Enclosed you will find the exercises for the NAACCR 2010-2011 Webinar Series Collecting Cancer Data: Uterine Malignancies. These exercises should be completed prior to the session. We will review the answers during the session.

The exercises were developed by the CSv2 training team. We have selected cases 3 and 6 from their selection of practice cases.

CSv2 codes are available at

http://web2.facs.org/cstage/schemalist.html

Gynecological Case # 3

HISTORY AND PHYSICAL

Date: 07/25/2010

History of Present Illness: This 76-year-old patient who has had postmenopausal bleeding off and on since February 2010. She initially saw her primary care physician who ordered a transvaginal ultrasound. This revealed a uterus measuring 11 x 4.8 x 4.5 cm. The endometrial stripe was 33 mm, possibility of a solid endometrial mass with dimensions of 33 x 36 x 39 mm. The ovaries were not identified. No free fluid was seen. Likewise an ultrasound of the abdomen was also done that showed no abnormalities. She was then referred to Dr. XX who subsequently did an endometrial biopsy and this comes back showing complex hyperplasia with atypia and area suspicious for endometrial adenocarcinoma. The patient has been referred to me for further evaluation and recommendations. The patient has a history of cardiovascular disease and sees a cardiologist, and was cleared by him. The patient continues to have bleeding of moderate amount, changing several pads a day.

General: No fevers, chills, fatigue, or weight loss.
Nodes: Denies swollen glands.
Chest Has had dyspnea on exertion, although she walked from the parking garage to the elevator today without trouble. Denies wheezing, cough or sputum production.
Cardiovascular:: Denies chest pain, orthopnea. Does not exercise.
Abdomen:: No weight loss, diarrhea, abdominal pain, hematemesis, or blood in stool.
Breasts: No pain, no lump, no discharge.
Urinary: No incontinence. No nocturia. No frequency.
Vulvar: No pain, no lesions, and no itching.
Vaginal: No relaxation, no itching, no discharge, and no lesions.
Musculoskeleral: Chronic low back pain.
Neurologic: No history of seizures, paralysis, alteration of gait or coordination.
Psychiatric: Denies depression, anxiety.
Data Reviewed :

- Last Pap July 2010, negative.
- Last mammogram July 2010, benign.
- Colonoscopy, never.
- Bone mineral density study, never.

Past Medical History: : Hypertension, aortic stenosis, headaches, Stokes-Adams attack, pacemaker 2005, stroke to her left eye.
Past Surgical History: Cesarean section x 2, tonsil and adenoidectomy, pacemaker.
Family History: The patient is adopted.
Social History: Occasional social ethanol use. Denies tobacco or illicit drug use.
Physical Examination: Blood pressure 130/80, weight 231 pounds and height 5 feet 3 inches.

General: Well-developed, well-nourished female in no acute distress.
Neck: Supple, with full range of motion. No adenopathy, masses, or thyromegaly. Trachea midline.
Lungs: Clear bilaterally with no rales, rhonchi or wheezes. Normal effort.
Cardiovascular auscultation: Reveals no murmurs or rubs; normal S1, S2.
Lymph Node Survey: No supraclavicular, axillary, or inguinal adenopathy.

Abdomen: Soft, nontender, without masses. No palpable hernia. No organomegaly. No hernias.
Vulva: General appearance normal; external genitalia with no lesions.
Urethra:: Normal size, normal location, with no lesions or prolapse. No masses, tenderness, prolapse, or scarring.
Bladder: No masses or tenderness.
Vagina: Vagina is very narrow and atrophic. Difficult to insert 1 finger.
Cervix: is grossly normal, with normal size.
Bimanual Examination: Reveals the uterus is upper limit of normal size. Smooth contour. No adnexal masses.
Anus: No lesions, no relaxation. Normal sphincter tone.
Rectovaginal: Reveals no masses, nodularity, or hemorrhoids. Anus, perineum normal, without lesions or relaxation. Stool sample was not indicated.
Peripheral Lower Extremities: No edema, tenderness, cords.
Psychiatric: Patient is oriented to person, place, and time. Mood is normal. Affect is normal. The patient had been hospitalized in January 2010 with an infection. She had had carotid Doppler bilateral ultrasounds done. These have been scanned into the chart. The patient does have bilateral atheromatous changes, but no evidence for stenosis. No findings of hemodynamically significant stenosis on either carotid arteries.

Impression:

1. Complex hyperplasia with atypia, possible adenocarcinoma of the endometrium.
2. Hypertension.
3. Aortic stenosis.
4. Stroke to her left eye.
5. Stokes-Adams attacks.

Recommendations:: 1. TAH/BSO with lymphadenectomy as indicated.

OPERATIVE REPORT

Date of Procedure: 08/13/2010

Preoperative Diagnoses:1. Complex hyperplasia with atypia, possible adenocarcinoma of the endometrium. 2. Vaginal stenosis

Postoperative Diagnoses:1. Grade 2 adenocarcinoma of the endometrium, FIGO Stage IB. 2. Vaginal stenosis

Indication for procedure: This is a 76-yo patient referred after an endometrial biopsy for postmenopausal bleeding showed complex hyperplasia with atypia in an area suspicious for adenocarcinoma. The patient had also had transvaginal ultrasound and had an endometrial stripe of 33 mm. The patient has number medical problems. The patient is brought to the operating room for definitive surgical management

Procedure: 1. Exploratory laparotomy. 2. TAH/BSO. 3. Bilateral pelvic lymphadenectomy

Operative Findings: The uterus was normal in size and shape. The ovaries were small and atrophic. There were no palpably enlarged periaortic nodes. There was one enlarged right obturator lymph node. Exploration of the upper abdomen was limited because of the patient's size and the incision. There was no obvious enlargement or abnormalities to the liver, stomach, spleen, and pancreas.

Procedure in details: The patient was brought to the operating room. After induction of general anesthesia the legs were frog legged and the vulva and vagina were prepped with Betadine scrub and solution. A Foley catheter was placed. The abdomen was prepped with ChloraPrep. The patient was sterilely draped. A midline abdominal incision was made by excising the previous cesarean section incision. This was carried down to the fascia. The fascia was incised and the peritoneal cavity was entered. Cytologic washings were obtained and the abdomen was explored as described above. Bookwalter retractor was used for exposure. The bowel was packed from the pelvis with the Bookwalter retractor and laps. The uterus was grasped with Kelly clamps on either side. The retroperitoneal spaces were opened bilaterally. Each round ligament was identified, clamped, cut and suture ligated. Each ureter was either identified by visualization or palpation. The infundibulopelvic ligaments were isolated, clamped, cut and doubly ligated. The uterine vessels were skeletonized. The bladder peritoneum was pulled up onto the uterus, but dissected off it without any difficulty. The uterine vessels were then clamped, cut and suture ligated bilaterally. Continuing with clamp, cut, ligature technique we continued down the sides of the cervix until the vagina was entered and the uterus, cervix, tubes and ovaries were removed. Angle sutures were placed at each angle of the vagina with 0 Vicryl suture, and the intervening vagina was closed with interrupted 0 Vicryl suture.

The uterus was opened by myself. There was approximately a 3 x 3 cm mass within the While waiting for frozen section to return, I began a pelvic lymphadenectomy. This was begun on the right. The lymph nodes along the right external iliac artery, vein, and hypogastric artery were removed and sent for permanent section. The obturator space was further dissected. The obturator nerve was identified and there was a node that was upper limits of normal size in this area that was removed. There was bleeding from the obturator artery that was controlled with a clip. Subsequently at the end of the case this area was dry and FloSeal was placed in this area. The obturator nerve was identified throughout this time.

Attention was now directed to the left side of the pelvis. The lymph nodes along the left external iliac artery, vein, and hypogastric artery were removed. The obturator nerve was identified and those nodes in the obturator fossa anterior to the nerve were removed. FloSeal was placed in this area after first visualizing it and seeing that there was no bleeding. At this point, the pelvis had been irrigated. There was no evidence of any further bleeding. The angle sutures were cut, and the laps were removed, and several sheets of Seprafilm were placed between the peritoneum and the omentum. The fascia was closed with a #1 looped PDS suture beginning superiorly and inferiorly, and tying proximally mid incision. This was a bulk closure including fascia and peritoneum. The subcutaneous tissues were irrigated. We next placed an ON-Q pump. This was done by making two small incisions superior and lateral to the midline incision. The blunt tunneler with the catheter was inserted into the subcutaneous spaces. This was done after we had closed the subcutaneous tissue with a running 2-0 plain gut. This was done bilaterally. Each catheter was inserted through the sheath, the sheath was cracked and removed, and the catheters taped to the anterior abdominal wall. Subsequently then, the skin was closed with a running 4-0 Monocryl suture beginning superiorly and inferiorly, and tying proximally mid incision. This was a subcuticular closure. The patient was then awakened and taken to the recovery room in stable condition. Lap, needle, sponge and instrument count was correct.

PATHOLOGY REPORT
Date: 8/13/2010

Clinical: Complex hyperplasia with atypia

Gynecological Case # 3

Specimen
1. Uterus and cervix, with bilateral tubes and ovaries.
2. Right pelvic and obturator lymph nodes.
3. Left pelvic and obturator lymph nodes.
4. Additional right obturator lymph node.

Procedure: TAH/BSO

Final Diagnosis:
- Endometrium, Invasive endometrioid adenocarcinoma.
- Bilateral fallopian tubes and ovaries with no significant abnormality
- Right pelvic and obturator lymph nodes, regional resection: two lymph nodes negative for metastatic carcinoma. (0/2)
- Left pelvic and obturator lymph nodes regional resection: seven lymph nodes negative for metastatic carcinoma (0/7)
- Additional right obturator lymph node, excisional biopsy: one lymph node negative for metastatic carcinoma (0/1)

Macroscopic:
Tumor Size: Greatest dimension: 5 cm
Additional dimensions: 4 x 2 cm
Other Organs Present: Right and left ovaries and right and left fallopian tubes

Microscopic:
Histologic Type: Endometrioid adenocarcinoma
Histologic Grade:G2 - 6% to 50% nonsquamous solid growth
Comment: Although the frozen section slide and permanent frozen section control show predominantly a histologic Grade 1 pattern, additional sections of tumor for permanent sections reveal an increased percentage of nonsquamous solid growth and therefore, the histologic grade for the entire tumor is given a Grade 2.
Myometrial Invasion: Invasion present.
Specify depth of invasion: 2.1 cm.
Specify myometrial thickness: 2.5 cm
Pathologic Staging:
Primary Tumor (pT): pT1b, Tumor is confined to the corpus uteri and invades one-half or more of the myometrium.
Regional Lymph Nodes (pN): pN0, No regional lymph node metastasis
Number examined: 10
Number involved: 0
Distant Metastasis (pM): pMx: Cannot be assessed
Margins: Uninvolved by invasive carcinoma
Venous/Lymphatic Invasion: Absent
Note: Pathologic staging pT1b N0 MX 1. Endometrial adenocarcinoma, grade 2, in frozen section. More than 50% of myometrial thickness invasion present.

Gross: 1. Received fresh is a 101 gm opened uterus with bilateral tubes and ovaries measuring 9.5 x 5 x 5 cm. The serosa is pink to tan and glistening. The cut surface of the uterus shows a 5 x 4 x 2 cm well-circumscribed endometrial mass. The cut surface of the mass is rubbery and tan to

yellow. The mass invades more than 50% of the myometrium, in fact invades almost 90% of the myometrium. The full thickness myometrium is 2.5 cm, and the invasion goes to a depth of 2.1 cm grossly. The lower uterine segment appears free in the anterior and posterior aspects. The endocervical canal is patent. The squamocolumnar junction is distinct. The exocervix is pink to tan and glistening. The cut surface of the cervix looks unremarkable. The right fallopian tube measures 5.5 cm in length by 0.5 cm in diameter. The serosa is pink to tan and glistening. The right ovary measures 2.5 x 1.5 x 0.7 cm. The external surface is rubbery, lobulated, and pink. The cut surface of the right ovary appears unremarkable. Some corpus albicans are identified. The left fallopian tube measures 4.5 cm in length by 0.4 cm in diameter. The serosa is pink to tan and listening. The attached left ovary measures 2 x 1 x 0.7 cm. The cut surface shows corpus albicans.

CYTOLOGY REPORT
Date: 08/13/2010

Specimen : Pelvic Wash, Peritoneal cytology 200mls of cloudy pink fluid
Interpretation: Negative for malignant cells. Moderate numbers of mesothelial cells present.

CSv2 ANSWER WORKSHEET

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
1	**Patient Name -**		
CANCER IDENTIFICATION			
2	Primary Site		
3	Histology		
4	Behavior		
5	Grade		
6	Grade system type		
7	Grade system value		
8	Lymph-vascular invasion		
STAGE OF DISEASE AT DIAGNOSIS			
9	CS Mets at Dx - Bone		
10	CS Mets at Dx - Lung		
11	CS Mets at Dx - Liver		
12	CS Mets at DX - Brain		
COLLABORATIVE STAGING			
13	CS Tumor Size		
14	CS Extension		
15	CS Tumor Size/Ext Eval		
16	CS Lymph Nodes		
17	CS Lymph Nodes Eval		
18	Regional Nodes Positive		
19	Regional Nodes Examined		
20	CS Mets at Dx		
21	CS Mets Eval		
22	CS Site-Specific Factor 1		
23	CS Site-Specific Factor 2		
24	CS Site-Specific Factor 3		
25	CS Site-Specific Factor 4		
26	CS Site-Specific Factor 5		
27	CS Site-Specific Factor 6		
28	CS Site-Specific Factor 7		
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46	CS Site-Specific Factor 25		

Gynecological Case # 6

DISCHARGE SUMMARY
Date of Admission: 09/10/2010
Date of Discharge: 09/12/2010

Admission Diagnoses: 1. Adenocarcinoma of the cervix, stage 1B1. 2. Exophytic, polypoid cervical mass. 3. Anemia

Procedures: Radical Hysterectomy, Bilateral Salpingo-Oophorectomy, and Bilateral Pelvic Lymph Node Dissection.

History of Present Illness: 28-year-old para 5, who post-coital bleeding and abnormal uterine bleeding off and on for the past 2 months. She was seen for this complaint. She has a history of an IUD. He performed a Pap smear which returned as an AGUS Pap. A biopsy of the cervix was also performed and the reportedly was invasive adenocarcinoma. She was referred to for surgical management. Slides were reviewed; they represented a poorly differentiated, invasive adenocarcinoma.

Past Medical History: Significant for migraine headaches.
Past Surgical History: Cesarean section x 1, prior cryosurgery of the cervix with mild dysplasia in approximately 2003.
Family History: Family history was negative for ovarian, uterine, breast or colon cancer.
Social History: The patient smokes one pack of cigarettes daily, denies ethanol or illicit drug use.

Physical Examination: Initial physical exam on presentation. A mass present within the vaginal canal which represented a polypoid mass arising from the cervix, consistent with carcinoma. It measured approximately 3-4 cm.

Hospital Course: It was recommended that the patient have surgical management with a radical hysterectomy and bilateral salpingo-oophorectomy and bilateral pelvic lymphadenectomy. She went to the operating room for the above-stated procedure. The estimated blood loss was 200 cc. Postoperatively, she did well. Pain was controlled. She had a voiding trial which she passed with a post-void residual of 10 cc. Her postoperative hemoglobin and hematocrit was 10.4 and 31.8. Preoperative hemoglobin and hematocrit were 12.6 and 38.1. The patient was discharged to home on postoperative day # 2 in stable condition with a temperature maximum of 100.0. The remainders of her vital signs were within the normal range. Her urine output remained more than adequate. Final pathology report was pending at the time of dictation.

HISTORY AND PHYSICAL
Date: 08/15/2010

History of Present Illness: This is a 28-year-old para- 5 woman who has had post-coital bleeding and abnormal uterine bleeding off and on for the past 2 months. She has a history of an IUD (intra-uterine device). She did a Pap smear, which subsequently returned as an AGUS and also did a biopsy of the cervix at the same time. The pathologist read this as an invasive adenocarcinoma. The slides were reviewed and it represents a poorly differentiated invasive adenocarcinoma. She has now been referred for further recommendations.

ROS
General:No fever, chills, fatigability, or weight loss
Nodes: Denies swollen glands
Chest: Denies DOE, cyanosis, wheezing, cough and sputum production
Cardiovascular: Denies chest pain, PND, orthopnea or reduced exercise tolerance
Abdomen: No weight loss. Denies diarrhea, abdominal pain, hematemesis, or blood in stool
Breasts: No pain, no lump, no discharge
Urinary: No incontinence. No nocturia. No frequency
Vulfar: No pain, no lesions, and no itching
Vaginal: Complains of post-coital bleeding and irregular bleeding for the past 2 months
Musculoskeletal: No joint stiffness or swelling. Denies back pain
Neurologic: No history of seizures, paralysis, alteration of gait or coordination

Laboratory: Last Pap 08/01/2010: AGUS. Last Mammogram: Never

Past Medical History: Significant for migraine headaches
Past Surgical History: C-section x 1, prior cryosurgery of the cervix for mild dysplasia in perhaps 2003
Family History: Negative for ovarian, uterine, breast, colon cancer
Social History: Smokes 1 pack of cigarettes daily. Denies ethanol or illicit drug use

Physical Examination: Blood pressure 110/70, weight 111 pounds, height 64 inches
General: Well-developed, well-nourished female in no acute distress
Neck: Supple, with full range of motion. No adenopathy, masses, or thyromegaly. Trachea midline.
Lungs: Clear bilaterally with no rales, rhonchi or wheezes. Normal effort.
Cardiovascular Auscultation: Reveals no murmurs or rubs; normal S1, S2.
Lymph Nodes Survey: No supraclavicular, axillary, or inguinal adenopathy.
Abdomen: Soft, nontender. No masses. No hernia. No organomegaly. Low transverse incision
Vulva: General appearance normal; external genitalia with no lesions.
Urethra: Normal size, normal location, with no lesions or prolapse. No masses, tenderness, prolapse, or scarring.
Bladder: No masses or tenderness.
Vagina: Upon inserting the speculum, there is a mass that presents itself within the vaginal canal. Further inspection of this reveals that this is a polypoid mass arising from the cervix. It is consistent with carcinoma. It bleeds very easily. It is friable. The polypoid cervical mass measures approximately 3 x 4 cm. The cervical body itself on bimanual rectovaginal examination is normal in size. The uterus is also neutral in position and normal in size. No adnexal masses are noted. No abnormalities are noted on rectal examination.
Peripheral Lower Extremities: No edema, tenderness, cords.

Impression: Adenocarcinoma of the cervix presenting as an exophytic polypoid mass.

Recommendations:
1. Chest x-ray
2. CT scan of the abdomen and pelvis.

3. Further surgical management with radical hysterectomy, bilateral salpingo-oophorectomy, and bilateral pelvic lymphadenectomy. The patient was consented today. All questions were answered.

RADIOLOGY REPORT
Date: 08/30/2010

CT of Abdomen and Pelvis with contrast
Clinical: Endocervix Cancer

Results: CT of the abdomen and pelvis was performed with oral and intravenous contrast. Lung bases are clear and liver parenchyma is unremarkable with one or two tiny hyperdensities, too small to characterize. Bile ducts and gallbladder appear normal. Pancreas and spleen appear normal. Both kidneys appear normal and function well. No hydronephrosis can be seen. Retroperitoneal structures are normal and no retroperitoneal lymphadenopathy or ascites can be seen. The uterus is slightly prominent in size and there is in intrauterine device in place. The ovaries are minimally prominent but no masses can be seen.
Impression: 1. No evidence of metastatic disease. 2. Intrauterine device in place.

OPERATIVE REPORT
Date: 9/10/2010

Preoperative Diagnosis: FIGO Stage IBI Adenocarcinoma of the Cervix.
Postoperative Diagnosis: FIGO Stage IBI Adenocarcinoma of the Cervix.

Procedures: Radical Hysterectomy, Bilateral Salpingo-Oophorectomy, Bilateral Pelvic Lymphadenectomy.

Operative Note: This is a 28-year-old patient. She had an adenocarcinoma cervix. She had undergone a metastatic workup that included chest x-ray that was negative and a CT scan that showed no evidence of metastatic disease. She was brought to the operating room for definitive surgical management.

Operative Findings: The cervical lesion is mostly an exophytic lesion, approximately, 4x4 cm. The ovaries were normal in appearance. The uterus was normal. Both tubes were normal. Along the right pelvic sidewall was an enlarged node, approximately, 2 x 1 cm, that was soft. There was also a lymph node, approximately, 8 x 8 mm at the area of the left uterine artery medial to the ureter. This would be in the parametrium. The additional exploration of the upper abdomen revealed both lobes of the liver to be normal. Stomach, pancreas, and spleen normal to palpation. Both kidneys were normal to palpation.

PATHOLOGY REPORT # 1
Date: 8/01/2010

Specimen: Outside slides labeled “cervical biopsy”.

Diagnosis: Designated as cervical biopsy – Poorly Differentiated Invasive Adenocarcinoma

PATHOLOGY REPORT # 2
Date: 09/11/2010

Clinical: Cervical cancer.

Specimen:
1. Right pelvic lymph node
2. Right obturator lymph nodes
3. Right common iliac lymph nodes
4. Left pelvic lymph nodes
5. Left obturator lymph nodes
6. Left common iliac lymph nodes
7. Left para-cervical lymph node
8. Uterus, cervix, upper vagina, bilateral tubes and ovaries

Final Pathology Diagnosis:

1. Lymph nodes (right pelvic lymph node dissection): metastatic adenocarcinoma. Metastatic adenocarcinoma to 1 of 4 lymph nodes. Comment: A small subcapsular nest of adenocarcinoma is identified measuring 1.4 mm in maximum dimension. The tumor does not extend into the perinodal tissue.
2. Lymph nodes (right obturator lymph node dissection): 5 of 5 lymph nodes free of tumor
3. Lymph nodes (right common iliac lymph node dissection): 2 of 2 lymph nodes free of tumor
4. Lymph nodes (left pelvic lymph node dissection): 3 of 3 lymph nodes free of tumor
5. Lymph nodes (left obturator lymph nodes dissection): 3 of 3 lymph nodes free of tumor
6. Lymph nodes (left common iliac lymph node): 1 of 1 lymph node free of tumor
7. Lymph node (left para-cervical lymph node): 1 of 1 metastatic adenocarcinoma

Comment: Small subcapsular nests of mucinous adenocarcinoma are identified within the lymph node measuring up to 2 mm in greatest dimension. Tumor does not extend extranodally

8. Uterus (Radical Hysterectomy specimen):
   Invasive poorly differentiated mucinous cervical adenocarcinoma (4.0 cm maximum diameter) with focal lymphatic invasion;
   Vaginal resection margins are free of tumor;
   Metastatic adenocarcinoma to left para-cervical lymph node. Tumor extends to within 0.5 cm of the soft tissue margin;
   Weakly proliferative endometrium;
   Intrauterine device
   Myometrium and serosa showing no significant histological abnormality;
   Fallopian tubes (2): no significant histological abnormality
   Ovaries (2): cystic follicles, corpora albicantia: ovaries free of tumor

Comment: The tumor is categorized according to the TNM staging criteria as a FIGO stage IIIB (T1b1 N1 MX) lesion.

CSv2 ANSWER WORKSHEET

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
1	**Patient Name -**		
CANCER IDENTIFICATION			
2	Primary Site		
3	Histology		
4	Behavior		
5	Grade		
6	Grade system type		
7	Grade system value		
8	Lymph-vascular invasion		
STAGE OF DISEASE AT DIAGNOSIS			
9	CS Mets at Dx - Bone		
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COLLABORATIVE STAGING			
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