COLLECTING CANCER DATA: UTERUS

2017-2018 NAACCR WEBINAR SERIES

Q&A

• Please submit all questions concerning webinar content through the Q&A panel.
• Reminder:
• 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.
AGENDA

- Primary Site/Multiple Primary and Histology Rules
- Staging
- Quiz 1
- Treatment
- Quiz 2
- Case Scenarios
HISTOLOGY-CERVIX

- Columnar Epithelium
  - Adenocarcinoma
- Squamous Epithelium
  - Squamous cell carcinoma
- Squamo-columnar junction
  - Original
  - New

CARCINOMA IN SITU OF THE CERVIX, CIN, AND THE BETHESDA SYSTEM

- In 1993 a NAACCR multidisciplinary group recommended that until
  - There is a strong local interest
  - Sufficient resources are available to collect all high grade squamous intraepithelial lesions
    That population based registries discontinue collection
- NAACCR and NPCR adopted this recommendation at that time.
- SEER and CoC adopted it effective for 1/1/1996.
NEW TERMS FOR 2018

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HISTOLOGY- ENDOMETRIUM

Adenocarcinoma of the endometrium

- **Type 1**
  - Endometrioid adenocarcinoma
  - Mucinous
- **Type 2**
  - Undifferentiated
  - Carcinosarcoma
  - Serous carcinoma
  - Clear cell carcinoma
  - Mucinous carcinoma
## MP/H RULES‐TABLE 2 OTHER SITES

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<th>Combination Term</th>
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### EXAMPLE

- A single tumor of the endometrium:
  - Endometrioid with clear cell differentiation.
- Rule H16 refers us to Table 2
  - Mixed cell adenocarcinoma 8323/3
NEW TERMS/BEHAVIORS FOR 2018

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<td>3 Mullerian adenosarcoma (C54. _, C55.9)</td>
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Red indicates change in behavior

STAGING CERVIX UTERI

SUMMARY STAGE/AJCC STAGE
HUMAN PAPILLOMA VIRUS (HPV) INFECTION

- Epidemiologic studies convincingly demonstrate that the major risk factor for development of preinvasive or invasive carcinoma of the cervix is HPV infection
  - About two-thirds of all cervical cancers are caused by HPV 16 and 18
  - Infection with HPV is common
  - Pap tests look for changes in cervical cell caused by HPV infection

SYMPTOMS

- Cervix
  - Often asymptomatic
  - Screening
  - HPV Vaccine

**CERVIX**
- Ectocervix
- External os
- Endocervix
- Internal os

**CERVICAL ECTROPION**
- The central (endocervical) columnar epithelium protrudes out through the external os of the cervix and onto the vaginal portion of the cervix
- Undergoes squamous metaplasia, and transforms to stratified squamous epithelium.
FIGO GRADE VS FIGO STAGE

*FIGO (INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS)*

- FIGO Staging is based on clinical staging, careful clinical examination before any definitive therapy has begun.
- Exception: ovary, which includes surgical exploration.
- It is based on the percentage of cells in the tumor that grow in sheets (called solid tumor growth) rather than form glands. It may also take into account how abnormal the cells appear.

SUMMARY STAGE

- Cervix Uteri
  - Stage group for in situ even though not reportable
  - Any invasive tumor confined to cervix is localized
  - Invasion of the bladder and rectum is regional unless tumor invades through the wall into the mucosa
  - Para-aortic lymph nodes are distant (regional for AJCC)
AJCC STAGE CERVIX UTERI

- 7th edition Chapter 35 page 397
- 8th edition Chapter 52 page 649
  - AJCC ID-52
  - Errata-Changes to Author List

FIGO STAGING OF CERVICAL CARCINOMAS

- Driven by the primary tumor (see T values)
  - Stage I is confined to the cervix
  - Stage II is carcinoma that extends beyond the cervix, but does not extend into the pelvic wall.
  - Stage III is carcinoma that has extended into the pelvic sidewall
  - Stage IV is carcinoma that has extended beyond the true pelvis or has clinically involved the mucosa of the bladder and/or rectum.

http://screening.iarc.fr/viaviliappendix1.php
RULES FOR CLASSIFICATION

• Clinical Staging
  • FIGO uses clinical staging
  • Determined prior to start of definitive therapy
  • Clinical examination
    • Palpation, inspection, colposcopy, endocervical curettage, hysteroscopy, cystoscopy, proctoscopy, intravenous urography, and x-ray of lungs and skeleton
    • Cone biopsy (usually)
  • Lymph node status
    • Radiologic-guided fine needle aspiration, laparoscopic or peritoneal biopsy, or lymphadenectomy

RULES FOR CLASSIFICATION

• Clinical Staging
  • CT, MRI, PET
    • Ignore for staging
    • May be used to make treatment plan
RULES FOR CLASSIFICATION

• Pathologic Staging
  • Based on information acquired before treatment and supplemented by additional evidence from surgery, particularly from pathologic exam of resected tissues
  • Does not change clinical staging

OCCULT AND IN SITU

• Occult means cervical cancer has been identified, but primary tumor has not.
• In situ indicates malignant cells are present, but they have not invaded beyond the basement membrane.
  • Not reportable to any standard setters
  • Can be assigned a Tis in 7th edition
  • Cannot be assigned T value in 8th edition
PRIMARY TUMOR

• Tumors confined to the uterus
  
  **Cone Biopsy**

  ![Image of reproductive system with cone biopsy](http://www.cancer.ca/en/)

  - cervix
  - vagina
  - uterus
  - the cone of tissue removed

PRIMARY TUMOR

• Tumor beyond the uterus
• Pelvic wall involvement
• Hydronephrosis
• Lower third of the vagina
• Mucosa of the bladder or rectum

![Image of reproductive system with tumor](en/)

**Uterus**
DISTANT METASTASIS

- Para-aortic lymph nodes
- Mediastinal lymph nodes
- Lung
- Peritoneal
- Skeleton
STAGE GROUPING

• 8th Edition Changes
  • In situ removed
  • N1 removed from Stage 3B
  • Any N

POP QUIZ 1

• Colposcopy: A cervical lesion confined to the cervix.
• Bimanual pelvic exam under anesthesia was negative for parametrial masses and lymphadenopathy.
• Cone biopsy:
  • Histology: Squamous cell carcinoma
  • Stromal invasion: 4.2mm
  • Horizontal extent: 23mm
• Chest x-ray: Normal
• PET/CT scan: No skeletal abnormalities; a single highly metabolic pelvic lymph node measuring 1.5cm. No additional metastasis identified.
• Patient was treated with chemotherapy and radiation.

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**POP QUIZ 2**

- Colposcopy: Visible lesion encompassing lower half of cervix and upper vagina. No visible involvement of the lower vagina. Horizontal spread of 7cm.
  - Bimanual exam: Negative
  - CT shows 7.5 cm lesion confined to the uterus.
- Cone biopsy: Extensive moderately differentiated squamous cell carcinoma. Stromal invasion present. Tumor involves inked margins.
- Radical hysterectomy:
  - 8.4 cm keratinizing squamous cell carcinoma involving cervix and vaginal cuff. Margins negative.
  - 51 nodes negative for metastasis

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### Data Item

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**SSF VS SSDI**

**SSF**
- FIGO Stage

**SSDI**
- FIGO Stage
QUESTIONS?

STAGING CORPUS UTERI
SUMMARY STAGE/AJCC STAGE
ENDOMETRIAL CARCINOMA

- Risk factors
  - Post menopausal estrogen therapy (unopposed)
  - Obesity
  - High-fat diet
  - Early menarche and late menopause

- Symptoms
  - Abnormal vaginal bleeding (most often in postmenopausal period)

LAYERS OF THE UTERUS

- Endometrium
  - Functional
  - Basal
- Myometrium
- Parametrium
  - The loose connective tissue around the uterus.
- Perimetrium
  - Peritoneum covering of the fundus and ventral and dorsal aspects of the uterus
SUMMARY STAGE
• Corpus Uteri
  • Any invasive tumor confined to corpus uteri is localized
  • Extension to cervix is regional
  • Invasion of the bladder and rectum is regional unless tumor invades through the wall into the mucosa
  • Para-aortic lymph nodes are distant (regional for AJCC)

RULES FOR CLASSIFICATION
• Clinical Staging
  • Based on evidence acquired before initiation of treatment
• Pathologic Staging
  • FIGO uses surgical/pathologic staging
  • Based on information acquired before treatment supplemented by information acquired from pathologic assessment of resected tissues
  • Record depth of myometrial invasion with thickness of myometrium
  • Assess regional lymph nodes surgically/pathologically
### FIGO STAGE ENDOMETRIUM

#### Carcinoma

- **IA** Tumor confined to the uterus, no or < ½ myometrial invasion
- **IB** Tumor confined to the uterus, > ½ myometrial invasion
- **II** Cervical stromal invasion, but not beyond uterus
- **IIIA** Tumor invades serosa or adnexa
- **IIIB** Vaginal and/or parametrial involvement

#### Sarcoma

- **IA** Tumor limited to uterus < 5 cm
- **IB** Tumor limited to uterus > 5 cm
- **IIA** Tumor extends to the pelvis, adnexal involvement
- **IIB** Tumor extends to extra-uterine pelvic tissue

### PRIMARY TUMOR

**CARCINOMA/CARCINOSARCOMA**

- Invasion of myometrium
- Involvement of cervix
PRIMARY TUMOR
CARCINOMA/CARCINOSARCOMA

- Serosa
- Adnexa
- Vagina
- Parametrium
- Bladder
- Bowel

PRIMARY TUMOR
SARCOMA

- Extension
- Tumor size
  - ≥ or ≤ 5cm
DISTANT METASTASIS

Endometrium
- Intra abdominal metastasis
  - Peritoneal surfaces
  - Omentum

Distant
- Lung
- Distant lymph nodes
POP QUIZ 3

- 86 year old white female presents with 3-4 days of vaginal spotting, associated with minor cramping.
- Pelvic ultrasound: 2.7cm endometrial thickness
- Biopsy of endometrium: Endometrial adenocarcinoma, endometrioid type, FIGO grade 3

Abdominal CT:
- There is an ill defined and thickened appearance to the endometrium in keeping with history of endometrial neoplasm.
- No adenopathy or distant metastasis.

![Data Table]

POP QUIZ 3 CONT.

- Robotic assisted total hysterectomy, bilateral salpingoopherectomy, washings:
  - Endometrial adenocarcinoma, endometrioid type, FIGO Grade II,
  - Tumor was superficially invasive, arising in a 2.3 cm endometrial polyp in a background of endometrial hyperplasia.
    - Superficial myometrial invasion at the base of the polyp (0.2 cm with myometrial thickness of 2.5 cm)
    - LVI: not present
    - Margins: negative
    - No lymph nodes removed

![Data Table]
SSF VS SSDI

SSF
- FIGO Stage
- Peritoneal Cytology
- Number of Positive Pelvic Nodes
- Number of Examined Pelvic Nodes
- Number of Positive Para-Aortic Nodes
- Number of Examined Para-Aortic Nodes

SSDI
- FIGO Stage
- Peritoneal Cytology
- Number of Positive Pelvic Nodes
- Number of Examined Pelvic Nodes
- Number of Positive Para-Aortic Nodes
- Number of Examined Para-Aortic Nodes

QUESTIONS?
TREATMENT
SURGERY, RADIATION, CHEMOTHERAPY

SURGERY

Hysterectomy
- subtotal
- total
- radical
**SURGERY – CORPUS UTERI**

- Total Hysterectomy with Bilateral Salpingo-Oophorectomy (50)
  - Not fertility sparing
  - Pelvic nodal dissection w/wo aortic nodal dissection
    - External iliac, internal iliac, obturator and common iliac nodes for staging

**SURGERY - CERVIX UTERI**

- Dilatation and Curettage (D&C)
  - For invasive cancers code as an incisional biopsy (02)
  - For In situ cancers code as surgery (25)
**SURGERY – CERVIX UTERI**

- **LEEP (Loop Electrocautery Excision Procedure)**
  - Local tumor destruction (15)
    - No specimen sent to pathology
  - Local tumor excision (28)
    - Specimen sent to pathology
- **Cone biopsy (27)**
  - With gross excision of lesion (24)

---

**SURGERY – CERVIX UTERI**

- Radical vaginal trachelectomy with laparoscopic lymphadenectomy procedure with or without SLN mapping
  - Fertility sparing option
  - Stage IA-2
  - Stage IB-1
    - Lesions of 2cm diameter or less
SURGERY – CERVIX UTERI

- Radical hysterectomy with bilateral pelvic lymph node dissection with or without SLN mapping
- FIGO Stage IA-2, IB and IIA lesion
- Fertility preservation is not desired

CHEMORADIATION - CERVIX UTERI

- Advanced-stage disease
  - FIGO stage IIB and above
- Preferred regimens
  - Cisplatin
  - Cisplatin/fluorouracil
CHEMOTHERAPY - CORPUS UTERI

- Carboplatin
- Cisplatin
- Paciltaxel

RADIATION – CORPUS UTERI

- External Beam Radiation Therapy (EBRT)
  - Directed to pelvis with or without para aortic region
- Brachytherapy
  - More common after hysterectomy
## RADIATION – CERVIX UTERI

- **Brachytherapy**
  - Patients who are not candidates for surgery
  - Intracavitary approach
- **External Beam Radiation Therapy (EBRT)**
  - CT-based planning and conformal blocking - standard
  - Intact cervix
- **Adjuvant Radiation Therapy**
  - Following hysterectomy

## RADIATION – CERVIX UTERI

- **Intraoperative Radiation Therapy**
  - Recurrent disease within previously radiated volume
RADIATION DATA ITEMS FOR 2018

- Phase I Radiation Primary Treatment Volume
- Phase I Radiation to Draining Lymph Nodes
- Phase I Radiation Treatment Modality
- Phase I External Beam Radiation Planning Technique
- Phase I Dose per Fraction
- Phase I Number of Fractions
- Phase I Total Dose
RADIATION PRIMARY TREATMENT VOLUME

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RADIATION TO DRAINING LYMPH NODES

This a very new data item

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**EXTERNAL BEAM RADIATION PLANNING TECHNIQUE**

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POP QUIZ – CORPUS UTERI PART 1

• Patient presents with postmenopausal bleeding.
• A gynecologic exam showed a hysteroscopy and biopsy was done that showed endometrioid carcinoma limited to the uterus.
• The patient had a TAH-BSO.
  • Pathology showed endometrioid carcinoma, grade 2, FIGO Stage IB.

Surgical Codes 2017

<table>
<thead>
<tr>
<th>Surgery Codes</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Diagnostic and Staging Procedure</td>
<td>02</td>
</tr>
<tr>
<td>Surgical Procedure of Primary Site</td>
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</tr>
<tr>
<td>Scope of Regional Lymph Node Surgery</td>
<td>0</td>
</tr>
<tr>
<td>Surgical Procedure/Other Site</td>
<td>0</td>
</tr>
</tbody>
</table>
POP QUIZ –CORPUS UTERI PART 2

• Following the TAH-BSO the physician discussed adjuvant treatment options of observation or vaginal brachytherapy. The patient chose to have vaginal brachytherapy.

• Radiation Summary patient 3 fractions of high dose radiation for total of 45 Gy to the vagina.

• How would you code the radiation treatment fields?

<table>
<thead>
<tr>
<th>Radiation Codes</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Primary Treatment Volume</td>
<td>29</td>
<td>72</td>
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<tr>
<td>Radiation to Draining Lymph Nodes</td>
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<td>00</td>
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<tr>
<td>Radiation Treatment Modality</td>
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<td>11</td>
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<tr>
<td>External Beam Radiation Planning Technique</td>
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<td>88</td>
</tr>
<tr>
<td>Number of Fractions</td>
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<td>003</td>
</tr>
<tr>
<td>Total Dose</td>
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<td>004500</td>
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</table>
POP QUIZ – CERVIX UTERI PART 1

• A patient was found to have a cervical lesion during her annual gynecologic exam. The lesion extended into the endometrium. A biopsy was positive for squamous cell carcinoma.

• A cone biopsy was performed and pathology came back as squamous cell carcinoma.

• The patient then went on to have a total abdominal hysterectomy and pelvic lymph node dissection.

<table>
<thead>
<tr>
<th>Surgery Codes</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Diagnostic and Staging Procedure</td>
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<tr>
<td>Surgical Procedure of Primary Site 1</td>
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<tr>
<td>Surgical Procedure of Primary Site 2</td>
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<tr>
<td>Scope of Regional Lymph Node Surgery</td>
<td>5</td>
</tr>
<tr>
<td>Surgical Procedure/Other Site</td>
<td>0</td>
</tr>
</tbody>
</table>
POP QUIZ - CERVIX UTERI PART 2

- Patient then received IMRT radiation therapy to the upper vagina and pelvic lymph nodes. She also received concurrent chemotherapy with cisplatin.

<table>
<thead>
<tr>
<th>Radiation/Chemotherapy Data Items</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Primary Treatment Volume</td>
<td>29</td>
<td>72</td>
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<tr>
<td>Radiation to Draining Lymph Nodes</td>
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<td>Chemotherapy</td>
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QUESTIONS?

QUIZ 2

CASE SCENARIOS

COMING UP....

• Collecting Cancer Data: GIST and Soft Tissue Sarcomas
  • 01/11/2018

• Collecting Cancer Data: Stomach and Esophagus
  • 02/01/2018
Fabulous Prizes Winners

CE CERTIFICATE QUIZ/SURVEY

- Phrase
- FIGO
- Link

Thank You

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