BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

CARCINOMA OF THE RECTUM STAGING DIAGRAM

SITE: ☐ Distal (<5 cm) ☐ Mid (5-10 cm) ☐ Upper (11-15 cm)
☐ Rectosigmoid Junction ☐ Rectum, NOS

* The most distal location of the tumour is used to define tumour location *

HISTOLOGY: _____

☐ New	☐ Recurrent Disease	☐ Referred for Follow up
Referred as part of definitive treatment (initial treatment of disease).	Definitive treatment already received. Referred at recurrence. Staged at initial diagnosis.	Previously treated and followed elsewhere before referral. Staged at initial diagnosis.

Cancer Detected by Screening: ☐ YES ☐ NO ☐ UNKNOWN

TNM 2009 ____*	**T**	X	0		*is*	1		2	3	4	
Clinical/	**N**	X	0			1		2			
Radiological	**M**		0			1	1a	1b	Site(s): ☐ Liver ☐ Lung ☐ Distant Nodal ☐ Other _____		
TNM 2009 ____*	**T**	X	0		*is*	1		2	3	4	4a 4b
Pathological	**N**	X	0	0i+		1	1mi	1a	1b 1c	2	2a 2b
	M					1	1a	1b	Site(s): ☐ Liver ☐ Lung ☐ Distant Nodal ☐ Other _____		

*Prefix **Y**: Identifies cases in which staging was performed during or following initial multimodal therapy.
i.e.: preoperative radiation or chemo/radiation

Primary Tumour Resected	☐ Yes ☐ No ☐ Unknown	**Perineural Invasion**	☐ None ☐ Yes ☐ Unknown
Primary Tumour Complication	☐ None ☐ Obstruction ☐ Perforation ☐ Both ☐ Unknown	**Lymphatic Invasion**	☐ None ☐ Yes ☐ Unknown
Residual Tumour (see reverse)	☐ 0 ☐ 1 ☐ 2 ☐ Unknown	**Vascular Invasion**	☐ None ☐ Yes ☐ Unknown
Radial Margin	☐ Positive or ≤ 1 mm ☐ > 1 mm ☐ Unknown	**Preoperative CEA**	☐ _____ ☐ Not Done ☐ Unknown
# Nodes Removed	☐ _____ ☐ None ☐ N/A ☐ Unknown	**MSI Status**	☐ Not Done ☐ Low ☐ High ☐ Unknown
# Nodes Positive	☐ _____ ☐ None ☐ N/A ☐ Unknown	**Differentiation**	☐ Well ☐ Moderate ☐ Poorly ☐ Undifferentiated/Anaplastic
Synchronous CRC Cancer	☐ Yes ☐ No ☐ Not Evaluated If Yes, please complete separate staging diagram		

Completed by: _____ Date: _____ (dd/mm/yy)

Diagnosis/Stage Amended to: _____

Reason: _____

By: _____ Date: _____ (dd/mm/yy)

NOTIFY DATA QUALITY & REGISTRY IF STAGE/DIAGNOSIS IS AMENDED

CARCINOMA OF THE RECTUM STAGING DIAGRAM

AJCC 7th Edition for Diagnosis Date ≥ 01 January 2010

Definitions for T, N, and M Descriptors

PRIMARY TUMOR (T)

TX	Primary tumour cannot be assessed
T0	No evidence of primary tumour
Tis	Carcinoma *in situ*; intraepithelial or invasion of lamina propria[1]
T1	Tumour invades submucosa
T2	Tumour invades muscularis propria
T3	Tumour invades through the muscularis propria into the subserosa or into non-peritonealized pericolic or perirectal tissues
T4	Tumour directly invades other organs or structures and/or perforates visceral peritoneum
T4a	Tumour perforates visceral peritoneum[4]
T4b	Tumour directly invades or is adherent to other organs or structures[2, 3]

Note[1]: Tis includes cancer cells confined within the glandular basement membrane (intraepithelial) or invasion into the mucosal lamina propria (intramucosal) with no extension through the muscularis mucosae into the submucosa.

Note[2]: Direct invasion in T4b includes invasion of other organs or segments of the colorectum by way of the serosa or mesocolon (e.g. invasion of the sigmoid colon by a carcinoma of the cecum), as confirmed on microscopic examination or for tumours in a retroperitoneal or subperitoneal location, direct invasion of other organs or structures by virtue of extension beyond the muscularis propria.

Note[3]: Tumour that is clinically adherent to other organs or structures, macroscopically, is classified cT4b. However, if pathology reveals that no tumour is present in the adhesion, microscopically, the classification should be pT1-3, depending on the anatomical depth of wall invasion.

Note[4]: Visceral peritoneal (serosal) involvement by tumour cells is indicated by the following findings:

- Tumour present at the serosal surface with inflammatory reaction, mesothelial hyperplasia, and/or erosion/ulceration
- Free tumour cells on the serosal surface (in the peritoneum) with underlying ulceration of the visceral peritoneum

REGIONAL LYMPH NODES (N) – see notes below re: mesenteric nodules & site-specific regional nodes

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis (histological examination of a regional lymphadenectomy will ordinarily include 12 or more lymph nodes)
N0i+	No regional lymph node metastasis histologically, positive morphological findings for ITC
N1	Metastasis in 1-3 regional lymph nodes
N1mi	Micrometastasis only, i.e. no metastasis larger than 0.2 cm
N1a	Metastasis in 1 regional lymph node
N1b	Metastasis in 2 to 3 regional lymph nodes
N1c	Tumour deposit(s), i.e. satellites, in the subserosa or in non-peritonealized pericolic or perirectal soft tissue without regional lymph node metastasis (see note below re: mesenteric nodules/deposits)
N2	Metastasis in 4 or more regional lymph nodes
N2a	Metastasis in 4 to 6 regional lymph nodes
N2b	Metastasis in 7 or more regional lymph nodes

DISTANT METASTASIS (M)

M0	No distant metastasis (only applicable for clinical staging – i.e. if a cM1 is biopsied and is negative, it becomes cM0, not pM0)
M1	Distant metastasis
M1a	Distant metastasis confined to a single organ or site (e.g. liver, lung, ovary, non-regional lymph node)
M1b	Distant metastasis to more than one organ/site or to the peritoneum (see note below re: mesenteric nodules/deposits)

RESIDUAL TUMOUR (R)

0	Complete resection, margins histologically negative, no residual tumour left after resection
1	Incomplete resection, microscopic tumor at or within ≤ 1 mm of any margin
2	Incomplete resection, margins macroscopically or grossly involved or gross disease remains after resection
9	Unknown

VASCULAR INVASION (V) – please see note re: Mesenteric Nodules below

0	None
1	Yes
9	Unknown

NOTE: MESENTERIC NODULES/DEPOSITS or TUMOR NODULES/DEPOSITS

- Tumour deposits (satellites), i.e. macroscopic or microscopic nests or nodules, in the pericolorectal adipose tissue's lymph drainage area of a primary carcinoma without histological evidence of residual lymph node in the nodule, may represent discontinous spread, venous invasion with extravascular spread (V1/2) or a totally replaced lymph node (N1/2). If such deposits are observed with lesions that would otherwise be classified as T1 or T2, then the T classification is not changed, but the nodule(s) is recorded as N1c. Peritumoral deposits or satellite nodules are generally irregularly contoured. If a nodule is considered by the pathologist to be a totally replaced lymph node (generally having a smooth contour), it should be recorded as a positive lymph node and not as a satellite, and each nodule should be counted separately as a lymph node in the final pN determination.
- The V and L substaging should be used to identify the presence or absence of vascular or lymphatic invasion. Vascular Invasion is coded as positive if vascular invasion is microscopically visible (V1) or if vascular invasion is macroscopically or grossly visible (V2).
- Extensive mesenteric disease is coded M1b disease.