

Directly Coded Summary Stage Corpus Uteri



Directly Coded Summary Staging is Back

- ❑ **Summary Staging (known also as SEER Staging) bases staging of solid tumors solely on how far a cancer has spread from its point of origin.**
- ❑ **It is an efficient tool to categorize how far the cancer has spread from the original site as the staging categories are broad enough to measure the success of cancer control and other epidemiologic efforts**
- ❑ **Summary Stage uses all information available in the medical record as it is a combination of clinical and pathologic information on the extent of disease**
- ❑ **Information within four (4) months of diagnosis**

To Begin the Staging Process, Abstractors Should Always Review:

History and Physical Exam

Radiology Reports

Operative Reports

Pathology Reports

Medical Consults

Pertinent Correspondence



Determining how a Tumor Should be Staged requires the Registrar to:

- ❑ Read the Physical Exam and Work Up documents.**
- ❑ Read operative and pathology reports.**
- ❑ Review imaging reports for documentation of any spread.**
- ❑ Become familiar with the anatomy of the endometrium and the regional and distant lymph node chains.**
- ❑ Refer to the online manuals regularly and periodically check the site for updates and/or changes.**



Assigning the Correct Summary Stage Code

Nine possible codes for Summary Stage

- ☐ 0 = In-Situ
- ☐ 1 = Local
- ☐ 2 = Regional disease by direct extension only
- ☐ 3 = Regional disease with only regional lymph nodes involved
- ☐ 4 = Regional disease by both direct extension and regional lymph node(s)
- ☐ 5 = Regional disease that is not otherwise specified
- ☐ 7 = Distant sites or distant lymph node involvement
- ☐ 8 = Benign and borderline CNS tumors
- ☐ 9 = Unknown if there is extension or metastatic disease (unstaged, death certificate only cases)



Important for Registrars to Know

Available in the *SEER Summary Staging Manual 2000* are 2 lists of Ambiguous Terminology with terms that clarify whether or not a finding is part of the malignant process.

These lists instruct the registrar to either:

* Consider as Involvement

OR

* Do Not Consider as Involvement



Become Familiar With How Cancers May Spread

- ❑ **Lymphatic Spread** is often evident in any of the following: aortic, iliac, parametrial, paracervical, and sacral lymph node chains.
- ❑ **Hematogenous Spread** is most commonly found in bone, liver, lung or brain.



Corpus Uteri is Composed of 3 Anatomic Structures

- ❑ **Endometrium – (Mucosa)**
 - **Columnar Epithelium**
 - This has no blood vessels or lymphatics
 - **Basement Membrane**
 - **Stroma (Lamina Propria)**
 - Connective tissue contains blood vessels, nerves and glands in some regions
- ❑ **Myometrium – 3 layers**
- ❑ **Serosa (Tunica Serosa)**



What does In-Situ Mean?

- ❑ **In-situ is defined as malignancy without invasion.**
 - Only occurs with epithelial or mucosal tissue
 - Sarcomas cannot be in situ
- ❑ **Must be microscopically diagnosed to visualize the basement membrane.**
 - In-situ of the endometrium may also be referred to as non-invasive, pre-invasive, non-infiltrating (or used to be called FIGO Stage 0; current FIGO no longer has a stage 0).
- ❑ **If pathology states the tumor is in-situ with microinvasion it is no longer staged as in-situ but is considered to be at least a localized disease.**

In-situ disease is coded as Summary Stage 0.



Staging In-situ Cancers Requires Knowledge of a Specific Exception

In-situ is a non-invasive malignancy and is coded as Summary Stage '0'

UNLESS

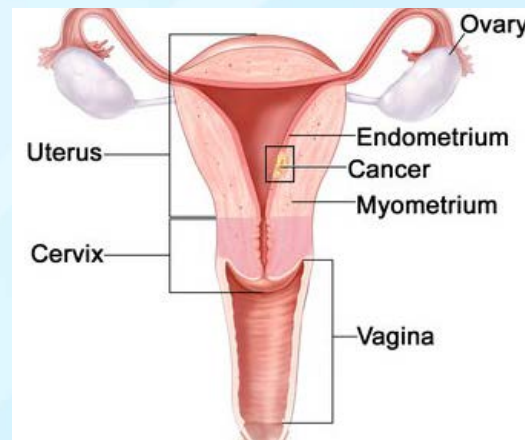
- ❑ Primary Tumor was documented in the pathology report as having only an in-situ behavior but there is an additional statement confirming malignancy has spread and is present in a local, regional node(s) or distant site.....
- ❑ Should that occur, the in-situ stage is not valid and the stage must be documented to reflect the regional or distant disease.

What does Localized Mean?

Localized corpus uteri cancer is a malignancy which is

- ☐ **Confined to the endometrium (stroma)**
- ☐ **Myometrium/serosa (or tunica serosa) of the corpus invasion**
- ☐ **Localized, NOS or FIGO stage I with no further information**

Localized disease is coded as Summary Stage 1



****FIGO stages in summary stage are not current and may not be used**



Staging of Regional Disease

- ❑ Review records to confirm that tumor extent is more than localized.
- ❑ Review all pertinent reports looking for specific regional disease references and exclusions of distant spread. Terms to watch for are seeding, implants and nodules – scrutinize diagnostic reports for regional disease spreading references to eliminate that spread is not distant.

Caution: A diagnosis of cancer with lymph node metastases means involvement by tumor – always confirm that the lymph nodes are regional.

What Does Regional Disease Mean?

Regional Disease indicates that the tumor has gone beyond the organ of origin but is not considered distant.

- **Regional by direct extension (code 2)**

Tumor has invaded surrounding organ(s) or adjacent tissues. May also be referred to as direct extension or contiguous spread.

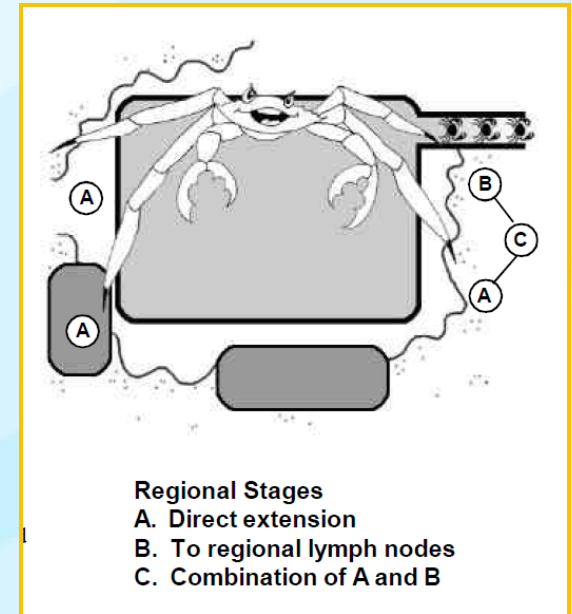
- **Regional to lymph nodes (code 3)**

Tumor cells may have traveled through the lymphatic system to regional lymph nodes where they remain and begin to “grow.”

- **Regional by direct extension and lymph nodes (code 4)**

Extension into adjacent structures or organs and lymph node involvement are both present.

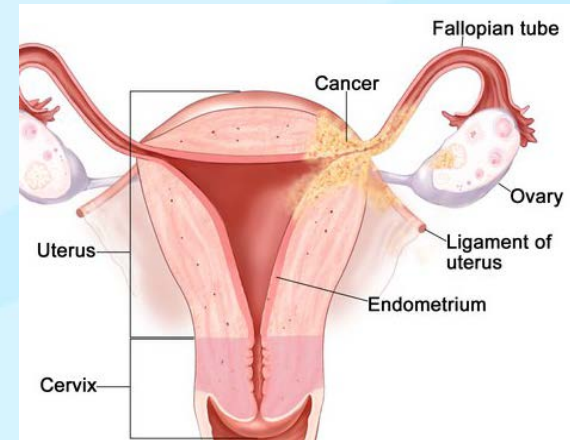
- **Regional (as stated by the physician but the site[s] of regional spread is/are not clearly documented) (code 5)**



Regional by Direct Extension

Direct extension regional Disease of the endometrium includes several possible sites. These include extension to, or involvement of:

- ❑ **Cervix uteri, NOS**
- ❑ **Endocervical glandular involvement only**
- ❑ **Cervical Stromal Invasion**
- ❑ **FIGO stages listed in Summary Stage 2000 are not current and may not be used**



Regional by Direct Extension is coded as Summary Stage 2.

Regional by Direct Extension cont'd

- ❑ Tumor has extended or metastasized to any of following sites:
 - Fallopian tube(s)
 - Broad, Round or Uterosacral Ligaments
 - One or both ovaries
 - Parametrium
 - Pelvic Serosa#
 - Pelvic tunica serosa#
 - Ureter*
 - Vulva*
- ❑ Cancer cells in ascites@
- ❑ Cancer cells in peritoneal washings@
- ❑ FIGO stages in summary stage are not current & may not be used

*Considered distant in Historic Staging

#Considered distant in SS 1977

@Not specifically categorized in Historic Staging or SS 1977

Regional by Direct Extension is coded as Summary Stage 2.

Regional by Direct Extension cont'd

Tumor has extended or metastasized to any of the following sites:

- ❑ **Extension or metastasis*#**
 - Bladder, NOS excluding mucosa
 - Bladder wall
 - Bowel wall, NOS
 - Rectum, NOS excluding mucosa
 - Vagina*
 - Pelvic wall(s)#

- ❑ **FIGO stages in summary stage are not current and may not be used**

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Regional by Direct Extension is coded as Summary Stage 2.



Regional Lymph Node Involvement Only

Tumor cells may have traveled through the lymphatic system to regional lymph nodes where they remain and begin to “grow.”

- ❑ Aortic, NOS – Includes lateral aortic or lumbar, para-aortic and periaortic#
- ❑ Iliac – Includes common, external, and internal or hypogastric, obturator
- ❑ Paracervical#
- ❑ Parametrial
- ❑ Pelvic, NOS
- ❑ Sacral, NOS – Includes lateral sacral or laterosacral; middle, promontorial or Gerota's node; presacral; and uterosacral#
- ❑ FIGO stages in summary stage are not current and may not be used

#Considered distant in SS 1977

Regional by Lymph Node Involvement only is coded as Summary Stage 3.

Regional Nodes for Corpus Uteri

❑ Aortic, NOS#

- Lateral or lumbar
- Para-aortic
- Periaortic

❑ Iliac

- Common
- External
- Internal or hypogastric, NOS
 - Obturator
- Paracervical#
- Parametrial
- Pelvic, NOS

#Considered distant in SS 1977

Regional to Lymph Nodes is coded as Summary Stage 3.

Regional Lymph Nodes cont'd

☐ Sacral, NOS#

- Lateral or laterosacral
- Middle (promontorial or Gerota's Node)
- Presacral
- Uterosacral

☐ FIGO stages in summary stage are not current & may not be used

☐ Regional Nodes, NOS

#Considered distant in SS 1977

Caution: Endometrial cancers with lymph node metastases means involvement by tumor – always confirm that the lymph nodes are regional.

Regional to Lymph Nodes is coded as Summary Stage 3

Regional Disease by Direct Extension and Lymph Nodes

- **Regional Extension from the primary site into:**
 - **adjacent structures or organs**
 - **and lymph nodes involvement are both present.**

**Regional disease by both direct extension and lymph nodes is
coded
as Summary Stage 4.**

When to Code Regional, NOS

- ❖ **It is unclear if the tissues involved are regional direct extension or lymph nodes**
- ❖ **Physician statement says “Regional disease” with no additional documentation in the medical record.**

**Regional Disease with no further information is coded as
Regional – NOS – Summary Stage 5**



Read Carefully

Carcinoma of the corpus uteri with *metastasis* to regional lymph nodes.

- ❑ This indicates that the involved lymph nodes are those that are the first to drain from the primary site and should be staged as regional to lymph nodes.
- ❑ Don't be misled by the term *metastases* – It doesn't always mean distant disease.



Important Notes to Remember

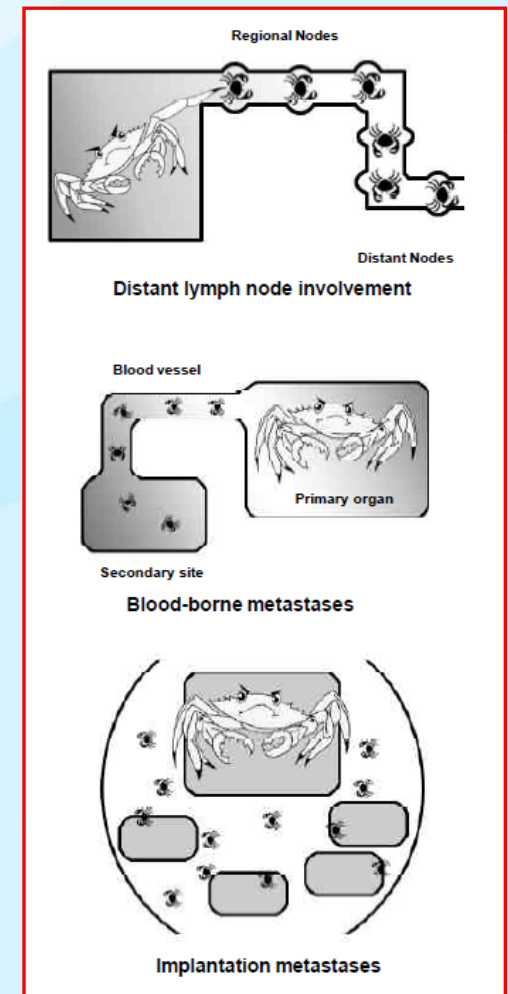
- ❑ Adnexa is defined as tubes, ovaries and ligaments
- ❑ Frozen pelvis means tumor extends to the pelvic sidewall(s). With no statement of involvement, code these cases as regional by direct extension. (With Historic Staging and SS 1977 these cases were coded as distant).
- ❑ If the physician states adnexa palpated with no mention of lymph nodes, the Registrar should assume nodes are not involved.
- ❑ If exploratory or definitive surgery was done with no mention of lymph nodes assume nodes are not involved.
- ❑ Sounding of the corpus is no longer a prognostic factor as it was in the past.
- ❑ Extension to bowel or bladder mucosa must be proven by biopsy. This is to rule out bullous edema.

Important to Know: This schema is also used for sarcomas of the myometrium in SS2000. Note: AJCC has separate staging in their corpus uteri chapter for sarcomas versus carcinomas.

What is Distant Stage (code 7)?

Distant Stage indicates that the tumor has spread to areas beyond the regional sites.

- ❑ These sites may be called:
 - Remote
 - Metastatic
 - Diffuse
- ❑ Distant lymph nodes are those that are not included in the drainage area of the primary tumor.
- ❑ Hematogenous metastases develop from tumor cells carried by the bloodstream and begin to grow beyond the local or regional areas.



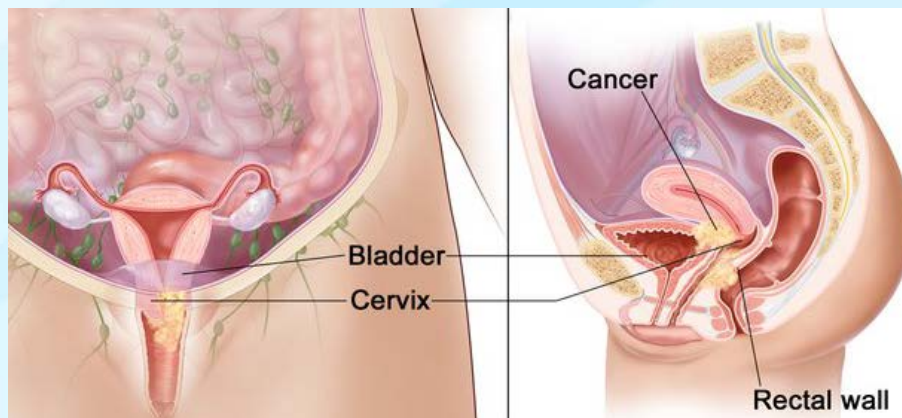
Distant Sites and Nodes

❑ Distant lymph node(s):

- Inguinal, NOS
 - Deep, NOS
 - Node of Cloquet or Rosenmuller (highest deep inguinal)
 - Superficial inguinal (femoral)*
- Other Distant Lymph Nodes

❑ Extension to:

- Bladder mucosa (excluding bullous edema)#
- Bowel Mucosa#
- FIGO stages in summary stage are not current and may not be used



*Considered distant in Historic Staging

#Considered distant in SS1977

Distant Sites and Nodes cont'd

☐ Further contiguous extension#:

- Abdominal serosa (peritoneum)
- Cul de sac (rectouterine pouch)
- Sigmoid colon
- Small intestine

☐ Metastasis

☐ FIGO stages in summary stage are not current and may not be used

#Considered regional in Historic Staging

Tips for the Abstractor

- ❑ If review of the patient's records documents distant metastases, the registrar can avoid reviewing records to identify local or regional disease.**
- ❑ Pathology reports that contain a statement of local, regional or metastatic spread cannot be staged as in-situ even if the pathology of the tumor states it.**
- ❑ If there are nodes involved, the stage must be at least regional.**
- ❑ If there are nodes involved but the chain is not named in the pathology report, assume the nodes are regional.**
- ❑ If the record does not contain enough information to assign a stage, it must be recorded as unstageable.**

Exercise 1– How Would You Stage This Case?

- ❑ Patient presented with abnormal vaginal bleeding. Physical examination was within normal limits – no abdominal masses or lymphadenopathy noted. Uterus and cervix did not reveal any abnormalities.**
- ❑ MRI was ordered and noted right fundal endometrium consistent with carcinoma. Further workup including CT of abdomen and pelvis did not reveal any additional abnormality.**
- ❑ Patient underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy with pathology noting moderately differentiated adenocarcinoma in the endometrium. No invasion of the myometrium, tubes or ovaries.**

Exercise 1– How Would You Stage This Case?

- ☐ **Patient presented with abnormal vaginal bleeding. Physical examination was within normal limits – no abdominal masses or lymphadenopathy noted. Uterus and cervix did not reveal any abnormalities.**
- ☐ **MRI was ordered and noted right fundal endometrium consistent with carcinoma. Further workup including CT of abdomen and pelvis did not reveal any additional abnormality.**
- ☐ **Patient underwent a total abdominal hysterectomy with bilateral salpingo-oophorectomy with pathology noting moderately differentiated adenocarcinoma in the endometrium. No invasion of the myometrium, tubes or ovaries.**
- ☐ **Summary Stage 1 Localized.**

Exercise 2 – How Would You Stage This Case?

- ❑ Patient presented with light spotting. No urinary frequency or incontinence. Normal findings with a speculum exam. Uterus was without tenderness. Rectovaginal exam did not find any rectal masses.
- ❑ Ultrasound noted only a thickened endometrial stripe. Chest and abdominal/pelvic CT within normal limits.
- ❑ Pathology from the total abdominal hysterectomy and bilateral salpingo oophorectomy revealed a well differentiated adenocarcinoma with invasion of the myometrium of 1.5 mm. No nodes present and therefore were unable to be assessed.

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- ❑ Summary Stage 1 localized, based on CT not showing regional involvement and no nodes resected.

Exercise 3 – How Would You Stage This Case?

- ❑ Patient presented with complaints of urinary incontinence. Physician ordered an IVP with findings negative for kidney and ureters issues but a pelvic mass was identified which appeared to be compressing the bladder.**
- ❑ An endometrial biopsy was identified as adenocarcinoma. Hysterectomy was done and the carcinoma was found to be invading the myometrium. Six pelvic nodes were involved.**

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- ❑ An endometrial biopsy was identified as adenocarcinoma. Hysterectomy was done and the carcinoma was found to be invading the myometrium. Six pelvic nodes were involved.
- ❑ Summary Stage 3, based on the regional lymph node involvement.

Exercise 4 – How Would You Stage This Case?

- ❑ Patient presented for her annual physical with a complaint of abdominal discomfort. Her physician noted a pelvic mass that was considered suspicious for malignancy.**
- ❑ She opted for and underwent a TAH-BSO which revealed an endometrial adenocarcinoma. There was invasion of the vagina. Seven of 18 nodes were positive for malignancy.**

Exercise 4 – How Would You Stage This Case?

- ❑ Patient presented for her annual physical with a complaint of abdominal discomfort. Her physician noted a pelvic mass that was considered suspicious for malignancy.
- ❑ She opted for and underwent a TAH-BSO which revealed an endometrial adenocarcinoma. There was invasion of the vagina. Seven of 18 nodes were positive for malignancy.
- ❑ Summary Stage 4, with direct extension to the vagina and lymph node involvement.

Excellent Resources for Summary Staging

- ❑ http://seer.cancer.gov/manuals/2013/SPCSM_2013_maindoc.pdf
- ❑ SEER Summary Stage 2000, SEER Training modules:
<http://training.seer.cancer.gov>
- ❑ SEER Coding Manuals – Historic – 1977.
- ❑ http://training.seer.cancer.gov/modules_site_spec.html
- ❑ <http://training.seer.cancer.gov/endometrium/abstract-code-stage/extent/>

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**Centers for Disease Control and Prevention
Chamblee Campus, Atlanta GA**

Presentation created by CDC
For questions, please contact your designated CDC/NPCR Education Training
Coordinator:

Donna M. Hansen, CTR
Auditor/Trainer

UC Davis Institute of Population Health
California Cancer Registry
1631 Alhambra Blvd, Suite #200
Sacramento, CA 95816
(916) 731-2543

Email: dhansen@ccr.ca.gov

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333
Telephone, 1-800-CDC-INFO (232-4636)/TTY:1-888-232-6348
E-mail: cdcinfo@cdc.gov Web:www.cdc.gov

