Uterus 2025

NAACCR 2024-2025 MONTHLY WEBINAR SERIES

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Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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Fabulous Prizes

3

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GUEST PRESENTER

Janine Smith, BS, ODS

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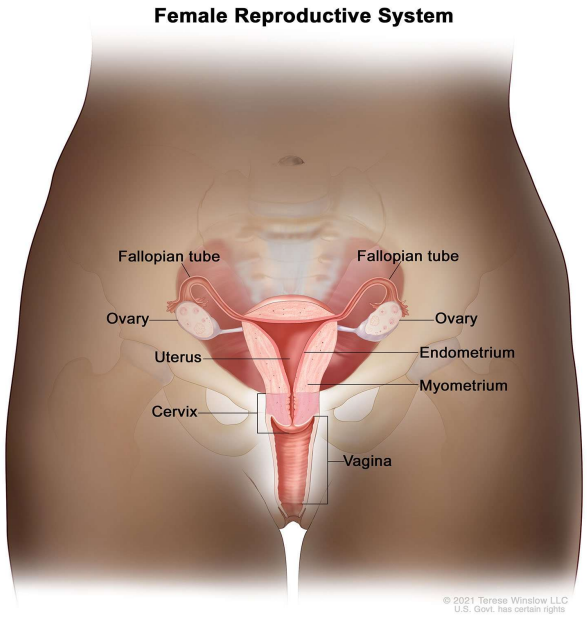
Agenda

- Anatomy/Overview
- Solid Tumor Rules
- Staging
- SSDIs



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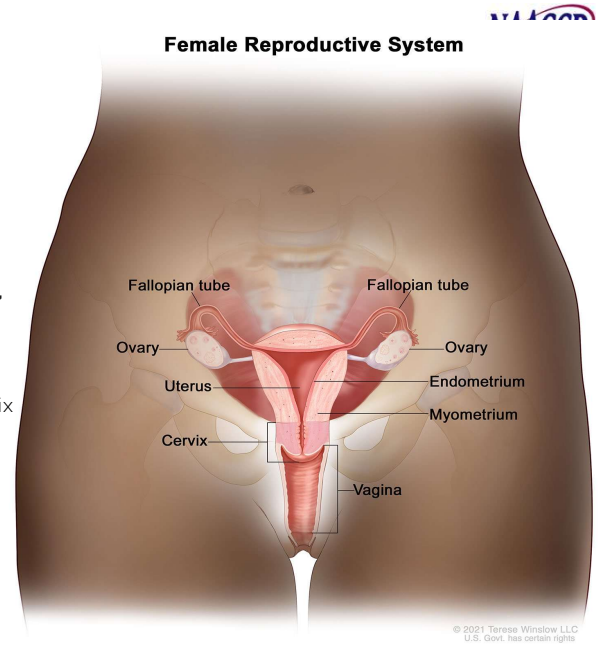
Primary Site Refresher

- We still use ICD-O-3 for cases diagnosed 01/01/2001 and later.
  - Topography codes were NOT updated in ICD-O-3.2
- Resources for Coding Primary Site for Solid Tumors, in priority order:
  - ICD-O
  - SEER Program Manual–Including Coding Guidelines in Appendix C (there are no special guidelines for Uterus)
  - Solid Tumor Rules (no special guidelines for Uterus)
- Use all the available information in the medical record to code the primary site.
- Code the site where the tumor originated.



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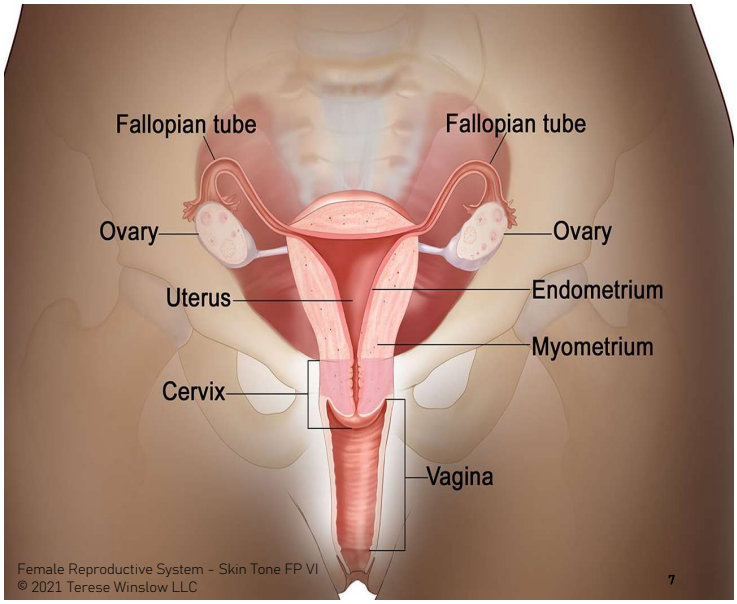
Topography Codes

- C55.9 Uterus, NOS
  - C53.9 Cervix Uteri
  - C54.9 Corpus Uteri
    - **C54.1 Endometrium**
    - C54.2 Myometrium
    - C54.0 Isthmus Uteri
    - C54.3 Fundus Uteri



Schemas and Protocols

EOD/SSDI

- Corpus Carcinoma and Carcinosarcoma
  - Endometrioid adenocarcinoma (8380)
  - Serous carcinoma (8441)
  - Clear cell carcinoma (8310)
  - Carcinosarcoma (8980) *mixed mullerian*
  - ….
- Corpus Adenosarcoma
  - Adenosarcoma (8933)
- Corpus Sarcoma
  - Leiomyosarcoma (8890)
  - Low grade endometrial stromal sarcoma (8931/3)
  - High grade endometrial Stromal sarcoma (8930/3)
  - …..

AJCC

- Corpus Uteri Carcinoma and Carcinosarcoma (Chapter 53)
  - Endometrioid adenocarcinoma (8380) Serous carcinoma (8441)
  - Clear cell carcinoma (8310)
  - ….
- Corpus Uteri Sarcoma (Chapter 54)
  - Adenosarcoma (8933)
  - Leiomyosarcoma (8890)
  - Low grade endometrial stromal sarcoma (8931/3)
  - High grade endometrial Stromal sarcoma (8930/3)
  - …

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Pop Quiz 1

Primary Site

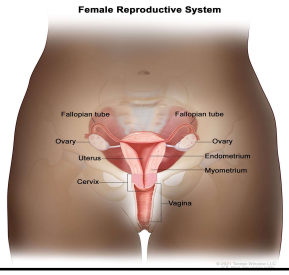
1. Endometrium
2. Myometrium
3. Cervix

Histology

A. Leiomyosarcoma

B. HPV associated squamous cell carcinoma

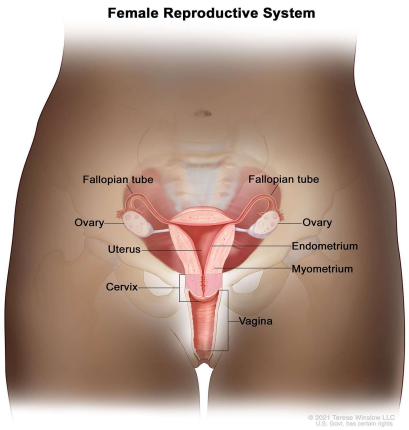
C. Endometrioid adenocarcinoma



U25 1

Primary Site Refresher – Uterine Sarcomas

- **Dilemma:** Often for **sarcomas** arising in the uterus, there are a lot of terms in the medical record that are vague and/or conflicting.
- As a general rule, the surgeon is usually in a better position to determine the site of origin compared to the pathologist.
- However, when a pathologist is looking at an <u>entire organ</u>, such as the Uterus, he/she may be able to pinpoint the site of origin within that organ.
  - *Carefully review the surgical path report Final DX, synoptic report, comments and addendums for indications of the primary site.*



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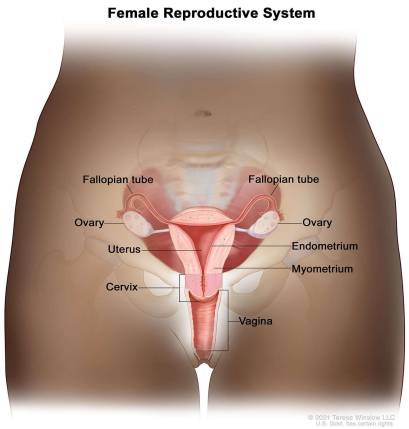
Primary Site Refresher – Uterine Sarcomas

- Sarcomas may arise in the walls of hollow organs and in the viscera covering an organ, such as the Uterus. Code the primary site to the organ of origin.
  - The pathology identifies a leiomyosarcoma carcinosarcoma of the uterine corpus. Code the primary site to corpus uteri (C549).
- Code the organ of origin as the primary site when leiomyosarcoma arises in an organ. Do not code soft tissue as the primary site in this situation.
  - Carcinosarcoma arises in the endometrium. Code the primary site to endometrium (C541).



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Endometrium, Myometrium, Corpus Uteri???? OH MY!

- When the medical record does not contain enough info to assign a primary site….
  - Consult the physician
  - If the physician cannot identify the primary site, assign Uterus NOS (C559)
  - If two possible sites are documented (e.g. corpus uteri and myometrium) within the Uterine system, assign C559

The primary site should be supported by the text documentation in your abstract! If it isn't obvious, make sure you provide rationale for your choice!

Don't forget to document in text any details from the medical record (MD statements, path report, etc) that support the primary site

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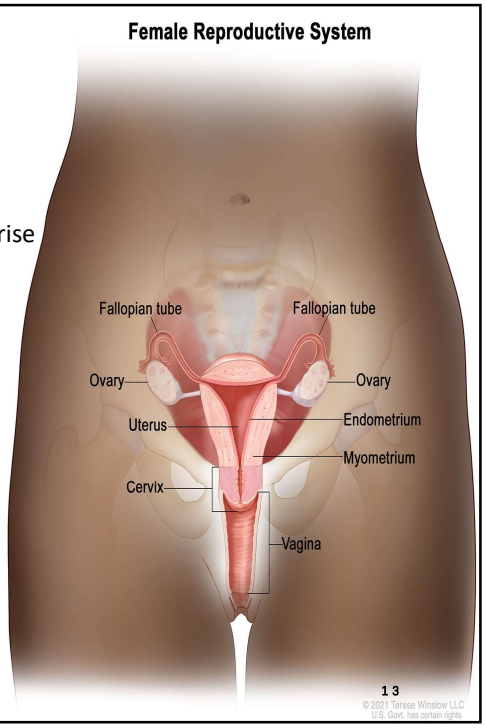
What is Primary Site?

- 7/14/24 CT A/P: 14cm pelvic mass of unclear origin
  - There was no biopsy, the patient went for surgical resection.
- 8/7/24 Operative Report: mass in the abdominal cavity appears to arise from posterior uterus
- 8/7/24 Pathology Final DX:
  - Uterus and bilateral fallopian tubes and ovaries:
    - Myometrium: sarcoma w/lymphovascular invasion
    - Cervix: involved by sarcoma
    - Endometrium: inactive
    - Ovaries and Tubes: neg for sarcoma
- 8/7/24 Pathology Synoptic report:
  - Tumor Site: Uterine corpus
  - Tumor Size: 15cm

C54.9
Corpus Uteri Sarcoma



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Grade

- Grade Table 13
  - Corpus Carcinoma and Carcinosarcoma
  - Corpus Sarcoma
- Grade Table 15
  - Corpus Adenosarcoma

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Grade Table 13

Corpus Carcinoma and Carcinosarcoma
Corpus Sarcoma

New Note 3: For endometrioid carcinomas only

- If "low grade" is documented, code 2 (FIGO Grade 2)
- If "high grade" is documented, code 3 (FIGO Grade 3)

Note 5: G3 includes anaplastic

Code	Description
1	G1 FIGO Grade 1 G1: Well differentiated
2	G2 FIGO Grade 2 G2: Moderately differentiated
3	G3 FIGO Grade 3 G3: Poorly differentiated or undifferentiated
9	Grade cannot be assessed (GX); Unknown

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Grade Table 14

Corpus Adenosarcoma

Note 4: G3 includes anaplastic

Note 5: Sarcomatous overgrowth (S) takes priority over L and H

- *Example*: Pathology report: Adenocarcinoma with sarcomatous overgrowth, high grade
  - Code Grade to S for the sarcomatous overgrowth

Code	Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated or undifferentiated
L	Low grade
H	High grade
S	Sarcomatous overgrowth
9	Grade cannot be assessed (GX); Unknown

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Things to Know!

- FIGO Grade 1 and 2 primarily apply to endometrioid adenocarcinoma.
  - All other carcinomas are high grade (grade 3).
- 3-5% of endometrial cancers are attributed to Lynch syndrome.
  - Caused by mutations in DNA mismatch repair genes.

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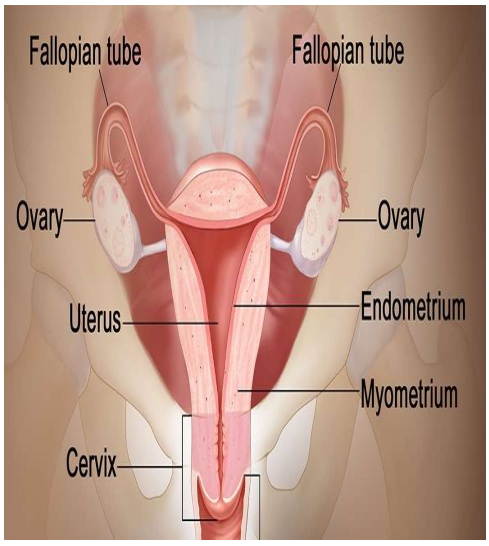
Things to Know!

- Depth of myometrial invasion is an important indicator of risk for lymph node metastasis and overall survival in stage 1 disease.
- Cervical stromal involvement increases the risk of recurrence and nodal mets.
- Patients with low-grade endometrial carcinoma and cervical stromal invasion within the inner half of the cervix treated with brachytherapy alone have favorable outcomes.
- Type 1 and Type 2 endometrial cancer
  - Type 1 is often related to excess estrogen (endometrioid)
  - Type 2 more aggressive (serous, clear cell, carcinosarcoma)



Female Reproductive System - Skin Tone FP VI

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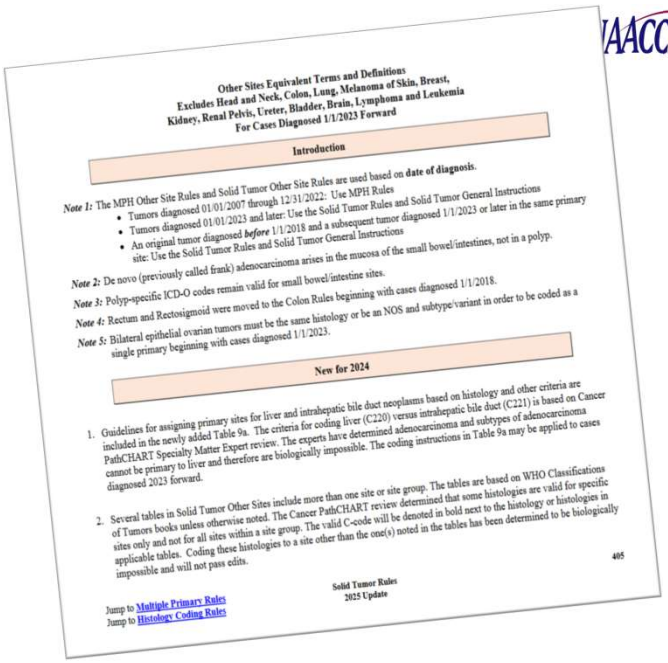
Solid Tumor Rules

Other Sites



Other Sites Equivalent Terms and Definitions
Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain, Lymphoma and Leukemia
For Cases Diagnosed 1/1/2023 Forward

Introduction

Note 1: The MPH Other Site Rules and Solid Tumor Other Site Rules are used based on **date of diagnosis.**

- Tumors diagnosed 01/01/2007 through 12/31/2022: Use MPH Rules
- Tumors diagnosed 01/01/2023 and later: Use the Solid Tumor Rules and Solid Tumor General Instructions
- An original tumor diagnosed ***before*** 1/1/2018 and a subsequent tumor diagnosed 1/1/2023 or later in the same primary site: Use the Solid Tumor Rules and Solid Tumor General Instructions

Note 2: De novo (previously called frank) adenocarcinoma arises in the mucosa of the small bowel/intestines, not in a polyp.

Note 3: Polyp-specific ICD-O codes remain valid for small bowel/intestine sites.

Note 4: Rectum and Rectosigmoid were moved to the Colon Rules beginning with cases diagnosed 1/1/2018.

Note 5: Bilateral epithelial ovarian tumors must be the same histology or be an NOS and subtype/variant in order to be coded as a single primary beginning with cases diagnosed 1/1/2023.

New for 2024

1. Guidelines for assigning primary sites for liver and intrahepatic bile duct neoplasms based on histology and other criteria are included in the newly added Table 9a. The criteria for coding liver (C220) versus intrahepatic bile duct (C221) is based on Cancer PathCHART Specialty Matter Expert review. The experts have determined adenocarcinoma and subtypes of adenocarcinoma cannot be primary to liver and therefore are biologically impossible. The coding instructions in Table 9a may be applied to cases diagnosed 2023 forward.

2. Several tables in Solid Tumor Other Sites include more than one site or site group. The tables are based on WHO Classifications of Tumors books unless otherwise noted. The Cancer PathCHART review determined that some histologies are valid for specific sites only and not for all sites within a site group. The valid C-code will be denoted in bold next to the histology or histologies in applicable tables. Coding these histologies to a site other than the one(s) noted in the tables has been determined to be biologically impossible and will not pass edits.

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Jump to Multiple Primary Rules
Jump to Histology Coding Rules

Solid Tumor Rules
2025 Update

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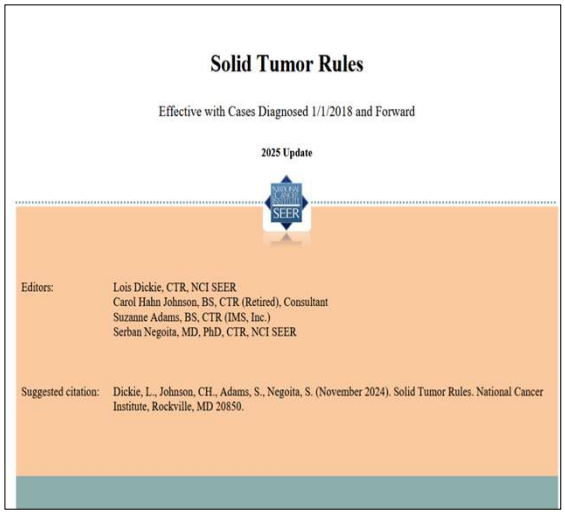
The Basics…

- For cases diagnosed 2018 and later…
- Always start with the MOST CURRENT version of Solid Tumor Rules (STR)
  - If there are differences in the rules by diagnosis year, that will be indicated in the manual.
- Uterine Sites are covered in "Other Sites"



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The Basics…

What the Rules Say for Other Sites (incl Uterine):

- Tumors diagnosed 01/01/2007 through 12/31/2022: Use **2007 MPH** General Instructions and Other Sites Rules
- Tumors diagnosed 01/01/2023 and later: Use the **Solid Tumor Rules** General Instructions and Other Sites rules
- An original tumor diagnosed ***before*** 1/1/2018 and a subsequent tumor diagnosed 1/1/2023 or later in the same primary site: Use the most current Solid Tumor Rules and Solid Tumor General Instructions

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The Basics…

Changes from 2007 MPH Rules:

- The previous 2007 MPH Rules instructed you to "Code the histology from the most representative specimen."
- For all sites included in Other Sites Solid Tumor Rules, now the instruction is to "Code the most **specific histology** from biopsy or resection.
  - When there is a discrepancy between the biopsy and resection (two distinctly different histologies), code the histology from the most representative specimen (the greater amount of tumor)."
- There is a new histology table 16 for "Uterine Corpus Histologies"

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Carcinoma vs. Adenocarcinoma

When are they equivalent, when are they not?

Equivalent	Not Equivalent
• A histology type is stated **in addition** to these terms: Example: Serous carcinoma and serous adenocarcinoma are both coded 8441	• Carcinoma, NOS (8010) is not equivalent to Adenocarcinoma, NOS (8140)

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This table is based on the most recent WHO Classification of Tumors Books and/or College of American Pathologist (C.A.P.) protocols and do not list all possible histologies that may arise in these sites.

Table 16: Uterine Corpus Histologies

Specific and NOS Terms and Code	Synonyms	Subtypes/Variants
Adenosarcoma **8933/3**	Mullerian adenosarcoma Adenocarcinoma with sarcomatous overgrowth	
Carcinoma, undifferentiated NOS **8020/3** *Note:* Carcinoma, undifferentiated NOS 8020/3 has been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.	Carcinoma, poorly differentiated Dedifferentiated carcinoma	
Carcinosarcoma, NOS **8980/3** *Note:* The most common carcinomas present in carcinosarcoma are endometrioid and/or serous.	Malignant mixed Mullerian tumor	
Clear cell adenocarcinoma **8310**		

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Table 16: Uterine Corpus Histologies

Specific and NOS Terms and Code	Synonyms	Subtypes/Variants
Endometrioid adenocarcinoma, NOS **8380** *Note:* Endometrioid adenocarcinoma, NOS 8380/2 and 8380/3 have been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.	Endometrial adenocarcinoma/carcinoma Endometrial atypical hyperplasia/endometrioid intraepithelial neoplasia **8380/2** Mismatch repair-deficient endometrioid carcinoma **8380/3** No specific molecular profile (NSMP) endometrioid carcinoma **8380/3** P53-mutant endometrioid carcinoma **8380/3** POLE-ultramutated endometrioid carcinoma **8380/3**	Endometrioid carcinoma with squamous differentiation **8570/3**
Mesonephric adenocarcinoma **9110/3**		Mesonephric-like adenocarcinoma **9111/3**

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Table 16: Uterine Corpus Histologies

Specific and NOS Terms and Code	Synonyms	Subtypes/Variants
Mixed cell adenocarcinoma **8323** *Note 1:* Mixed cell adenocarcinoma is comprised of endometrial carcinoma with two distinct histological types, in which one component is either serous or clear cell. Excludes dedifferentiated carcinoma and carcinosarcoma. *Note 2:* Mixed cell adenocarcinoma 8323/2 or 8323/3 have been designated biologically impossible for **myometrium (C542)** per Cancer PathCHART review.		
Mucinous carcinoma, NOS **8480** *Note:* Mucinous carcinoma, NOS 8480/3 and 8480/3 have been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.		Mucinous carcinoma, intestinal type **8144**
Neuroendocrine carcinoma NOS **8246/3** *Note:* Neuroendocrine carcinoma NOS 8246/3 has been designated biologically impossible for **Myometrium (C542)** per Cancer PathCHART review.		Large cell neuroendocrine carcinoma **8013/3** Mixed neuroendocrine non-neuroendocrine carcinoma (MiNEN) **8154/3** Small cell neuroendocrine carcinoma **8041/3**
Perivascular epithelioid tumor, malignant **8714/3**	PEComa, malignant	

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Table 16: Uterine Corpus Histologies

Specific and NOS Terms and Code	Synonyms	Subtypes/Variants
Primitive neuroendocrine tumor **9473/3**	PNET	
Sarcoma NOS **8800/3**		Endometrial stromal sarcoma, high grade **8930/3** Endometrial stromal sarcoma, low grade **8931/3** Epithelioid leiomyosarcoma **8891/3** Leiomyosarcoma NOS/spindle leiomyosarcoma **8890/3** Myxoid leiomyosarcoma **8896/3** Undifferentiated sarcoma **8805/3**
Serous carcinoma, NOS **8441**		
Squamous cell carcinoma **8070**		

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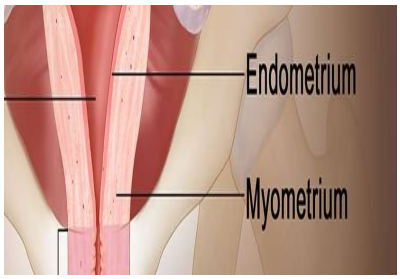
Histologies that are Biologically Impossible for Myometrium (C542)

Histology Code	Behavior	Description
8020	/3	Carcinoma, undifferentiated NOS
8380	/2 and /3	Endometrioid adenocarcinoma, NOS
8323	/2 and /3	Mixed cell adenocarcinoma
8480	/2 and /3	Mucinous carcinoma, NOS
8246	/3	Neuroendocrine carcinoma, NOS



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Quiz

What is the histology code?

- Carcinoma, undifferentiated: 8020/3
- Carcinoma: 8010/3
- Serous adenocarcinoma: 8441/3

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Quiz

What is the histology code?

- Endometrioid Adenocarcinoma: 8380/3
- Endometrial carcinoma: 8380/3
- Endometrial carcinoma with squamous differentiation: 8570/3

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Multiple Primary Rules

- For Uterine primaries, not much has changed from the 2007 MPH Rules
- Big change was adding Table 16: Uterine Corpus Histologies.
  - Rules revised/added to look-up histology code in Table 16 to determine single vs multiple primaries.
  - No longer determine multiple vs single based on the histology code differences at the first, second or third digit.

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Multiple Primary Rules

Unknown if Single or Multiple Tumors	
M1	Abstract a single primary when it is not possible to determine if there are single or multiple tumors.

Single Tumor	
M2	Abstract a single primary when there is a single tumor.

Multiple Tumors	
M12	Timing Rule: Abstract **multiple primaries** when the patient has a subsequent tumor after being clinically disease free for greater than **one year** after the original diagnosis or recurrence.
M13	Tumors with ICD-O-3 topography codes that are different at the **second** (CXxx) **and/or third characters** (CxXx) are **multiple primaries**.

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Multiple Primary Rules

Multiple Tumors	
M17	Abstract **multiple primaries** when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3, Table 3-23 in the Equivalent Terms and Definitions.
M18	Abstract a **single primary** when synchronous, separate/non-contiguous tumors are on the same row in Table 3-23 in the Equivalent Terms and Definitions.
M19	Abstract **multiple primaries** when separate/non-contiguous tumors are on multiple rows in Table 2-23 in the Equivalent Terms and Definitions. Timing is irrelevant
M20	Abstract **multiple primaries** when an invasive tumor occurs more than 60 days after an in situ tumor.
M21	Abstract a **single primary** when there are multiple tumors that do not meet any of the above criteria.

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Histology Rules

Priority Order for Using Documents to Identify Histology:

1. Code the histology diagnosed *prior* to neoadjuvant therapy.

> ***Exception***: If the initial diagnosis is based on histology from **FNA**, **smears**, **cytology**, or from a regional or metastatic site, and neoadjuvant treatment is given and followed by resection of primary site which identifies a different or specific histology, code the histology from the primary site.

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Histology Rules

Priority Order for Using Documents to Identify Histology:

2. Code the histology using the following priority list and histology rules.

- The list is hierarchical.
- Code the most specific pathology/tissue from either resection or biopsy.
  - *Note 1*: The term "most specific" usually refers to a subtype/variant.
  - *Note 2*: The histology rules instruct to code the invasive histology when there are in situ and invasive components in a single tumor.
  - *Note 3*: When there is a discrepancy between the biopsy and resection (two distinctly different histologies/different rows), code the histology from the most representative specimen (the greater amount of tumor).

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Histology Rules

Priority Order for Using Documents to Identify Histology:

1. Tissue or pathology report from primary site (code the most specific histology from either resection or biopsy)
2. Cytology
3. Tissue/pathology from metastatic site
4. Scans
5. Histology document by the physician

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Histology Rules

Example:

Biopsy: Undifferentiated sarcoma (8805/3 per Table 16)

Resection: Sarcoma (8800/3 per Table 16)

Histology Code = 8805/3

- 8805/3 is a subtype/variant of 8800/3 and therefore the most specific histology code.

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Histology Rules

Coding Histology

- Code the **most specific histology** or **subtype/variant**, regardless of whether it is described as:
  A. The majority or predominant part of tumor
  B. The minority of tumor
  C. A component
- The terms above (A, B, C) must describe a carcinoma or sarcoma in order to code a histology described by those terms.

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Histology Rules

Coding Histology

- Code the histology described as differentiation or features/features of ONLY when there is a specific ICD-O code for the "NOS with ____ features" or "NOS with ____ differentiation".
- This is change from the 2007 MPH Rules!

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Histology Rules

"Endometrioid adenocarcinoma with squamous differentiation"

Histology Code = 8570/3

- There is a specific histology code for this term

"Endometrioid carcinoma with extensive mucinous differentiation"

Histology Code = 8380/3

- There is not a specific histology code for this term. Ignore "extensive mucinous differentiation"

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Histology Rules

Coding Histology

- Code the specific histology described by **ambiguous terminology** (list provided in the manual) ONLY when A or B is true:
  - A. The only diagnosis available is **one** histology term described by ambiguous terminology.
  - B. There is a NOS histology and a more specific histology described with ambiguous terminology that is either confirmed by a physician OR patient is receiving treatment based on the specific histology.

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H Rules

- For Uterine primaries, a lot of the rules are the same as 2007 MPH rules, but there are some notable differences.

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H Rules – Single Tumor In-Situ Only

#	Rule
H1	Code the histology documented by the physician when the pathology/cytology report is not available.
H2	Code the histology when only one histologic type is identified. Use Table 16 – Uterine Corpus Histologies. New codes, terms, and synonyms are included in the table and coding errors may occur if the table is not used.
H6	Code the subtype/variant when a NOS and a single subtype/variant of that NOS are present. For Example: Sarcoma (8800) and Undifferentiated Sarcoma (8805), assign code 8805
H7	Code a **combination code** when there are multiple specific in situ histologies or when there is an NOS with multiple specific in situ histologies AND · The combination is listed in Table 2 in Equivalent Terms and Definitions, ICD-O and all updates OR · You receive a combination code from Ask A SEER Registrar

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H Rules – Single Tumor: Invasive and In-Situ Compontent

#	Rule
H8	Code the invasive histology when both invasive and in situ components are present. Use Table 16: Uterine Corpus Histologies, ICD-O, and all ICD-O updates to determine if the term containing both invasive and in situ histologies has a specific ICD-O code.

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H Rules – Single Tumor Invasive Only

#	Rule
H9	Code the histology documented by the physician when the pathology/cytology report is not available.
H10	Code the histology from a metastatic site when there is no pathology/cytology from the primary site.
H12	Code the histology when only one histologic type is identified.
H15	Code the subtype/variant when a NOS and a single subtype/variant of that NOS are present. For Example: Sarcoma (8800) and Undifferentiated Sarcoma (8805), assign code 8805
H17	Code dedifferentiated carcinoma (8020) when mixed with endometrioid carcinoma/adenocarcinoma. Dedifferentiated carcinoma is a distinct entity which has worse prognosis than endometrioid adenocarcinoma.
H21	Code a **combination code** when there are multiple specific histologies or when there is an NOS with multiple specific histologies AND · The combination is listed in Table 2 in Equivalent Terms and Definitions, ICD-O and all updates OR · You receive a combination code from Ask A SEER Registrar

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H Rules – Multiple Tumors Abstracted as a Single Primary

#	Rule
H22	Code the histology documented by the physician when the pathology/cytology report is not available.
H23	Code the histology from a metastatic site when there is no pathology/cytology from the primary site.
H27	Code the histology when only one histologic type is identified.
H32	Code the single **invasive** histology for **combinations of invasive and in situ**. Ignore the in situ terms.
H34	Code the subtype/variant when a NOS and a single subtype/variant of that NOS are present. For Example: Sarcoma (8800) and Undifferentiated Sarcoma (8805), assign code 8805
H35	Code a **combination code** when there are multiple specific histologies or when there is an NOS with multiple specific histologies AND · The combination is listed in Table 2 in Equivalent Terms and Definitions, ICD-O and all updates OR · You receive a combination code from Ask A SEER Registrar

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Let's Talk about Table 2: Mixed and Combination Codes

- ONLY refer to this table when instructed to do so by the H rules!
  - H7, H21, H35
- Most of the rows in the table don't apply to Uterine primaries.

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Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Adenocarcinoma AND At least two of the following: Papillary Clear cell Mucinous/colloid Signet ring Acinar	Adenocarcinoma with mixed subtypes/Adenocarcinoma combined with other types of carcinoma **8255** Note: Code 8255 does not apply to GYN primaries. Continue through the table to determine correct mixed histology code for GYN neoplasms.

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Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Gyn malignancies with two or more of the following: Clear cell Endometrioid Mucinous Papillary Serous Squamous	Mixed cell adenocarcinoma **8323** ← There is a row in Table 16 for this histology term/code Note: First refer to Table 16, ICD-O-3.2 and ICD-O updates to confirm if the mixed histology has a specific code. Example: Serous papillary adenocarcinoma is coded 8441 per ICD-O-3.2.

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Table 2: Mixed and Combination Codes

Required Histology Terms	Histology Combination Term and Code
Any combination of the following sarcomas: Myxoid Round cell Pleomorphic	Mixed Liposarcoma 8855 This histology is Impossible for Uterine Primary Site codes per Cancer PathCHART (CPC)

Bottom Line: Not likely Rules H7, H21, H35 will apply!

If you get that far in the rules (they are the last rules for each section), you may need to review the rules again and confirm an earlier rule did not apply.

If you really get stuck, you should submit a question to Ask A SEER Registrar.

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Example

Primary Site: Fundus
Histology: 8896/3 (myxoid leiomyosarcoma)

What is the primary site and histology code?

7/10/24 CT Abd/Pelvis-19 cm pelvic mass

8/4/24 Exploratory laparotomy: 30cm uterus, residual disease after 2-3mm nodules removed from mesentery;

8/4/24 Pelvic mass bx-leiomyosarcoma - 8890/3

8/11/24 Surgical Path Report Synoptic:

Tumor Site - Uterus, not otherwise specified: Fundus
Tumor Size - Greatest Dimension (Centimeters)
Tumor Size - 25
Histologic Type - Myxoid leiomyosarcoma - 8896/3
Histologic Grade - Not applicable
Myometrial Invasion - Not applicable

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Pop Quiz

What is the histology code?

Histology: 8896/3 (myxoid leiomyosarcoma)

- 3/2023 Pt presents for endometrial and bilat adnexal masses, needs tissue diagnosis; MD performs Exploratory Lap, pelvic bxs, D&C:
  - Endometrial curettings: **High grade papillary serous carcinoma** – 8441/3
  - Mesenteric nodule bxs: **High grade serous carcinoma** – 8441/3
- 4/2023 – 8/2023 Chemotherapy
- 8/2023 Surgery (TAH/BSO, peritoneal biopsy)
- Path report Final DX:
  - UTERUS:
    - **Mixed epithelial adenocarcinoma (serous and clear cell), high grade (see comment).**
      - Minimum myometrial invasion identified (1.5 mm).
      - Angiolymphatic invasion through out the full thickness of myometrium.
      - Uterine serosa involved by carcinoma.
- Path report Synoptic:
  - Tumor site: endometrium
  - Histologic type: **mixed adenocarcinoma (serous and clear cell)** – 8323/3

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Staging

AJCC

Summary Stage

EOD

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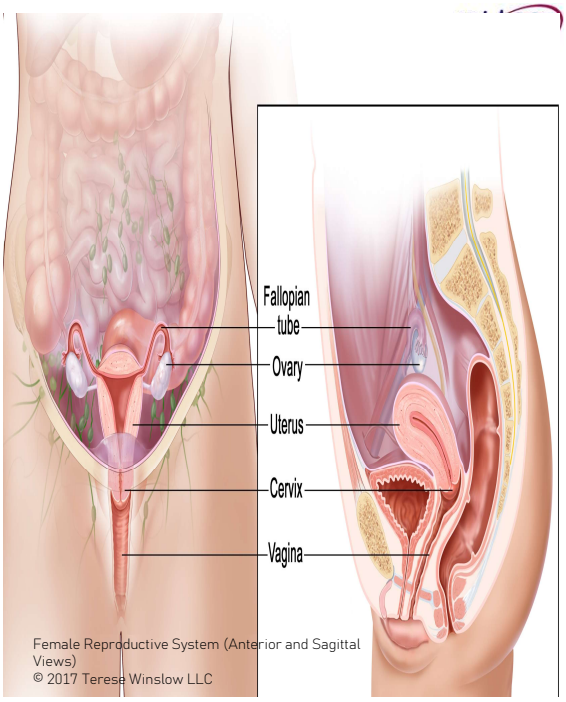
Summary Stage

- Corpus Uteri
  - Any invasive tumor confined to corpus uteri is localized
    - *Malignant cells in peritoneal cytology make the case* ***regional*** *even if tumor is confined to uterus.*
  - Extension to cervix is regional
  - Invasion of the bladder and rectum is regional unless tumor invades through the wall into the mucosa (distant)



Female Reproductive System (Anterior and Sagittal Views)

AJCC Stage

Chapter 53 Carcinoma and Carcinosarcoma pg 669

Chapter 54 Sarcoma pg 679

https://ajccstaging.org/en/female-reproductive-organs

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AJCC Rules for Classification

- Clinical Staging
  - Based on evidence acquired before initiation of treatment
- Pathologic Staging
  - Hysterectomy (or partial hysterectomy) required for pT
  - *If criteria for pT are met and clinical assessment of regional nodes is completed, cN may be used in the pN field.*

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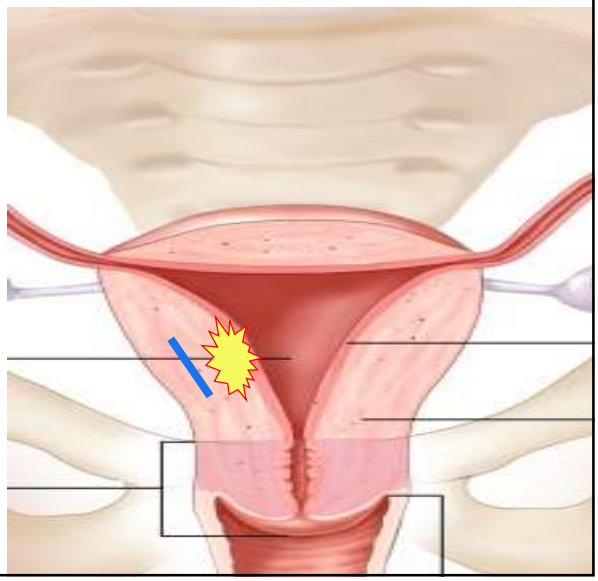
Is the tumor confined to the uterus?

- If yes…
  - Is the tumor confined to the inner or outer half of the myometrium?
  - Is the cervix involved?
    - Endocervical glandular involvement?
    - Stromal involvement?



Female Reproductive System
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Chapter 53 Carcinoma and Carcinosarcoma pg 674

Critical Thinking Exercise

Exercise 1: Which scenario represents Pathologic Stage 1B disease?

Assume no clinical indication of metastasis

Scenario A

TAH/BSO with pelvic lymphadenectomy, and pelvic washings:
- Pathology:
  - 4.5 cm endometrioid adenocarcinoma with 89% myometrial invasion
- Uterine Serosal Involvement:
  - None
- Cervical Involvement:
  - None
- Other Tissue Involvement:
  - None
- FIGO Grade: 3
- Pelvic LNs
  - Positive: 0
  - Examined: 11

Scenario B

- MRI:
  - Tumor measuring 4cm with 2cm invasion into the myometrium. Myometrium 2.7cm thickness. Tumor confined to corpus uteri.
- Biopsy of endometrium:
  - Endometrial adenocarcinoma, endometri… typ… FIGO grade 3
- Abdominal CT…
  - There is … and thickened … ce to the endometrium consistent with endometrial neoplasm. No adenopathy or distant metastasis.
- Patient refused further w/up or treatment.

Scenario C

TAH/BSO with pelvic lymphadenectomy, and pelvic washings:
- Pathology:
  - 4.5 cm endometrioid adenocarcinoma with 89% myometrial invasion
- Uterine Serosal Involvement:
  - Positive
- Cervical Involvement:
  - …
- Other … Involvement:
  - …
- FIGO G…
- Pelvic LNs
  - Positive: 0
  - Examined: 11

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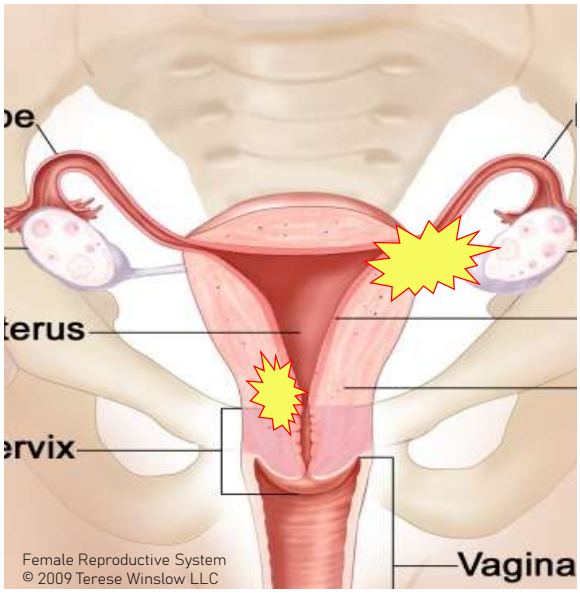
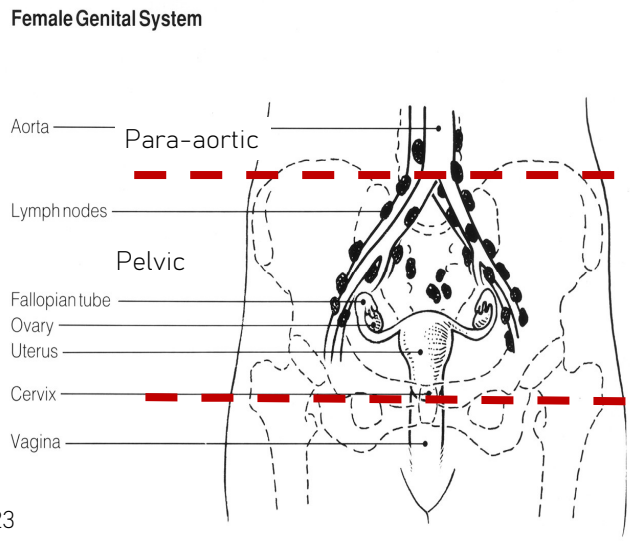
Has the tumor spread beyond the uterus?

- Invasion into the cervix?
  - Glandular invasion?
  - Stromal invasion?
    - What percentage of the wall has been invaded?
- Invasion into the uterine serosa?
- Invasion into other tissues?
  - Adnexa (ovaries and fallopian tubes)
  - Parametrium
  - Bladder
  - Bowel wall



Are lymph nodes involved?

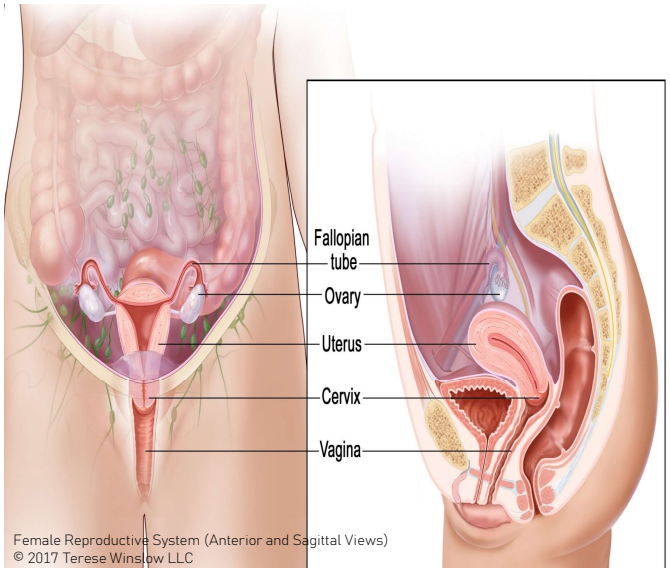
- Are the para-aortic nodes involved?
- Are the pelvic nodes involved?
- How much mets is in the lymph node?
  - Isolated tumor cells
  - Micrometastasis
  - Macrometastasis



https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.14923

Does the patient have distant mets?

- Stage IVA: The cancer has spread to the mucosa of the rectum or bladder.
- Stage IVB: The cancer has spread to lymph nodes in the groin area, and/or it has spread to distant organs, such as the bones or lungs.



Female Reproductive System (Anterior and Sagittal Views)
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Chapter 53 Carcinoma and Carcinosarcoma pg 674

Critical Thinking Exercise

Exercise 2: Which scenario represents Pathologic Stage 3C2 disease?

Assume no clinical indication of metastasis

Scenario A

TAH/BSO with pelvic lymphadenectomy, Cystectomy, and pelvic washings:
- Pathology:
  - 6.5 cm endometrioid adenocarcinoma extending through myometrium
- Uterine Serosal Involvement: Positive
- Cervical Involvement: None
- Other Tissue Involvement:
  - Parametrium
  - Bladder with mucosal involvement.
- FIGO Grade: 3
- LVI neg
- Pelvic LNs
  - Positive: 1
  - Examined: 11
- Para-aortic
  - Postive: None
  - Examined: None

Scenario B

TAH/BSO with SLNbx, and pelvic washings:
- Pathology:
  - 2.5 cm endometrioid adenocarcinoma with 45% myometrial invasion
- Uterine Serosal Involvement: None
- Cervical Involvement: None
- Other Tissue Involvement: None
- FIGO Grade: 3
- LVI neg
- Pelvic LNs
  - Positive: 0
  - Examined: 4
- Para-aortic
  - Postive: None
  - Examined: None

Scenario C

TAH/BSO with pelvic lymphadenectomy, and pelvic washings:
- Pathology:
  - 4.5 cm endometrioid adenocarcinoma with invasion through myometrium.
- Uterine Serosal Involvement: None
- Cervical Involvement: None
- Other Tissue Involvement: Parametrium,
- FIGO Grade: 3
- LVI neg
- Pelvic LNs
  - Positive: 3 (macrometastasis)
  - Examined: 11
- Para-aortic
  - Postive 1(micrometastatsis)
  - Examine 3

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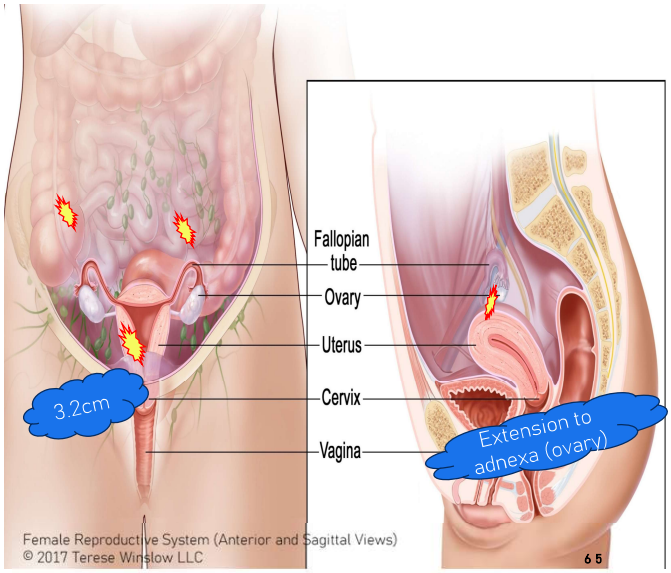
Leiomyosarcoma and endometrial stromal sarcoma

- Tumor size drives the T value when the tumor is confined to the uterus.
- Extension drives the T value when tumor has gone beyond the uterus



See page 683 and 686

Chapter 54 Carcinoma and Carcinosarcoma pg 683

Critical Thinking Exercise

Exercise 3: Which scenario represents Pathologic Stage 1B disease?

Assume no clinical indication of metastasis

Scenario A

TAH/BSO with pelvic lymphadenectomy, Cystectomy, and pelvic washings:
- Pathology:
  - 2.5 cm leiomyosarcoma extending through 60% of the myometrium
- Uterine Serosal Involvement:
  - None
- Cervical Involvement:
  - None
- Other Tissue Involvement:
  - None
- Grade: N/A
- LVI: neg
- Pelvic LNs
  - Positive: 0
  - Examined: 11

Scenario B

TAH/BSO with SLNbx, and pelvic washings:
- Pathology:
  - 5.5 cm adenosarcoma with 45% myometrial invasion
- Uterine Serosal Involvement:
  - None
- Cervical Involvement:
  - None
- Other Tissue Involvement:
  - None
- Grade: 3
- LVI: neg
- Pelvic LNs
  - Positive: 0
  - Examined: 4

Scenario C

TAH/BSO with pelvic lymphadenectomy, and pelvic washings:
- Pathology:
  6.5 cm low grade endometrial stromal sarcoma with invasion through 55% of the myometrium.
- Uterine Serosal Involvement:
  - None
- Cervical Involvement:
  - None
- Other Tissue Involvement:
  - Parametrium,
- Grade: 3
- LVI neg
- Pelvic LNs
  - Positive: 3 (macrometastasis)
  - Examined: 11

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Extent of Disease

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EOD Primary Tumor

Check with standard setter to determine if reportable!

- Non-invasive
  - Endometrial intraepithelial neoplasia (EIN) (8380/2)
  - Endometrial intraepithelial carcinoma (EIC) (8380/2)
  - Serous endometrial intraepithelial carcinoma (SEIC) (8441/2)

Code	Description
000	In situ, intraepithelial, noninvasive, preinvasive Endometrial intraepithelial neoplasia (EIN) (8380/2)
050	Endometrial intraepithelial carcinoma (EIC) (8380/2) Serous endometrial intraepithelial carcinoma (SEIC) (8441/2)

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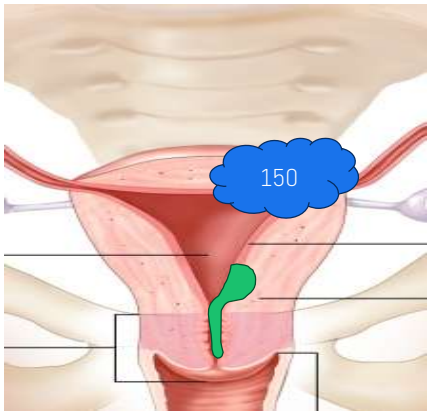
Endocervical vs Cervical Stroma



100	Confined to endometrium (stroma) › Invasion of inner half of myometrium FIGO Stage IA
150	Code 100 + Endocervical glandular involvement
200	Invasion of outer half of myometrium FIGO Stage IB
250	Code 200 + Endocervical glandular involvement
300	Invasion of myometrium, NOS Invasive cancer confined to corpus uteri Localized, NOS FIGO Stage I [NOS]
400	Code 300 + Endocervical glandular involvement
500	Cervical stroma Cervix uteri, NOS Tumor invading the stromal connective tissue of the cervix but not extending beyond the uterus FIGO Stage II

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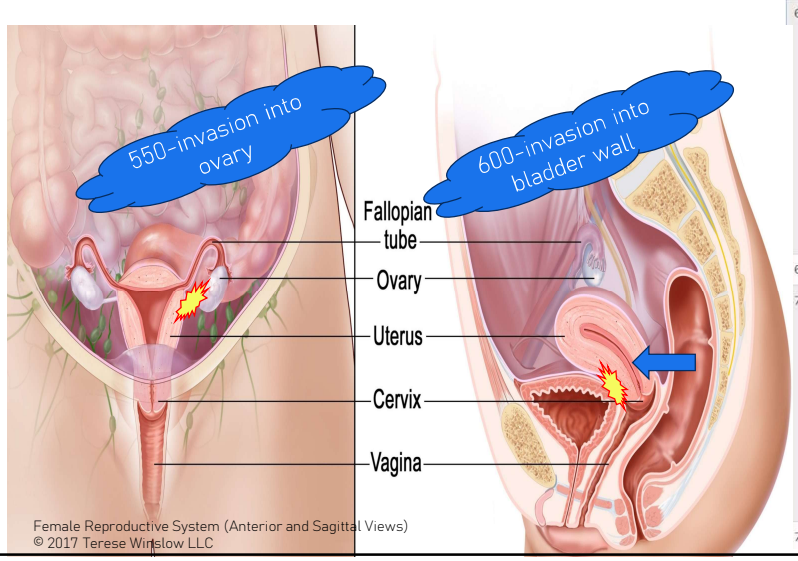
Beyond the Uterus



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550	Adnexa (direct extension or metastasis) › Fallopian tube(s) › Ovary(ies) Serosa, NOS Tunica serosa (visceral peritoneum of corpus, serosa covering the corpus) Tunica serosa of corpus FIGO Stage IIIA
600	Bladder, NOS (excluding mucosa) Ligaments (broad, round, uterosacral) Parametrium, NOS Parietal serosa of pelvic wall Pelvic wall(s) Rectal wall Rectum, NOS excluding mucosa Ureter Vagina (direct extension or metastasis) Visceral peritoneum of pelvic organs excluding serosa of corpus Vulva Described clinically as "frozen pelvis", NOS FIGO Stage IIIB
650	FIGO Stage III [NOS]
700	Infiltration of abdominal tissues, one of the following sites › Abdominal serosa (visceral or parietal peritoneum of abdomen) › Abdominal structures (other, NOS) › Abdominal tissue (infiltration) › Bladder mucosa (excluding bullous edema) › Bowel mucosal › Cul de sac (rectouterine pouch or Pouch of Douglas) › Sigmoid colon › Small intestine Further contiguous extension FIGO Stage IVA
750	FIGO Stage IV [NOS]

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SSDIs

Name	Default Value	Used in Derivation	NAACCR Item	Required By	Metadata
FIGO Stage	98	No	NAACCR #3836 figoStage	COC SEER	SSDI
Number of Positive Pelvic Nodes	X8	No	NAACCR #3902 numberOfPositivePelvicNodes	COC SEER (RC)	SSDI
Number of Examined Pelvic Nodes	X8	No	NAACCR #3900 numberOfExaminedPelvicNodes	COC SEER (RC)	SSDI
Number of Positive Para-Aortic Nodes	X8	No	NAACCR #3901 numberOfPositiveParaAorticNodes	COC SEER (RC)	SSDI
Number of Examined Para-Aortic Nodes	X8	No	NAACCR #3899 numberOfExaminedParaAorticNodes	COC SEER (RC)	SSDI
Peritoneal Cytology	8	Yes	NAACCR #3911 peritonealCytology	All	SSDI

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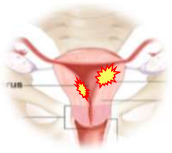
FIGO Stage



The FIGO Stage codes vary by schema, but the structure is the same

Most of the coding instructions are the same across the 3 schemes.

The Corpus Carcinoma and Carcinosarcoma schema has special instructions for EIC and SEIC.

There was a major revision to the instructions/notes for this SSDI with the 2023 Update. *These new instructions apply to all cases diagnosed 2018+.*

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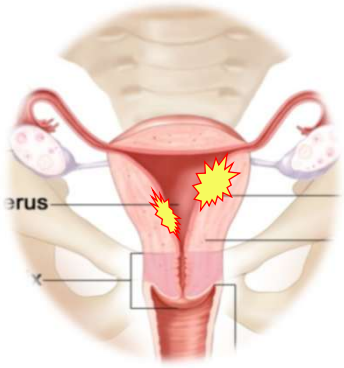
FIGO Stage

Note 1: Physician Statement

- There must be a statement about FIGO stage from the managing physician in order to code this data item.
  - Do not code FIGO stage based on the pathology report
  - Do not code FIGO stage based only on T, N, M
  - If "FIGO" is not included with a stated stage, then do not assume it is a FIGO stage



This is a big change from prior coding instructions!

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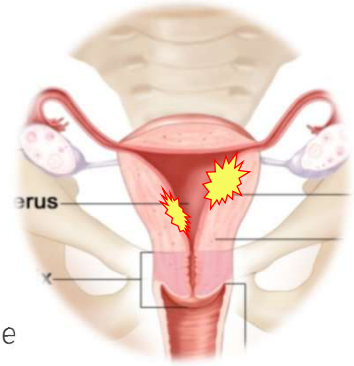
FIGO Stage

Note 2: FIGO Stage vs FIGO Grade

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



Note 3: Multiple FIGO stages

- If there is more than one FIGO stage provided from the clinical and pathological work up, code the most **extensive** FIGO stage.

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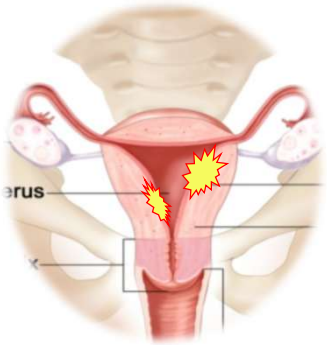
FIGO Stage – Corpus Carcinoma/Carcinosarcoma

Note 4: EIC, SEIC, EIN

- For Endometrial intraepithelial carcinoma **(EIC)** (8380/2) and Serous endometrial intraepithelial carcinoma **(SEIC)** (8441/2), assign the FIGO stage based on the managing physician's documentation of FIGO. (See Note 1).
  - If FIGO stage for EIC or SEIC is not documented by the managing physician, code unknown (code 99)
  - Do not code 97 (in situ) for EIC or SEIC since FIGO does not have a Stage 0
  - If diagnosis is Endometrial intraepithelial neoplasia **(EIN)** (8380/2), code 97.



Note 5: Remaining in situ histologies

- Code 97 for any remaining in situ histologies (/2) since the FIGO stage definitions do not include Stage 0.

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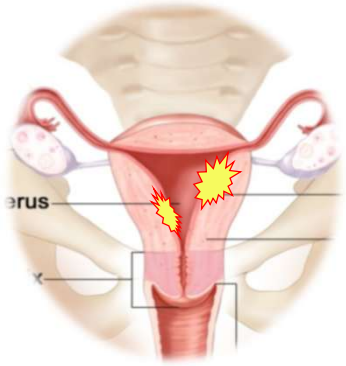
FIGO Stage – Corpus Adenosarcoma and Corpus Sarcoma

Note 4: FIGO Stage 0 (in-situ)

- The FIGO stage definitions do not include Stage 0 (Tis).
- Code 97 for any non-invasive neoplasm (behavior /2)



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What is FIGO Stage?

Example #1

- Path report: Endometrioid adenocarcinoma FIGO GR 3; pT1a pN0 cM0 FIGO stage IA;
- Stage IA per Medical Oncologist
- FIGO Stage? 99

Code	Description
1	FIGO Stage I
1A	FIGO Stage IA
1B	FIGO Stage IB
2	FIGO Stage II
3	FIGO Stage III
3A	FIGO Stage IIIA
3B	FIGO Stage IIIB
3C	FIGO Stage IIIC
3C1	FIGO Stage IIIC1
3C2	FIGO Stage IIIC2
4	FIGO Stage IV
4A	FIGO Stage IVA
4B	FIGO Stage IVB
97	Carcinoma in situ (intraepithelial, noninvasive, preinvasive)
98	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 98 will result in an edit error.)
99	Not documented in medical record FIGO stage not assessed or unknown if assessed

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What is FIGO Stage?

Example #2

- 3/8/23 Pelvis US: lesion in Lt ovary
- 3/22/23 CT AP: metastatic burden w/in abdomen and pelvis; likely ovarian or endometrial primary; thickened endometrium suggests malig; multiple peritoneal infradiaphragmatic implants
- 4/6/23 Adnexal mass biopsy: adenocarcinoma c/w mullerian origin
- Clinical stage IIIC per MD
- 5/9/23-Pt received neoadjuvant carbo/taxol
- 8/23/23 Surgery post-neoadv tx : TAH/BSO, omentectomy, tumor debulking
- Path report: FIGO Gr 2 endometrioid ca (best regarded as endometrial origin); ypT3a ypNx, pM1b FIGO Stage 4B

What is FIGO Stage?_____99

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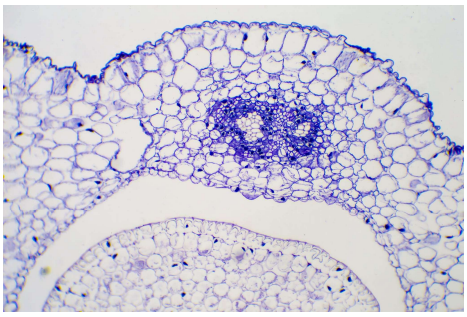
Peritoneal Cytology

- Records the results of cytologic examination of fluid taken from the pelvic and peritoneal cavities.
- Source documents to find this information:
  - Cytology reports (look for multiple reports)
  - Pathology report (look at the synoptic report as it is part of the CAP protocol checklist)
  - Look for report with results of peritoneal washings, peritoneal lavage, paracentesis (if no surgery), peritoneal ascitic fluid



80

Peritoneal Cytology

- A physician statement of peritoneal cytology can be used when no other information is available.
- Do not forget there is a Code 1 for peritoneal cytology that is atypical and/or suspicious.
- **Assign Code 9** when
  - No cytological specimen is available
  - Peritoneal cytology not evaluated (assessed)
  - Unknown if Peritoneal Cytology evaluated (assessed)

Code	Description
0	Peritoneal cytology/washing negative for malignancy
1	Peritoneal cytology/washing atypical and/or suspicious
2	Peritoneal cytology/washing malignant (positive for malignancy)
3	Unsatisfactory/nondiagnostic
7	Test ordered, results not in chart
8	Not applicable: Information not collected for this case (If this item is required by your standard setter, use of code 8 will result in an edit error.)
9	Not documented in medical record Peritoneal cytology not assessed or unknown if assessed

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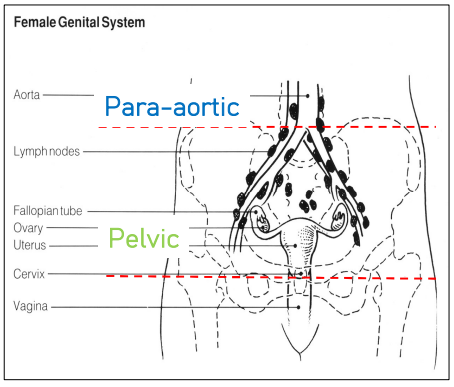
Number of Examined and Positive Pelvic and Para-Aortic Lymph Nodes

- Collected for all three Corpus schemas
- 2 data items for Pelvic Lymph Nodes (positive and examined)
- 2 data items for Para-Aortic Lymph Nodes (positive and examined)



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Pelvic vs Para-Aortic Lymph Nodes

Pelvic lymph nodes

- Iliac, NOS
  - Common
  - External
  - Internal (hypogastric) (obturator)
- Paracervical
- Parametrial
- Pelvic, NOS
- Sacral, NOS
  - Lateral (laterosacral)
  - Middle (promontorial) (Gerota's node)
  - Uterosacral

Para-aortic nodes

- Aortic
- Lateral aortic/lateral lumbar
- Para-aortic, NOS
- Periaortic

If a lymph node dissection is done and only "nodes" are documented without specifying pelvic or para-aortic, **assume they are pelvic.**

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Number of Examined Pelvic Lymph Nodes

- Record the number of nodes examined based on pelvic nodal dissection!
- Physician statement of examined pelvic nodes can be used to code this data item when no other information is available.
- **Code 00** when
  - no lymph nodes examined by FNA, core biopsy or removal of LNs (e.g. SLN bx or LND)
- **Code X6** when
  - There was ONLY an aspiration or core biopsy of pelvic lymph nodes.
- **Code X9** when
  - Not documented in the medical record
  - Unknown if Pelvic lymph nodes removed
  - Pelvic lymph nodes not evaluated (assessed)

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Number of Examined Para-Aortic LNs

- Record the number of nodes examined based on para-aortic nodal dissection!
- Physician statement of examined para-aortic nodes can be used to code this data item when no other information is available.
- Code 00 when
  - no lymph nodes examined by FNA, core biopsy or removal of LNs (e.g. SLN bx or LND)
    - Para-aortic nodes are not routinely examined unless there is suspected involvement
- Code X6 when
  - There was ONLY an aspiration or core biopsy of para-aortic lymph nodes.
- Code X9 when
  - Not documented in the medical record
  - Unknown if para-aortic lymph nodes removed
  - Para-aortic lymph nodes not evaluated (assessed)

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Number of Positive Pelvic Lymph Nodes

- Record the number of positive nodes based on pelvic nodal dissection!
- Physician statement of positive pelvic nodes can be used to code this data item when no other information is available.
- Isolated tumor cells
  - For this data item, do not include isolated tumor cells (ITCs).
- Micrometastasis and macrometastasis
  - Micrometastasis and macrometastasis may be listed separately on the pathology report. Add these two together to get the total number of positive nodes.

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Number of Positive Pelvic Lymph Nodes

- **Code X6** when
  - There was ONLY an aspiration or core biopsy of pelvic lymph nodes and it was *positive*.
- **Code X9** when
  - Only a FNA or core biopsy is done and it is negative
  - Not documented in the medical record
  - Pelvic lymph nodes not evaluated (assessed)
  - No lymph nodes removed
  - Unknown if Pelvic lymph nodes evaluated (assessed)
- Instructions for Para-aortic Lymph Nodes are the same.

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Example

- There was a biopsy of primary site only
- CT imaging: no mets disease, no LAD
- Surgery is TAH/BSO with pelvic lymph node dissection
- Path report say 0/11 pelvic LNs, no para-aortic LNs submitted

	Number Examined	Number Positive
Pelvic lymph nodes	11	00
Para-aortic lymph nodes	00 (no para-aortic nodes examined)	X9 (no para-aortic lymph nodes removed)

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Questions?

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Fabulous Prizes

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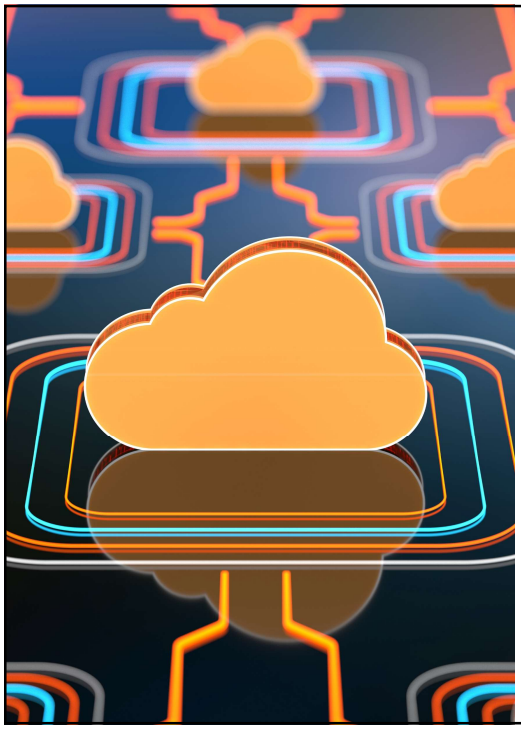

Coming Up!

- Leveraging Technology to Improve Efficiently in Hospital Based Cancer Registry
  - Michelle Webb, ODS-C
  - Kelly Merriman, MPH, PhD, ODS
  - 7/09/25 and 7/10/25
- Solid Tumor Rules 2025
  - Denisse Harrison, ODS
  - 8/06/24 and 8/07/25

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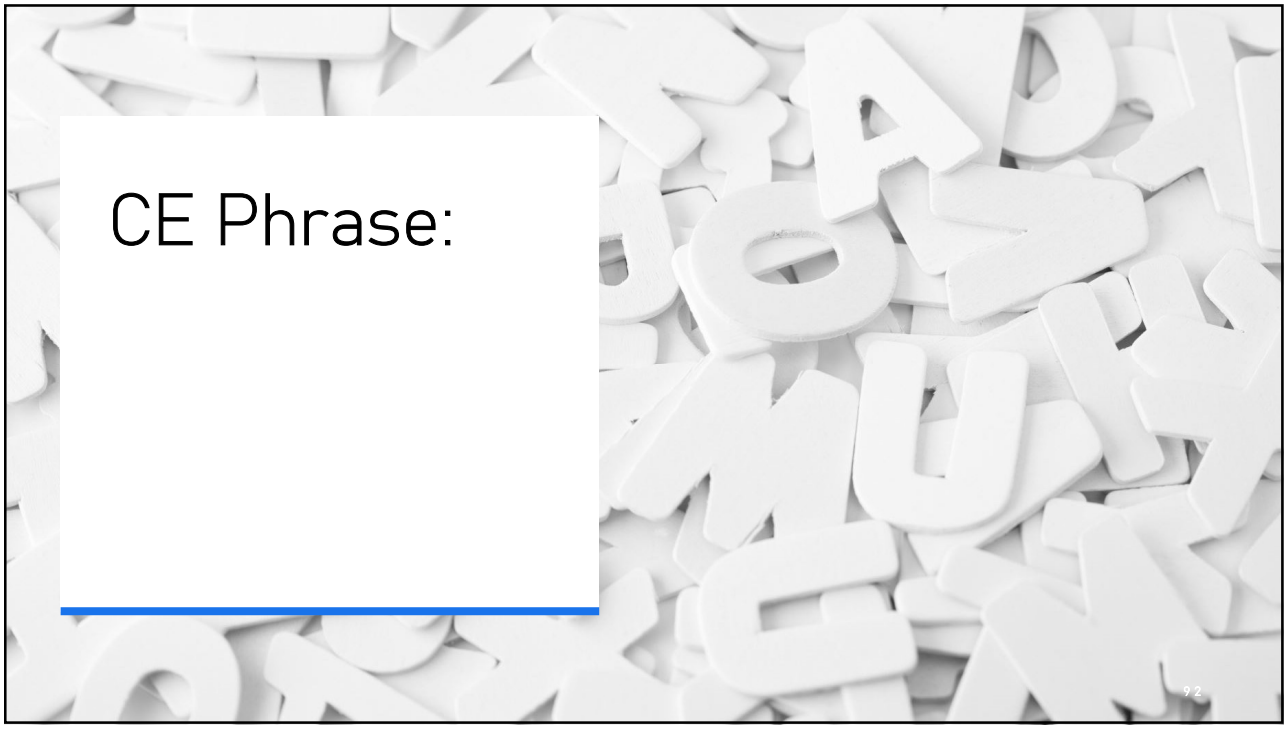

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Thank you!!!