### CORPUS UTERI CARCINOMA STAGING FORM

(Carcinosarcomas should be staged as carcinomas)

<table>
<thead>
<tr>
<th>Clinical Stage Category Definitions</th>
<th>Pathologic Stage Category Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tumor size:</strong> ___________</td>
<td><strong>Tumor size:</strong> ___________</td>
</tr>
<tr>
<td><strong>Laterality</strong></td>
<td><strong>Laterality</strong></td>
</tr>
<tr>
<td>□ Left □ Right □ Bilateral</td>
<td>□ Left □ Right □ Bilateral</td>
</tr>
</tbody>
</table>

#### PRIMARY TUMOR (T)

- **T1** — Tumor limited to endometrium or invades less than one-half of the myometrium
- **T1b** — Tumor invades one-half or more of the myometrium
- **T2** — Tumor invades stromal connective tissue of the cervix but does not extend beyond uterus
- **T3a** — Tumor involves serosa and/or adnexa (direct extension or metastasis)
- **T3b** — Vaginal involvement (direct extension or metastasis) or parametral involvement
- **T4** — Tumor invades bladder mucosa and/or bowel mucosa (bullous edema is not sufficient to classify a tumor as T4)

* FIGO staging no longer includes Stage 0 (Tis)

** Endocervical glandular involvement only should be considered as stage I and not Stage II.

#### REGIONAL LYMPH NODES (N)

- **N0** — No regional lymph node metastasis
- **N1** — Regional lymph node metastasis to pelvic lymph nodes
- **N2** — Regional lymph node metastasis to para-aortic lymph nodes, with or without positive pelvic lymph nodes

#### DISTANT METASTASIS (M)

- **M0** — No distant metastasis (no pathologic M0; use clinical M to complete stage group)
- **M1** — Distinct metastasis (includes metastasis to inguinal lymph nodes Intersperitoneal disease, or lung, liver, or bone. It excludes metastasis to para-aortic lymph nodes, vagina, pelvic serosa, or adnexa)

---

Form No: MR0661
EC App 12/94 Revised EC 05/10
**Data Form for Cancer Staging**

**CORPUS UTERI STAGING FORM**

### Anatomic Stage • Prognostic Groups

<table>
<thead>
<tr>
<th>GROUP</th>
<th>T</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>0*</td>
<td>T1s</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>I</td>
<td>T1</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IA</td>
<td>T1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IB</td>
<td>T1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>II</td>
<td>T2</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>III</td>
<td>T3</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIA</td>
<td>T3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIB</td>
<td>T3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIC1</td>
<td>T1-T3</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td>IIIC2</td>
<td>T1-T3</td>
<td>N2</td>
<td>M0</td>
</tr>
<tr>
<td>IVA</td>
<td>T4</td>
<td>Any N</td>
<td>M0</td>
</tr>
<tr>
<td>IVB</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>

### Pathologic

<table>
<thead>
<tr>
<th>GROUP</th>
<th>T</th>
<th>N</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>0*</td>
<td>T1s</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>I</td>
<td>T1</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IA</td>
<td>T1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IB</td>
<td>T1b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>II</td>
<td>T2</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>III</td>
<td>T3</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIA</td>
<td>T3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIB</td>
<td>T3b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>IIIC1</td>
<td>T1-T3</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td>IIIC2</td>
<td>T1-T3</td>
<td>N2</td>
<td>M0</td>
</tr>
<tr>
<td>IVA</td>
<td>T4</td>
<td>Any N</td>
<td>M0</td>
</tr>
<tr>
<td>IVB</td>
<td>Any T</td>
<td>Any N</td>
<td>M1</td>
</tr>
</tbody>
</table>

*F.I.C.O. no longer includes Stage 0 (T1s)

Carcinomas should be staged as carcinoma.

Stage unknown

### Prognostic Factors (Site-Specific Factors)

**REQUIRED FOR STAGING:** None

**CLINICALLY SIGNIFICANT:**

- F.I.C.O. Stage: ___________
- Peritoneal cytology results: ___________
- Pelvic nodal dissection with number of nodes positive/examined: ___________
- Para-aortic nodal dissection with number of nodes positive/examined: ___________
- Percentage of non-endometrioid cell type in mixed histology tumors: ___________
- Omentectomy performed: ___________

### Histologic Grade (G) (also known as overall grade)

- 2 grade system
- 3 grade system
- 4 grade system
- No 2, 3, or 4 grade system is available

Endometrioid adenocarcinomas should be graded according to the degree of differentiation of the adenocarcinoma as follows:

- G1 5% or less of a non-squamous or non-monolocular solid growth pattern
- G2 6% to 50% of a non-squamous or non-monolocular solid growth pattern
- G3 More than 50% of a non-squamous or non-monolocular solid growth pattern

**Notes on Pathologic Grading**

1. Notable nuclear atypia, inappropriate for the architectural grade, raises the grade by one.
2. Serous, clear cell, and mixed mesodermal tumors are Grade 3.

---

**General Notes:**

For identification of special cases of TNM or pTNM classifications, the 'm' suffix and 'yp', 'r', and 'n' prefixes are used. Although they do not affect the stage grouping, they indicate cases needing separate analysis.

'p' suffix indicates the presence of multiple primary tumors in a single site and is recorded in parentheses: pT(m)NM.

'y' prefix indicates those cases in which classification is performed during or following initial multimodality therapy. The cTNM or pTNM category is identified by a 'y' prefix.

The ypTNM or yp-pTNM categorizes the extent of tumor actually present at the time of that examination. This 'y' categorization is not an estimate of tumor prior to multimodality therapy.

'r' prefix indicates a recurrent tumor when staged after a disease-free interval, and is identified by the 'r' prefix: rTNM.

'a' prefix designates the stage determined at autopsy: aTNM.

Surgical margins is data field recorded by registrars describing the surgical margins of the resected primary site specimen as determined only by the pathology report.
Data Form for Cancer Staging
CORPUS UTERI STAGING FORM

ADDITIONAL DESCRIPTORS

Lymphatic Vessel Invasion (L) and Venous Invasion (V) have been combined into Lymph-vascular Invasion (LVI) for collection by cancer registrars. The College of American Pathologists’ (CAP) Checklist should be used as the primary source. Other sources may be used in the absence of a Checklist. Priority is given to positive results.

- Lymph-vascular Invasion Not Present (absent) Not Identified
- Lymph-vascular Invasion Present/Identified
- Not Applicable
- Unknown/Indeterminate

Residual Tumor (R)
The absence or presence of residual tumor after treatment. In some cases treated with surgery and/or with neoadjuvant therapy there will be residual tumor at the primary site after treatment because of incomplete resection or local and regional disease that extends beyond the limit of ability of resection.

- RX Presence of residual tumor cannot be assessed
- R0 No residual tumor
- R1 Microscopic residual tumor
- R2 Macroscopic residual tumor

☐ Clinical stage was used in treatment planning (describe): _________________________________

☐ National guidelines were used in treatment planning  ☐ NCCN  ☐ Other (describe): _________________________________

General Notes (continued):
neoadjuvant treatment is radiation therapy or systemic therapy (consisting of chemotherapy, hormone therapy, or immunotherapy) administered prior to a definitive surgical procedure. If the surgical procedure is not performed, the administered therapy no longer meets the definition of neoadjuvant therapy.

Physician signature _________________________________ Date/Time _________________________________
Data Form for Cancer Staging

CORPUS UTERI STAGING FORM

Illustration
Indicate on diagram primary tumor and regional nodes involved.