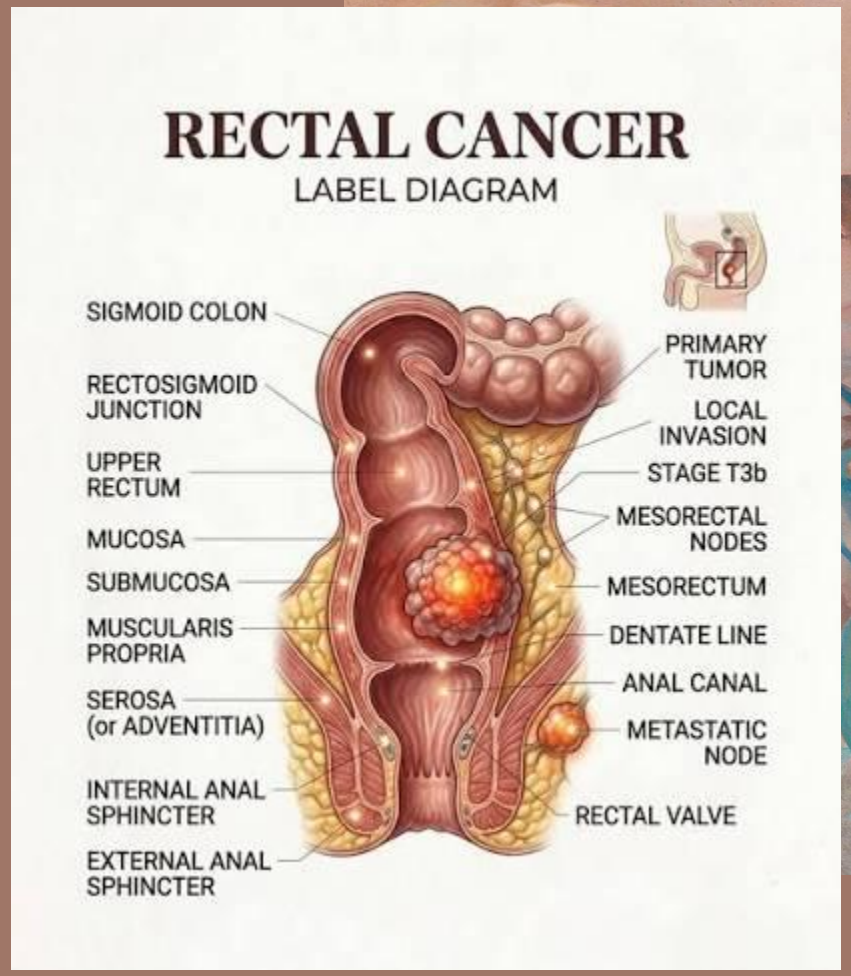
ANAL- RECTAL CASE STUDY

Emily Freeman, RHIT, ODS-C



Physical exam:

- 52 yo female presented with blood and mucous in stool. this has been ongoing for several weeks. she has complaints of mild abd pain and difficulty evacuating her stools. she has never had a prior colonoscopy. She previously attempted to undergo a colonoscopy, but prep did not work at the time. Former smoker x 20 years (quit several years ago, currently vapes). Married.

PMHx: HTN, HLD, GERD

FMHx: Lung cancer in father, breast cancer in mother



Case Summary- Abstract comments

Scopes:

- **8/18/25 Colonoscopy @ Outside facility 1** : Digital rectal exam was then done. This demonstrated a palpable perianal mass. Additionally, there was another **palpable mass at approximately 20 cm from the anal verge.** The colonoscope was then introduced. This did demonstrate a mass at the perianal region. Multiple biopsies were obtained with the forceps. Upon advancing the scope to approximately 20 cm from the anal verge, there was a **large nearly obstructive mass highly suspicious for colorectal cancer**. Multiple representative biopsies were done. I was able to advance the scope beyond the mass. This area was marked with an ink tattoo. The colonoscope was then advanced all the way to the sigmoid colon. No other lesions were identified.

- **9/5/25 Colonoscopy @ Our facility (Dr. Dolejs)**: A digital rectal exam revealed an anterior anal mass. A well-lubricated colonoscope was then introduced and advanced under direct visualization to the cecum with photo documentation of appendiceal orifice and ileocecal valve. The scope was carefully withdrawn with withdrawal time of 20 minutes during which all mucosal surfaces were carefully inspected. She had two right-sided colon polyps and three left-sided colon polyps. One of the right-sided colon polyps and one of the left-sided colon polyps were somewhat sizable after excision. There was some oozing from the post-polypectomy sites that were both controlled with 11-mm clips. The rest of the post-polypectomy sites were hemostatic, and all the polyps were retrieved. **Importantly, the adenocarcinoma she has really started just proximal to the third valve in the upper rectum to rectosigmoid colon. This was about at 12-15 cm.** It was hemi-circumferential but easily traversable. Also, very important to note the tattoo was actually about 3-4 cm proximal to the mass, unfortunately. Then she had the **anal canal mass as well.**

- **12/18/25 Sigmoidoscopy @ Our Facility(Dr. Dolejs)**: The findings are at about 12-15 cm in upper rectum to rectosigmoid, visualization was difficult b/c of overlying stool. Within that limitation, still did have a raised area with some erythema, but looked better. **Anteriorly, in anal canal, had a flat, whitish appearing scar at site of prior anal cancer. This appears to mostly be resolved.**

- **4/23/26 Colonoscopy @ Our Facility**: At this site, the overlying mucosal appeared much better. It did feel like there was some firmness or mass underlying this. I did take a few cold forceps biopsies to try to aid with this. Impression: At the site of her **upper rectal cancer, I think she likely has had a near-complete response**. I am concerned there may be some residual cancer.

Case Summary- Abstract comments

Scans/imaging:

- **8/26/25 MRI pelvis @ Outside facility 1** : Semi annular (12-6 o'clock) solid tumor in the **mid to upper rectum** with lower margin of the tumor 5.8 cm above the **anorectal junction with tumor measuring 4.9 cm in craniocaudal length.** The tumor invades through the muscularis propria with 5.8 mm invasion into the mesorectal fat anteriorly. The tumor directly abuts the posterior aspect of the uterus and peritoneum without evidence of direct invasion. Tumor also directly abuts the anterior peritoneal reflection with mild enhancement of the anterior peritoneal reflection suspicious for invasion. No extramural vascular invasion identified. Tumor is located predominantly superior to the anterior peritoneal reflection. There are multiple mesorectal lymph nodes identified. The most suspicious lymph node measures 6.6 mm in short axis and is round in shape with no other additional malignant characteristics. No distant metastatic disease identified.
  IMPRESSION: 1. T4a N0 M0 rectal carcinoma as described above.
- **(Anal)** there is an avidly enhancing solid **3.2 x 2.0 x 3.6 cm mass** involving the **left aspect of the anal canal (10-5 o'clock).** The perianal skin is not involved. There is invasion of the internal sphincter, intersphincteric plane, and external sphincter. The inferior margin of the tumor is 3.6 cm from the anal margin and extends just up to the anorectal junction. There is invasion of the puborectalis and levator ani muscles on the left. No nearby suspicious lymph nodes are evident.
    - **T2 N0 M0 anal carcinoma as described above.**
- **8/26/25 CT CAP @ Outside facility 1**: Patient's known anorectal malignancy is poorly visualized on this exam. There are several adjacent nodular densities in the perirectal fat which were not present on comparison dated 11/6/2019 and raise concern for potential local lymph node involvement.
- **12/18/25 MRI Pelvis @ Our Facility:**

1. Nondiagnostic DWI images limit evaluation, however there is fibrosis with no definite residual viable tumor involving the mid/upper rectum. Correlation with direct visualization is recommended. *Of note, on the initial staging MRI 08/26/2025, appearance was more consistent with T3b than T4a as mentioned in the excerpt from the outside report.*
2. The previously noted mass involving the anal canal is no longer appreciated.
3. No enlarged mesorectal or extramesorectal lymph nodes.

- **4/21/26 CT CAP @ Our Facility:** Posttherapy changes are noted in the pelvis. No new or suspicious masses or lymphadenopathy are identified
- **4/21/26 MRI Pelvis @ Our Facility:**

1. No discrete anal canal mass identified.
2. Progressive scarring/fibrosis along the mid-upper rectal wall. No evidence of residual viable tumor.
3. No pathologic pelvic lymphadenopathy.

Case Summary- Abstract comments

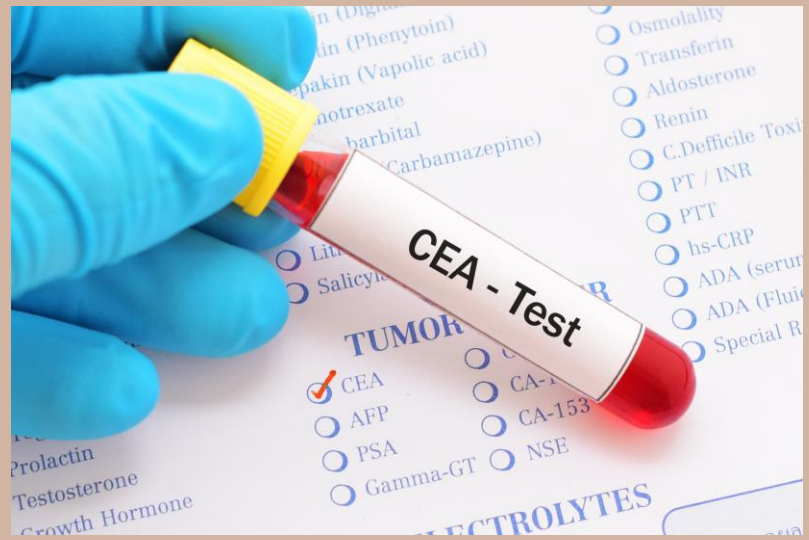
Pathology:

8/18/25 Sigmoid Mass Bx/Anal mass bx (Rectal per Surgeon) @ Outside facility:

- (A)Invasive moderately differentiated adenocarcinoma.
- (B) Invasive moderately differentiated squamous cell carcinoma (P16 not tested for or mentioned in chart).

<u>Post Treatment colonoscopy biopsy:</u>

- **4/23/26 Rectal Mass Bx @ Our Facility**: Superficial fragments of benign colonic mucosa. Comment: The patient's clinical history of both adenocarcinoma and squamous cell carcinoma is noted. Histologic sections of the "rectal mass" show only superficial fragments of colonic mucosa. **There is no diagnostic evidence of malignancy identified.**



Lab tests:

- **8/26/25 CEA:** 0.9 ng/mL
- (rectosigmoid primary) **MSI stable** (path report states results of IHC staining for DNA expression in part b (correlates with RECTAL tumor)

Staging: (Tumor board)

- (Rectosigmoid primary):T4a N0
- (Anal primary): T2 N0

Case Summary- Abstract comments

Remarks:

9/2/25 1st Consult w/ Dr. Dolejs(Surgeon) @ Our Facility: I'd like to start with a C/S (colonoscopy). She had a flex sig previously and there is some discrepancy about the adeno being palpable but then being at 20 cm. Think we need to clarify this.

9/11/25 TB(Tumor board) Notes: Dr. Dolejs presented case and clarified that patient has a rectosigmoid primary (upper rectum)- He would like to follow this case in TB for updates, but it's not required to be included in the NARPC standards. patient has a synchronous primary anal cancer SQCC. Dr. Heckman plans to treat Anal primary first with XRT/chemo and noted that XRT to Anal primaries will include the rectal primary in the field. **Dr. Scales (radiologist) reviewed all imaging and noted staging for rectum to be T4a N0, and anal: T2 N0- concern for involvement of vagina noted.**

9/16/25 Dr. Heckman(Med Onc) @ Outside facility 1: Plan to initiate concurrent radiation & chemotherapy to treat anal cancer primarily (below). Based on TB discussion; rectal cancer would be included in radiation field. Fluorouracil (5-FU) 750 mg/m2/day IV continuous infusion over 120 hours, started on days 1 & 29 (total dose: 7500 mg/m2)
Mitomycin 12 mg/m2 (maximum dose of 20 mg) IV bolus once per day on days 1 & 29
- Further treatment depending on response. Tentatively planning for FOLFOX followed by imaging +/- surgery for the rectal adenocarcinoma after completion of C/RT for the anal Sqcc.

11/10/25 Dr. Dolejs(Surgeon) @ Our Facility: timeline complicated by rectal cancer. Repeat MRI in 6 weeks and see her in office for exam after. As long as it looks like she has a good response from her anal SQCC, next step is to perform chemo as part of TNT (Total Neoadj therapy) and hoping for a complete clinical response. She had a rough time with mitomycin chemo, but discussed chemo for rectal cancer will not involve this.

12/23/25 Dr. Heckman (Med Onc) @ Our Facility: initiated concurrent chemoradiation 9/29/25 to tx anal cancer primarily, based on TB discussion; rectal cancer would be included in rad field. Plan for consolidation chemotherapy as part of TNT therapy.

1/6/26 Dr. Heckman(Med Onc): MRI and Flex Sigmoidoscopy with PR (partial response) of rectal adenocarcinoma

4/28/26 Dr. Dolejs (surgeon): I think for the **rectal cancer, she has had a nCR (near complete response).** For the **anal cancer, I think she has NED** (No evidence of disease). Discussed options of LAR with DLI (diverting loop ileostomy) vs short term surveillance and she is going to think about this and let us know after we call her after tumor board.

5/14/26 Dr. Dolejs (surgeon) @ our facility: Discussed options of TME (Total mesorectal resection) vs. close surveillance. Patient elected for close surveillance.

Case Summary- Abstract comments

Treatment Text:

- Chemotherapy:
  - 9/29/25 Dr. Heckman @ Outside facility #1: Concurrent chemoradiation w/ mitomycin C and 5FU (anal primary)
  - 1/6/26 Dr. Heckman (Med/onc) @ Outside facility 1: FOLFOX (rectal primary)
- Beam radiation:
  - 9/29/25-11/7/25 Dr. Schneider (Rad/onc) @ Outside facility 2: IMRT, Photons. Rectum/Anus: 5400 cGy in 30 fx. SIB Pelvic LNS: 4500 cGY in 30 fx. (treating both primaries).



Case Summary- Abstract comments

Remarks: continued (Recurrence- Rectosigmoid primary)

8/5/26 post treatment/surveillance Flex sigmoidoscopy @ Our Facility (Dr. Dolejs) surgeon: Proc: After informed consent was obtained, the patient was positioned in the left lateral position. A well lubricated sigmoidoscope was inserted into the anal canal and advanced to 15 cm. The ***findings are in the upper rectum, just proximal to third valve, has a clear recurrence/progression of rectal cancer.*** *More distally, in* ***anus, has flat white scar with some heaped up borders around it but no signs of recurrence.*** Excess air was removed while the scope was withdrawn. The prep was adequate. The patient tolerated the procedure well.

9/16/26 Dr. Dolejs office visit post sigmoidoscopy @ Our Facility: With NED in regard to anal SCC, have discussed options of APR vs LAR with DLI. She and her husband have **elected for LAR with DLI.** Will plan for DV-assisted LAR with DLI with ureteral stents. Discussed all r/b/a with a shared decision-making aid. She agrees and wishes to proceed.

Case Summary- Abstract comments

RECTOSIGMOID - ABSTRACT

Date of diagnosis: 08/18/2025

Site: C19.9

Site text: Rectosigmoid

Histology: 8140/3

Histology text: Adenocarcinoma

Sequence: 01

Class of Case: 30 – initial dx and all first course tx done elsewhere.

Laterality: 00 (not a paired organ)

Reporting Source: 01 -Hospital/clinic

Tumor size: 049 (mm)

Lymphovascular invasion (LVI): 09 – unknown/indeterminate/not mentioned

Diagnostic Conf: 01 – Positive Histology

 # positive reg nodes: 98

 # reg nodes exam'd: 00

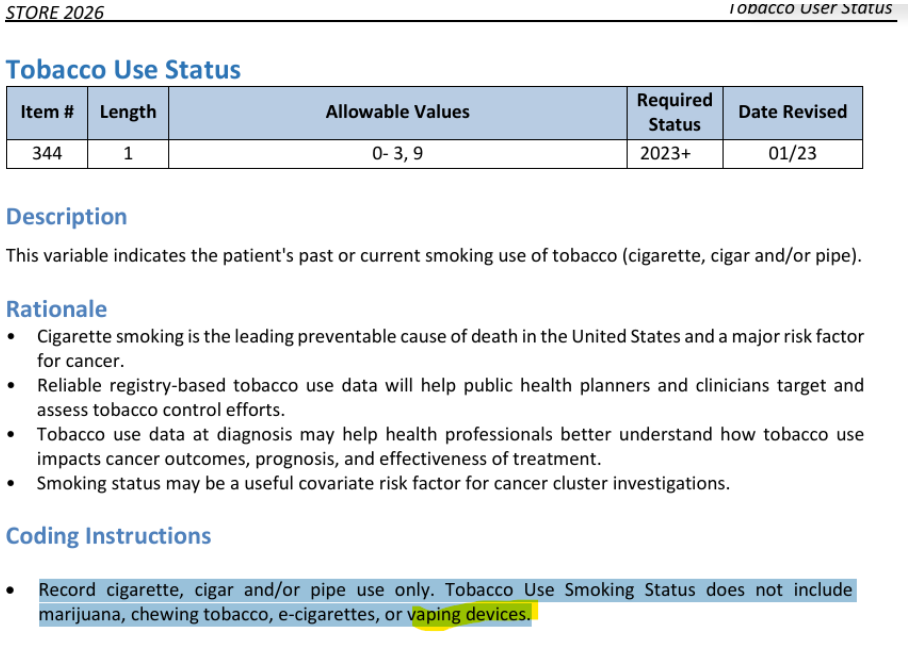
Place of dx text: Outside Facility 1

ICD- 10 Comorbidities: I10- HTN

Date of first contact (facility): 09/02/2025

Institution referred from: Outside facility 1

Tobacco Use (2022): 02- Former smoker



STORE 2026 *Tobacco User Status*

Tobacco Use Status

Item #	Length	Allowable Values	Required Status	Date Revised
344	1	0- 3, 9	2023+	01/23

Description

This variable indicates the patient's past or current smoking use of tobacco (cigarette, cigar and/or pipe).

Rationale

- Cigarette smoking is the leading preventable cause of death in the United States and a major risk factor for cancer.
- Reliable registry-based tobacco use data will help public health planners and clinicians target and assess tobacco control efforts.
- Tobacco use data at diagnosis may help health professionals better understand how tobacco use impacts cancer outcomes, prognosis, and effectiveness of treatment.
- Smoking status may be a useful covariate risk factor for cancer cluster investigations.

Coding Instructions

- Record cigarette, cigar and/or pipe use only. Tobacco Use Smoking Status does not include marijuana, chewing tobacco, e-cigarettes, or vaping devices.

RECTOSIGMOID - ABSTRACT

Staging:
Clinical

- **Grade:** 02 – G2: Moderately Differentiated
- **T Class:** cT4a
- **T Class Suffix:** blank
- **N Class:** cN0
- **N Class suffix:** blank
- **M Class:** cM0
- **Stage grouping:** 2B

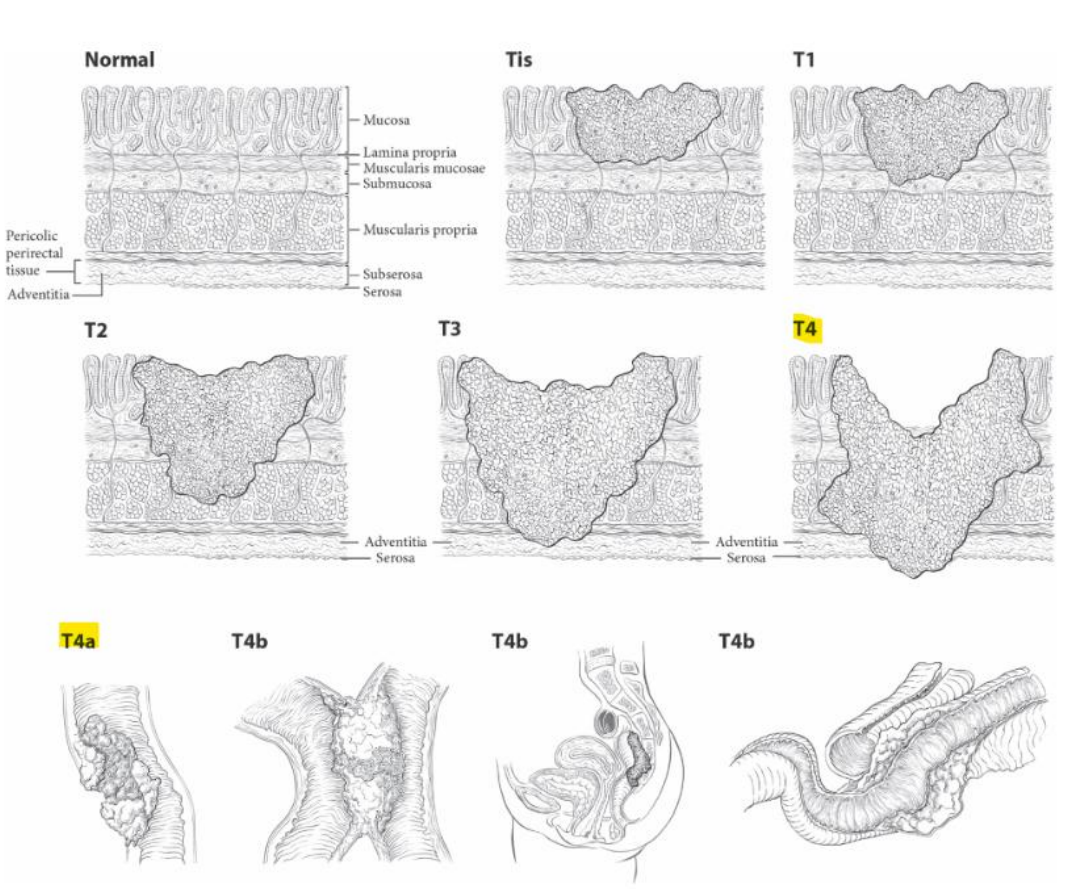


Fig. 20.5. T1-T3 as defined in Definition of Primary Tumor (T). T4 is a tumor that penetrates or perforates the visceral peritoneum in the parts of the colon or rectum covered only by peritoneum (T4a) or that invades an adjacent structure or organ (T4b)

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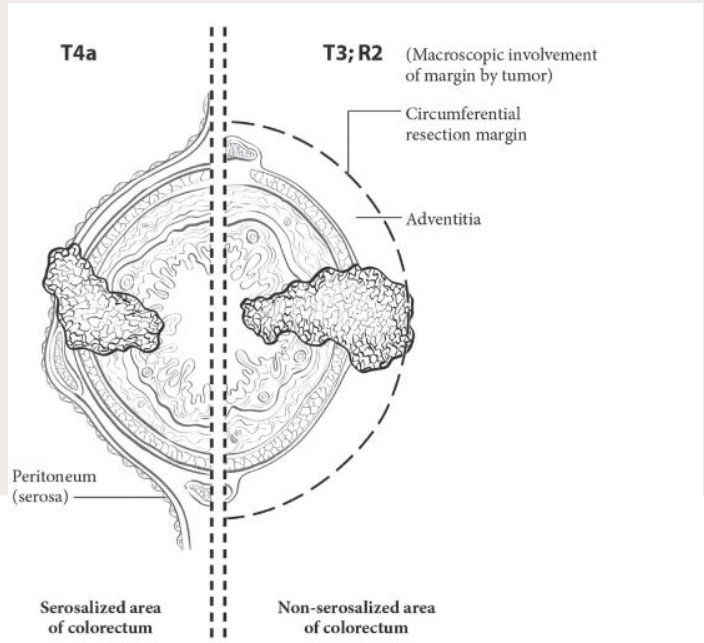


Fig. 20.8. Depiction of T4a lesions and the importance of the circumferential margin

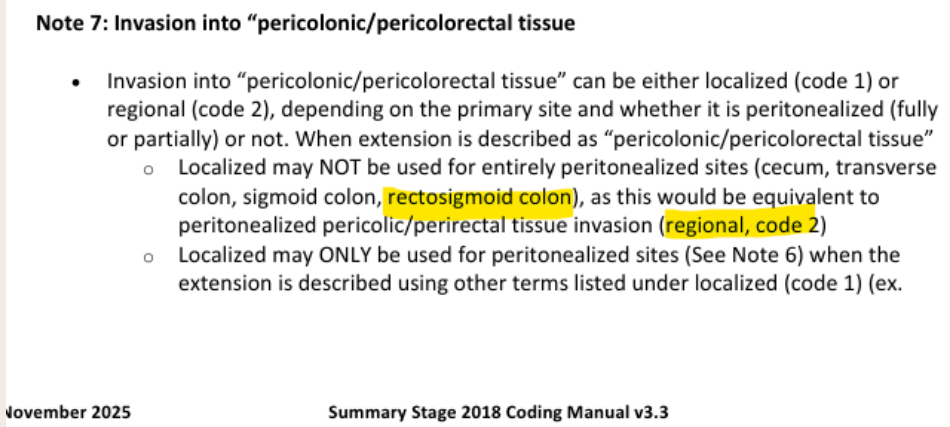
Staging:
Pathological

- **Grade:** 09 – unknown/cannot be assessed.
- **T Class:** blank
- **T Class Suffix:** blank
- **N Class:** blank
- **N Class suffix:** blank
- **M Class:** blank
- **Stage grouping:** 99 – unknown, not staged

RECTOSIGMOID - ABSTRACT

8/26/25 MRI pelvis @ Outside facility 1 : Semi annular (12-6 o'clock) solid tumor in the *mid to upper rectum* with lower margin of the tumor 5.8 cm above the anorectal junction with tumor measuring 4.9 cm in craniocaudal length. **The tumor invades through the muscularis propria with 5.8 mm invasion into the mesorectal fat anteriorly. The tumor directly abuts the posterior aspect of the uterus and peritoneum without evidence of direct invasion. Tumor also directly abuts the anterior peritoneal reflection with mild enhancement of the anterior peritoneal reflection suspicious for invasion. IMPRESSION: 1. T4a N0 M0 rectal carcinoma as described above.**

Summary stage manual v3.3 *(pg. 154-163)*



Note 7: Invasion into "pericolonic/pericolorectal tissue

- Invasion into "pericolonic/pericolorectal tissue" can be either localized (code 1) or regional (code 2), depending on the primary site and whether it is peritonealized (fully or partially) or not. When extension is described as "pericolonic/pericolorectal tissue"
  - Localized may NOT be used for entirely peritonealized sites (cecum, transverse colon, sigmoid colon, rectosigmoid colon), as this would be equivalent to peritonealized pericolic/perirectal tissue invasion (regional, code 2)
  - Localized may ONLY be used for peritonealized sites (See Note 6) when the extension is described using other terms listed under localized (code 1) (ex.

November 2025 Summary Stage 2018 Coding Manual v3.3 155

SEER Additional items:

- **SEER summary stage:** 02 – Direct Extension
  Mets bone: 00 - none
  Mets Liver: 00- none
  Mets brain: 00- none
  Mets Distant Lymph nodes: 00- none
  Mets Lung: 00 – none
  Mets Other: 00 - none

RECTOSIGMOID - ABSTRACT

SSDI manual- **<u>00200: Colon and Rectum</u>** (pg. 115)

- (Lynch Syndrome) MSI – results can also be listed as MMR- Instructions on how to code are detailed in the manual.

Description
Microsatellite instability (MSI) stable; microsatellite stable (MSS); negative, NOS AND/OR Mismatch repair (MMR) intact, no loss of nuclear expression of MMR proteins MMR proficient (pMMR or MMR-P)

SSDI:

- **CEA (Carcinoembryonic Antigen) Pretreatment lab value:** 0.9 ng/mL
- **CEA (carcinoembryonic Antigen) Pretreatment interpretation:** 0 – CEA negative/normal; within normal limit
- **Circumferential Resection Margin (CRM):** XX.7 – No resection of primary site surgical procedure did not remove enough tissue
- **KRAS:** 9 – not documented in the medical record/unknown
- **Microsatellite Instability (MSI):** 0 – MSI stable
- **Perineural Invasion:** 9 – not documented
- **Tumor Deposits**: X9 – not documented in medical record
- **BRAF mutational analysis:** 9 – not documented/unknown
- **NRAS Mutational analysis:** 9 – not documented/unknown

RECTOSIGMOID - ABSTRACT

Surgery comments:

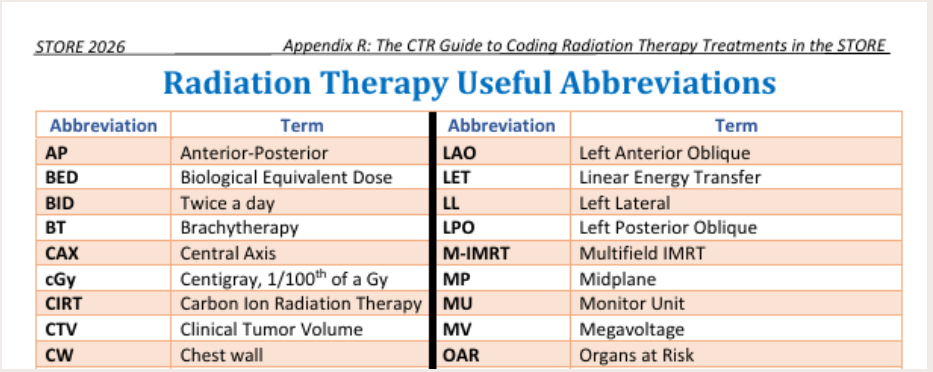
8/18/25 Sigmoid Mass Bx (Rectal per Surgeon) @ Outside Facility 1

Treatment:

- **DX/Staging**
  - **(our Facility) Procedure:** 00 – no diagnostic or staging surgical procedure
  - **Start Date:** 08/18/2025
  - **(outside facility #1) Procedure**: 02 – biopsy

- **Surgery (our Facility)**
  - **Reason for no surgery of primary site :** 01 – not performed
  - **Date of 1st Surgical procedure:** blank
  - **Date of most definitive surgery:** blank
  - **Date of surgical discharge:** blank
  - **Readmission of to same hospital:** 00 – no surgery

RECTOSIGMOID - ABSTRACT



STORE 2026 Appendix R: The CTR Guide to Coding Radiation Therapy Treatments in the STORE

Radiation Therapy Useful Abbreviations

Abbreviation	Term	Abbreviation	Term
AP	Anterior-Posterior	LAO	Left Anterior Oblique
BED	Biological Equivalent Dose	LET	Linear Energy Transfer
BID	Twice a day	LL	Left Lateral
BT	Brachytherapy	LPO	Left Posterior Oblique
CAX	Central Axis	M-IMRT	Multifield IMRT
cGy	Centigray, 1/100th of a Gy	MP	Midplane
CIRT	Carbon Ion Radiation Therapy	MU	Monitor Unit
CTV	Clinical Tumor Volume	MV	Megavoltage
CW	Chest wall	OAR	Organs at Risk

Radiation (Beam) comments:

9/29/25-11/7/25 Dr. Schneider@ Outside facility 2: IMRT, Photons.

Rectum: 5400 cGy in 30 fx

SIB(Boost) Pelvic LNS: 4500 cGY in 30 fx

Resources:

- *Appendix R (STORE) Coding Radiation therapy treatment.*
- *Be aware of radiation therapy useful abbreviations (pg. 404)*

Radiation:

- **Radiation/surgery sequence:** 00 – no radiation and/or Ca-directed surgery
- **Reason for no radiation:** 00 –radiation was administered
- **Total dose volume:** 005400
- **Discontinued early:** 01 – radiation treatment completed as prescribed
- **Date Radiation started:** 09/29/2025
- **Date Radiation ended**: 11/07/2025
- **Number of Phases:** 02

Phase 1----

- **Summary of Therapy** : 01 – beam radiation
- **Facility:** Facility #2
- **Physician:** Dr. Schneider
- **Regional/boost:** 00 – regional
- **Treatment volume:** 54 – rectum
- **Radiation to Nodes:** 00 – no radiation treatment to nodes
- **Treatment modality:** 02 – External beam, photons
- **Planning Technique:** 05 – IMRT
- **Number of fractions:** 030
- **Total dose:** 005400
- **Dose per fraction:** 00180

Phase 2----

- **Regional boost:** 01 –boost
- **Treatment Volume:** 06 – pelvic lymph nodes
- **Radiation to nodes:** 88 – N/A
- **Treatment Modality:** 02 – external beam/photons
- **Planning Tech:** 05 – IMRT
- **Number of Fractions:** 030
- **Total dose:** 004500
- **Dose per fraction:** 00150

RECTOSIGMOID - ABSTRACT

Treatment comments:

9/29/25 Dr. Heckman (Med Onc) @ outside facility 1: Concurrent chemoXRT with mitomycin C and 5fu; (anal primary)

1/6/26 Dr. Heckman(Med Onc) @ Outside facility 1: FOLFOX **(rectal primary)**

*treatment plan: 9/16/25 Dr. Heckman(Med Onc) @ Outside facility 1: *Plan to initiate concurrent radiation & chemotherapy to treat anal cancer primarily. Based on TMB discussion; rectal cancer would be included in radiation field.* Fluorouracil (5-FU) 750 mg/m2/day IV continuous infusion over 120 hours, started on days 1 & 29 (total dose: 7500 mg/m2)Mitomycin 12 mg/m2 (maximum dose of 20 mg) IV bolus once per day on days 1 & 29

- Further treatment depending on response. Tentatively planning for FOLFOX followed by imaging +/- surgery for the rectal adenocarcinoma after completion of C/RT for the anal Sqcc.

Resources:

Synchronous Primary - Neoadjuvant Treatment - CAnswer Forum

- SEER*Rx Interactive Antineoplastic Drugs Database

Chemotherapy:

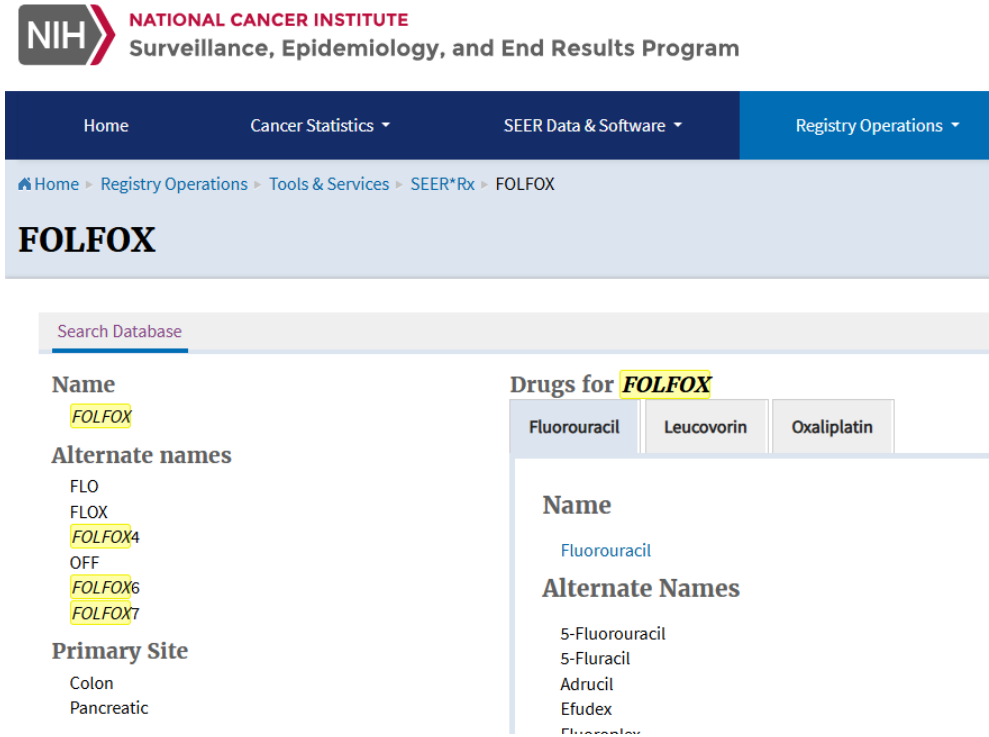
- Our Facility: **Procedure:** 00 – no chemo
- **Outside facility 1:** 03 – Multiple Agents/combination
- **Date of first chemotherapy** (this course): 01/06/2026

Hormone:

- Our Facility: **procedure:** 00 – no hormone

Immunotherapy:

- Our Facility: **procedure:** 00 – no immunotherapy



RECTOSIGMOID - ABSTRACT

4/28/26 Dr. Dolejs (surgeon): *I think for the **rectal cancer,** she has had a nCR **(near complete response).***

5/14/26 Dr. Dolejs (surgeon) @ our facility: Discussed options of TME vs close surveillance. *They have elected for close surveillance.*

8/5/2026 post treatment/surveillance Flex sigmoidoscopy @ Our Facility (Dr. Dolejs) surgeon: Proc: After informed consent was obtained, the patient was positioned in the left lateral position. A well lubricated sigmoidoscope was inserted into the anal canal and advanced to 15 cm. The **findings are in the upper rectum, just proximal to third valve, has a clear recurrence/progression of rectal cancer.**

9/21/26 LAR- pathology (our Facility): all margins negative; rpT3 N0.

Recurrence:

- **Date of First Recurrence:** Blank
- **Type of First Recurrence**: 00- disease free
- **Date contact/death:** 09/25/2026
- **Date cancer status:** 09/21/2026
- **Cancer Status:** 00 – No recurrence

Type of First Recurrence

Item #	Length	Allowable Values	Required Status	Date Revised
1880	2	00, 04, 06, 10, 13-17, 20-22, 25-27, 30, 36, 40, 46, 51-59, 60, 62, 70, 88, 99	All Years	06/05, 01/10, 01/11, 01/13, 01/15, 01/18

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Check the SEER *Multiple Primary and Histology Coding Rules Manual* or the current Solid Tumor Rules to determine which subsequent tumors should be coded as recurrences.
- If the patient has never been disease-free (code 70), continue to track for disease-free status which may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical; record the highest-numbered applicable response, with the following limits. The first time a patient converts from disease status (70) to disease-free, change the code to 00. Then the first time a patient converts from 00 to a recurrence, then record the proper code for the recurrence. No further changes (other than corrections) should be made.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence as 59. If one of these is controlled by drugs (for example, Gleevec for CML), the patient is in remission.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If the recurrent primary is identified later, revise the codes appropriately.

**Case was never disease free (after first course tx), so would have been entered before the progression as (Type of first recurrence: 70- never dx free)*
**then after 2nd course surgery (LAR on 9/21/26) would be 00- never disease free)*
**Date of first recurrence: this would be blank since patient was not dz free during first course. (see Store pg. 273)*

RECTOSIGMOID - ABSTRACT

2nd course treatment-

- Add all comments about progression/recurrence to comments area for each, and if your software allows you can add the 2nd course treatment/coding.

**Only complete 2nd course tx coding if your facility requires it.*

2nd course surgery: (not required)

- **Reason for no Surgery of primary site:** 00 – surgery performed
- **Date of most Definitive surgical resection of primary site:** 09/21/26
- **Date of surgery:** 09/21/2026
- **Date of surgical discharge:** 09/23/2026
- **Readmission to the same hospital with in 30 days:** 00 – no surgery performed or not admitted in 30 days.
- **Surgical Approach (2010):** 03 – Minimally invasive (such as endoscopic or laparoscopic)
- **Surgical procedure/other site:** 00 - none
- **Primary Surgeon:** Dr. Dolejs
- **Facility where CA-Directed surgery performed:** Our Facility
- **Surgical Margins of primary site:** 00 – no Residual
- **Scope of regional lymph node surgery:** 05 – 4 or more lymph nodes removed
- **Number of nodes removed:** 18

ANAL CANAL– ABSTRACT

Date of diagnosis: 09/02/25

Site: C21.1

Site text: Anal Canal

Histology: 8070/3

Histology text: Squamous cell carcinoma, NOS

Sequence: 02

Class of Case: 30

Laterality: 00 – Not a paired organ

Reporting Source: 01 – Hospital Inpatient

Tumor size: 036

Lymphovascular invasion (LVI): 09 – unknown/indetermined/not mentioned.

Diagnostic Conf: 01 – Positive histology

 # positive reg nodes: 98

 # reg nodes exam'd: 00

Place of dx text: Outside Facility 1

ICD- 10 Comorbidities: I10- HTN

Date of first contact (facility): 09/02/2025

Institution referred from: Outside facility 1

Tobacco Use (2022): 02- Former smoker

ANAL CANAL – ABSTRACT

Surgery comments:

8/18/25 Rectum Mass Bx (Anus per Surgeon) @ Outside facility #1: Invasive moderately differentiated squamous cell carcinoma (p16 NOT tested for or mentioned in chart)

4/23/26 Anal Mass Bx @ our Facility: Benign colonic mucosa. Comment: Sections of the anal mass show benign colonic mucosa; again, no diagnostic evidence of malignancy is identified.

Treatment:

- **DX/Staging**
  - **(our Facility) Procedure:** 00 – no diagnostic or staging surgical procedure
  - **Start Date:** 08/18/2025
  - **(outside facility #1) Procedure**: 02 – biopsy

- **Surgery (our Facility)**
  - **Reason for no surgery of primary site :** 01 – not performed
  - **Date of 1st Surgical procedure:** blank
  - **Date of most definitive surgery:** blank
  - **Date of surgical discharge:** blank
  - **Readmission of to same hospital:** 00 – no surgery

ANAL CANAL – ABSTRACT

Comments:

Dr. Heckman @ Outside facility #1:
T2N0 Anal Squamous cell carcinoma

- **8/26/25 MRI pelvis @ Outside facility 1** : **(Anal)** there is an avidly enhancing solid **3.2 x 2.0 x 3.6 cm mass** involving the **left aspect of the anal canal (10-5 o'clock).** The perianal skin is not involved. There is invasion of the internal sphincter, intersphincteric plane, and external sphincter. The inferior margin of the tumor is 3.6 cm from the anal margin and extends just up to the anorectal junction. There is invasion of the puborectalis and levator ani muscles on the left. No nearby suspicious lymph nodes are evident. **T2 N0 M0 anal carcinoma as described above.**

Staging:

Clinical

Grade: 2 – G2: Moderately differentiated (low grade)

T Class: cT2

T Class Suffix:

N Class: cN0

N Class suffix:

M Class: cM0

Stage grouping: 2a

Pathological
Grade: 09 – unknown/cannot be assessed.

T Class: blank

T Class Suffix: blank

N Class: blank

N Class suffix: blank

M Class: blank

Stage grouping: 99 – unknown, not staged

ANAL CANAL – ABSTRACT

ANUS

8000-8700, 8720-8790, 8940-8960, 8965-8983, 9000, 9050-9111, 9270, 9300-9312, 9340-9363, 9380-9539, 9541

C210-C212, C218
C210: Anus, NOS (excluding skin of anus and perianal skin C445)
C211: Anal canal
C212: Cloacogenic zone
C218: Overlapping lesion of rectum, anus and anal canal

8/26/25 MRI pelvis @ Outside facility 1 : **(Anal)** there is an avidly enhancing solid 3.2 x 2.0 x 3.6 cm mass involving the left aspect of the anal canal (10-5 o'clock). The perianal skin is not involved. **There is invasion of the internal sphincter, intersphincteric plane, and external sphincter.** The inferior margin of the tumor is 3.6 cm from the anal margin and extends just up to the anorectal junction. There is invasion of the puborectalis and levator ani muscles on the left. No nearby suspicious lymph nodes are evident. T2 N0 M0 anal carcinoma as described above.

**abstract- See SEER summary stage manual: per MRI above invasion of external sphincter- confirms 02- direct extenion for summary stage of anal primary.*

SEER Additional items:

- **SEER summary stage:** 02 – Direct Extension
- **Mets bone:** 00 - none
- **Mets Liver:** 00- none
- **Mets brain:** 00- none
- **Mets Distant Lymph nodes:** 00- none
- **Mets Lung:** 00 – none
- **Mets Other:** 00 - none

1 Localized only (localized, NOS)

- Confined to anus, NOS
- Incidental finding of malignancy in hemorrhoid, NOS
- Intramucosa
- Lamina propria
- Mucosa, NOS
- Muscularis mucosae
- Muscularis propria (internal sphincter)
- Submucosa (superficial invasion)

2 Regional by direct extension only

- Ischiorectal fat/tissue
- Perianal skin
- Perineum
- Perirectal skin
- Rectal mucosa or submucosa
- Rectal wall
- Skeletal muscle(s)
  - Anal sphincter (external)
  - Levator ani
- Subcutaneous perianal tissue
- Vulva

ANAL CANAL – ABSTRACT

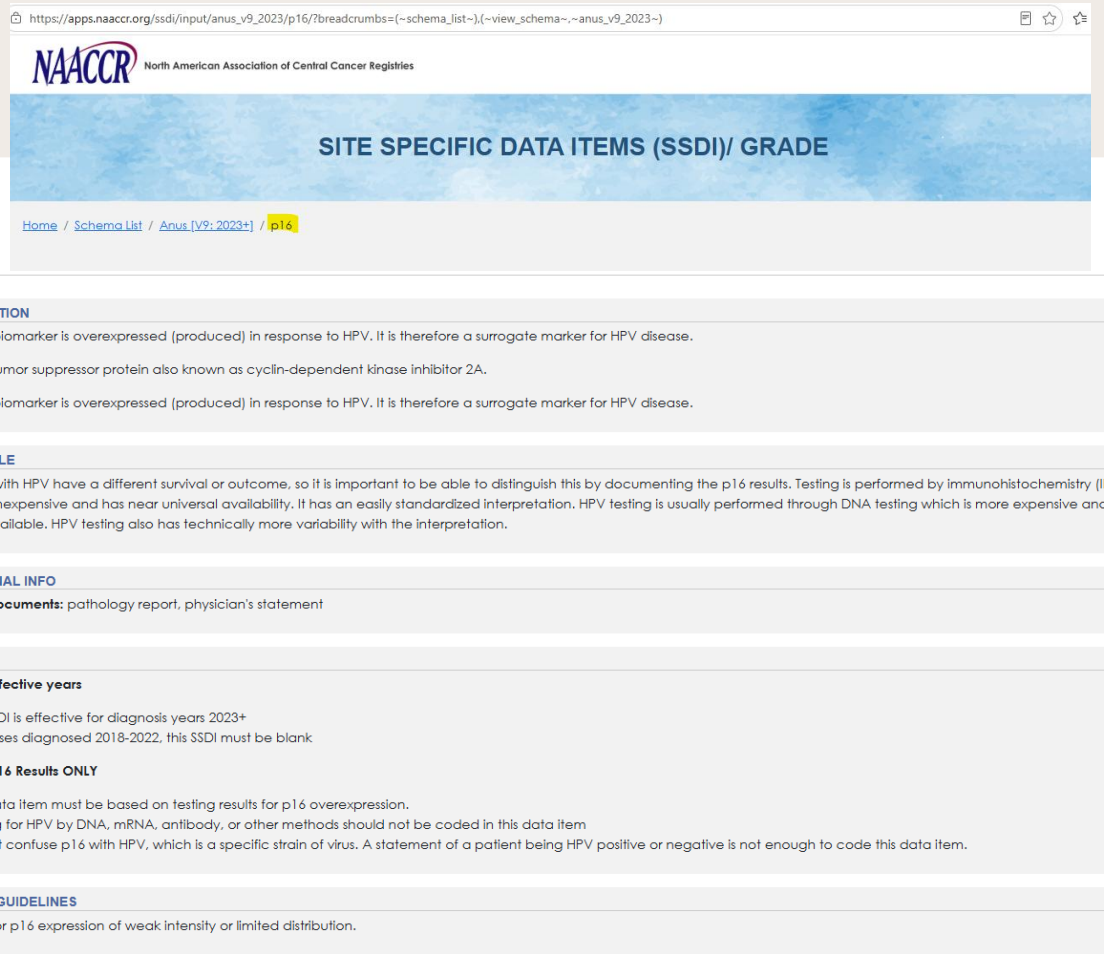
Comments:

- 8/18/25 Sigmoid Mass Bx/Anal mass bx (Rectal per Surgeon) @ Outside facility 1:
- (A) Invasive moderately differentiated adenocarcinoma.
- **(B) Invasive moderately differentiated squamous cell carcinoma (P16 not tested for or mentioned in chart).**

**always pull up SSDI manual -* Schemas | SSDI Data |

SSDI:

P16: 9 – not tested for p16; unknown



https://apps.naaccr.org/ssdi/input/anus_v9_2023/p16/?breadcrumbs=(~schema_list~),(~view_schema~,~anus_v9_2023~)

NAACCR North American Association of Central Cancer Registries

SITE SPECIFIC DATA ITEMS (SSDI)/ GRADE

Home / Schema List / Anus [V9: 2023+] / p16

P16

DESCRIPTION

The p16 biomarker is overexpressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease.

p16 is a tumor suppressor protein also known as cyclin-dependent kinase inhibitor 2A.

The p16 biomarker is overexpressed (produced) in response to HPV. It is therefore a surrogate marker for HPV disease.

RATIONALE

Patients with HPV have a different survival or outcome, so it is important to be able to distinguish this by documenting the p16 results. Testing is performed by immunohistochemistry (IHC) which is inexpensive and has near universal availability. It has an easily standardized interpretation. HPV testing is usually performed through DNA testing which is more expensive and less widely available. HPV testing also has technically more variability with the interpretation.

ADDITIONAL INFO

Source documents: pathology report, physician's statement

NOTES

Note 1: Effective years

- This SSDI is effective for diagnosis years 2023+
- For cases diagnosed 2018-2022, this SSDI must be blank

Note 2: p16 Results ONLY

- This data item must be based on testing results for p16 overexpression.
- Testing for HPV by DNA, mRNA, antibody, or other methods should not be coded in this data item
- Do not confuse p16 with HPV, which is a specific strain of virus. A statement of a patient being HPV positive or negative is not enough to code this data item.

CODING GUIDELINES

Code 0 for p16 expression of weak intensity or limited distribution.

ANAL CANAL – ABSTRACT

Radiation (Beam) comments:

9/29/25-11/7/25 Dr. Schneider@ Outside facility 2: IMRT, Photons.

Anus: 5400 cGy in 30 fx

SIB(Boost) Pelvic LNS: 4500 cGY in 30 fx

Resources:

- *Appendix R (Store) Coding Radiation therapy treatment.*
- *Be aware of radiation therapy useful abbreviations (pg. 404)*

Radiation:

- **Radiation/surgery sequence:** 00 – no radiation and/or Ca-directed surgery
- **Reason for no radiation:** 00 –radiation was administered
- **Total dose volume:** 005400
- **Discontinued early:** 01 – radiation treatment completed as prescribed
- **Date Radiation started:** 09/29/2025
- **Date Radiation ended**: 11/07/2025
- **Number of Phases:** 02

Phase 1----

- **Summary of Therapy** : 01 – beam radiation
- **Facility:** Facility #2
- **Physician:** Dr. Schneider
- **Regional/boost:** 00 – regional
- **Treatment volume:** 55 – anus
- **Radiation to Nodes:** 00 – no radiation treatment to nodes
- **Treatment modality:** 02 – External beam, photons
- **Planning Technique:** 05 – IMRT
- **Number of fractions:** 030
- **Total dose:** 005400
- **Dose per fraction:** 00180

Phase 2----

- **Regional boost:** 01 –boost
- **Treatment Volume:** 06 – pelvic lymph nodes
- **Radiation to nodes:** 88 – N/A
- **Treatment Modality:** 02 – external beam/photons
- **Planning Tech:** 05 – IMRT
- **Number of Fractions:** 030
- **Total dose:** 004500
- **Dose per fraction:** 00150

ANAL CANAL – ABSTRACT

Treatment comments:

9/29/25 Dr. Heckman (Med Onc) @ outside facility 1: Concurrent chemoXRT with mitomycin C and 5fu; **(anal primary)**

1/6/26 Dr. Heckman(Med Onc) @ Outside facility 1: FOLFOX (rectal primary)

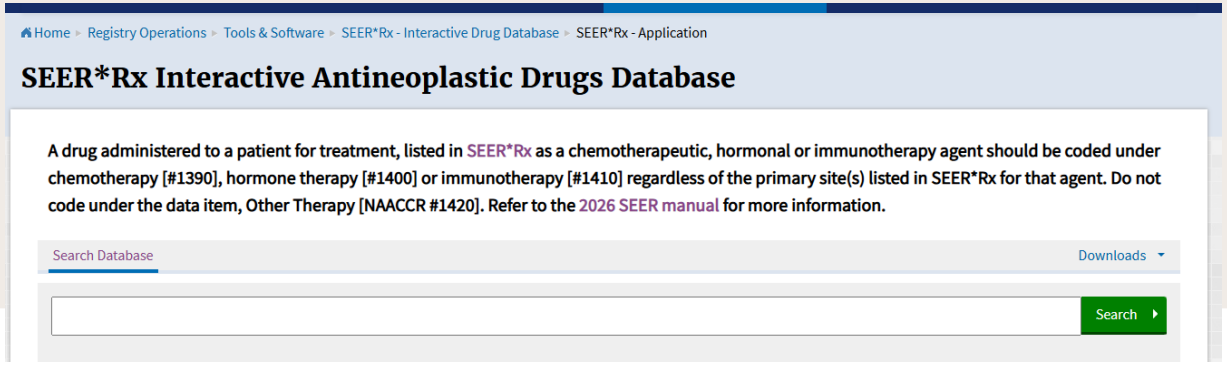
***treatment plan: 9/16/25 Dr. Heckman(Med Onc) @ Outside facility 1:** *Plan to initiate concurrent radiation & chemotherapy to treat anal cancer primarily. Based on TB discussion; rectal cancer would be included in radiation field.* Fluorouracil (5-FU) 750 mg/m2/day IV continuous infusion over 120 hours, started on days 1 & 29 (total dose: 7500 mg/m2)Mitomycin 12 mg/m2 (maximum dose of 20 mg) IV bolus once per day on days 1 & 29

- Further treatment depending on response. Tentatively planning for FOLFOX followed by imaging +/- surgery for the rectal adenocarcinoma after completion of C/RT for the anal Sqcc.

Resources:

Synchronous Primary - Neoadjuvant Treatment - CAnswer Forum

- SEER*Rx Interactive Antineoplastic Drugs Database



Chemotherapy:

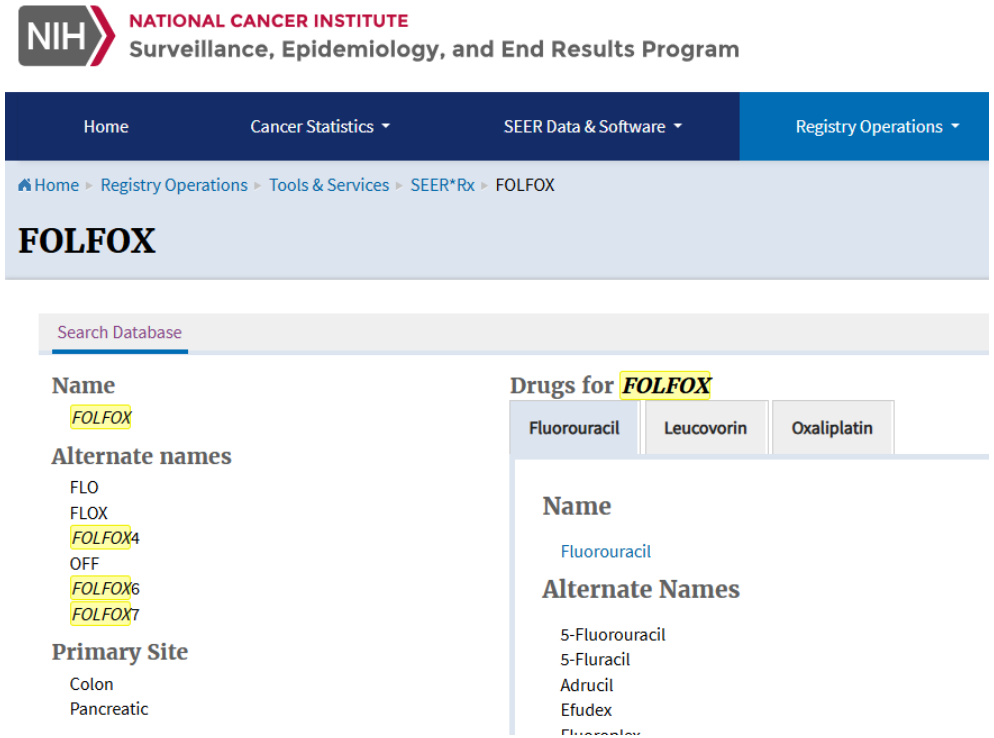
- Our Facility: **Procedure:** 00 – no chemo
- **Outside facility 1:** 03 – Multiple Agents/combination
- **Date of first chemotherapy** (this course): 09/29/25

Hormone:

- Our Facility: **procedure:** 00 – no hormone

Immunotherapy:

- Our Facility: **procedure:** 00 – no immunotherapy



ANAL CANAL – ABSTRACT

Comments:

12/18/25 Sigmoidoscopy @ Our Facility(Dr. Dolejs): Anteriorly, in anal canal, had a flat, whitish appearing scar at site of prior anal cancer. This appears to mostly be resolved.

12/18/25 MRI Pelvis @ Our Facility:
The previously noted **mass involving the anal canal is no longer appreciated.**
No enlarged mesorectal or extramesorectal lymph nodes.

4/21/26 CT CAP @ Our Facility: Posttherapy changes are noted in the pelvis. No new or suspicious masses or lymphadenopathy are identified

4/21/26 MRI Pelvis @ Our Facility:
1. No discrete anal canal mass identified.
3. No pathologic pelvic lymphadenopathy.

4/28/26 Dr. Dolejs (surgeon): For the **anal cancer, I think she has NED** (No evidence of disease).

Recurrence:

- **Date of First Recurrence:** Blank
- **Type of First Recurrence**: 00- disease free
- **Date contact/death:** 09/25/2026
- **Date cancer status:** 12/18/25
- **Cancer Status:** 01 – No evidence of this tumor

RESOURCES



Summary Stage Manual v3.3

Coding Guidelines Rectosigmoid Junction C199

Solid Tumor Rules 2026.1 Update

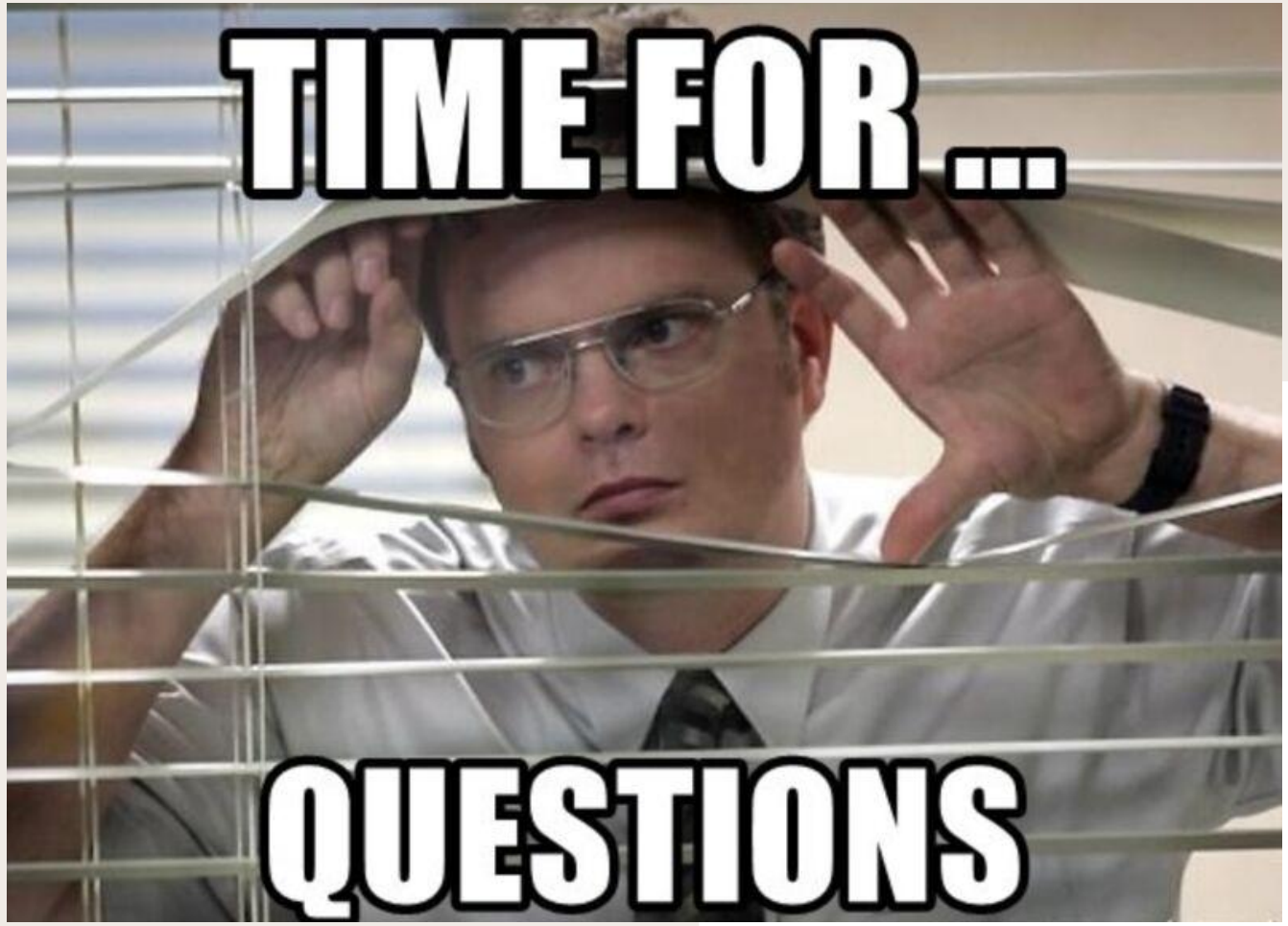
store-manual-2025.pdf

SEER*Rx Interactive Antineoplastic Drugs Database

AJCC 8th edition

Site-specific Data Item (SSDI) Manual v3.3

p16 | SSDI Data |



Thank you!

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