T2 = Confined to pelvis
T3 = Outside pelvis (abdomen)

Clarification on T1, if STIC is not involved:
T1 is limited to ovary, OR T1 is limited to fallopian tube. It cannot be both.
So, an ovarian primary with involvement of a fallopian tube would be at least a T2.
(See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/104356)

If the capsule is ruptured, pay attention to whether it happened prior to surgery, during surgery, or after it was out of the patient.

Ruptured before surgery = T1c2
Ruptured during surgery = T1c1
Ruptured after it's out of the patient does not affect staging.

The following are in the PELVIS:

Adnexae	Mesosalpinx (Mesovarium)	Rectum
Bladder	Ovaries	Sigmoid colon
Bladder serosa	Parametrium	Sigmoid mesentery
Cul-de-sac	Pelvic peritoneum	Ureter (pelvic portion)
Fallopian tubes	Pelvic wall	Uterus
Ligament(s) (broad, ovarian, round, suspensory)		Uterine serosa

The following are in the ABDOMEN:

Abdominal mesentery	Kidneys	Retroperitoneal LNs
Abdominal peritoneum	Liver (peritoneal surface)	Spleen (peritoneal surface)
Diaphragm	Omentum	
Gallbladder	Pancreas	Stomach
Infracolic omentum	Pericolic gutter	Ureter (outside pelvis)
Intestines (large or small, except C187, C199, C209)		

Carcinomatosis, in the case of ovarian cancer, may refer to peritoneal implants, especially when the implants are numerous. So, this would be included in the T category, not the M category.

Synchronous primary tumors in paired organs: When both ovaries are involved, you will not use the (m) suffix since this is covered by the T category.
(See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/95224)

N category:
Regional LNs:

- Intra-abdominal
- Para-aortic, NOS
    - Aortic
    - Lateral aortic
    - Lateral lumbar
    - Periaortic
- Retroperitoneal, NOS
- Subdiaphragmatic
    - (primary peritoneal)
- Regional LN(s), NOS
    - LN(s), NOS
- Pelvic, NOS
    - Iliac, NOS
        - Common
        - External
        - Internal (hypogastric, obturator, NOS)
    - Paracervical
    - Parametrial
    - Sacral, NOS
        - Lateral (laterosacral)
        - Middle (promontorial) (Gerota's LN)
        - Presacral
        - Uterosacral

Inguinal LNs are now considered distant, so they will not be included in the N category.

Pay attention to the size of the LNs. If you don't have the size, you can use N1.

The (histologically confirmed) next to N1 is for pathological N only. It does not have to be histologically confirmed to assign a clinical N1.
(See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/84393)

M category:
Make sure you don't use cM1a. If you have a positive pleural effusion, it would be a pM1a in the clinical and/or pathological stage.
(See CAnswer Forum: https://cancerbulletin.facs.org/forums/node/98376)

Transmural involvement of intestine, which is tumor going from the surface all the way through the wall = M1b. It must be mucosal involvement for it to count. (Ex: tumor going through the serosa to the muscularis propria does not count.)

Stage group:
T3 (without the a, b, or c) with M0 will give you a Stage 99.

Summary Stage (https://seer.cancer.gov/tools/ssm/)**:**

Ovary and Primary Peritoneal Carcinoma is separate from Fallopian Tube.

See Notes 3-6 in the manual.

Involvement of the pelvis is code 2. Involvement of the abdomen is code 7.
See above regarding what is in the pelvis vs abdomen EXCEPT:

Unlike AJCC staging, ANY liver or spleen involvement (whether capsular or parenchymal) is code 7.

Note that code 7 Distant does not exactly line up with Stage IV in AJCC.
An AJCC/FIGO stage of IIIA, IIIA2, IIIB, IIIC or III, NOS) is a code 7 in Summary Stage.

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SSDI's (https://apps.naaccr.org/ssdi/list/)**:**

FIGO Stage:

With Version 3.0 of the SSDI manual (can be used for 2018+ cases): "FIGO" must be stated to be coded; if "FIGO" is not included with a stated stage, then do NOT assume it is a FIGO stage.

Version 3.1 **Note 1:** There must be a statement about FIGO stage from the managing physician in order to code this data item.

FIGO stage is not the same thing as FIGO grade. Only code FIGO stage in this field, do not code FIGO grade.

CA-125 Pretreatment Interpretation:

Must be prior to treatment and from blood or serum only, not fluid from chest or abdominal cavity.

Residual Tumor Volume Post Cytoreduction:

Look for a mention of cytoreduction or debulking. It's usually done for Stage III or greater cancer. They can have quite an extensive surgery without it being a cytoreductive/ debulking surgery.

The surgery to remove as much cancer in the pelvis and/or abdomen as possible, reducing the "bulk" of the cancer, is called "debulking" or "cytoreductive" surgery. It is performed when there is widespread evidence of advanced stage of ovarian cancer with obvious spread to other organs outside the ovary, typically in the upper abdomen, intestines, the omentum (the fat pad suspended from the transverse colon like an apron), the diaphragm, or liver.

For 2023 use surgical codes A600, A610, A620 or A630

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Text:

Pathologic:

Text as usual, making sure to include everything needed to back up the stage.

Physical Exam:

Text as usual, making sure to include signs and symptoms pertinent to ovarian cancer, such as abdominal bloating, early satiety, unintentional weight loss, pelvic discomfort, and change in bowel habits. Also include the physician's physical exam information.

Xray/Scan:

Text as usual, making sure to enter the results of US, MRI, CT, PET, etc., related to the primary malignancy and/or metastatic disease.

Scopes:

There most likely won't be any scopes for ovarian cancer.

Lab Tests:

Enter the results of the CA-125 (making sure to include whether it's normal or elevated).

Operations:

Make sure to include the size of residual disease if there was a debulking surgery.

Remarks:

Include information (if available) regarding cancer status.

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Therapy:

Surgery:

For Stage I, they may have a TAHBSO (total abdominal hysterectomy & bilateral salpingo-oophorectomy).

For Stages II – IV, they may have a debulking surgery in addition to a TAHBSO.

Notes for Code A610, Debulking WITH colon and/or small intestine resection:

- Does not have to be the whole colon; a partial colectomy counts for this.
- An appendectomy without colectomy also counts for this.

Radiation:

Rarely used for ovarian cancer.

Chemotherapy:

Platinum-based chemotherapy is recommended for Stages II – IV, and sometimes for Stage I ovarian cancer. The preferred regimen is Carboplatin & Taxol (Paclitaxel), although other drugs such as Docetaxel, Doxil, or Cisplatin may be given.

Chemotherapy may be given prior to surgery, or it may not be given until after surgery.

They may also include a PARP inhibitor such as Olaparib (Lynparza) if the patient has a BRCA mutation, which would also be coded as chemotherapy.

For Stage III ovarian cancer, they may have Hyperthermic Intraperitoneal Chemotherapy (HIPEC), where chemotherapy (Cisplatin) is delivered directly to the abdomen during surgery. Code this just as you would code any chemotherapy, and make sure to include it when coding Systemic Surgery Sequence.

Hormone/Endocrine:

Rarely used to treat epithelial ovarian cancers. More likely to be used if the cancer comes back rather than as initial treatment. More commonly used to treat ovarian stromal tumors.

Immunotherapy:

Bevacizumab (Avastin) may be administered with chemotherapy and then continued as maintenance therapy. Other drugs may be given as well.

Other Therapy:

Code any treatment that cannot be defined as surgery, radiation, or systemic therapy here.

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Sources (in addition to the manuals):
Ovary 2019 webinar (NAACCR 2018-2019 webinar series)
CAP Protocol: Ovary, Fallopian Tube, or Peritoneum
NCCN Guidelines: Ovarian Cancer
*SEER*Educate*
Ovary, Fallopian Tube, Primary Peritoneal presentation, OCRA 2022, Denise Harrison

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