GYN Malignancies

FCDS 2012/2013 Educational Webcast Series
October 18, 2012
Steven Peace, BS, CTR
Mayra Espino, BA, RHIT, CTR

Updated for 2012 Requirements and CSv02.04

Presentation Outline

- Anatomy of the Female Reproductive System
- Overview of Major GYN Cancer Characteristics
- Multiple Primary and Histology Coding Rules
- Collaborative Stage Data Collection System (CSv2)
- C.S. Site Specific Factors
- Treatment Options
Presentation Outline

- Cervix, Vagina, Vulva – SCC & HPV and Melanoma
- Corpus Uteri – Epithelial (carcinoma, Mullerian tumor)
- Corpus Uteri – Mesenchymal (pure sarcoma)
- Corpus Uteri – Mixed Tumors (adenosarcoma)
- Ovary/Fallopian Tube – Epithelial Stromal Tumors (serous, mucinous, endometrioid)
- Ovary/Fallopian Tube – Germ Cell Tumors
- Ovary/Fallopian Tube – Borderline Malignancy
- Primary Peritoneal Malignancy

Female Reproductive System
Female Reproductive System

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Female Reproductive System
Female Reproductive System

Female External Genitalia

Typical Chain of Events

- General History & Physical
- Gynecologic Exam – routine or symptoms
- PAP/D&C – cytology
- Colposcopy/Biopsy – histology
- Conization – Biopsy or Treatment
- Hysterectomy – Treatment
- TAH/BSO – Treatment
- Omentectomy (debulking)
Overview – Cervix, Vagina, Vulva

- Incidence and Mortality
- Causes & Risk Factors
- Signs and Symptoms
- WHO Classification
- MP/H Rules
- Collaborative Stage Core Items
- Collaborative Stage SSFs
- Treatment Guidelines

Incidence and Mortality

- **Cervix – 2012 estimates**
  - U.S. New Cases – 12,170
  - U.S. Deaths – 4,220
  - FL. New Cases – 910
  - FL. Deaths – 300

- **Vulva – 2012 estimates**
  - U.S. New Cases – 4,490
  - U.S. Deaths – 950
  - FL. New Cases – 340
  - FL. Deaths – 70

- **Vagina – 2012 estimates**
  - U.S. New Cases – 2,680
  - U.S. Deaths – 840
  - FL. New Cases – 187
  - FL. Deaths – 63
Cervical Cancer - Global

Source: Global Cancer Facts & Figures 2007

Causes and Risk Factors

Environmental
- HPV Infection
- Birth Control Pills
- Smoking
- Not Getting Screened

Genetic
- Median age at dx 48
- DES Exposure
- Family History
Signs and Symptoms

- #1 - HPV Infection
- Unusual vaginal discharge
- Vaginal bleeding between periods
- Bleeding after menopause
- Bleeding or pain during sex

http://www.medicinenet.com/cervical

PAP and HPV Testing

- >6 Million Women in U.S. have HPV Infection – at risk
- >33% of Women Eligible for Screen are NOT Screened
- Routine Screening detects most cancers pre-invasive
- PAP/HPV Screening detects >90% of cancers
- Annual PAP No Longer Routine
- Post-Menopausal Risk
- Other HPV Cancers
WHO Histologic Classification

- Squamous cell carcinoma
- Adenocarcinoma
- Adenosquamous carcinoma

Other Characteristics

- Not Reportable Non-invasive carcinoma (after 1/1/96)
  - CIS (cervix)
  - CIN III
- Reportable Intraepithelial Neoplasia
  - CIS (except cervix)
  - Vulva VIN III
  - Vaginal VAIN III
- Skin of vulva – reportable as C51.9
Overview – Corpus Uteri

- U.S. Incidence and Mortality
- Causes & Risk Factors
- Signs and Symptoms
- WHO Classification
- MP/H Rules
- Collaborative Stage Core Items
- Collaborative Stage SSFs
- Treatment Guidelines

Incidence and Mortality

- Uterine Corpus – 2012 estimates
  - U.S. New Cases – 47,130
  - FL. New Cases – 2,910
  - U.S. Deaths – 8,010
  - FL. Deaths – 494
Causes and Risk Factors

Environmental
- Birth Control pills
- Smoking
- Obesity
- Diabetes,
- High-fat-diet
- Early age at menarche
- Reproductive and menstrual history
- Nulliparity
- Late menopause
- Tamoxifen (hormone replacement)
- Radiation Therapy

Genetic
- Family history
- Lynch syndrome
- Older age (55 years or older)

Signs and Symptoms
- Abnormal vaginal bleeding (other than during menstruation) spotting
- Abnormal vaginal discharge
- Pelvic pain
- Pain during intercourse
- Pain or difficulty when emptying the bladder
WHO Histologic Classification

- Adenosarcoma
  - 8380

- Carcinoma and Carcinosarcoma
  - 8000-8790, 8980-8981, 9700-9701

- Sarcoma
  - 8890-8898, 8930-8931

Other Characteristics

- ICD-O-3 term “stromal endometriosis” [8931/3] - Reportable
Overview – Ovary

- U.S. Incidence and Mortality
- Causes & Risk Factors
- Signs and Symptoms
- WHO Classification
- MP/H Rules
- Collaborative Stage Core Items
- Collaborative Stage SSFs
- Treatment Guidelines

Incidence and Mortality

- Ovary – 2012 estimates
  - U.S. New Cases – 22,280  FL. New Cases – 1495
  - U.S. Deaths – 15,500  FL Deaths - 1040

- Primary Peritoneal New Cases - ??
- Primary Peritoneal Deaths - ??

- Impact on Change in Classification - ??
Causes and Risk Factors

Environmental
- Investigated but not conclusively associated with the development of this neoplasm
- Oophorectomy reduces risk of ovarian and fallopian tube cancer but may increase risk for primary peritoneal cancer after prophylactic salpingo-oophorectomy

Genetic
- Family history
- BRCA1 and BRCA2 mutations
- Lynch syndrome
- HNPCC syndrome (hereditary nonpolyposis colorectal cancer)
- Fallopian Tube-NCCN suggested that these cancer may be the origin of some ovarian and primary peritoneal cancers

Signs and Symptoms
- Suspicious/palpable pelvic mass detected on abdominal/pelvic exam
- Ascites
- Abdominal distention
- Bloating
- Pelvic or abdominal pain
- Difficulty eating or feeling full quickly eating or feeling full quickly
- Urinary symptoms (urgency or frequency) without other obvious source of malignancy
Signs and Symptoms

- Screening Options – not supported
  - Transvaginal Ultrasound
  - Pelvic Examination
  - CA-125

- CA-125 is a tumor marker for ovarian cancer - monitor disease progression.

- Normal is , 35 U/ml

WHO Histologic Classification

- **Ovarian Epithelial**
  - Serous cystadenocarcinoma
  - Mucinous cystadenocarcinoma
  - Endometrioid adenocarcinoma
  - Clear cell cystadenocarcinoma

- **Ovarian Germ Cell Tumors**
  - Dysgerminoma
  - Embryonal carcinoma
  - Choriocarcinoma
  - Teratoma – malignant reportable

- **Borderline Malignant Neoplasms**
WHO Histologic Classification

<table>
<thead>
<tr>
<th>Granulosa cell tumors</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>Malignant</td>
</tr>
<tr>
<td>Juvenile</td>
<td>Malignant</td>
</tr>
<tr>
<td>Thecoma</td>
<td></td>
</tr>
<tr>
<td>Thecomas typical</td>
<td>Benign</td>
</tr>
<tr>
<td>Thecomas, lutenized</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Thecoma with increased mitotic figures</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Fibroma</td>
<td></td>
</tr>
<tr>
<td>Cellular fibroma</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Cellular fibroma with increased mitotic figures</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Fibrosarcoma</td>
<td>Benign</td>
</tr>
<tr>
<td>Stromal tumor with minor sex cord elements</td>
<td>Benign</td>
</tr>
<tr>
<td>Sclerosing stromal tumor</td>
<td>Benign</td>
</tr>
<tr>
<td>Signet ring stromal tumors</td>
<td>Benign</td>
</tr>
<tr>
<td>Unclassified</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Sertoli-Leydig cell tumors</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Well differentiated</td>
<td>Malignant</td>
</tr>
<tr>
<td>Intermediate differentiation</td>
<td>Malignant</td>
</tr>
<tr>
<td>Poorly differentiated</td>
<td>Malignant</td>
</tr>
<tr>
<td>Sertoli-Leydig tumors with heterologous elements</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Sertoli cell tumors</td>
<td>Benign</td>
</tr>
<tr>
<td>Leydig cell tumors</td>
<td>Benign</td>
</tr>
<tr>
<td>Stromal-Leydig cell tumors</td>
<td>Benign</td>
</tr>
<tr>
<td>Sex cord tumors with annular tubules (SCTAT)</td>
<td>Malignant</td>
</tr>
<tr>
<td>Microscopic SCTAT associated with Peutz-Jeghers syndrome</td>
<td>Malignant</td>
</tr>
<tr>
<td>Gynandroblastoma</td>
<td>Malignant/Malignant potential</td>
</tr>
<tr>
<td>Unclassified sex cord stromal tumors</td>
<td>Malignant potential</td>
</tr>
<tr>
<td>Steroid cell tumors</td>
<td>Malignant</td>
</tr>
</tbody>
</table>

Other Characteristics

- Changes in classification of ovarian neoplasms
- Changes in case reportable rules
  - Borderline Malignancy
  - Primary Peritoneal
  - Primary Ovarian
Other Characteristics

Borderline Neoplasm of Ovary

- 1973 – 1989: Not Reportable, ICD-O
- 2015 –: Not Reportable, ICD-O-4

Other Characteristics

Epithelial Neoplasms – Ovary

- Serous cystadenocarcinomas.
- Mucinous cystadenocarcinomas.
- Endometrioid adenocarcinomas.
- Clear cell cystadenocarcinomas.
- Other & Mixed
Other Characteristics

- Epithelial Neoplasms – Peritoneum
  - Serous cystadenocarcinomas.
  - Mucinous cystadenocarcinomas.
  - Endometrioid adenocarcinomas.
  - Clear cell cystadenocarcinomas.
  - Other & Mixed

- Epithelial Neoplasms – Ovary/Peritoneum
  - Bulky Disease at First Presentation
  - Common Sites for Seeding
    - Peritoneum
    - Diaphragm
    - Liver Surface
  - Pulmonary & Pleural Involvement Common
Other Characteristics

- **Historical Assessment**

- **Classified as Ovarian in Origin**
  - Serous Tumors with Ovarian Involvement
  - Mucinous Tumors with Ovarian Involvement

- **Current Evaluation Criteria – evolving**

- Improvements in Imaging and IHC/FISH expected to reduce misclassification

Other Characteristics

- Serous Tumors forming 6mm mass in ovary should be considered **ovarian primaries**.

- Serous Tumors forming multiple small ovarian masses should be considered **peritoneal if the disease is mainly extraovarian**.

- Mucinous neoplasms metastatic to ovary are often misclassified as **ovarian primaries**.
Multiple Primary and Histology Coding Rules

ALL GYN Sites – See Other Sites
- Terms & Definitions
- Multiple Primary Rules
- Histology Coding Rules

Parametrium - Connective tissue of the pelvic floor extending from the fibrous subserous coat of the supracervical portion of the uterus laterally between the layers of the broad ligament

Uterine adnexa - Appendages of the uterus, namely the ovaries, fallopian tubes, and ligaments that hold the uterus in place
Terms and Definitions

Other Sites Terms and Definitions

Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Uterus, Bladder, Brain, Lymphoma and Leukemia

<table>
<thead>
<tr>
<th>Column 1: Required Histology</th>
<th>Column 2: Combined with Histology</th>
<th>Column 3: Combination Term</th>
<th>Column 4: Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gyn malignancies with two or more of the histologies in column 2</td>
<td>Clear cell</td>
<td>Mixed cell adenocarcinoma</td>
<td>8723</td>
</tr>
<tr>
<td></td>
<td>Endometroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mucinous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Papillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Squamous</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transitional (Brenner)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiple Primary Rules

M0
Are there bilateral epithelial tumors (6000-6190) of the ovary within 60 days of diagnosis?

SINGLE PRIMARY

M1
Are there tumors in both the left and right sides of a paired site (Table 1)?

MULTIPLE PRIMARY

M2
Is the diagnosis adenocarcinoma in adenomatous polypectomy cell (6080-6090) with one or more malignant polytype?

SINGLE PRIMARY

Tumors may be present in a single or multiple segments of the colon, rectosigmoid, rectum.

Table 1 - Paired Organs and Sites with Laterality
Multiple Primary Rules

M10
Are there tumors diagnosed more than one (1) year apart?

Yes

No

MULTIPLE PRIMARY

M15
Is there an invasive tumor following an in situ tumor more than 60 days after diagnosis?

Yes

No

MULTIPLE PRIMARY

1. The purpose of this rule is to ensure that the case is counted as an incident (invasive) case when incidence data are analyzed.

2. Avoid double counting cases even if the medical record or physician states it is recurrence or progression of disease.

Histology Coding Rules

H13
Is there a malignant neoplasm, NOS (8000) and a more specific histology?

Yes

No

Is there carcinoma, NOS (8010) and a more specific carcinoma?

No

Is there squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma?

No

Is there adenocarcinoma, NOS (8140) and a more specific adenocarcinoma?

No

Is there melanoma, NOS (8720) and a more specific melanoma?

No

Is there carcinoma, NOS (8000) and a more specific carcinoma?

No

The specific histology may be identified as type, subtype, predominancy, with features of major, or with differentiation. The terms architecture and pattern are subtypes only for an in situ cancer.

Example 1: Adenocarcinoma, predominantly mucinous. Code mucinous adenocarcinoma 8480.

Histology Coding Rules

H21
Is the diagnosis in situ squamous intraepithelial neoplasia grade III of the vulva (VIN III) vagina (VIN III), or anus (AIN III)?

NO

YES

Code 8077/2
Squamous intraepithelial neoplasia, grade III.

1. VIN, VAIN, and AIN are squamous cell carcinomas. Code 8077 cannot be used for glandular intraepithelial neoplasia such as, prostatic intraepithelial neoplasia (PIN) or pancreatic intraepithelial neoplasia (PAN).

2. This code may be used for reportable by agreement codes.

Histology Coding Rules

H16
Does the tumor have multiple specific histologies or is there a non-specific histology with multiple specific histologies?

NO

YES

Code the appropriate combinations/ mixed code (Table 2)

- Example 1 (multiple specific histologies): Mucoepidermoid and papillary adenocarcinoma. Code 8255 (adenocarcinoma with mixed subtypes)
- Example 3 (non-specific with multiple specific histologies): Adenocarcinoma with papillary and clear cell features. Code 8255 (adenocarcinoma with mixed subtypes)
Staging GYN Cancers

Federation Internationale de Gynecologie et d'Obstetrique (FIGO)

- Use the FIGO stage stated in the medical record by the clinician or pathologist
- When both FIGO stage and extension detail are available, record the code with extension detail in preference to a statement of FIGO stage
- FIGO, TNM, CS are nearly identical – CS has more details
- Examples
  - 100 FIGO Stage I
  - 112 FIGO Stage IA2 (cervix)
  - 220 FIGO Stage IIB
  - 330 FIGO Stage III C
  - 331 FIGO Stage III C1 (corpus)
  - 410 FIGO Stage IVA
### Staging

**Table 1**  
American Joint Committee on Cancer (AJCC)  
TNM and FIGO Staging System for Ovarian and Primary Peritoneal Cancer (7th ed., 2010)

<table>
<thead>
<tr>
<th>Primary Tumor (T)</th>
<th>TNM</th>
<th>FIGO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TX</strong></td>
<td>Primary tumor cannot be assessed</td>
<td></td>
</tr>
<tr>
<td><strong>T0</strong> No evidence of primary tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T1</strong> I</td>
<td>Tumor limited to ovaries (one or both)</td>
<td></td>
</tr>
<tr>
<td><strong>T1a</strong> IA</td>
<td>Tumor limited to one ovary; capsule intact, no tumor on ovarian surface; No malignant cells in ascites or peritoneal washings</td>
<td></td>
</tr>
<tr>
<td><strong>T1b</strong> IB</td>
<td>Tumor limited to both ovaries; capsule intact, no tumor on ovarian surface; No malignant cells in ascites or peritoneal washings</td>
<td></td>
</tr>
<tr>
<td><strong>T1c</strong> IC</td>
<td>Tumor limited to one or both ovaries with any of the following: capsule ruptured, tumor on ovarian surface, malignant cells in ascites or peritoneal washings</td>
<td></td>
</tr>
<tr>
<td><strong>T2</strong> II</td>
<td>Tumor involves one or both ovaries with pelvic extension</td>
<td></td>
</tr>
<tr>
<td><strong>T2a</strong> IIA</td>
<td>Extension and/or implants on uterus and/or tube(s)</td>
<td></td>
</tr>
<tr>
<td><strong>T2b</strong> II</td>
<td>Extension to and/or implants on other pelvic tissues. No malignant cells in ascites or peritoneal washings</td>
<td></td>
</tr>
<tr>
<td><strong>T2c</strong> IIC</td>
<td>Pelvic extension and/or implants (T2a or T2b) with malignant cells in ascites or peritoneal washings</td>
<td></td>
</tr>
</tbody>
</table>

**Regional Lymph Nodes (N)**

- **NX** Regional lymph nodes cannot be assessed
- **N0** No regional lymph node metastasis
- **N1** IIC Regional lymph node metastasis

**Distant Metastasis (M)**

- **M0** No distant metastasis
- **M1** IV Distant metastasis (excludes peritoneal metastasis)

Note: Liver capsule metastasis is T3/Stage III; Liver parenchymal metastasis, M1/Stage IV. Pleural effusion must have positive cytology for M1/Stage IV.

**Continued**

### Staging (Continued)

**Table 1 (Continued)**

<table>
<thead>
<tr>
<th>Stage Grouping</th>
<th>T1</th>
<th>N0</th>
<th>M0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage IA</td>
<td>1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IB</td>
<td>1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IC</td>
<td>1c</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage II</td>
<td>2</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage III</td>
<td>3</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIIC</td>
<td>3c</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Any T</td>
<td>1</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>

Note: For histologic grade and histopathologic type, see AJCC staging manual.
**Cervix/Vulva/Vagina**

- Based on Clinical Evaluation
- **T**: Depth of Invasion (CS Ext)
- **N** and **M**: Standard

### Table

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
<th>TNM 6 Map</th>
<th>SS7 Map</th>
<th>SS2000 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>In situ, intraepithelial, noninvasive, preinvasive; Cancer in situ with endocervical gland involvement (See Note 3)</td>
<td>Tis</td>
<td>Tis</td>
<td>IS</td>
<td>IS</td>
</tr>
<tr>
<td>010</td>
<td>Cervical intraepithelial neoplasia (CIN) Grade III</td>
<td>Tis</td>
<td>Tis</td>
<td>IS</td>
<td>IS</td>
</tr>
<tr>
<td>110</td>
<td>Minimal microscopic stromal invasion less than or equal to 3 mm in depth (measured from the base of the epithelium) and less than or equal to 7 mm in horizontal spread</td>
<td>T1a1</td>
<td>T1a1</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>FIGO Stage IA1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>120</td>
<td>Microscopic stromal invasion greater than 3 mm and less than or equal to 5 mm in depth, (measured from the base of the epithelium) and less than or equal to 7 mm in horizontal spread</td>
<td>T1a2</td>
<td>T1a2</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>FIGO Stage IA2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>135</td>
<td>Invasive carcinoma confined to cervix, microscopic size of stromal invasion and horizontal spread not specified</td>
<td>T1aNOS</td>
<td>T1aNOS</td>
<td>L</td>
<td>L</td>
</tr>
<tr>
<td>140</td>
<td>FIGO Stage IA [NOS]</td>
<td>T1aNOS</td>
<td>T1aNOS</td>
<td>L</td>
<td>L</td>
</tr>
</tbody>
</table>
Corpus Uteri
- Based on Surgical Evaluation
- TNM based on FIGO staging
  - T: Depth of Invasion
  - N and M: Standard
  - Leiomyosarcoma, endometrial stromal sarcoma
    - 8890-8898, 8930-8931
  - Carcinoma and Carcinosarcoma
    - 8000-8790, 8980-8981, 9700-9701
  - Adenosarcoma
    - 8933
### Staging Uterine Carcinoma

#### Table 1: AJCC Tumor-Node-Metastasis (TNM) and International Federation of Gynecology and Obstetrics (FIGO) Surgical Staging Systems for Endometrial Cancer

<table>
<thead>
<tr>
<th>Stage</th>
<th>FIGO</th>
<th>TNM</th>
<th>Categories</th>
<th>Surgical-Pathologic Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>T0</td>
<td>0</td>
<td>0</td>
<td>No evidence of primary tumor</td>
<td>No regional lymph node metastasis.</td>
</tr>
<tr>
<td>T1</td>
<td>A</td>
<td>IA</td>
<td>Carcinoma limited to the endometrium</td>
<td>Regional lymph node metastasis to pelvic nodes, with or without positive pelvic lymph nodes.</td>
</tr>
<tr>
<td>T1a</td>
<td>A</td>
<td>IA</td>
<td>Carcinoma limited to the endometrium</td>
<td>Regional lymph node metastasis to para-aortic lymph nodes, with or without positive pelvic lymph nodes.</td>
</tr>
<tr>
<td>T1b</td>
<td>IB</td>
<td>IB</td>
<td>Tumor invades one-half or more of the myometrium</td>
<td>No distant metastasis.</td>
</tr>
<tr>
<td>T2</td>
<td>IB</td>
<td>IB</td>
<td>Tumor invades stromal component of the myometrium.</td>
<td>No distant metastasis.</td>
</tr>
<tr>
<td>T3</td>
<td>A</td>
<td>IIIA</td>
<td>Tumor involves serosa and/or adnexa (direct extension or metastasis.</td>
<td>Distant metastasis includes metastasis to para-aortic lymph nodes, vagina, pelvic serosa, or spleen.</td>
</tr>
<tr>
<td>T4</td>
<td>A</td>
<td>IV</td>
<td>Tumor involves bladder and/or bowel mucosa, and/or distant metastases.</td>
<td>Distant metastasis includes metastasis to para-aortic lymph nodes, vagina, pelvic serosa, or spleen.</td>
</tr>
</tbody>
</table>

#### Code Table: Collaborative Stage Data Collection System

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>TNM 7 Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>In situ, intraepithelial, noninvasive, preinvasive</td>
<td>Tis</td>
</tr>
<tr>
<td>100</td>
<td>Invasive cancer confined to corpus uteri</td>
<td>T1NOS</td>
</tr>
<tr>
<td>110</td>
<td>Confined to endometrium (stroma)</td>
<td>T1a</td>
</tr>
<tr>
<td>120</td>
<td>Tumor invades less than one-half of myometrium, invasion of inner half of myometrium</td>
<td>T1a</td>
</tr>
<tr>
<td>123</td>
<td>Endocervical glandular involvement WITH tumor limited to endometrium or invading less than one-half of myometrium (see Note 3)</td>
<td>T1a</td>
</tr>
<tr>
<td>125</td>
<td>FIGO Stage IA</td>
<td>T1a</td>
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<tr>
<td>130</td>
<td>Tumor invades one-half or more of myometrium, invasion of outer half of myometrium (see Note 4)</td>
<td>T1b</td>
</tr>
<tr>
<td>133</td>
<td>Endocervical glandular involvement WITH tumor invading one-half or more of myometrium (see Note 3)</td>
<td>T1b</td>
</tr>
</tbody>
</table>
Ovarian

Based on Combined Clinical/Surgical Evaluation

T: based on bilaterality, positive ascites, other sites

N and M: standard
1. Ascites Positive ascites changes stages I and II to IC and IIC.

2. Pelvic organs* coded to FIGO Stage II
   * Adnexa, bladder (including serosa), uterine ligaments, cul de sac, fallopian tubes, parametrium, pelvic peritoneum, pelvic wall, rectum, sigmoid colon, ureter, uterus, uterine serosa

3. Abdominal organs* coded to FIGO III
   * Abdominal mesentery, diaphragm, gallbladder, infracolic omentum, kidneys, large intestine except rectum and sigmoid, peritoneal surface of liver, omentum, pancreas, pericolic gutter, peritoneum, NOS, small intestine, spleen, stomach, ureters
   * Involvement may be direct or discontinuous

Gynecologic Cancers

4. CS Mets at DX
   * Liver parenchymal metastases area coded in M1
   * Implants (discontinuous metastases) seeding, salting, studding, talcum powder appearance
   * Determine whether implants are
     › T2 in the Pelvis
     › T3 outside the pelvis
     › M1
   * Implants outside the pelvis must be microscopically confirmed and coded.

5. Post Cytoreduction (debulking) - Residual Tumor Status
Surgical Staging Should Include:

- Removal of para-aortic lymph nodes
- Removal pelvic lymph nodes
- Removal primary tumor
- Uterus
- Cervix
- Vagina
- Peritoneal washing
- Removal of omentum
- Liver examination with biopsy as indicated
- Scraping of under right diaphragm
Primary Peritoneal
- Based on Combined Clinical/Surgical Evaluation
- T: based on positive ascites and other involvement
- N and M: standard

1. Ascites Positive ascites changes stages I and II to IC and IIC.

2. Pelvic organs* coded to FIGO Stage II
   - Adnexa, bladder (including serosa), uterine ligaments, cul de sac, fallopian tubes, parametrium, pelvic peritoneum, pelvic wall, rectum, sigmoid colon, ureter, uterus, uterine serosa

3. Abdominal organs* coded to FIGO III
   - Abdominal mesentery, diaphragm, gallbladder, infracolic omentum, kidneys, large intestine except rectum and sigmoid, peritoneal surface of liver, omentum, pancreas, pericolic gutter, peritoneum, NOS, small intestine, spleen, stomach, ureters
   - Involvement may be direct or discontinuous

Gynecologic Cancers
4. CS Mets at DX
- Liver parenchymal metastases area coded in M1
- Implants (discontinuous metastases) seeding, salting, studding, talcum powder appearance
- Determine whether implants are
  - T2 in the Pelvis
  - T3 outside the pelvis
  - M1
- Implants outside the pelvis must be microscopically confirmed and coded.

5. Post Cytoreduction (debulking) - Residual Tumor Status

## FCDS Required GYN Site Specific Factors

<table>
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<tr>
<th>Schema Name</th>
<th>2012 FCDS Required</th>
<th>Additional CoC Required</th>
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<td>FallopianTube</td>
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<tr>
<td>Vulva</td>
<td>11</td>
<td>10</td>
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</tbody>
</table>
CS Coding Issues

CS TUMOR SIZE: Instructions for Coding

- **Use of code 990.** Code 990, Microscopic focus or foci only and no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

- **Note:** The terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded to 990. If the tumor is described as both a microscopic focus and a specific size, code the specific size.

- **Example:** Ovary specimen: extensive cystic disease with focal areas of tumor seeding.

  - Disregard “focal” and code tumor size to 999 unknown.

Collaborative Stage Data Collection System User Documentation and Coding Instructions: Part I Section 1. Effective January 1, 2012 pg. 30, Version 02.04

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CS Coding Issues

- **CS Extension**

  - For certain sites such as ovary, discontinuous metastasis is coded in the CS Extension field area.

  - **Contiguous (direct) extension only.** With the exception of mucinous carcinoma of the corpus uteri, ovary, fallopian tube and female peritoneum, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

Collaborative Stage Data Collection System User Documentation and Coding Instructions: Part I Section 1. Effective January 1, 2012 pg. 34 & 35 Version 02.04
CS Coding Issues

CODING “NONE” VS. “UNKNOWN” IN THE COLLABORATIVE STAGE DATA COLLECTION SYSTEM, TNM AND SUMMARY STAGE

- INACCESSIBLE LYMPH NODES RULE
  - Regional lymph nodes are not palpable for inaccessible lymph nodes sites such as corpus uteri and ovary
  - The best description concerning regional lymph nodes will be on imaging studies or in the surgeon’s evaluation at the time of exploratory surgery or definitive surgery
  - If regional lymph nodes for these sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative (code 000) based on the inaccessible lymph nodes rule

Collaborative Stage Data Collection System User Documentation and Coding Instructions: Part I Section 1. Effective January 1, 2012 pg. 49 Version 02.04
NCCN Treatment Guidelines
Cervix, Vulva, Vagina

Surgery
Radiation Therapy

- External radiation therapy uses high-energy X-rays
- Internal radiation, or brachytherapy

Chemotherapy

**CHEMOTHERAPY REGIMENS FOR RECURRENT OR METASTATIC CERVICAL CANCER**

First-line combination therapy
- Cisplatin/paclitaxel
- Carboplatin/paclitaxel
- Cisplatin/topotecan
- Cisplatin/gemcitabine

Possible first-line single agent therapy
- Cisplatin (preferred as a single agent)
- Carboplatin
- Paclitaxel

Second-line therapy
- Bevacizumab
- Docetaxel
- 5-FU (5-fluorouracil)
- Gemcitabine
- Ifosfamide
- Vinorelbine
- Mitomycin
- Topotecan
- Cephalosporin (category 3)
- Vinorelbine (category 3)
### Chemotherapy

#### Drugs Approved for Prevention/Treatment of HPV Infection or Cancer

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Description</th>
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<tbody>
<tr>
<td>Cervix (Recombinant HPV Bivalent Vaccine)</td>
<td>Recombinant Human Papillomavirus (HPV) Bivalent Vaccine</td>
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</tr>
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<td>Gardasil (Recombinant HPV Quadrivalent Vaccine)</td>
<td>Recombinant Human Papillomavirus (HPV) Quadrivalent Vaccine</td>
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<td>Blenoxane (Bleomycin)</td>
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<td>Cisplatin</td>
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<td>Hycamtin (Topotecan Hydrochloride)</td>
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<td>Platinol (Cisplatin)</td>
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<td>Platinol-AQ (Cisplatin)</td>
<td></td>
</tr>
<tr>
<td>Topotecan Hydrochloride</td>
<td></td>
</tr>
</tbody>
</table>

### NCCN Treatment Guidelines

Corpus Uteri – Endometrium Uterus

- Decisions
- Evidence
- Values
- Resources
NCCN Treatment Guidelines
Uterine Neoplasms

INITIAL EVALUATION
H&P
CBC (including platelets)
Endometrial biopsy
Chest x-ray
Current cervical cytology consistent with NCCN Cervical Cancer Screening Guidelines

Optional:
Liver function tests/chemistry profiles
Consider genetic counseling/testing for young patients (<55 years) and those with significant family history of endometrial and/or colorectal cancer
(See Lynch syndrome/HNPCC in NCCN Colorectal Cancer Screening Guidelines)

INITIAL CLINICAL FINDINGS

Disease limited to uterus
Pure endometrioid
Suspected or gross cervical involvement
Suspected extravesical disease
See Primary Treatment (ENDO-1)
See Primary Treatment (ENDO-2)
See Primary Treatment (ENDO-3)

Papillary serous or clear cell carcinoma
Carcinosarcoma

All staging in guideline is based on updated 2010 FIGO staging. (See ST.1 and ST.2)

Endometrial Carcinoma
Primary Surgery

Endometrial Carcinoma

Hysterectomy

THISSD: Total hysterectomy + bilateral salpingo-oophorectomy
RH: Radical hysterectomy

Pathologic assessment to include:
- Nodal
  - Level of nodal involvement (pelvic, common iliac, para-aortic)
  - Pelvic lymphadenectomy
  - Uterus
  - Ratio of depth of myometrial invasion to myometrial thickness
  - Cervical stromal or glandular involvement
  - Tumor size
  - Tumor location (fundus vs lower uterine segment/cervix)
  - Histologic subtype with grade
  - Lymphovascular space invasion
  - Consider screening for inherited mismatch repair disease to identify familial cancer syndromes, such as Lynch syndrome/HNPCC in young patients (<55 years) with a significant family history and/or selected pathologic risk features
  - See NCCN Colorectal Cancer Screening Guidelines
  - Fallopian tubes/ovaries
Endometrial Carcinoma – Primary Surgery

Endometrial Carcinoma – Post-Surgical Evaluation
Endometrial Carcinoma – Radiation

PRINCIPLES OF RADIATION THERAPY

1. Tumor-directed RT refers to RT directed at sites of known or suspected tumor involvement, and may include external beam and/or brachytherapy. In general, tumor-directed external-beam RT (EBRT) is directed to the pelvis or the para-aortic region. Brachytherapy can be delivered: 1) to an intact uterus, either preoperatively or definitively; or 2) more commonly, to the vagina after hysterectomy. For the purposes of these guidelines, whole abdominal radiotherapy is not considered to be tumor-directed RT.

2. Pelvic radiotherapy should target the gross disease (if present), the lower common iliac, external iliac, internal iliac, parametrial, upper vaginal, para vaginal tissue, and presacral lymph nodes (in patients with cervical involvement). Extended-field radiotherapy should include the pelvic volume and also target the entire common iliac chain and para-aortic lymph node region. The upper border of the extended field depends on the clinical situation but should at least be to the level of the renal vessels. External-beam doses for microscopic disease should be 45-50 Gy. Multiple conformal fields based on CT-treatment planning should be utilized.

3. Brachytherapy doses for definitive therapy are individualized based on the clinical situation. For preoperative therapy in patients with gross stage IIIB disease, in general, a total dose of 75-80 Gy low-dose rate equivalent to the tumor volume is recommended. For vaginal brachytherapy, the dose should be prescribed to the vaginal surface or at a depth of 0.5 cm from the vaginal surface; the dose depends on the use of EBRT.

4. The target for vaginal brachytherapy after hysterectomy should be limited to the upper vagina.

5. For high-dose rate brachytherapy, when used as a boost to EBRT, doses of 4-6 Gy X 2-3 fractions prescribed to the vaginal mucosa are commonly used.

6. For lower-dose rate vaginal brachytherapy alone, commonly used regimens include 7 Gy X 3 prescribed at a depth of 0.5 cm from the vaginal surface or 6 Gy X 5 fractions prescribed to the vaginal surface.

Endometrial Carcinoma – Chemo

Endometrial Carcinoma

SYSTEMIC THERAPY FOR RECURRENT, METASTATIC OR HIGH-RISK DISEASE
(STRONGLY ENCOURAGE PARTICIPATION IN CLINICAL TRIALS)

HORMONE THERAPY
- Progestational agents
- Tamoxifen
- Aromatase inhibitors

CHEMOTHERAPY REGIMENS
- Cisplatin/docetaxel (category 1)
- Cisplatin/doxorubicin (category 1)
- Paclitaxel/docetaxel (category 1)
- Roferamide plus paclitaxel (category 1 for carcinoma concomitantly with adjuvant chemotherapy)
- Carboplatin/paclitaxel
- Carboplatin/docetaxel
- Cisplatin
- Paclitaxel
- Doxorubicin
- Liposomal doxorubicin
- Paclitaxel
- Docetaxel (category 2B)
- Bevacizumab (category 2B)
- Etoposide/Roferamide (for carcinoma concomitantly with adjuvant chemotherapy)
- Roferamide (for carcinoma concomitantly with adjuvant chemotherapy)

1 Cisplatin, carboplatin, paclitaxel, docetaxel, and doxorubicin may cause drug-related
2 Cisplatin, carboplatin: equivalent doses: 15 mg/m²/week (maximum 40 mg/m²/week) or 6 mg/day (maximum 24 mg/day)
3 Chemotherapy regimens are for endometrial histologies, papillary serous carcinomas, or clear cell carcinomas. A few of the agents can also be used for angiogenesis, as stated.
4 Docetaxel may be considered for patients in whom paclitaxel is contraindicated.
5 Etoposide may be considered for use in patients who have progressed on prior cytotoxic chemotherapy.
Uterine Sarcoma – Post Clinical/Surgical Evaluation

INITIAL CLINICAL FINDINGS

Disease limited to uterus
- Medically inoperable
- Operable

Known or suspected extraterine disease
- MRI or CT based on symptoms or clinical suspicion of metastases

PRINCIPLES OF RADIATION THERAPY

- Tumor-directed RT refers to RT directed at sites of known or suspected tumor involvement, and may include external beam and/or brachytherapy. In general, tumor-directed external-beam RT (EBRT) is directed to the pelvis with or without the para-aortic region. Brachytherapy can be delivered: 1) to an intact uterus, either preoperatively or definitively; or 2) more commonly, to the vagina after hysterectomy. For the purposes of these guidelines, whole abdominal radiotherapy is not considered to be tumor-directed RT.

- Pelvic radiotherapy should target the gross disease (if present), the lower common iliacs, external iliacs, internal iliacs, parametria, upper vaginal/para-vaginal tissue, and presacral lymph nodes (in patients with cervical involvement). Extended-field radiotherapy should include the pelvic volume and also target the entire common iliac chain and para-aortic lymph node region. The upper border of the extended field depends on the clinical situation but should at least be to the level of the renal vessels. External-beam doses for microscopic disease should be 45-50 Gy. Multiple conformal fields based on CT-treatment planning should be utilized.

- Brachytherapy doses for definitive therapy are individualized based on the clinical situation. For preoperative therapy in patients with gross stage IIB disease, in general, a total dose of 75-80 Gy low-dose rate equivalent to the tumor volume is recommended. For vaginal brachytherapy, the dose should be prescribed to the vaginal surface or at a depth of 0.5 cm from the vaginal surface; the dose depends on the use of EBRT.
  - The target for vaginal brachytherapy after hysterectomy should be limited to the upper vagina.
  - For high-dose rate brachytherapy, when used as a boost to EBRT, doses of 4-6 Gy X 2-3 fractions prescribed to the vaginal mucosa are commonly used.
  - For high-dose rate vaginal brachytherapy alone, commonly used regimens include 7 Gy X 3 prescribed at a depth of 0.5 cm from the vaginal surface or 6 Gy X 5 fractions prescribed to the vaginal surface.

Uterine Sarcoma

All staging in guideline is based on updated 2010 FIGO staging. (See ST.2)
Uterine Sarcoma – Chemo

Uterine Sarcoma

SYSTEMIC THERAPY FOR UTERINE SARCOMA

CHEMOTHERAPY REGIMENS¹
(Clinical trials strongly recommended)
- Doxorubicin
- Gemcitabine/docetaxel
- Consider other single-agent options
  (all agents are category 2B):
- Decarbazine
- Docetaxel
- Epirubicin
- Gemcitabine
- Ifosfamide
- Lipoosomal doxorubicin
- Paclitaxel
- Temodalomide

HORMONE THERAPY (ESS only)
- Medroxyprogesterone acetate
- Megestrol acetate
- Aromatase inhibitors (category 2B)
- GnRH analogs (category 2B)
- Tamoxifen (category 2B)

NCCN Treatment Guidelines
Ovary / Primary Peritoneum

Decisions
Evidence
Values
Resources
Ovary, Primary Peritoneum – Surgery

PRINCIPLES OF PRIMARY SURGERY (1 of 3)

1. In general, a vertical midline abdominal incision should be used in patients with a suspected malignant ovarian neoplasm.
2. Intraoperative pathologic evaluation with frozen sections may assist in management.
3. Quantify the extent of initial and residual disease; document in operative notes.

Ovary or Peritoneum apparently confined to an ovary or to the pelvis.

- The following procedures should be considered part of the surgical management of patients with ovarian cancer apparently confined to an ovary or to the pelvis:
  - Hydrosalpinx, bilateral salpingectomy, and bilateral oophorectomy should be performed with every effort made to keep an encapsulated mass intact during removal.
  - Unilateral salpingo-oophorectomy (USO) for patients desiring to preserve fertility may be considered in select patients. [See OV-A 2 of 3]
  - Omentectomy should be performed.
  - Cecal lymph node dissection should be performed by stripping the nodal tissue from the cecum and the aorta bilaterally to at least the level of the inferior mesenteric artery and preferably to the level of the renal vessels.
  - Pelvic lymph nodes should be dissected. Removal of lymph nodes overlying and medial to the external iliac and hypogastric vessels, from the obturator fossa anterior to the obturator nerve, and overlying and anterolateral to the common iliac vessel is preferred.
  - In low malignant potential, although data show upstaging with lymphadenectomy and omentectomy, other data show this surgery does not affect overall survival.

Ovary, Primary Peritoneum – Surgery

Ovarian cancer involving the upper abdomen.

- In general, the following procedures should be part of the surgical management of patients with ovarian cancer involving the upper abdomen in an effort to achieve maximal cytoreduction. Residual disease < 1 cm defines optimal cytoreduction; however, maximal effort should be made to remove all gross disease.
  - Aspiration of ascites or peritoneal lavage should be performed for peritoneal cytologic examinations. For obvious disease beyond ovaries, cytologic assessment of ascites and/or lavage specimens would not alter stage or management.
  - Hysterectomy, bilateral salpingectomy, and bilateral oophorectomy should be performed.
  - All involved omentum should be removed.
  - Suspicious and/or enlarged nodes should be resected, if possible.
  - These patients with tumor nodules outside the pelvis < 2 cm (presumed stage IIIb) should have bilateral pelvic and para-aortic lymph node dissection as previously described.

Continued on OV-A 2 of 3

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

OV-A
1 of 3
**Ovary, Primary Peritoneum – Surgery**

- Primary Surgery
- Radical pelvic dissection
- Bowel resection
- Diaphragm or other perifonal surface stripping
- Splenectomy
- Partial hepatectomy
- Cholecystectomy
- Partial cystectomy
- Ureteroenocystomy
- Distal pancreatectomy
- Ancillary Palliative Surg
- Paraentesis
- Thoracentesis/pleurodesis
- Ureteral stents/nephrostomy
- Surgical relief or intestinal obstruction
- Gastrostomy tube
- Vascular access device
- Indwelling peritoneal or pleural catheter
- Intestinal stents
- Video-assisted thoracoscopy

**Ovary, Primary Peritoneal Post Surgical Evaluation**

[Diagram showing the process of diagnosis and primary treatment based on previous surgery and findings.]

---

1. Standard recommendation includes a patient evaluation by a gynecologic oncologist prior to initiating chemotherapy. Published data demonstrate that primary assessment and debulking by a gynecologic oncologist result in a survival benefit. See Principles of Primary Surgery (OV-A).
2. Based on clinical judgment of gynecologic oncologist, surgery may be performed after 6 cycles.
3. See Principles of Chemotherapy (OV-B) and Management of Drug Reactions (OV-C).
Drugs Approved for Ovarian Cancer Treatment

Adriamycin PFS (Doxorubicin Hydrochloride)
Adriamycin RDF (Doxorubicin Hydrochloride)
Carboplatin
Cladiren (Cyclophosphamide)
Cisplatin
CYCLOPHOSPHAMIDE
Cytoxan (Cyclophosphamide)
Doxorubicin Hydrochloride
DOXIL (Doxorubicin Hydrochloride Liposome)
Doxorubicin Hydrochloride Liposome
Evacet (Doxorubicin Hydrochloride Liposome)
Gemcitabine Hydrochloride
Gemzar (Gemcitabine Hydrochloride)
Hycamtin (Topotecan Hydrochloride)
LipoDox (Doxorubicin Hydrochloride Liposome)
Neosar (Cyclophosphamide)
Paclitaxel
Paraplatin (Carboplatin)
Paraplatin (Carboplatin)
PLATINOL (CISPLATIN)
PLATINOL-AQ (CISPLATIN)
Taxol (Paclitaxel)
Topotecan Hydrochloride
Ovary/Primary Peritoneal Palliative Care

- Comfort care given to a patient who has a serious or life-threatening disease
- Addresses the emotional, physical, practical, and spiritual issues of cancer
- Provided by a specialist who works with a team of other healthcare professionals
- Palliative Care is different from hospice care – it can begin at time of diagnosis and last throughout the patient’s life
- Hospice Care is end of life care often accompanied by palliative care for pain control and symptom control.

Problem Areas for Registrars

- Where did neoplasm originate
  - Primary Site
  - Anatomic Proximity of sites
  - Biopsy of Involved Site or Primary Site
  - Similar histologic type(s)
  - Few natural barriers to slow spread
  - Ovary versus Peritoneum
  - Inaccessible Sites (corpus uteri, ovary)
Problem Areas for Registrars

- **Question**
  Primary Site—Ovary/Peritoneum: How should the Primary Site field be coded when no resection is done and it is uncertain whether the primary site is in the ovary or the peritoneum?

- **Answer**
  Use the best information available to identify the primary site. In this case, it is the physician’s clinical assessment. Code the Primary Site to C56.9 [Ovary] for this example because the ovary is indicated to be the primary site according to the physicians involved.

  When there is no surgical procedure involving the removal of the ovaries, code the Primary Site based on the clinical assessment of the disease location. If the disease is only noted to be in the peritoneum, code site to peritoneum, NOS. If the disease is seen clinically in both the ovary and the peritoneum, code site to ovary.
Additional Resources

- 2003 WHO Classification of Tumours of Female Genital Organs, World Health Organization, Lyon, France, 2003
- NCI Physician Data Query for Healthcare Professionals
- Multiple Primary and Histology Coding Rules, SEER 2007
- Collaborative Stage Data Collection System, AJCC, 2012
- FIGO Staging Classifications for GYN Cancers, FIGO, 2012
- NCCN Evidence Based Treatment Guidelines, NCCN, 2013

Questions