




# Genitourinary Neoplasms

Updated for 2012 Requirements and CSv02.04

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FCDS Educational Webcast Series  
February 28, 2013



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## Presentation Outline

- General Information and Anatomy
  - Kidney – Renal Parenchyma
  - Kidney – Renal Pelvis
  - Ureters
  - Bladder
  - Prostate
- Multiple Primary and Histology Coding Rules (MPH)
- Collaborative Stage Data Collection System (CSv02.04)
- FCDS Required Site Specific Factors (SSFs)
- NCCN Treatment Guidelines
- Text Documentation

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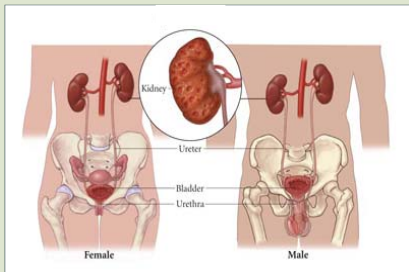
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## Genitourinary System



Female Male

Source: <http://medicaltrue.com/urinary-tract>

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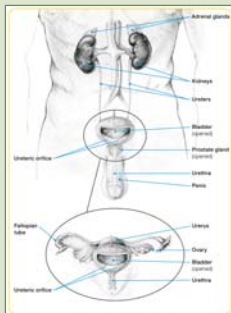
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## Genitourinary System



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Source: [http://cancerciv.org.au/bladder\\_cancer](http://cancerciv.org.au/bladder_cancer)

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## Kidney



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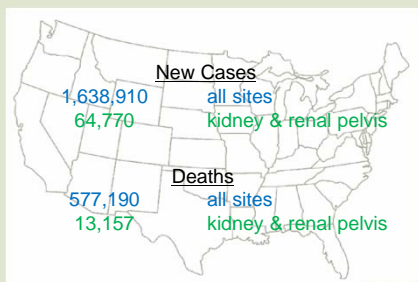
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## U.S. Incidence/Mortality



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Source: American Cancer Society Cancer Facts and Figures 2012

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## Risk Factors/Screening

### Risk Factors

- Cigarette Smoking
- First-degree relative
- Long-term PCB exposure
- Long-term use of medicines
- Obesity

### Screening

- None
- CT Scan
- Ultrasound
- Incidental Finding



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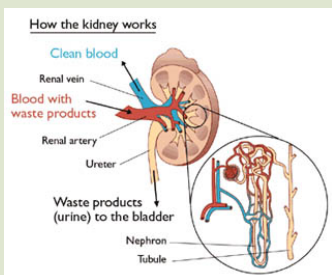
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## Kidney - Anatomy



Source: [http://foxriverwatch.com/kidney\\_cancer](http://foxriverwatch.com/kidney_cancer)

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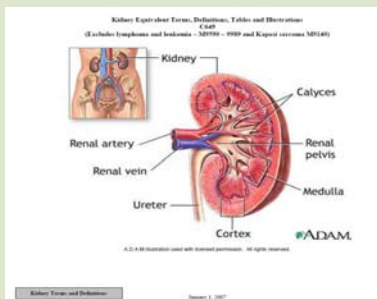
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## Kidney - Anatomy



Source: 2007 Multiple Primary and Histology Coding Rules

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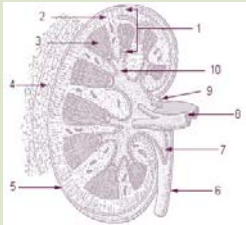
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## Kidney - Anatomy



1. Parenchyma
2. Cortex
3. Medulla
4. Perirenal fat
5. Capsule
6. Ureter
7. Pelvis of kidney
8. Renal vessels
9. Hilum
10. Calyx

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Source: <http://training.seer.cancer.gov>

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## Kidney - Anatomy

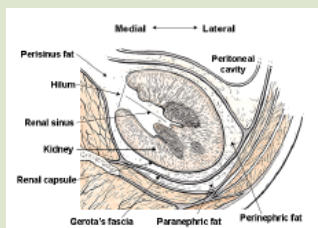


Figure I-2-13. Structures Adjacent to Kidney

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Source: Collaborative Stage Data Collection System, Part I, Section 2

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## Kidney - Histology

### Renal Cell Carcinoma and Renal Cell Carcinoma Subtypes

- 8312 Renal cell carcinoma is a **GROUP** term for glandular (adeno) carcinoma of the kidney
- 8255 Adenocarcinoma with mixed subtypes\*\*
- 8260 Papillary (Chromophil)\*
- 8310 Clear Cell
- 8316 Cyst associated, cystic
- 8317 Chromophobe\*
- 8318 Sarcomatoid (Spindle cell)
- 8319 Collecting duct type (Bellini duct)
- 8320 Granular cell
- 8510 Medullary carcinoma, NOS; medullary adenocarcinoma
- 8959 Malignant cystic nephroma

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Source: 2007 Multiple Primary & Histology Coding Rules

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## Kidney - MPH Rules

Kidney MPH Includes:

- o Kidney Parenchyma
- o Renal Parenchyma (C649)

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**Kidney Equivalent Terms, Definitions, Tables and Illustrations**  
C649  
(Excludes lymphoma and leukemia - M9590 - 9989 and Kaposi sarcoma M9148)

**INTRODUCTION**

Renal cell carcinoma (RCC) is a group term for glandular (adenocarcinoma) of the kidney. Approximately 85% of all malignancies of the kidney are renal cell and specific renal cell types.

Transitional cell carcinoma rarely arises in the kidney parenchyma (C649). Transitional cell carcinoma found in the upper urinary system usually arises in the renal pelvis (C639). Only code transitional cell carcinoma to kidney in the rare instance when pathology confirms the tumor originated in the parenchyma of the kidney.

**Equivalent or Equal Terms**

- Medullary and multiventricular
- Renal cell carcinoma (RCC) and hypernephroma (obsolete term)
- Tumor, mass, lesion, and neoplasm

**Definitions**

**Adenocarcinoma with mixed subtypes (R255):** A mixture of two or more of the specific renal cell carcinoma types listed in Table 1.

**Carcinoma of the collecting ducts of Bellini/collecting duct carcinoma (R319)** is a malignant epithelial tumor. There is controversy about the relationship between medullary carcinoma and collecting duct carcinoma; some advocate that there is a relationship, others are not convinced. Genetic studies are ongoing. We will code medullary carcinoma originating in the kidney to R319 so we can differentiate between the medullary and the collecting duct carcinoma.

**Chromophobe RCC (R317)** is a rare form of kidney cancer. Chromophobe is a renal carcinoma characterized by large pale cells with prominent membranes.

**Clear cell RCC (R318)** is the most common type of RCC. Clear cell is composed of clear or eosinophilic cytoplasm. Clear cell is architecturally diverse, with solid alveolar and sarcomatous patterns the most common.

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**Kidney Equivalent Terms, Definitions, Tables and Illustrations**  
C649  
(Excludes lymphoma and leukemia - M9590 - 9989 and Kaposi sarcoma M9148)

**Table 1 - Renal cell carcinoma and specific renal cell types**

*Table Instructions: Use this table to identify specific renal cell carcinoma types.*  
*Note: Renal cell carcinoma, NOS (R312) is the non-specific term under which the specific renal cell carcinoma types are listed. This table is a complete listing of specific renal cell carcinoma types.*

Column 1: Code	Column 2: Specific Renal Cell Carcinoma Types
E260	Papillary (Chromophil) *
R310	Clear Cell
R316	Cyst associated, cystic
R317	Chromophobe *
R318	Unconcentrated (Spindle cell)
R319	Collecting duct type (Bellini duct)
R320	Gonadole cell
R310	Medullary carcinoma, NOS; medullary adenocarcinoma
B959	Malignant cystic nephroma; malignant multilocular cystic nephroma

\*Note: Chromophil and chromophobe are different histologies

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### Kidney MPH Rules - Example 2

- Patient has two tumors in upper pole of left kidney.
- Both are T1a neoplasms (small tumor size)
  
- Histology 1: RCC papillary type (8260/3)
- Histology 2: RCC tubulocystic type (8316/3)
  
- One Primary or Two Primaries ?
  - Two Primaries per Rule M10
  - Two different subtypes of RCC – not RCC and a subtype
  
- Histologic Type/Histology Code ?
  - 8260/3 – RCC papillary type
  - 8316/3 – RCC cystic type

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### Kidney MPH Rules - Example 3

- Patient has one tumor in upper pole of right kidney.
  
- Histology: RCC with papillary and cystic features
  
- One Primary or Two Primaries ?
  - One Primary = One Tumor
  
- Histologic Type/Histology Code ?
  - 8255/3 – adenocarcinoma with mixed subtypes
  - Per Rule H6

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### Kidney – Collaborative Stage



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### CS Mets at Dx

Code	Description
00	No distant metastasis
10	Distant lymph node(s)
20	Extension to: Contralateral kidney Contralateral ureter Liver from left kidney Spleen from right kidney
40	Homologous ipsilateral adrenal (suprarenal) gland metastasis (Contiguous involvement coded in C8 Extension) Distant metastasis except distant lymph node(s) Carcinomatosis
50	OBSOLETE DATA CONVERTED V1003 See code 55 40 + 10 Distant metastasis plus distant lymph node(s)
55	(40 or 20) + 10 Distant metastasis or extension coded in 20 plus distant lymph node(s)
60	Distant metastasis, NOS Stated as M1 with no other information on distant metastasis
99	Unknown, distant metastasis not stated Distant metastasis cannot be assessed Not documented in patient record

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- ### CS Site-Specific Factors
- SSF1: Invasion Beyond Capsule
  - SSF2: Vein Involvement
  - SSF3: Ipsilateral Adrenal Gland Involvement
  - SSF4: Sarcomatoid Features
  - SSF5: Histologic Tumor Necrosis ← Not Required
  - SSF6: Fuhrman Nuclear Grade
  - SSF7: Size of Metastasis in Lymph Nodes ← Not Required
  - SSF8: Extranodal Extension

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## Kidney Cancers - Treatment



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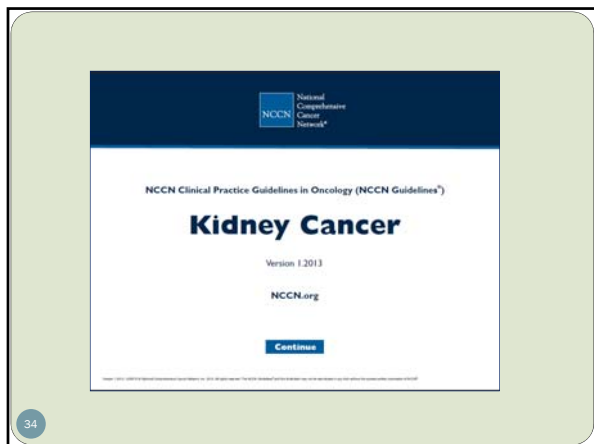
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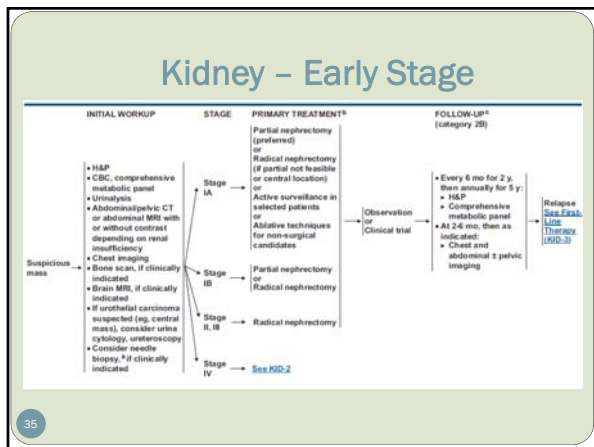
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### Kidney – Early Stage

**PRINCIPLES OF SURGERY**

- Nephron-sparing surgery (partial nephrectomy) is appropriate in selected patients, for example:
  - Small unilateral tumors (T1a and selected patients T1b)
  - Uninephric state, renal insufficiency, bilateral renal masses, and familial renal cell cancer
- Open, laparoscopic, or robotic surgical techniques may be used to perform radical and partial nephrectomies.
- Regional lymph node dissection is optional but is recommended for patients with adenopathy on preoperative imaging or palpable/visible adenopathy at time of surgery.
- Adrenal gland resection may be omitted if adrenal is uninvolved and tumor is not high risk on the basis of size and location.
- Special teams may be required for extensive inferior vena cava involvement.
- Observation or ablative techniques (eg, cryosurgery, radiofrequency ablation):
  - Can be considered for patients with clinical stage T1 renal lesions who are not surgical candidates.
  - Biopsy of small lesions may be considered to obtain or confirm a diagnosis of malignancy and guide surveillance, cryosurgery and radiofrequency ablation strategies.
  - Randomized phase III comparison with surgical resection (ie, radical or partial nephrectomy by open or laparoscopic techniques) has not been done.
  - Ablative techniques are associated with a higher local recurrence rate than conventional surgery.<sup>1,2</sup>
- Generally, patients who would be candidates for cytoreductive nephrectomy prior to systemic therapy have:
  - Excellent performance status (ECOG PS <2)
  - No brain metastasis

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### Kidney – Late Stage

STAGE	PRIMARY TREATMENT <sup>a</sup>
Stage IV	Potentially surgically resectable solitary metastatic site → Nephrectomy + surgical metastasectomy <sup>b</sup> → Relapse → <a href="#">See First-Line Therapy (KID-3)</a>
	Potentially surgically resectable primary <sup>d</sup> with multiple metastatic sites → Cytoreductive nephrectomy in select patients prior to systemic therapy → <a href="#">See First-Line Therapy (KID-3)</a>
	Medically or surgically unresectable <sup>d</sup> → <a href="#">See First-Line Therapy (KID-3)</a>

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### Kidney – Late Stage

	FIRST-LINE THERAPY <sup>a</sup>	SUBSEQUENT THERAPY <sup>a</sup>
Relapse or Stage IV and medically or surgically unresectable	Predominant clear cell histology → Clinical trial or Sorafenib (category 1) or Temsirolimus (category 1 for poor-prognosis patients; category 2B for selected patients of other risk groups) or Bevacizumab + IFN (category 1) or Pazopanib (category 1) or High dose E-2 for selected patients <sup>d</sup> or Sorafenib for selected patients and Best supportive care. <sup>b</sup> <a href="#">See NCCN Guidelines for Palliative Care</a>	Clinical trial or Targeted therapy: • After tyrosine kinase inhibitor therapy: • Everolimus (category 1) • Axitinib (category 1) • Sorafenib (category 2A) • Sunitinib (category 2A) • Temsirolimus (category 2B) • Bevacizumab (category 2B) • Pazopanib (category 3) • After cytokine therapy: • Axitinib (category 1) • Sorafenib (category 1) • Sunitinib (category 1) • Pazopanib (category 1) • Temsirolimus (category 2A) • Bevacizumab (category 2A) or Cytokine therapy: • E-2 (category 2B) and Best supportive care. <sup>b</sup> <a href="#">See NCCN Guidelines for Palliative Care</a>
	Non-clear cell histology → <a href="#">See Systemic Therapy (KID-4)</a>	

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### Kidney – Late Stage

	SYSTEMIC THERAPY <sup>a,b</sup>
Relapse or Stage IV and medically or surgically unresectable	Non-clear cell histology → Clinical trial (preferred) or Temsirolimus (category 1 for poor-prognosis patients; category 2A for other risk groups) or Sorafenib or Sunitinib or Pazopanib (category 3) or Erlotinib (category 3) or Axitinib (category 3) and Best supportive care. <sup>b</sup> <a href="#">See NCCN Guidelines for Palliative Care</a>

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## Urothelial Neoplasms



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## Urothelium

The layer of transitional epithelium that lines the wall of the renal pelvis, ureters, the bladder, and parts of the urethra

The lining is made up of transitional epithelial cells that stop urine from entering the body.

Urine consists of water and waste products.

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## Field Effect Theory

The field effect theory suggests that the urothelium has undergone a widespread change, perhaps in response to a carcinogen, making it more sensitive to malignant transformations.

As a result, multiple tumors arise more easily.

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## Implantation Theory

The implantation theory suggests that tumor cells in one location lose their attachments and float in the urine until they attach (implant) on another site.

Urothelial tumors commonly spread in a head-to-toe direction, for example from the renal pelvis to the ureter(s) to the bladder.

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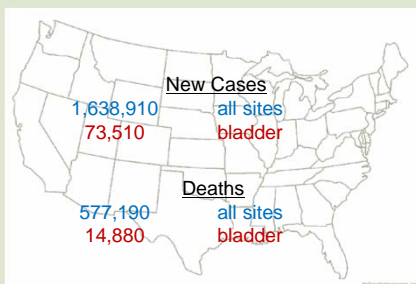
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## U.S. Incidence/Mortality



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Source: American Cancer Society Cancer Facts and Figures 2012

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## Risk Factors/Screening

### Risk Factors

- Cigarette Smoking
- Chemical Exposures: dyes, solvents, paints, rubber, benzene, etc.
- Cyclophosphamide
- Chronic Inflammation
- Parasite Schistosoma

### Screening

- None
- Blood in Urine
- Ultrasound
- Cystoscopy
- Incidental Finding



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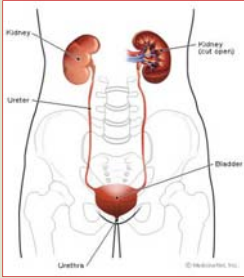
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### Anatomy



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Source: <http://www.medicinenet.com>

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### Anatomy

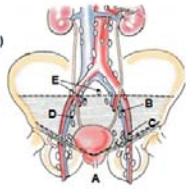
#### Lymph Nodes – Ureter, Bladder

**Bladder and Distal Ureter**

- Perivesical (A)
- Iliac, internal (hypogastric) (B)
- Obturator (C)
- Iliac, external (D)
- Sacral (E), presacral
- Pelvic, NOS (all nodes within shadowed area)

**Also for ureter:**

- Periureteral
- Iliac, common



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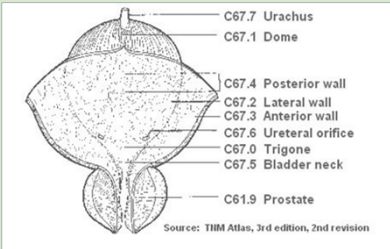
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### Anatomy



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Source: *TIIM Atlas*, 3rd edition, 2nd revision

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## Anatomy

**Bladder Wall**

Mucosa  
Submucosa  
Muscular layer  
Serosa

Lumen  
Adventitia

Source: Feneis, Pocket Atlas of Human Anatomy, 2nd ed.

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## Anatomy

- Urothelium
  - Mucosa
  - Epithelium
  - Transitional Epithelium
  - Mucosal Surface
  - Transitional Mucosa
  - Tunica Mucosa
  - Vesicae Urinariae
- Lamina Propria
  - Submucosa
  - Suburothelial Connective Tissue
  - Subepithelial Tissue
  - Stroma
  - Muscularis Mucosa
  - Transitional Epithelium
- Muscularis Propria
  - Submucosa
  - Muscularis Externa
  - Smooth Muscle

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## Histology

- ❖ Urothelial Carcinoma = Transitional Cell Carcinoma
- ❖ Squamous Cell Carcinoma
- ❖ Adenocarcinoma
- ❖ Small Cell Carcinoma
- ❖ Small Cell Neuroendocrine

Urinary bladder  
mucosa  
transitional epithelium  
submucosa

Source: <http://ws.collin.edu/mweis/A&P>

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## Histology

**Table 1 – Urothelial Tumors**  
*Note:* Excludes pure squamous carcinoma, glandular (adeno) carcinoma, or other bladder tumor histologies.

Urothelial/Transitional Cell Tumors	Code
With squamous differentiation	8120
With glandular differentiation	
With trophoblastic differentiation	
Nested	
Microcystic	
Transitional cell, NOS	8130
Papillary carcinoma	
Papillary transitional cell	
Micropapillary	8131
Lymphoepithelioma-like	8082
Plasmacytoid	8122
Sarcomatoid	
Giant cell	8031
Undifferentiated	8020

52 Source Multiple Primary & Histology Coding Rules - Table 1 – Urothelial Tumors

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## Histology

**Papillary**                      **Flat (sessile)**

**Non-invasive**    **Invasive**                      **In situ**                      **Invasive**

53 Source Multiple Primary & Histology Coding Rules - Table 1 – Urothelial Tumors

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## Tumor Grade

**Urothelial Neoplasia**

Known USA risk factors include:  
 Smoking                      Cyclophosphamide  
 Certain dyes                      Phenacetin

**Grade 0 / I**

Urothelium

Normal

Just Thick

**Grade II**

"Atypical Hyperplasia"  
Probably means nothing

Papilloma /  
Papillary CA Grade I

Inverted Papilloma  
(benign)

**Grade III**

Carcinoma in situ  
Many invasive bladder  
cancers arise in flat CIS

Papillary CA Grade II  
"Low Grade"

Papillary CA Grade III  
"High Grade"

Flat lesions: Discomfort is itchy.  
 Papillary lesions: Hematuria is itchy.

54 Source: <http://pathguy.com/lectures/bladder.htm>

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## Tumor Grade

**Table 1. Principles of Pathology Management: Malignancy Grading of Bladder Carcinoma: Old and New Systems<sup>a,b</sup>**

Modified Bergkvist 1987	WHO 1973	WHO/ISUP 1998 Consensus WHO, 2004
Papilloma grade 0	Papilloma	Papilloma
Papilloma with atypia grade 1	TCC grade 1	Papillary urothelial neoplasm of low malignant potential
Urothelial carcinoma grade 2A	TCC grade 1	Urothelial carcinoma, low-grade
Urothelial carcinoma grade 2B	TCC grade 2	Urothelial carcinoma, low-grade or high-grade
Urothelial carcinoma grade 3	TCC grade 3	Urothelial carcinoma, high-grade

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Source: ncn.org

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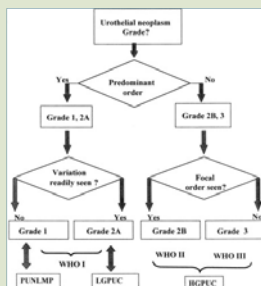
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## Tumor Grade



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Source: <http://sciencedirect.com>

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## Urothelial MPH Rules

Urothelial MPH Includes:

- o Kidney Renal Pelvis
- o Ureter
- o Bladder
- o Urinary Other

(C659, C669, C670-C679, C680-C689)



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### Urothelial MPH – Example 2

- Patient with history of invasive cancer of the bladder in 2001 being seen in 2013 with new tumor in right ureter (TCC).
- Histology 1: Urothelial Carcinoma of Bladder – 8120/3
- Histology 2: TCC of Ureter – 8120/3
- One Primary or Two Primaries? Two
  - Rule M7 – tumors greater than 3 years apart
  - NOTE: Rule M8 includes all urothelial (except C679 only M6)
- Seq 01 – dx 2001 – C679 M8120/3
- Seq 02 – dx 2013 – C659 M8120/3

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### Urothelial MPH – Example 3

- Patient with history of invasive cancer of the bladder in 2011 being seen now with new tumor in right ureter (TCC).
- Histology 1: Urothelial Carcinoma of Bladder – 8120/3
- Histology 2: TCC of Ureter – 8120/3
- One Primary or Two Primaries? One
  - Rule M8 – tumors less than 3 years apart
  - NOTE: Rule M8 includes all urothelial (except neoplasms that occur only in the bladder C679 – then use Rule M6)
- Diagnosis 2011 with Primary Site C679 and Histology 8120/3
- Ureter TCC diagnosed less than 3 years after bladder – Rule M8

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### Bladder– Collaborative Stage



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# Urothelial Cancers - Treatment



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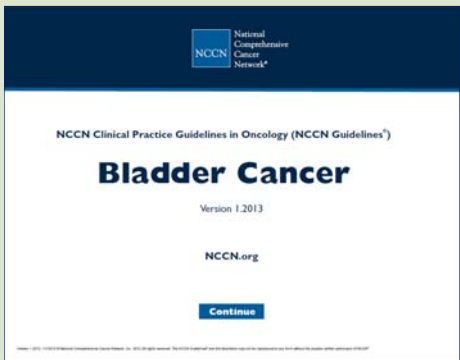
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**NCCN Guidelines Version 1.2013**  
**Bladder Cancer**

**PRINCIPLES OF PATHOLOGY MANAGEMENT**

- Tumors in many cases that would have been classified as grade 2 by the WHO 1973 grading system are now classified as high-grade using the WHO 2004 and the ISUP/WHO 1998 systems.
- The pathology report on biopsy/TURBT specimens should specify:
  - If muscularis propria (detrusor muscle) is present and, if present, whether this structure is invaded by tumor
  - Presence or absence of lymphovascular space invasion
  - Presence or absence of adjacent carcinomas in situ

Malignancy Grading of Bladder Carcinoma: Old and New Systems*		
Modified Berkson 1987	WHO 1973	WHO/ISUP 1998/Castaneda WHO 2004
Papilloma grade 0	Papilloma	Papilloma
Papilloma with atypia grade 1	TCC grade 1	Papillary urothelial neoplasm of low malignant potential
Urothelial carcinoma grade 2A	TCC grade 1	Urothelial carcinoma, low-grade
Urothelial carcinoma grade 2B	TCC grade 2	Urothelial carcinoma, low-grade or high-grade
Urothelial carcinoma grade 3	TCC grade 3	Urothelial carcinoma, high-grade

\*From Dicker MJ. Bladder Cancer. Current Diagnosis and Treatment. Totowa, NJ 2007. With kind permission of Springer Science + Business Media, LLC.

Note: All recommendations are in category 2B 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 explicitly encouraged.

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# PROSTATE



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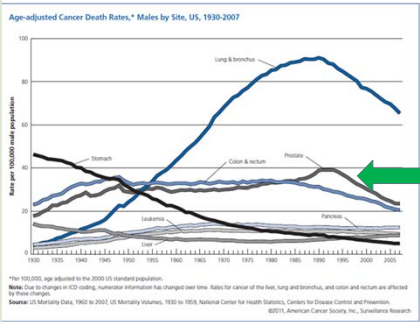
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## Age-Adjusted Cancer Death Rates, Males by Site, U.S. 1930-2007



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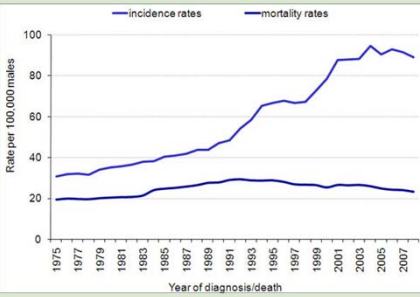
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## Incidence / Mortality



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Prostate Cancer 1975-2008

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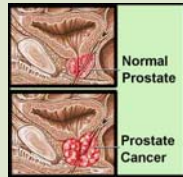
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## Risk Factors/Screening

- Most common male cancer
- 2nd leading cause of cancer death in U.S. men
- African-American men 2.5 x higher death rate others
- Estimated new cases: 240,890; deaths: 33,720
- Risk Factors:
  - Age
  - Race/Ethnicity
  - Family history
  - Genetics
  - Diet
- Screening
  - DRE
  - PSA



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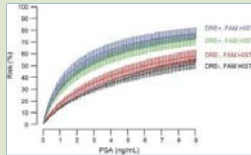
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## Screening Recommendations

- U.S. Preventive Services Task Force
- American Urological Association
- American Cancer Society
- ASCO/NCCN Guidelines
- Individual Urologist
- High-Risk Patients



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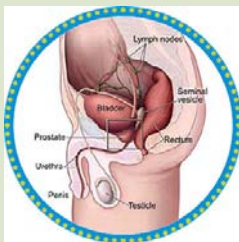
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## Anatomy



- The prostate is a gland found ONLY in men
- It is located in front of the rectum and under the bladder
- The size of a healthy prostate gland is about the size of a walnut

Source: <http://www.abbottdiagnostics.com>  
U.S. National Cancer Institute

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### Anatomy

Source: SEER Training Website, [www.training.seer.cancer.gov](http://www.training.seer.cancer.gov)

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### Anatomy

Source: SEER Training Website, [www.training.seer.cancer.gov](http://www.training.seer.cancer.gov)

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### Histology

- 99% Adenocarcinoma
  - Code acinar as adenoca
- 1% Other
  - Sarcoma
  - Small cell carcinoma
  - Lymphoma
- PIN III
  - Do NOT abstract
  - 30% men develop Ca
  - Follow-up for 2 years

Image source: Medical Center Institute

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## Prostate - MPH Rules

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## Prostate - MPH Rules


- Only **ONE** Prostate Cancer DX per patient lifetime
- Dx of Acinar Carcinoma, Code to 8140 (Adenocarcinoma)

**ICD-O-3 Site Codes**

Related Adjectives

Prostate = prostab-

ICD-O-3	Term
C61.9	Prostate gland, Prostate, NOS



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## Prostate MPH - Example

- Patient seen as outpatient as follow-up to elevated PSA.
- Patient had multiple biopsies in multiple prostate lobes
- All specimens were positive for adenocarcinoma
- One primary or Multiple? One
  - Single Tumor
  - Multiple Biopsies
- Histologic Type? Adenocarcinoma

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## Clinical Stage/Pathological Stage

### Clinical Extension

- CS Ext – Clinical Stage
- Prior to Prostatectomy
- Clinical Evaluation Only
  - Bx for Elevated PSA
  - Clinically Inapparent
  - Clinically Apparent
- Used to Develop a Treatment Plan

### Pathological Extension

- SSF3 – Pathological Stage
- PROSTATECTOMY
- Pathological Evaluation
  - Surgical Findings
  - Prostatectomy Specimen
- Code 970 if No Surgery
- Surgery is Part of the Treatment Plan

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## Clinical Stage: Why Important??

- Clinical Stages T1a and T1b
  - Incidentally detected during a TURP
- Clinical stages T1c and T2
  - PSA test positive – detects earlier stage
- Clinical Stage T3
  - DRE detects palpable disease sufficient to indicate that the tumor has penetrated through the prostate capsule

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## Clinical Stage: Why Important??

- Clinical Stage T4
  - Indicates local invasion of a structure adjacent to the prostate other than the seminal vesicle(s).
    - T4a indicates a DRE exam with tumor invading the bladder neck, external sphincter or rectum.
    - T4b indicates clinical findings of invasion into the levator muscles or a tumor that is fixed to the pelvis.

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### Clinical Stage Illustrations

The illustrations show the progression of prostate cancer from T1c to T4 (a,b). T1c shows a small tumor in the peripheral zone. T2 (a,b,c) shows increasing tumor size and involvement of the peripheral zone. T3 (a,b,c) shows tumor extension into the seminal vesicles, urethra, or bladder neck. T4 (a,b) shows tumor extension into the rectum or bladder.

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Material provided by Prostate Cancer Research Institute (PCRI)

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### Pathological Stage Criteria

**Prostate**

**CS Site-Specific Factor 3**  
**CS Extension - Pathologic Extension**

- Note 1: Include information from prostatectomy and autopsy in this field and not in CS Extension - Clinical Extension. Only use histologic information from prostatectomy, including simple prostatectomy with negative margins, and autopsy in this field. Information from biopsy of extraprostatic sites is coded in CS Extension - Clinical Extension, information from needle core biopsy of prostate is coded in CS Site-Specific Factor 14.
- Note 2: Code 970 if there is no prostatectomy performed within the first course of treatment.
- Note 3: Limit information in this field to first course of treatment in the absence of disease progression.
- Note 4: AJCC considers "in situ carcinoma of prostate gland" an impossible diagnosis. Any case so coded is mapped to TX for AJCC stage and in situ Summary Stage.
- Note 5: When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found (for example, involvement in one lobe, both lobes, or more).
- Note 6: When the apical margin, distal urethral margin, bladder base margin, or bladder neck margin is involved and there is no extracapsular extension, use code 400.
- Note 7: Involvement of the prostatic urethra does not alter the extension code.
- Note 8: "Tumor peters" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 400.
- Note 9: For information regarding stage calculations, refer to CS Extension - Clinical Extension Note 6 and the special calculation extra tables.

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### NOT A PROSTATECTOMY

00 None, no surgery of primary site, autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS  
 Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19

10 Local tumor destruction, NOS

- 14 Cryoprostatectomy (Cryoablation)
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10-17  
 [NOTE: Code Transurethral Microwave Thermotherapy (TUMT) as 16  
 Code High Intensity Focused Ultrasound (HIFU) as 17  
 Code Transurethral Needle Ablation (TUNA) as 17]

20 Local tumor excision, NOS

- 21 Transurethral resection (TURP), NOS
- 22 TURP cancer is incidental finding during surgery for benign disease
- 23 TURP patient has suspected/known cancer

Any combination of 20-23 WITH

- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

[NOTE: Codes 24 to 26 above combine 10 Local tumor excision, NOS, 21 TURP, NOS, 22 TURP incidental or 23 TURP suspected/known cancer with 24 Cryosurgery, 25 Laser or 26 Hyperthermia]  
 Specimen sent to pathology from surgical events 20-26

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**NOT A PROSTECTOMY**

80 Prostatectomy, NOS  
Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

**When NO PROSTECTOMY**  
**CS SSF 3 MUST = 970**

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**Prostatectomy Procedures**

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS, total prostatectomy, NOS  
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs: pelvic exenteration  
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs.  
The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.  
[NOTE: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen] Do *not* prostatectomy would be coded as any other prostatectomy depending on the extent of the procedure codes 50-90 per FORDS.

**When PROSTECTOMY IS PERFORMED**  
**CS SSF 3 CANNOT = 970**

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**Pathologic Extension - SSF 3**

021	OBsolete DATA CONVERTED V0200 See code 210 Involves one half of one lobe or less	ERROR	ERROR	ERROR	ERROR
022	OBsolete DATA CONVERTED V0200 See code 220 Involves more than one half of one lobe, but not both lobes	ERROR	ERROR	ERROR	ERROR
023	OBsolete DATA CONVERTED V0200 See code 230 Involves both lobes	ERROR	ERROR	ERROR	ERROR
030	OBsolete DATA CONVERTED V0300 See code 300 Localized, NOS Confined to prostate, NOS Intra-capsular involvement only Stage B, NOS	ERROR	ERROR	ERROR	ERROR
031	OBsolete DATA REVIEWED AND CHANGED V0302 Into prostatic apex/along in prostatic apex, NOS (See Site Specific Factor 4)	ERROR	ERROR	ERROR	ERROR
032	OBsolete DATA CONVERTED V0300 See code 330 Invasion into (but not beyond) prostatic capsule	ERROR	ERROR	ERROR	ERROR
033	OBsolete DATA REVIEWED AND CHANGED V0302 Along in prostatic apex, (See Site Specific Factor 4)	ERROR	ERROR	ERROR	ERROR

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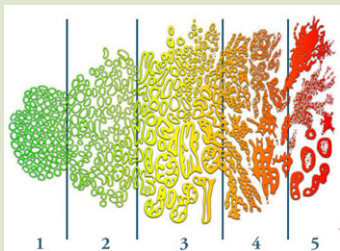
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### Gleason Pattern(s) and Score



<http://www.stjohnprovidence.org>

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1  
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### Gleason Score to Grade Conversion

Gleason Score	Grade/Differentiation
Gleason 2-6	Well Differentiated
Gleason 7	Moderately Differentiated
Gleason 8-10	Poorly Differentiated

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### Prostate Cancer - Treatment



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## Questions



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