Uterus 2025
June 12, 2025
Q&A

	Question	Answer
1.	In slide 11, are we not supposed to code leiomyosarcoma to myometrium? as per quiz. Thanks	Leiomyosarcoma most often arises in the myometrium, however, it can also arise in other sites as well. This example shows it arising in the endometrium, which is rare but not impossible.
2.	Why would you not code the scenario from July on slide 13 to myometrium?	We went with C549 Corpus Uteri based on the path synoptic report that said tumor site was uterine corpus. However, Jim and I did have a debate on myometrium vs uterine corpus with myometrial invasion present. Leiomyosarcoma can arise in either site.
3.	We have been told to code leiomyosarcoma to c54.2 SINQ 20051024 Old so maybe this has changed	We have submitted a question to SEER asking if this has been updated. We will update the Q&A with the answer when it is received.
4.	For slide 13 scenario, Per CAP, choices for primary site for Uterine Sarcoma are uterine corpus, uterine cervix, or Uterus, not otherwise specified. There is nothing more specific to pick for primary site.	The last one *Uterine NOS* has a fill in the blank in the CAP protocol so the pathologist can put in a subsite I think in the case we used for the quiz, the pathologist checked this and then filled in the blank with Fundus.
5.	Slide 32 states to no long determine multiple vs single based on the histology code differences at the first, second, or third digit; However m13 states to code using the difference in digits. Could you expand on this?	At one time, we determined multiple primaries based on differences in the *histology codes*. If the first 3 digits were the same, we would say it's the same primary. If they were different, we would count them as multiple primaries. That is no longer part of the multiple primary rules. Rule M13 refers to differences in *topography* (primary site) codes and not histology codes.

6.	Pathology states high-grade serous carcinoma. When going through the histology rules would you use 8441/3 Serous carcinoma NOS from Table 16, or would you go to the NAACCR ICD-0 3.2 excel spreadsheet and use 8461/3 High grade serous carcinoma?	We checked with SEER and 8460/3 Low grade serous carcinoma, and 8461/3 High grade serous carcinoma should not be assigned to an endometrial primary. The entity in the endometrium is just called 'serous carcinoma' and so is given the code 8441/3 (although all serous carcinomas of the endometrium are high grade the grade is not considered part of the name).
7.	So, if path stated endometrium adenocarcinoma and squamous cell, would that be code 8570? What is the difference between the combination code of 8323 and 8570? Does the path have to state the words, " with squamous differentiation to code 8570"?	Yes, the path report needs to state it exactly as it is shown in Table 16 to assign 8570/3.
8.	If you go under the Staging Report Format in AJCC 8461 is in blue font and the note states, "Histology is not ideal for clinical use in patient care, as it describes an unspecified or outdated diagnosis. Data collectors may use this code only if there is not enough information in the medical record to document a more specific diagnosis."	After the webinar we received some further information. Please see the answer in #6 above. This supports what is in AJCC.
9.	If you go to Table 2 the two or more GYN malignancies has an example that serous papillary adenocarcinoma is 8441. Would that not be the same as papillary serous adenocarcinoma?	Yes, they are the same. Code 8441/3.
10.	When you state the rules don't allow you to use the mixed combination code of 8323, what exact rule are you referring to? Because h21 state Code a combination code when there are multiple specific histologies or when there is an NOS with multiple specific histologies. In this case it seems to be multiple specific histologies. Also the priroty order rule states When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows),	The first priority order rule says you always code the histology prior to neoadjuvant therapy. Since the patient had neoadjuvant therapy, we code the histology from the endometrial curettings, *which are a tissue* diagnosis of the primary site. If the patient did not have neoadjuvant therapy, then you are correct, we would assign 8323/3. I hope that makes sense. We can discuss further live.

	code the histology from the most representative specimen (the greater amount of tumor), the most representative specimen would be the surgery correct (8323)?	
11.	M20 rule. If the biopsy is in situ and part of the plan is to do resection but the resection was performed more than 60 days and the behavior turns out to be invasive. Does M20 rules still applies?	If it is 1 tumor, then it is 1 primary. If there was an insitu tumor removed and a second invasive tumor was identified more than 60 days later, then rule M20 could apply.
12.	Why would SEER not put papillary serous carcinoma in table 16 with instructions to use 8441 if that is the code they wish instead of leaving it out and having registrars got to ICDO 3 to find a code? We have been told that the topography code beside these codes in ICDO 3 are common sites but does not mean they can't happen in other sites	All good points Gail! I agree with you about the topography codes listed next to the histology codes. My hope is that us asking these questions again for Uterine sites will result in some updates to the table in the future so we all have more clarity.
13.	Can you please comment on staging endometrial intraepithelial carcinoma (EIC)? Summary Stage and EOD consider this in situ. The AJCC manual summary of changes specifically stages “endometrial intraepithelial carcinoma (EIC) should be considered a T1 cancer”. Recently we have been made aware of CAnswer Forum posts advising registrars to leave the T category BLANK rather than use T1 as instructed by the manual. We are unclear on when this change in direction occurred or the rationale as to why.	EIC and EIN are different entities (although they share the same histology code) and therefore are handled differently for staging. For AJCC Staging: EIN: leave the T category blank EIC: it is considered a T1 per the AJCC manual. We confirmed this with AJCC after the webinar. Here is a new CAnswer Forum post: Endometrial primaries EIN vs EIC - CAnswer Forum

		Also a reminder, Summary Stage, EOD and AJCC are 3 separate staging systems so they do occasionally have different ways to stage things like they do here for EIN, EIC and SEIC. Just follow the rules for each staging system.
14.	For AJCC chapter 53, if a polypectomy was done, cancer was confined to the polyp, and it was considered definitive treatment, would it qualify for pathologic stage?	I found a post on the CAnswer forum indicating that if the physician indicates that the polypectomy was the definitive treatment, it can be used to assign the pT.
15.	It's interesting that stage IVA is cM0. It's based solely on T4 disease.	I agree! The prognosis for a T4 must be pretty bad.
16.	Will we get the answers to these scenarios and slides?	Yes!
17.	Not sure if anyone is aware, but the FIGO Stage for Endometrial Cancer was updated in 2023. Physicians may be staging with the new FIGO Stage. This does not always match the available FIGO Stages in the SSDI. I did ask CAnswer forum what to do in this situation and was told I could convert it to the older FIGO Stage: https://cancerbulletin.facs.org/forums/node/147958	They are different. I would be very cautious when trying to convert from the new version to the old version. If you are given a FIGO stage that does not match the available codes, I would assign code 99.
18.	The new FIGO is not accepted by most physicians, and there are many journal articles and lectures talking about the problems with it. FIGO realized the problem and is working on a revision.	Thank you!
19.	SINQ question 20250001 says Report EIN/CAH or focal EIN/CAH (8380/2) based on the biopsy. WHO Classification of Tumors online, Female Genital Tumors (5th ed.), defines EAH/EIN as a simultaneous change of epithelial cytology and an increased number of endometrial glands in a defined region. The preferred term is atypical hyperplasia of the endometrium; terms not recommended include complex atypical endometrial hyperplasia; simple atypical	Thank you!

	endometrial hyperplasia; endometrial intraepithelial neoplasia.	
20.	I'm training a new registrar, can you explain why it would be grade 2 for a low grade. If so, why do we have Grade 1?	I'm assuming there is a clinical reason why some pathologist group these primaries into low and high grade rather than assigning grade 1, 2, or 3. Regardless of the reason,, we have been told (by pathologist experts) that a low grade endometrioid adenocarcinoma should be assigned a grade 2. Grade 3 should be used to assign grade for a high grade endometrioid adenocarcinoma.
21.	Regarding the case where the patient had a D&C, neoadjuvant therapy and then surgery, I guess I don't understand what the exception is for assigning histology after neoadjuvant therapy. Can you talk through what it means?	The exception says if the initial diagnosis is based on histology from a FNA, smear or cytology or from a regional/mets site, then you can assign the histology from primary site surgery after neoadjuvant therapy. This does not apply to this case because the endometrial curetting's are a tissue diagnosis of the primary site. and therefore, we use that diagnosis instead of the surgical path diagnosis. Does that make sense?
22.	we need to doble check but for ovary HIGH GRADE serous carcinoma, and for endometrium may be 8441\3	We received confirmation to assign code 8441/3 for high grade serous carcinoma of the endometrium.
23.	CancerPATH Chart states C54.1 8461/3 High grade serous carcinoma Valid.	It does, but we have confirmed that Cancer PathCHART will change the combination of C54.1 to 8461/3 to impossible. After the webinar we received some further information which confirms we should code 8441 for Endometrium.
24.	Would we be able to code the FIGO stage if the physician copy/pasted the pathology report in their office visit notes? I have seen several physicians do this.	If all they have done is paste the actual path report into the note (which they often do), then that does not qualify as a physician statement.

		If the physician confirms the FIGO stage “per” the path report, then that seems to me like it would meet the criteria of a physician statement and you can assign the FIGO stage.