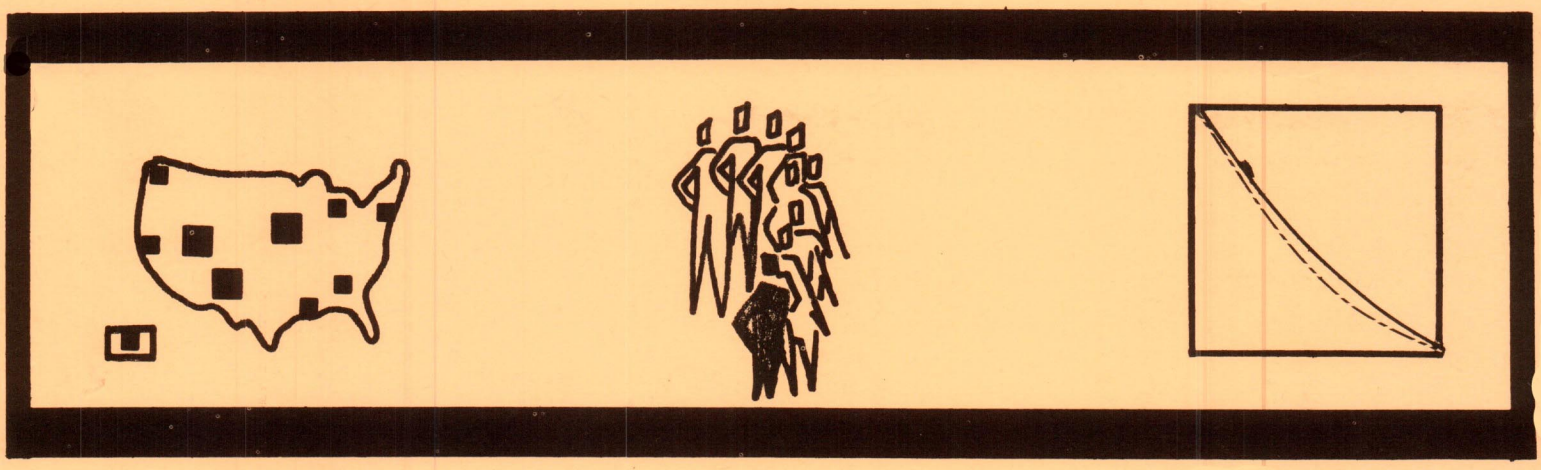
April 1977

ABSTRACTING INSTRUCTIONS
EXTENT OF DISEASE
And
DIAGNOSTIC PROCEDURES

Cancer Surveillance
Epidemiology and
End Results Reporting

SEER Program



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service • National Institutes of Health

ABSTRACTING INSTRUCTIONS

EXTENT OF DISEASE
AND
DIAGNOSTIC PROCEDURES

For

The Cancer Surveillance, Epidemiology And

End Results (SEER) Program

April, 1977

EXTENT OF DISEASE
AND
DIAGNOSTIC PROCEDURES

ABSTRACTING INSTRUCTIONS

Part I Expanded 13-Digit Extent of Disease Coding Schemes

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TABLE OF CONTENTS

EXTENT OF DISEASE AND DIAGNOSTIC PROCEDURES

ABSTRACTING INSTRUCTIONS

Part I Expanded 13-digit Coding Schemes

	Page
General Instructions	1
Site-Specific Instructions for:	
Stomach, excluding cardioesophageal junction (510-519)	6
Colon/Rectum (530-534, 536-537, 540-541)	11
Bronchus and Lung, excluding Carina (622-629)	16
Malignant Melanoma of Skin (730-737, 841-844, 871-872, 874; histology 872 thru 879)	20
Breast (740-749, 759)	24
Cervix Uteri (800-809)	31
Corpus Uteri (820-828)	35
Prostate (859)	39
Bladder (880-886, 888-889)	43
Lymph Nodes and Lymphoid Tissue (960-969, 416, 460, 471, 491, 640, 692; histology 959 thru 969, 975)	47
Sample Abstracting Form	51

GENERAL INSTRUCTIONS FOR ABSTRACTING EXTENT OF DISEASE AND DIAGNOSTIC PROCEDURES

Abstracting for Extent of Disease should be limited to 1) all information available by the end of the first hospitalization for definitive surgical resection if done within two months of diagnosis, or 2) two months after diagnosis for all other cases --both treated and untreated.

If a patient has radiation therapy followed by definitive surgery within two months of diagnosis, include all information available through definitive surgery in determining the Oper/Path assessment of extent of disease. The separate clinical evaluation will be limited to procedures up to the initiation of definitive therapy.

In contrast, the information for the clinical fields in the Diagnostic Procedures includes only those procedures which provided a basis for the clinician to make a diagnosis upon which he started treatment. To fulfill the obligations for this field include all pertinent procedures regardless of findings. We are interested in whether or not a procedure was done, not in the result of that procedure. Since the same information may be applicable to both fields (Extent of Disease and Diagnostic Procedures), the instructions have been combined. When instructions are needed for Diagnostic Procedures only, they will be specified.

Enter information in chronological order within each section of the abstract form giving dates and names of all procedures. Thus, at a glance, it can be determined if the information seems complete and logical.

Prepare one abstract for:

A single organ (or segment of the colon) which has independent primaries of the same histology.

A single organ which has one tumor of mixed histologies.

Prepare separate abstracts for:

Each tumor of a different definitive histologic type appearing in an organ.

Each paired organ other than ovary, if independent primaries are found in both organs.

Each segment of the colon in which independent primaries are found.

Record all significant negative and positive diagnostic findings.

See the site-specific instructions for details to be abstracted. If there is no statement regarding a specific item, so state.

The logical sequence in abstracting extent of disease information is given in the following sections.

I. HISTORY AND PHYSICAL EXAMINATION

Review the history and physical examination described by the clinician at first diagnostic work-up of cancer. Record the dates and all pertinent details.

A. Description of primary tumor

Describe the location of the tumor(s) within the primary organ, e.g., lobe, quadrant, etc. Record any mention of multiple tumors or foci.

Record the actual size of the lesion (all dimensions). Pay particular attention as to whether the measurement is in millimeters, centimeters, inches, or is a descriptive term, i.e., "size of walnut". If there is more than one tumor, record the size of the largest.

B. Direct extension of tumor

Record any pertinent details regarding direct extension of tumor to other organs or structures.

C. Lymph nodes

The clinician will describe the palpability and mobility of accessible lymph nodes, both regional and distant. He may use such terms as "discrete", "freely movable", "slightly fixed", "matted", and "attached to deep structures". He may describe the size, shape, and consistency of these nodes. Of particular importance is the clinician's statement as to whether the nodes are suspected of tumor involvement or whether they are considered tumor free.

If lymph nodes are described as, for example, "mass", "enlarged", "matted", "visible swelling", they are to be considered involved. Often it is necessary to read the entire description, such as, a comparison with the other side, to determine this. If you are still in doubt, ask a clinician whether the lymph nodes are involved or not.

When there is a mass demonstrated in the mediastinum, retroperitoneum and/or mesenteric, and there is no specific information as to the tissue involved, assume the involvement to be nodal in determining extent of disease.

Identify lymph nodes as specifically as possible and indicate if lymph nodes are ipsilateral, contralateral, or bilateral.

D. Distant site involvement

If mention is made of probable distant site involvement, record. For any site you may find mention of:

Organomegaly	Pleural effusion
Neurological findings	Ascites
Masses	

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Review diagnostic reports of x-rays, scanning, echography, and other imaging techniques for mention of tumor involvement. Record all pertinent positive and negative findings as well as the date(s) and name(s) of the procedures. Both positive and negative findings are required for the Extent of Disease, but only the name of the procedure is required for Diagnostic Procedures. If a report such as a chest X-ray is negative, record as "negative"; it is not necessary to copy details unrelated to cancer. If "metastatic series" is reported, ascertain what studies constitute the metastatic series and record the results of each study.

A. Record the size and location of the tumor giving all dimensions. Indicate if the tumor appears multifocal. If there is more than one measureable tumor, record the size of the largest.

B. Record in detail the description of the tumor and/or lymph nodes.

C. It is not necessary to record X-rays or scans for conditions unrelated to cancer spread.

III. LABORATORY TESTS

Indicate the test results and normal values (range) for the following:

Alkaline phosphatase* for all sites
Acid phosphatase for prostate (serum** and marrow)
CEA (carcinoembryonic antigen) for colon and rectum
Serum calcium* for breast
24-hour urine test for pigments (urinary melanogins) for melanoma

*Generally found in automated chemistries (also known as SMA-12 or biochemical profile)

**Record total serum acid phosphatase only if prostatic acid phosphatase fraction is not available.

Record only those tests used in the diagnostic work-up <u>prior</u> to any definitive therapy.

IV. MANIPULATIVE PROCEDURES

Record all manipulative procedures used in diagnostic work-up <u>prior</u> to definitive therapy and state findings, both positive and negative. Some examples of manipulative procedures are:

Colonoscopy
Cystoscopy
Mediastinoscopy
Peritoneoscopy
Proctosigmoidoscopy

Record size and location of tumor, description of lymph nodes, and involvement of other tissues and organs.

V. CYTOLOGY REPORTS

Name each source and specify the highest class (I-V) from each source including:

Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Abstract pertinent findings from reports of exploratory surgeries and surgical resections. Observations stated in operative reports should be recorded even if at variance with the clinical observations. Note size and location of tumor.

A. The operative report supplements the pathology report by providing information on involvement of organs or tissues not resected.

B. Include statements on nodes involved and removed.

C. Include pertinent findings at laparotomy and thoracotomy.

VII. PATHOLOGY REPORTS (including autopsy)

Abstract both the gross and microscopic pertinent findings, whether positive or negative; indicate the procedure and whether findings are gross or microscopic. Record:

A. Histology

1. Cell type
2. Degree of differentiation (grade)
3. Behavior of the neoplasm

B. Multifocal tumors

Indicate the pathologist's description of multiple tumors or multiple foci of tumor cells. The terms multifocal and multicentric are equivalent.

C. Size of Tumor

If more than one tumor, record dimensions of the largest.

D. Direct extension of tumor

1. Record in detail the description of the primary tumor within the primary site including depth of invasion.

2. Record direct extension of tumor beyond primary site.

E. Lymph nodes

Identify all nodes biopsied and/or excised (regional and/or distant) and indicate if positive or negative. Indicate if any node(s) are fixed (perinodal extension of tumor). If there is no description of resected node(s) in the pathology report, so state. If the only statement is "highest" node in operative specimen, so record. For breast, indicate the number of nodes removed and the number positive.

F. Distant site

Record any and all sites of distant involvement.

G. Autopsy reports

Record pertinent findings if autopsy report is available and meets the rules for inclusion.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Palpation of abdomen
Palpation of accessible lymph nodes
Palpation of secondary masses
Rectal examination (presence of "rectal shelf")

II. X-RAYS, SCANS AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Upper GI series
Esophagram
Air contrast studies
X-ray of abdomen
Small bowel series
Barium enema

Chest x-ray
Bone survey
Pyelogram (intravenous or retrograde)
Angiogram

Brain scan
Bone scan
Liver/spleen scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Alkaline phosphatase
CEA (carcinoembryonic antigen)

IV. MANIPULATIVE PROCEDURES

Specifically identify:

- Gastroscopy
- Esophagoscopy
- Upper GI endoscopy and/or photography
- Colonoscopy
- Peritoneoscopy (laparoscopy)

V. CYTOLOGY REPORTS

Record the highest class (I-V) from each source.

- Gastric washings
- Gastric brushings

- Ascitic fluid (paracentesis)
- Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

- Exploratory laparotomy/celiotomy

- Resection procedures
  - Gastrectomy
  - Esophagogastrectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multiple tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. DIRECT EXTENSION OF TUMOR

1. Depth of Invasion:

   In situ tumor (no invasion of the lamina propria)

   Confined to mucosa (lamina propria or muscularis mucosae; intramucosal)

   Submucosa (thru muscularis mucosae); includes invasion of stalk (if polyp)

   Superficial invasion
   Muscularis propria
   Subserosal tissue
   Serosa
   Diffuse involvement of stomach wall
   Linitis plastica

   "Localized" without further details or "extension through wall" should be recorded if this is the only information available.

2. Extension to adjacent tissues such as:

   Perigastric fat
   Greater omentum
   Gastrocolic ligament
   Lesser omentum
   Gastrohepatic ligament

   Extension into "adjacent tissues" should be recorded if this is the only information available.

3. Mucosal implants within stomach

4. Extension beyond primary site area to:

   Duodenum (specify whether intraluminal, intramural, transmural or via serosa)
   Esophagus (specify whether intraluminal, intramural, transmural or via serosa)
   Gastroesophageal junction

   Transverse colon
   Small intestine, other than duodenum
   Spleen
   Liver
   Diaphragm
   Pancreas

   Other organs or tissues involved by <u>direct</u> extension (specify)

B. LYMPH NODES

1. Specifically identify:

Splenic hilar
- Pancreaticolienal
- Peripancreatic
- Left gastroepiploic
- Splenic

Superior gastric
- Lesser curvature
- Lesser omentum
- Gastrohepatic
- Left gastric
- Paracardial
- Cardiac
- Cardioesophageal

Inferior gastric
- Greater curvature
- Greater omentum
- Gastrocolic
- Gastroepiploic, right or NOS
- Pyloric (subpyloric/infrapyloric)

- Hepatic
- Portal
- Celiac
- Para-aortic

- Mesenteric
- Retroperitoneal

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Nodes adjacent to tumor"
"Perigastric, NOS"
"Regional node(s)"
"Distant node(s)"

C. Distant site involvement

1. Specifically identify:

Metastasis in lung (specify if solitary or multiple)
Implants on pleura
Implants in thoracic cavity
Ovary
Liver
Bone
Brain
Implants on the intestinal tract (including implants on the serosa of the stomach), peritoneum or mesenteries

2. Specify any other distant site(s)

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

If primaries are found in more than one segment of the colon and rectum, prepare separate abstracts.

I. HISTORY AND PHYSICAL EXAMINATION

A. Record significant findings from:

Rectal examination
Palpation of abdomen
Palpation of accessible lymph nodes
Palpation of secondary masses

B. Significant associated or previously existing conditions to watch for are familial polyposis, ulcerative colitis, and Gardner's syndrome.

II. X-RAYS, SCANS AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Barium enema
Air contrast studies
X-ray of abdomen
Small bowel series
Chest x-ray
Bone survey
Pyelogram (intravenous or retrograde)
Angiogram

Brain scan
Bone scan
Liver/spleen scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Alkaline phosphatase
CEA (carcinoembryonic antigen)

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Colonoscopy
Proctoscopy
Sigmoidoscopy
Cystoscopy
Peritoneoscopy (laparoscopy)

V. CYTOLOGY REPORTS

Record the highest class (I-V) from each source.

Colon washings
Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE REPORTS

Specifically identify:

Exploratory laparotomy/celiotomy

Resection procedures

Segmental resection
Colectomy
Hemicolectomy

Proctectomy
Anterior resection
Abdominal-perineal resection

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multiple tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Direct extension of tumor

1. Depth of Invasion:

   In situ tumor (no invasion of the lamina propria)

   Confined to mucosa (lamina propria or muscularis mucosae; intramucosal)
   Submucosa (thru muscularis mucosae); includes invasion of stalk (if polyp)

   Superficial invasion
   Muscularis propria
   Subserosal tissue
   Serosa
   "Localized" without further details or "extension through wall" should be recorded if this is the only information available.

2. Extension to tissues such as:

   Free surface of serosa
   Mesentery
   Mesenteric fat
   Pericolic or perirectal fat
   Greater omentum
   Gastrocolic ligament
   Rectovaginal septum

   Extension into "adjacent tissues" should be recorded if this is the only information available.

3. Intraluminal extension to other segments of the colon or rectum (specify)

4. Extension beyond primary site area to:

   Small intestine
   Stomach
   Retroperitoneum
   Other organs or tissues involved by direct extension (specify)

B. Associated lesions

Adenomatous polyp and/or villous adenoma and/or carcinoma elsewhere in colon or rectum

Record also the presence or absence of benign lesions (adenomatous polyp and/or villous adenoma) in direct association with the cancer, e.g. carcinoma arising in a villous adenoma or adenomatous polyp or residual adenoma at the margins of the cancer.

B. Associated Lesions (continued)

"Associated lesions" are to be recorded only if they are stated to be adenomatous polyps or villous adenomas. Polyp, NOS, must be verified as adenomatous to be recorded. If cancer arises in a polyp, the polyp is assumed to be adenomatous.

C. Lymph nodes

1. Specifically identify:

Pericolic or perirectal
Epicolic

Ileocolic
Right colic
Middle colic
Left colic
Inferior mesenteric
Superior mesenteric

Superior hemorrhoidal
Middle hemorrhoidals
Sigmoidal
Superior rectal
Hypogastric (internal iliac)

Sacral
Para-aortic
Inguinal

Supraclavicular
Scalene
Cervical

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Nodes adjacent to tumor"
"Regional node"
"Mesenteric node"
"Colic node"
"Ileopelvic node"
"Distant node"

4. Record "nodule(s) in pericolic or perirectal fat." This is considered regional spread by the way of the lymphatic system--probably lymph node(s) whose configuration has been obliterated by tumor.

D. Distant site involvement

1. Specifically identify:

Metastasis in lung (specify if solitary or multiple)
Implants on pleura
Implants in thoracic cavity
Ovary
Liver
Bone
Brain
Implants on the intestinal tract, peritoneum or mesenteries

2. Specify any other distant site(s)

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

If both lungs are involved, see general abstracting instructions for paired organs.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Palpation of secondary masses
Palpation of accessible lymph nodes

Record presence of:

Superior vena cava syndrome
Horner's syndrome
Recurrent laryngeal nerve paralysis (hoarseness)
Phrenic nerve paralysis (fixed diaphragm)
Pancoast syndrome

II. X-RAYS, SCANS AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Chest x-ray
Tomograms, planigrams
Bone survey
Angiogram
Esophagogram

Brain scan
Bone scan
Liver/spleen scan

Significant findings of chest x-rays are:

Hilar mass
Mediastinal mass (widening)

Indicate if masses are stated to be nodes or questionable nodes.

If no hilar or mediastinal mass or no information, so state.

Record other significant findings:

Atelectasis
Obstructive pneumonitis
Pleural effusion

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Alkaline phosphatase

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Bronchoscopy
Laryngoscopy
Mediastinoscopy (note if positive or negative hilar and/or mediastinal node(s))

V. CYTOLOGY REPORTS

Report the highest class (I-V) from each source:

Sputum
Pleural fluid (thoracentesis)
Bronchial washings or brushings
Ascitic fluid (paracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

Exploratory thoracotomy

Resection procedures

Segmental resection
Lobectomy
Pneumonectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multifocal tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Determine whether primary site is lung or main stem bronchus. If primary is in the lung (or segmental bronchi), specify lobe(s) involved.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Description of tumor in lung(s) and main stem bronchi

1. Lobes involved (include mention of contiguous tumor where tumor crosses major fissure):

   Right (specify if upper, middle, or lower)
   Left (specify if upper, lower or lingula)

2. Main stem bronchi involved. Record relationship of tumor margin to carina (e.g., distance in cm)

3. "Localized" or "hilar region of lung" without further details should be recorded if this is the only information available.

B. Direct extension of tumor

Specifically identify:

Pericardium (specify if parietal or visceral)

Pulmonary artery or vein
Azygos vein
Superior vena cava
Recurrent laryngeal nerve
Vagus nerve
Phrenic nerve (fixed diaphragm)
Cervical sympathetic nerves

Carina
Trachea
Esophagus
Heart

Pleura (specify if parietal or visceral)

Adjacent rib
Sternum
Chest wall
Skeletal muscle
Skin of chest
Superior sulcus (Pancoast) tumor
Brachial plexus

Vertebra
Diaphragm
Abdominal organs

Other organs or tissues involved by direct extension (specify)

C. Lymph nodes

1. Specifically identify:

Intrapulmonary

Hilar:
- Bronchial
- Parabronchial
- Pulmonary root

Subcarinal, carinal

Mediastinal:
- Paratracheal
- Paratracheobronchial
- Paraesophageal
- Pericardial
- Para-aortic (above diaphragm)

Contralateral or bilateral hilar or mediastinal
Supraclavicular (specify if ipsilateral, contralateral, or bilateral)
Scalene (specify if ipsilateral, contralateral, or bilateral)
Other cervical

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Regional node(s)"
"Distant node(s)"

D. Distant site involvement

1. Specifically identify:

Implants in thoracic cavity; implants on pleura
Bone
Liver
Adrenal gland(s)
Brain

2. Specify any other distant site(s).

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

I. HISTORY AND PHYSICAL EXAMINATION

A. Record history of pre-existing lesion (mole or nevus at same location prior to present melanoma).

B. Record significant findings from:

Examination of skin:

Primary lesion (including size, type, presence of ulceration)

Satellite lesions (including location or distance from primary lesion; size of largest tumor)

Palpation of accessible lymph nodes
Palpation of secondary masses

(See VIII for site-specific details)

II. X-RAYS, SCANS AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Chest x-ray
Lymphangiogram (to detect distant nodes)
Bone survey

Brain scan
Bone scan
Liver/spleen scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

24-hour urine analysis for pigment
Alkaline phosphatase

IV. MANIPULATIVE PROCEDURES

Not applicable for this site

V. CYTOLOGY REPORTS

Record the highest class (I-V) from each source.

Cytology of primary site
Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE REPORTS

Specifically identify:

Wide excision
Resection
Amputation
Lymphadenectomy

Excisional biopsy is not treatment unless it is the only procedure within the two-month limit.

VII. PATHOLOGY REPORTS (including autopsy)

Record type, size (both surface size and thickness), presence of ulceration, association with pre-existing nevus, vessel invasion, depth of invasion, satellite tumors, lymph nodes, and distant sites.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Record history of pre-existing lesion (mole or nevus at same location prior to present melanoma)

B. Primary Site Vessel Invasion

Record mention of tumor cells in lymphatics between the primary tumor and the first chain of nodes. This may result in a "shower phenomenon" which is different from "satellite" tumors.

C. Type of Melanoma

Record type of melanoma as:

Lentigo maligna (Hutchinson's melanotic freckle)
"Superficial spreading"* (melanoma with lateral spreading intra-epidermal component)
Acral lentiginous
Nodular
Melanoma, type not specified (pigmented melanoma, NOS)

*"Superficial melanoma" is not "superficial spreading" type

Record if primary lesion arises in:

Giant hairy nevus
Blue nevus
Junctional nevus
Intradermal or compound nevus

Nevus, NOS

(Melanomas generally do not arise in previously existing lesions.)

D. DEPTH OF INVASION

In situ
Intra-epidermal (Level 1)
Papillary dermis (Level 2)
Papillary-reticular dermal interface (Level 3)
Reticular dermis (Level 4)
Subcutaneous tissue (Level 5)

Dermis, NOS

"Through entire dermis"
Record distance of satellite nodule(s) from outer border of primary lesion.

F. Lymph nodes

1. Specifically identify (indicate if unilateral or bilateral involvement):

   Preauricular
   Parotid
   Submaxillary (submandibular)
   Upper deep jugular chain
   Posterior cervical
   Upper cervical
   Cervical, NOS
   Supraclavicular

   Axillary
   Epitrochlear
   Inguinal
   Popliteal

2. Include any mention of fixation of nodes

3. Specify any other lymph nodes involved

4. Also record statements such as:

   "Nodes adjacent to tumor"
   "Regional node"
   "Distant node"
   "Nodes, NOS"

G. Distant site involvement

1. Specifically look for:

   Lung
   Liver
   Brain
   Spleen
   Heart
   GI tract
   Bone

2. Specify any other distant site(s)

3. Generalized metastases or "distant metastasis" should be recorded if this is the only information available.

If both breasts are involved, see general abstracting instructions for paired organs.

I. HISTORY AND PHYSICAL EXAMINATION

Record description of palpation of:

Both breasts and axillae
Bilateral lymph nodes (specifically axillary, cervical, and supraclavicular)

(See VIII A and B for specific details)

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Mammography (both breasts)
Xerography (both breasts)
Thermography (both breasts)

Chest x-ray
Skull x-ray
Bone survey
Angiography
Lymphography

Bone scan
Brain scan
Liver/spleen scan

III. LABORATORY TESTS

Record test results and normal values (range) for:

Alkaline phosphatase
Serum calcium

IV. MANIPULATIVE PROCEDURES

Record all manipulative procedures. For breast these procedures would only be done for distant metastases.

V. CYTOLOGY REPORTS

Record the highest class (I-V) from each source.

- Ductal fluid
- Aspirated tumor cells
- Eroded/inflammatory skin of breast, including areola
- Ascitic fluid (paracentesis)
- Pleural fluid (thoracentesis)

VI. OPERATIVE REPORTS

Specifically identify:

- Exploratory laparotomy/thoracotomy for distant metastases
- Resection procedures
  - Mastectomy (specify if simple or radical and with or without node(s))
  - Lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multiple tumors, size, location, primary site vessel invasion, direct extension of of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII A and C for site-specific details)

VIII. DETAILED EVALUATION

A. Location

No primary found

Upper outer quadrant (UOQ), (including
axillary tail tumors)
Upper inner quadrant (UIQ)

Lower outer quadrant (LOQ)
Lower inner quadrant (LIQ)

Upper half, upper midline
Lower half, lower midline

Outer (lateral) half, outer midline
Inner (medial) half, inner midline

Central (subareolar)
More than one tumor mass in the same breast
Diffuse

Laterality and location may be combined, i.e.,
RUIQ for right upper inner quadrant.

Location may also be described in "o'clock"
terms, i.e., "2 o'clock", 5 o'clock", etc.

B. Clinical evaluation of primary tumor

1. Within the breast

Freely movable
Mobile
Nonfixed
Well circumscribed
Fixed within the breast

2. Nipple and areola

Attachment to nipple and/or areola
Induration of nipple
Retraction of nipple (not to be confused with inversion which is a congenital condition, usually bilateral)
Paget's disease of nipple

3. Overlying skin

Dimpling
Retraction of skin
Tethering
(These are considered to be due to shortening of Cooper's ligament.)

Adherence to skin
Attachment to skin
Induration or thickening of skin of breast
Fixation to skin (complete or incomplete)

(These imply direct extension to skin)

Edema	Satellite nodules in skin of involved breast
En curraise	
Erythema	Lenticular nodules
Inflammation	Peau d'orange
Ulceration	"Pig skin"

(These imply extensive skin involvement)

Specify presence and location of adjacent skin involvement including satellite nodules in adjacent skin (e.g., over the sternum, upper abdomen, or axilla)

4. Deeper structures

Fixation or attachment to pectoral muscle or fascia
Deep fixation to underlying tissue
Fixation to chest wall, intercostal muscles, serratus anterior muscle, and/or ribs

5. "Inflammatory carcinoma"

   Not all breast cancers with inflammation are considered inflammatory. Only when a specific diagnosis of "inflammatory carcinoma" is made, should it be so recorded.

6. Preoperative edema of the ipsilateral arm is indicative of poor axillary lymph node drainage (possible involvement), and should be recorded.

C. Pathological evaluation

1. Depth of invasion:

   In situ only, intraductal, non-infiltrating
   Infiltrating, invasive

2. Extension to tissues such as:

   Nipple and/or areola

   (Record the presence of Paget's disease of the nipple and indicate whether or not there is associated cancer.)

   Skin of breast (dermal lymphatics)
   Subcutaneous tissue
   Adjacent skin (upper abdomen, axilla)

   Pectoral fascia
   Pectoral muscle

   Chest wall
   Intercostal muscles
   Serratus anterior muscle
   Ribs

3. Record metastatic nodule(s) within breast. This is considered as localized spread by way of the lymphatic system.

D. Lymph nodes

1. Specifically identify:

a. Regional lymph nodes (ipsilateral)

"Axillary nodes" or "Regional nodes" should be recorded.

From the pathology report also record the number of nodes examined and the number of positive nodes.

Other terms which you may encounter are:

Low axillary, including external mammary (adjacent to tail of breast)
Midaxillary (including central, interpectoral, Rotter's node)
High axillary (including subclavicular and axillary vein nodes)

Internal mammary (parasternal)

Record "nodule(s) in axillary fat." This is considered regional spread by the way of the lymphatic system--probably lymph node(s) whose configuration has been obliterated by tumor.

b. Distant lymph nodes

Supraclavicular
Infraclavicular
Cervical

Contralateral axillary
Contralateral internal mammary

2. Specify any other lymph nodes mentioned.

3. "Distant nodes" should be recorded if this is the only information available.

E. Distant Site Involvement

1. Specifically identify:

   Bone
   Opposite breast parenchyma
   Lung; implants on pleura; implants in thoracic cavity
   Implants on peritoneum
   Ovary
   Adrenal
   Liver
   Brain
   Skin including nodules (specify location)

2. Specify any other distant site(s).

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Pelvic examination including examination under anesthesia
Examination at dilatation and curettage (D&C)
Palpation of abdomen
Palpation of accessible lymph nodes
Palpation of secondary masses

If clinically there is no detectable cancer, so state.

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Lymphangiogram

Pelvic x-ray (scout film)
Pyelogram (intravenous or retrograde)
Cystogram
Chest x-ray
Bone survey

Bone scan
Liver/spleen scan
Brain scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Alkaline phosphatase

IV. MANIPULATIVE PROCEDURES

Specifically identify:

- Colposcopy
- Culdoscopy
- Cystoscopy
- Hysteroscopy
- Laparoscopy
- Peritoneoscopy
- Proctosigmoidoscopy

V. CYTOLOGY REPORTS

Report the highest class (I-V) from each source.

- Cervical (Pap test, vibra, Gravelee jet washer)
- Ascitic fluid (paracentesis)
- Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

- Conization (In situ only)
- Exploratory laparotomy (staging laparotomy)
- Resection procedures
  - Trachelectomy
  - Hysterectomy
  - Bilateral salpingo-oophorectomy
  - Pelvic exenteration
  - Pelvic lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multifocal tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Direct extension of tumor

1. Depth of Invasion:

   In situ; intraepithelial; non-invasive; pre-invasive
   Minimal stromal invasion; "micro invasion"
   Invasive cancer confined to cervix and/or endocervix

2. Extension beyond the cervix to:

   Corpus
   Body of uterus
   Vaginal wall (specify if upper 2/3, lower 1/3, or third not specified).

      Fornices
      Anterior (vesicovaginal) and/or posterior (rectovaginal) septum
      Lateral wall

   Rectum (specify whether rectal wall or mucosa)
   Bladder (specify whether bladder wall or mucosa)

   Parametrium (including uterosacral ligament and non-ovarian adnexae)
   Pelvic wall(s)
   Ureter (specify whether intramural or extramural)
   Urethra

   Cul-de-sac
   Intestines
   Vulva

   If there is no information about extension beyond the cervix, so state.

3. If there is evidence of "bulbous edema" of the bladder, so state.

4. If "frozen pelvis" is specified, so state.

B. Lymph nodes

1. Specifically identify:

Paracervical
Parametrial

Iliac
Hypogastric
Obturator
Sacral (laterosacral, presacral, uterosacral or promontary)

Lumbar
Aortic (para-aortic or periaortic)
Inguinal

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Pelvic node(s)"
"Regional node(s)"
"Distant node(s)"

C. Distant Site Involvement

1. Specifically identify:

Metastasis in lung (specify if solitary or multiple)
Implants on pleura and/or in thoracic cavity

Implant(s) in vagina
Ovary
Liver
Bone
Brain
Peritoneal involvement outside true pelvis

2. Specify any other distant site(s)

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be record if this is the only information available.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Pelvic examination, including examination under anesthesia
Examination at dilatation and curettage (D&C)
Palpation of abdomen
Palpation of accessible lymph nodes
Palpation of secondary masses

If clinically there is no detectable cancer, so state.

Enlargement of the uterine cavity is measured with a sound from the external os. Record sounding in centimeters. If no exact size is given, record any statement of enlarged uterine cavity.

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Lymphangiogram

Hysterosalpingogram
Pelvic x-ray (scout film)
Pyelogram (intravenous or retrograde)
Chest x-ray
Bone survey

Bone scan
Liver/spleen scan
Brain scan

III. LABORATORY TESTS

None are recorded for corpus

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Culdoscopy
Cystoscopy
Hysteroscopy
Laparoscopy
Peritoneoscopy
Proctosigmoidoscopy

V. CYTOLOGY REPORTS

Report the highest class (I-V) from each source.

Endometrial (Pap test, vibra, Gravelee jet washer)
Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

Exploratory laparotomy

Resection procedures

Hysterectomy
Bilateral salpingo-oophorectomy
Pelvic exenteration
Pelvic lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multifocal tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Direct extension of tumor

1. Depth of Invasion:

In situ; intraepithelial; non-invasive; pre-invasive

Invasive cancer confined to corpus::

Confined to endometrium
Invasion of myometrium (specify if inner one-half, outer one-half, or NOS)
Invasion of serosa

2. Direct extension beyond corpus extending to:

Cervix
Parametrium (including uterosacral broad and and round ligaments)

Pelvic wall(s)
Ovary and/or fallopian tube(s)
Vagina
Vulva

Bladder (specify whether bladder wall or mucosa)
Rectum (specify whether rectal wall or mucosa)
Ureter (specify intramural or extramural)
Cul-de-sac
Abdominal organ(s) (sigmoid colon; small intestine)

3. If "frozen pelvis" is specified, so state.

B. Lymph nodes

1. Specifically identify:

Paracervical
Parametrial

Iliac
Hypogastric
Obturator
Sacral (laterosacral, presacral, uterosacral, or promontory)

Lumbar
Aortic (para-aortic or periaortic)
Inguinal

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Pelvic node(s)"
"Regional node(s)"
"Distant node(s)"

C. Distant Site Involvement

1. Specifically identify:

Metastasis in lung (solitary or multiple)
Implants on pleura and/or in thoracic cavity

Ovary
Liver
Bone
Brain
Peritoneal involvement (seeding) outside true pelvis

2. Specify any other distant site(s)

3. Generalized metastases, carcinomatosis, or "distant metastases" should be recorded if this is the only information available.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Rectal examination
Palpation of accessible lymph nodes
Palpation of secondary masses

If clinically there is no detectable cancer, so state.

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Lymphangiogram

Pyelogram (intravenous or retrograde)
Chest x-ray
Skull x-ray
Bone survey

Bone scan
Brain scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Prostatic serum acid phosphatase (total acid phosphatase only if prostatic is not available)
Marrow acid phosphtase (from marrow aspirate)

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Cystoscopy (with or without TUR)
Proctosigmoidoscopy
Peritoneoscopy

Laparoscopy

V. CYTOLOGY REPORTS

Record the highest class (I-V) from each source.

Bladder washings
Urinary sediment
Prostatic fluid after massage
Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

Exploratory laparotomy

Resection procedures:

Prostatectomy
Orchiectomy (specify if bilateral)
Lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multifocal tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

Record reports of bone marrow aspiration and/or biopsy.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Direct extension of tumor

1. Depth of invasion:

In situ tumor only

Invasive cancer confined to prostate:
Intra-capsular tumor
Invasion of prostatic capsule
Penetration of capsule (into periprostatic tissues)

2. Direct extension beyond prostate to:

Lateral sulci
Seminal vesicle(s)
Bladder
Extraprostatic urethra (membraneous or penile)

Rectum
Bone
Muscle
Pelvic wall

3. Prostatic "fixation" should be recorded if this is the only information available.

4. If "frozen pelvis" is specified, so state.

B. Lymph nodes

1. Specifically identify:

Periprostatic

Iliac
Hypogastric
Obturator
Sacral (laterosacral, presacral, or promontory)

Lumbar
Aortic (para-aortic, periaortic)
Inguinal

2. Specify any other lymph node(s) mentioned.

3. Also record statements such as:

"Regional node(s)"
"Distant node(s)"

C. Distant site involvement

1. Specifically identify:

   Pelvic bones (pubis, ilium, ischium, innominate)
   Other bone (specify, e.g., spine, ribs, femur, humerus)
   Lung
   Liver
   Brain

2. Specify any other distant site(s).

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

I. HISTORY AND PHYSICAL EXAMINATION

Record significant findings from:

Pelvic examination including bimanual examination of pelvic nodes
Palpation of abdomen
Palpation of accessible lymph nodes
Palpation of secondary masses
Rectal examination

II. X-RAYS, SCANS, AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Pelvic x-ray (scout film)
Pyelogram (intravenous or retrograde)
Cystogram
Lymphangiogram
Chest x-ray
Bone survey

Bone scan
Liver/spleen scan
Brain scan

III. LABORATORY TESTS

Indicate the test results and normal values (range) for:

Alkaline phosphatase
BUN

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Cystoscopy* (with or without TUR)
Laparoscopy
Peritoneoscopy
Panendoscopy*

*Record size of largest tumor, record gross description of tumor; record presence of multiple tumors.

V. CYTOLOGY REPORTS

Report the highest class (I-V) from each source.

Urinary sediment
Bladder washings
Ascitic fluid (paracentesis)
Pleural fluid (thoracentesis)

VI. OPERATIVE PROCEDURES

Specifically identify:

Exploratory laparotomy

Resection procedures

Cystectomy
Pelvic lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, multifocal tumors, size, primary site vessel invasion, direct extension of tumor, lymph nodes, and distant sites.

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Direct extension of tumor

1. Depth of Invasion:

In situ; non-invasive; non-infiltrating
Confined to mucosa

Submucosa (subepithelial connective tissue; tunica propria; lamina propria)
Superficial layers of muscle (less than one half-way through muscle coat)
Deep muscle (half-way or more through muscle coat)
Muscle, NOS
"Localized" without further details should be recorded if this is the only information available

2. Extension beyond the bladder wall to:

Surrounding connective tissue
Perivesical fat
Periprostatic tissue
Adjacent tissue, NOS

Subserosal tissue
Serosa
Peritoneum

Urethra (specify prostatic, membranous, penile)
Ureter (specify if mucosal or transmural invasion)
Prostate (specify if invasion via prostatic urethra or transmural)
Uterus
Vagina
Pelvic wall (specify if fixed)
Rectum
Abdominal wall
Other viscera

B. Lymph nodes

1. Specifically identify:

Perivesical

External iliac
Internal iliac
Hypogastric
Obturator
Common iliac
Iliac, NOS

Lumbar
Aortic (para-aortic or periaortic)
Retroperitoneal
Inguinal

Supraclavicular
Scalene
Cervical

2. Specify any other lymph nodes mentioned

3. Also record statements such as:

"Pelvic node(s)"
"Regional node(s)"
"Distant node(s)"

4. It is important to differentiate between negative nodes and no information on nodes. There must be some kind of examination beyond a TUR to determine if regional nodes are negative.

C. Distant Site Involvement

1. Specifically identify:

Lung
Liver
Bone (pelvic and/or other)
Brain

2. Specify any other distant site(s)

3. Generalized metastases, carcinomatosis, or "distant metastasis" should be recorded if this is the only information available.

LYMPH NODES AND LYMPHOID TISSUE
4/27/77
960-969; 416, 460, 471, 491, 640, 692
Histology: 959 thru 969, 975

I. HISTORY AND PHYSICAL EXAMINATION

A. Record significant findings from:

Palpation of accessible lymph nodes
Palpation of secondary masses
Palpation of abdomen (hepatomegaly, splenomegaly)
Examination of accessible extra-nodal sites (e.g. skin, pharynx)

B. Significant symptoms:

Pruritus
Night sweats
Unexplained fever
Unexplained weight loss

If there is no quantitative statement, unexplained fever and/or weight loss should still be recorded.

II. X-RAYS, SCANS AND OTHER IMAGING TECHNIQUES

Record significant findings from:

Lymphangiogram

GI x-rays:
- Barium enema
- Air contrast studies
- Small bowel series
- Upper GI series

Chest x-ray
Tomogram
Bone survey
X-ray of abdomen
Pyelogram (intravenous or retrograde)
Inferior vena cavagram
Myelogram

Brain scan
Bone scan
Liver/spleen scan
Total body scan

III. LABORATORY TESTS

Indicate if neoplastic cells are present for:

Peripheral blood (CBC with differential)

IV. MANIPULATIVE PROCEDURES

Specifically identify:

Laparoscopy
Mediastinoscopy

V. CYTOLOGY REPORTS

Report neoplastic cells in:

Pleural fluid
Ascitic fluid
Bone marrow aspiration (see VII below)

VI. OPERATIVE REPORTS

Specifically identify:

Staging laparotomy/celiotomy
Thoracotomy

Resection procedures

Splenectomy
Lymphadenectomy

VII. PATHOLOGY REPORTS (including autopsy)

Record histology, lymph nodes, perinodal and extranodal involvement.

Specifically identify:

Lymph node(s) biopsy
Bone marrow aspiration/biopsy (Indicate if neoplastic cells present)
Liver biopsy

(See VIII for site-specific details)

VIII. DETAILED EVALUATION

A. Lymph nodes

1. Specifically identify (where applicable, state if unilateral or bilateral involvement):

   Above diaphragm:
   - Cervical (occipital, preauricular, submental, submandibular, internal jugular)
   - Supraclavicular and/or scalene
   - Neck node(s), NOS
   - Infraclavicular
   - Axillary/pectoral
   - Brachial/epitrochlear

   - Hilar
   - Mediastinal and/or peritracheal (including thymic region)

   Below diaphragm:
   - Iliac
   - Para aortic, retroperitoneal
   - Splenic hilar
   - Mesenteric
   - Abdominal node(s), NOS
   - Inguinal-femoral
   - Popliteal

2. Specify any other lymph nodes or regions involved

3. Specifically indentify fixation

B. Extranodal involvement

1. Specifically identify:

Spleen
Liver
Tonsils (lingual and/or palatine)
Adenoids (pharyngeal tonsils)
Thymus
Waldeyer's ring NOS

Lung/pleura
Central nervous system (CNS)
Bone

Bone marrow
Peripheral blood (if neoplastic cells present)

Stomach
Small bowel (Peyer's patches)
Large bowel

Soft tissue (incl. orbit, muscle)
Skin

2. Specify any other extranodal involvement mentioned.

INVESTIGATIVE AND DIAGNOSTIC PROCEDURES
(Name and Date All Procedures)

Registry or Hospital_____ Case Number_____
Final Diagnosis: Site_____ Histologic Type_____

Physical Examination

X-Rays, Scans, and Other Imaging Techniques
None☐

Laboratory Tests
None☐

Manipulative Procedures
None☐

Cytology /Hematology
None☐

Operative Procedures
None☐

Pathology Reports (gross and microscopic)
None☐

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ie: Extent of Disease Diagnostic Procedures

53	54	55	56	57	58	59	60	61	62	63	64	65		35	35	37	38