

(Pre-2007 multiple primary/histology rules are used for all sites except CNS)

Case 1: Colon/Rectum

History and Physical Examination

6/1 The patient is a 74-year-old male with a past medical history of medullary astroglioma resected 24 years ago with residual left sensory motor loss, right motor weakness and bladder incontinence, recently presented with rectal bleeding.

Imaging

6/5 CAT scan of abdomen/pelvis: Negative.

6/5 Chest X-ray: Negative for metastatic disease.

6/5 CAT scan of head: Negative for tumor.

Laboratory

6/6 CEA: Elevated.

Procedures

6/5 Colonoscopy with rectal biopsy: Lesion detected at 15 cm from anal verge.

6/30 Rectal resection with end colostomy, cystoscopy, placement of bilateral ureteral stents: Mid rectal tumor easily palpated with good 3–4 cm distal margins obtained. General examination of the abdomen did not reveal any other sites of metastatic disease. Rectum excised in toto.

Pathology

6/5 Rectal biopsy: Small fragments of adenocarcinoma in predominantly benign mucosa.

6/30 Rectal resection: Rectum specimen excision with well differentiated adenocarcinoma, mucinous type, 3.5 cm, with extension into superficial muscularis propria, inner half, and tumor metastasis to subserosal adipose tissue. Tumor extends to a depth of 0.8 cm and appears grossly to invade into the serosa. A separate metastatic tumor island with irregular contours is present with the fat. Rectal lymph nodes with metastatic adenocarcinoma present in 1 of 36 nodes. Surgical margins are free of tumor. Vascular invasion is not identified.

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Answers

Case 1 Colon/Rectum	Answer	Rationale
Date of Dx	06/05	Rectal biopsy; <i>FORDS</i> , p. 89
Primary Site	C20.9	Rectal resection op and path; <i>FORDS</i> , p. 91
Histology	8480/31	Rectal resection path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 87, histology coding rules for single tumor #6
CS Extension	55	Rectal resection path; appears grossly to invade into the serosa (50) and separate metastatic tumor island with irregular contours present with the fat (45); <i>Collaborative Staging (CS) Manual</i> , p. 281
CS Lymph Nodes	10	Rectal resection path; <i>CS Manual</i> , p. 282
CS Mets at Dx	00	Chest X-ray & CAT scan of head negative; <i>CS Manual</i> , p. 283
Surg Primary Site	50	Op report rectal resection, rectum excised in toto; <i>FORDS</i> , p. 259
Scope Reg LN Surg	5	Colon resection path, 36 LNs removed; <i>FORDS</i> , p. 139
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 2: Colon/Rectum

History and Physical Examination

1/6 The patient is a 65-year-old male with a four-year history of constipation who previously refused endoscopic evaluation. Stool guaiac was positive. Digital rectal examination revealed a rectal mass, probable carcinoma. Remainder of the exam is normal.

Imaging

1/14 CAT scan of abdomen/pelvis, MRI: Hemangioma of the liver and rectal tumor with shadowing in the peri-rectal soft tissue. No lymphadenopathy.

Laboratory

1/14 CEA: 10.6

Procedures

1/13 Colonoscopy with rectal biopsy: Large 5 cm exophytic rectal mass.

2/12 Diverting colostomy: Patient referred for radiation therapy.

6/29 Abdominoperineal resection (APR) with rigid sigmoidoscopy and placement of ureteral stents

Pathology

1/13 Rectal biopsy: Adenocarcinoma, well differentiated.

6/29 APR: Colorectal specimen post-radiation therapy with moderately differentiated adenocarcinoma, 2.5 cm, with extension into but not through the muscularis propria. Vascular space invasion is not identified. All 7 lymph nodes resected were negative for metastatic tumor.

Oncology

3/23 to 4/24: Patient received 4500 cGy total dose pre-operative external beam radiation therapy to the rectum in 25 fractions. 3/23 the patient received 5-FU chemotherapy with Leucovorin concomitant with XRT on in-house protocol. Plan includes surgery after completion of adjuvant therapy.

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Answers

Case 2 Colon/Rectum	Answer	Rationale
Date of Dx	01/06	Probable carcinoma per h & p; <i>FORDS</i> , p. 3
Primary Site	C20.9	H & P, colonoscopy; <i>FORDS</i> , p. 91
Histology	8140/32	Assign highest grade, APR path; <i>ICD-O-3</i> , rule G, p. 30
CS Extension	42	CS extension is taken from pre-op info when patient has pre-op adjuvant therapy; exophytic (on exterior of organ) mass per colonoscopy; <i>Collaborative Staging (CS) Manual</i> , p. 280
CS Lymph Nodes	00	CS lymph nodes taken from pre-op info when patient has pre-op adjuvant therapy, no lymphadenopathy per 1/14 MRI; <i>CS Manual</i> , p. 282
CS Mets at Dx	00	No mets per MRI; <i>CS Manual</i> , p. 283
Surg Primary Site	50	Abdominoperineal resection is total proctectomy; <i>FORDS</i> , p. 259
Scope Reg LN Surg	5	7 LNs resected; <i>FORDS</i> , p. 139
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	20	Per oncology note, pre-op external beam RT; <i>FORDS</i> , p. 155
Chemotherapy	02	5-FU is single agent, leucovorin is ancillary drug; <i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 3: Colon/Rectum

History

1/20 67-year-old female with a history of diabetes and hypertension presenting to the emergency room with two weeks of constipation and increasing abdominal pain. No vomiting, no bright red blood per rectum, + flatus.

Physical Examination

1/20 Normal with no adenopathy or organomegaly.

Imaging

1/27 CT of the chest, abdomen, and pelvis: Mediastinum demonstrates no definite mediastinal or hilar lymphadenopathy. There is no axillary lymphadenopathy seen. Liver demonstrates low attenuation, consistent with fatty infiltration. There is heterogeneous enhancement to the liver, especially to the left hepatic lobe. Given these findings, the possibility of a focal lesion cannot be excluded. MRI can be obtained if clinically indicated. Ascites is identified. Retroperitoneum demonstrates no evidence of lymphadenopathy.

Laboratory

Hematocrit 27.7 (37.0–47.0 normal ranges)

Hemoglobin 9.2 (12.0–16.0 normal ranges)

CEA 3.5 (pre-operative) within normal limits

Procedures

1/29 Proctosigmoidoscopy, exploratory laparotomy, sigmoid colon resection: Rigid proctosigmoidoscopy revealed no lesions to 16 cm but the scope was unable to pass the point. Colon was severely distended with cecum massively distended. Cecum was ischemic. There was circumferential obstructing sigmoid lesion; which was resected. Liver was negative for metastatic disease.

Pathology

1/29 Sigmoid colon resection: Adenocarcinoma with signet ring cell and scirrhous subtypes, 3.5 cm, invasive through the bowel wall into the pericolic fat. Vascular invasion is present. Six of seven (6/7) regional lymph nodes are positive for metastatic carcinoma. Margins are free of tumor.

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Answers

Case 3 Colon/Rectum	Answer	Rationale
Date of Dx	01/29	Sigmoid colon resection path; <i>FORDS</i> , p. 89
Primary Site	C18.7	Sigmoid colon resection op report; <i>FORDS</i> , p. 91
Histology	8255/39	Sigmoid colon resection path; adenocarcinoma with mixed subtypes; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 86, histology coding rules for single tumor #3
CS Extension	45	Sigmoid colon resection path; invasive through bowel wall into pericolic fat; <i>Collaborative Staging (CS) Manual</i> , p. 272
CS Lymph Nodes	30	Sigmoid colon resection path, 6/7 regional LNs; <i>CS Manual</i> , p. 275
CS Mets at Dx	00	Sigmoid colon resection op report; liver negative for metastatic disease; <i>CS Manual</i> , p. 275
Surg Primary Site	40	Sigmoid colon resection op report; <i>FORDS</i> , p. 255
Scope Reg LN Surg	5	Sigmoid resection path, 7 LNs removed; <i>FORDS</i> , p. 139
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 4: Colon/Rectum

History and Physical Examination

7/9 A 53-year-old man presented to the hospital last evening with bright red rectal bleeding. He stated that he had experienced left upper quadrant pain for about 1 week. On physical exam the abdomen was soft with bowel sounds present. The liver was not palpated and there was no rebound or guarding. Rectal exam showed a small amount of bright red blood.

Laboratory

CEA: 2.6 (normal < 3.0)

Procedures

7/9 Colonoscopy: Left sided colonoscopy found a constricting circumferential neoplastic mass at 35 cm, likely a carcinoma. Biopsy obtained.

7/10 Exploratory laparotomy; left hemicolectomy with transverse colosigmoidectomy; wedge resection, left lobe liver: Exploration of abdominal cavity revealed a normal stomach with no palpable abnormalities. Liver diffusely multinodular, possible metastatic lesions. There was a 4 cm mass in the sigmoid colon consistent with a carcinoma, with no gross evidence of extension through the bowel wall. No gross evidence of metastatic disease within the abdominal cavity.

Pathology

7/9 Biopsy of lesion in sigmoid colon: polyp with adenocarcinoma

7/10 Liver, wedge resection: Macronodular cirrhosis with mild inflammatory activity.

Sigmoid colon resection: Invasive, moderately to poorly differentiated adenocarcinoma. Tumor penetrates through the main muscular wall of the colon, transmural extension is not identified. 0/6 regional lymph nodes positive.

Oncology

Medical oncology consult: Chemotherapy not recommended at this time.

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Answers

Case 4 Colon/Rectum	Answer	Rationale
Date of Dx	07/09	Colonoscopy & biopsy; <i>FORDS</i> , p. 89
Primary Site	C18.7	Biopsy & sigmoid colon resection path; <i>FORDS</i> , p. 91
Histology	8140/33	Sigmoid colon resection path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 87 histology coding rules for multiple tumors in same organ reported as a single primary #2
CS Extension	40	Sigmoid colon resection; <i>Collaborative Staging (CS) Manual</i> , p. 272
CS Lymph Nodes	00	Sigmoid colon resection; <i>CS Manual</i> , p. 274
CS Mets at Dx	00	Liver wedge resection; <i>CS Manual</i> , p. 275
Surg Primary Site	40	Left hemicolectomy op report; <i>FORDS</i> , p. 255
Scope Reg LN Surg	5	Sigmoid colon resection path, 0/6 regional LNs Positive; <i>FORDS</i> , p. 139
Surg Proc/Other Site	4	Op report, wedge resection, left lobe liver; <i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	00	<i>FORDS</i> , p. 171
Hormone Therapy	00	<i>FORDS</i> , p. 171
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186

Case 5: Colon/Rectum

Consultation

Date of Consult: 5/15/XX

Reason for Consultation: New diagnosis of colon cancer.

History of Present Illness: Patient is a 56-year-old female who had a diagnosis of endometrial cancer, status post surgery followed by radiation therapy fifteen years ago. A few weeks ago the patient had a routine colonoscopic examination and the patient was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, XX. So far the findings are two areas of high-grade adenocarcinoma of the colon with pericolonic tissue invasion. No lymph nodes were positive. The sizes were 4 cm and 3 cm.

Postoperatively, the patient is in stable condition but the patient has nausea requiring NG tube. There is no fever and her vital signs are stable. Laboratory findings during the hospital stay showed that the patient has anemia with hemoglobin of 10.7 and normal CMP level. The patient has had some weight loss recently.

Past Medical History: Remarkable for trigeminal neuralgia, endometrial cancer as mentioned above.

Allergies: Penicillin.

Family History: Remarkable for a strong cancer history in mother, sister, and father including stomach cancer, colon cancer, and endometrial cancer.

Review of Systems: As mentioned above the patient has had some weight loss and irregular bowel movements and discomfort in the abdomen. Otherwise there are no significant findings prior to this surgery.

Physical Examination

Vital signs are stable. She is afebrile. She is mildly cachectic.

HEENT: Moderately pale, non-icteric. The patient has an NG tube in place.

Lungs: Clear auscultation and percussion.

Heart: Regular rate and rhythm without murmur.

Abdomen: Not distended but the patient does have decreased bowel sounds. The surgical site is healing well.

Extremities: Full range of motion of both extremities. No cyanosis. No clubbing. No edema.

Neurologic: Within normal range. There are no focal neurologic deficits.

Assessment: The patient has a new diagnosis of high-grade mucin producing signet ring cell adenocarcinoma. This is about 3–4 cm in size with pericolonic tissue invasion.

The patient was found to have a probable cystic lesion in the liver during the surgery. Since the patient has a high risk of cancer of the stomach and colon and endometrial cancer, I will check a CA19-9, CA125, and CEA. I also will send out for flow cytometry of this tumor for DNA ploidy and “S phase”. I would like to have a CT scan done before further procedures later on including chemotherapy.

Based upon all these reports and findings, the patient may get benefit from adjuvant chemotherapy. I discussed with the patient and family about these findings and the possible treatment plan.

Pathology Report (Case 5: Colon/Rectum)

Date: 4/15/XX

Specimens

1. Colon-mass biopsy at 135cm
2. Colon-polyp at 20cm
3. Rectum-polyp

Post-Operative Diagnosis

There was a single large annular circumferential friable mass present 135cm from the anus. Single medium sessile polyp was seen 20cm from the anus, which measured 7mm. Single large pedunculated medium sessile polyp was seen 20cm from the anus, which measured 7mm. Single large pedunculated polyp was seen in the rectum, which measured 1cm.

Diagnostic Opinion

1. Moderately differentiated adenocarcinoma, colon at 135cm.
2. Tubular adenoma, colon at 20cm.
3. Tubular adenoma with focal moderate dysplasia, rectum.

Clinical History

A positive family history of colon cancer

Gross Description

Specimen #1 labeled "colon mass" consists of six pieces of soft tissue measuring up to 2mm in diameter. The entire specimen is submitted.

Specimen #2 labeled "polyp at 20cm" consists of eleven pieces of soft tissue measuring up to 3mm in diameter. The entire specimen is submitted.

Specimen #3 labeled "Colon Polyp at rectum" consists of fourteen pieces of soft tissue measuring up to 1.3cm in diameter. The entire specimen is submitted.

Microscopic Description

1. Sections reveal multiple pieces of invasive tumor. The tumor is composed of crowded and fused glandular structures. These structures are lined by columnar epithelium. The nuclei are round to oval shape and hyperchromatic. Pleomorphism of the nuclei is seen. There are prominent nucleoli. Superficial ulcer is seen. There is acute inflammatory reaction.
2. Sections reveal pieces of tubular adenoma. There are crowded, irregular tubules, which are lined by tall columnar epithelium. The nuclei are cigar shape and hyperchromatic. Pseudostratification of nuclei is seen. Focal inflammatory reaction is observed.
3. Sections reveal pieces of tubular adenoma. There are crowded, irregular tubules, which are lined by tall columnar epithelium. The nuclei are cigar shape and hyperchromatic. Focal moderate dysplasia with stratification of nuclei is seen. Inflammatory reaction is observed.

Operative Report (Case 5: Colon/Rectum)

Date of Admission: 5/1/XX

Date of Procedure: 5/1/XX

Preoperative Diagnosis: Right colon cancer.

Postoperative Diagnosis: Right colon cancer, with adhesive bowel disease.

Procedures Performed: Exploratory laparotomy, lysis of adhesions, a right hemicolectomy, and excision of distal small bowel.

Drains: None.

Estimated Blood Loss: Less than 100 ml.

Complications: None.

Post-Procedure: To the Recovery Room in stable condition.

Procedure: The patient was brought to the Operating Room, and following administration of general anesthesia, the abdomen was prepped and draped in an aseptic manner.

A midline incision was performed. The abdomen was entered. There were adhesions. These were lysed. There were adhesions in the pelvis that were lysed. On exploration of the abdomen, the liver was found to be palpated; otherwise, unremarkable. There were no lesions in the colon other than in the right colon. In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum. This was removed en bloc.

The mesentery of the distal ileum was dissected, as well as the right colon was dissected along the white line of Toldt. The mesentery was clamped, incised, and ligated serially up to the hepatic flexure. The small bowel was incised, using a GIA stapling device. The colon was incised, using a GIA stapling device. The enterotomy was stapled, using a TA 60 stapler. The mesenteric defect was closed, using 3-0 PDS running suture.

The abdomen was irrigated profusely with normal saline followed by antibiotic solution. The midline incision was closed, using #1 PDS running suture. Retention sutures were with #1 Vicryl. The skin was closed with staples. The wound was dressed with a dry dressing.

The patient was brought to the Recovery Room in a stable condition.

Pathology Report (Case 5: Colon/Rectum)

Date: 5/1/XX

Post-Operative Diagnosis: Right colon carcinoma.

Diagnostic Opinion

1. Two areas of high grade adenocarcinoma of colon with pericolonic adipose tissue invasion and no evidence of lymph node metastasis, right colon and small intestine.
2. Fibrotic adhesion on serosa of small intestine, see description.

Clinical History: None listed.

Gross Description

Specimen labeled "right colon and small intestine" consists of portion of colon and small intestine. The colon portion measures 20 cm and small intestine portion measures 32 cm. Small intestine portion shows fibrotic adhesions between the loops of small intestine. Upon opening, there are two tumors in the colon measuring 4 cm and 3 cm with slightly polypoid and ulcerated appearance. These two tumors are located closely with 3 cm of normal colon between them. One is located near ileocolic junction with tumor invasion to deep colon wall, but no definitive pericolonic invasion. Other is located 3 cm distal from the previous tumor with tumor invasion probable to pericolonic tissue. There is 10 cm of normal colon mucosa distally from tumor area to the excision margin. Small intestine mucosa shows no evidence of tumor. Excision margin of specimen shows normal appearing mucosa. In mesenteric adipose tissue there are several lymph nodes measuring up to 0.3 x 0.5 cm with soft parenchyma. Representative sections are made.

Microscopic Description

Section "A" of the tumor located near ileocolic junction shows high-grade adenocarcinoma with signet ring carcinoma. The tumor shows invasion to deeper portion of the colon wall and subserosal area. There is no definitive tumor invasion to pericolonic adipose tissue. Section "B" of additional tumor shows high-grade adenocarcinoma with area of mucin production and tumor invasion to deeper portion of colon wall as well as tumor invasion to pericolonic adipose tissue on the surface of serosa. Section "M" from excision margin of small intestine and colon shows regular appearing small intestinal mucosa and colon mucosa. There are seven lymph nodes, which show no evidence of metastatic malignant tumor. Doctor XX reviewed the case. His opinion is:

- A. Mostly mucin-producing signet ring cell adenocarcinoma with probable invasion into pericolonic soft tissue.
- B. High-grade mucin-producing signet ring cell carcinoma and tumor invasion into pericolonic soft tissue. No evidence of lymph node metastasis.

Summary

- A. There are two high-grade adenocarcinomas. One is 4 cm in size and located in colon near ileocolic junction and tumor invasion to deeper portion of the wall and serosa. Other is located slightly distally and measuring 3 cm in size with tumor invasion to deeper portion of colon wall and focal extension to pericolonic adipose tissue on serosal surface. (PT3a/b)
- B. No evidence of lymph node metastasis among seven lymph nodes. (PNO)
- C. Distant metastasis cannot be assessed. (PMX)
- D. Excision margin is negative.
- E. Fibrotic adhesion of external surface of small intestine.

Radiology Report (Case 5: Colon/Rectum)

CT Abdomen and Pelvis With and Without

Date: 4/20/XX

History: Abnormal colonoscopy. History of abnormal mammogram. Colon cancer.

Findings: Computerized axial tomographic views of the abdomen and pelvis have been obtained at 5.0, 7.5 or 10.0 mm increments in a helical fashion from the domes of diaphragm to the pubic symphysis with and without IV contrast (150 cc of Omnipaque 300) with no comparison studies being available.

The liver shows multiple focal low-density lesions within it suggesting cystic lesions. The spleen, pancreas, gallbladder, and adrenal glands are unremarkable. The kidneys show a low-density lesion of the mid pole of the left kidney, most consistent with a left renal cyst. The kidneys, urinary bladder, and portions of the ureters seen are otherwise unremarkable. The uterus and ovaries are not definitely seen consistent with a prior hysterectomy and/or atrophy. The GI tract shows two areas of circumferential thickening involving the distal sigmoid colon and a colonic loop in the right lower quadrant/right pelvis. The vasculature shows faint vascular calcifications without evidence of aneurismal dilatation. There are shotty lymph nodes seen, but no definite lymphadenopathy demonstrated. The soft tissues and bony structures show no definite destructive lesions. The lung shows changes suggestive of COPD.

Conclusion

1. Two areas of circumferential colonic wall thickening effecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted although there are shotty lymph present, there is no definite lymphadenopathy demonstrated.
2. History of uterine cancer with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.
3. Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.

Radiology Report (Case 5: Colon/Rectum)

Whole Body PET Scan

Date: 4/25/XX

Clinical History: Colon carcinoma.

Technique

Radiopharmaceutical: The PET study was performed after the intravenous administration of 18.7 mCi of ¹⁸F Deoxyglucose injected through the right wrist. Emission scanning was performed 30 minutes later. Six bed positions were utilized for the emission scan. For the PET attenuation correction, a CT study was performed. Attenuation corrected images were displayed in the axial, coronal, and sagittal planes.

Findings

Correlation was made with the CT study of the abdomen and pelvis dated 20 April, XX. The radionuclide distribution in the liver is homogeneous. No focal areas of increased radionuclide uptake are seen within the liver. There is diffuse heterogeneous activity seen in the left abdomen. On correlation with the CT study, this is seen in the areas of small and large bowel in the left abdomen. No evidence of abnormal radionuclide uptake is seen in the pelvis. No increased retroperitoneal uptake is seen.

The radionuclide distribution in the chest is physiologic.

Impression

Radionuclide uptake in the left abdomen, representing a nonspecific finding.

No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

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Answers

Case 5 Colon/Rectum	Answer	Rationale
Date of Dx	04/15	Biopsy path; <i>FORDS</i> , p. 89
Primary Site	C18.2	Hemicolectomy op & path; <i>FORDS</i> , p. 91
Histology	8490/34	Hemicolectomy path; <i>SEER Program Coding and Staging Manual (PCSM) 2004</i> , p. 87, coding rules for multiple tumors #1, coding rules for single tumors #7; grade conversion, <i>SEER PCSM</i> , p. 93 and <i>FORDS</i> , p. 13
CS Extension	55	Hemicolectomy path summary, tumor invasion to deeper portion of wall & serosa (50), focal extension to pericolic adipose tissue (45); <i>Collaborative Staging (CS) Manual</i> , p. 273
CS Lymph Nodes	00	Hemicolectomy path, no evidence of mets among 7 LNs; <i>CS Manual</i> , p. 274
CS Mets at Dx	99	Op report, liver found to be palpated, otherwise negative; <i>CS Manual</i> , p. 274
Surg Primary Site	41	Op report, right hemicolectomy & excision of distal small bowel; <i>FORDS</i> , p. 255
Scope Reg LN Surg	5	Hemicolectomy op report, 7 LNs removed; <i>FORDS</i> , p. 139
Surg Proc/Other Site	0	<i>FORDS</i> , p. 142
Rad Reg Treatment Mod	00	<i>FORDS</i> , p. 155
Chemotherapy	99	Discussed is not recommended; <i>FORDS</i> , p. 172
Hormone Therapy	00	<i>FORDS</i> , p. 175
Immunotherapy	00	<i>FORDS</i> , p. 179
Hem Tsplt & End Proc	00	<i>FORDS</i> , p. 183
Other Treatment	0	<i>FORDS</i> , p. 186