

Case Scenario 1

History

79 year-old white male presents with hematuria and urinary frequency.

Imaging

3/25/12 CT IVP: Large bladder mass causing obstruction of the left ureter. Findings are worrisome for transitional cell carcinoma.

3/30/12 CT Chest/Abdomen/Pelvis:

1. Large transitional cell carcinoma in the left side of the urinary bladder involving the trigone and possibly extending into the distal left ureter. This results in left-sided hydronephrosis. There are lymph node metastases in the left side of the pelvis.
2. No evidence of urinary obstruction on the right.
3. Mild wall and fold thickening involving loops of jejunum consistent with some form of enteritis. There is no associated obstruction or perforation.
4. Colonic diverticulosis without evidence of diverticulitis.

4/30/12 PET/CT: Widespread osseous metastases. Malignant appearing lymph nodes identified in the posterior mediastinum and retroperitoneum of the abdomen and pelvis most concentrated in the left periaortic and left external iliac lymph node chain. Right hydronephrosis.

Procedure

4/2/12 Cystoscopy/TUR of large (greater than 5 cm) bladder tumor: The 23-French cystoscope was passed through the urethra into the bladder, and large tumor encountered at the bladder neck immediately. There was mild prostatic hypertrophy, but it appeared the bladder tumor was causing outlet obstruction which is probably the cause of his lower urinary tract symptoms. The tumor involved most of the trigone and completely obscured the left orifice and I was unable to identify the right orifice either. The tumor extended up along the left wall of the bladder towards the dome and came up to the bladder neck. The rest of the bladder was difficult to examine and was heavily trabeculated with multiple cellules however no other lesions were readily identified. The cystoscope was removed and the 24-French resectoscope sheath and obturator were inserted. Using the Iglesias resectoscope and 24 loop the bladder tumor was resected. After all specimens had been irrigated out the bladder and the resection site cauterized for hemostasis and control of any active bleeding areas, I attempted to identify the ureteral orifices, which had been resected through. However, I was still unable to identify them, therefore retrograde pyelograms could not be performed at this time. It is my impression that this tumor probably is muscle invasive and on bimanual exam, the bladder base seems to be fixed which would be consistent with this as well.

Pathology

4/2/12 High grade carcinoma with features of poorly differentiated neuroendocrine carcinoma and adenocarcinoma. Extensive invasion of deep muscularis propria is identified. Extensive lymph-vascular invasion is identified.

Patient opted for no treatment and went to hospice.

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Stage/ Prognostic Factors

CS Tumor Size		CS SSF 9	988
CS Extension		CS SSF 10	988
CS Tumor Size/Ext Eval		CS SSF 11	988
CS Lymph Nodes		CS SSF 12	988
CS Lymph Nodes Eval		CS SSF 13	988
Regional Nodes Positive		CS SSF 14	988
Regional Nodes Examined		CS SSF 15	988
CS Mets at Dx		CS SSF 16	988
CS Mets Eval		CS SSF 17	988
CS SSF 1		CS SSF 18	988
CS SSF 2		CS SSF 19	988
CS SSF 3		CS SSF 20	988
CS SSF 4	988	CS SSF 21	988
CS SSF 5	988	CS SSF 22	988
CS SSF 6	988	CS SSF 23	988
CS SSF 7	988	CS SSF 24	988
CS SSF 8	988	CS SSF 25	988

Treatment

Diagnostic Staging Procedure			
Surgery Codes		Radiation Codes	
Surgical Procedure of Primary Site		Radiation Treatment Volume	
Scope of Regional Lymph Node Surgery		Regional Treatment Modality	
Surgical Procedure/ Other Site		Regional Dose	
		Boost Treatment Modality	
Systemic Therapy Codes		Boost Dose	
Chemotherapy		Number of Treatments to Volume	
Hormone Therapy		Reason No Radiation	
Immunotherapy			
Hematologic Transplant/Endocrine Procedure			

Case Scenario 2

History

52 year-old white female presents with hematuria, back pain, lower extremity swelling, and itching.

Imaging

4/25/12 CT Abdomen/Pelvis: There is a moderate bilateral hydronephrosis and ureterectasis to the lower pelvic region where the ureters cannot be followed with certainty without IV contrast. The findings are consistent w/obstructive uropathy. Given the fact that there is diffuse bladder wall thickening and also calcification and/or a focal mass in the posterolateral aspect of the bladder, this is likely the cause of the obstructive uropathy. The findings in the bladder could be inflammatory and/or neoplastic in nature. There are numerous tiny sclerotic areas seen in the visualized skeleton. This is moderately worrisome for skeletal metastases, and a bone scan would be helpful for further evaluation.

4/28/12 CT Abdomen/Pelvis:

1. A 4.8 cm heterogeneous soft tissue density involving the right bladder wall could be due to neoplasm and/or hemorrhage.
2. Few prominent inguinal lymph nodes measuring up to 1 cm.
3. Bilateral hydronephrosis, right greater than left. Left ureteral stent.
4. Colonic diverticulosis most notably in the sigmoid colon.
5. Diffuse punctate to small sclerotic osseous lesions. Differential includes a benign process such as osteopoikilosis versus metastatic disease. Comparison with prior studies, if available, and/or further evaluation with a bone scan is suggested.

Surgical Reports

4/26/12-Cystoscopy with biopsy

5/3/12-Pelvic exenteration

Pathology

4/26/12 Bladder Biopsy: Poorly differentiated malignant neoplasm

5/3/12 Final Diagnosis:

- A) Small bowel mesentery biopsy: Metastatic high-grade urothelial carcinoma involving mesenteric soft tissue and lymph nodes.
- B) Right ovarian vein biopsy: Involvement of vein wall and surrounding soft tissue by invasive high-grade urothelial carcinoma.
- C) Left distal ureter excision: No evidence of tumor.
- D) Right distal ureter excision: No evidence of tumor.
- E) Pelvic exenteration: Urinary bladder with invasive high-grade urothelial carcinoma.
 - a. Tumor size: 3.8 x 3.0 x 2.7 cm
 - b. Extent of invasion: Tumor invades through the full-thickness of the bladder wall and extensively permeates into perivesical soft tissues.
 - c. Lymph-vascular invasion: Present.

- d. Margins: Tumor is present at the inked peripheral perivesical and right periureteral soft tissue margin; urethral, distal vaginal and bilateral ureteral margins are clear.
- e. Tumor does not involve the uterine corpus, cervix, vagina, or ovaries.
- f. Bilateral periadnexal/peritubal soft tissues are extensively permeated by tumor
- g. Metastatic carcinoma involves a single right perivesical lymph node.

PATHOLOGIC STAGE: pT3b pN1 pM1 (See comment).

Diagnostic Comments: The pathologic M1 stage is based on the presence of metastatic disease within the small bowel mesenteric soft tissues and mesenteric lymph nodes. The pN1 stage is based on the identification of a single perivesical lymph node involved by metastatic carcinoma.

Oncology

Chemotherapy recommended; patient unable to be reached to start treatment.

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Hematologic Transplant/Endocrine Procedure			