**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:**

<table>
<thead>
<tr>
<th>□ New</th>
<th>□ Recurrent Disease</th>
<th>□ Referred for Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred as part of definitive treatment (initial treatment of disease).</td>
<td>Definitive treatment already received. Referred at recurrence. Staged at initial diagnosis.</td>
<td>Previously treated and followed elsewhere before referral. Staged at initial diagnosis.</td>
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</tbody>
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**Cancer Detected by Screening:**
- [ ] Yes
- [ ] No
- [ ] Unknown

**TNM 2009**

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*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

**Primary Tumour Complication**
- [ ] None
- [ ] Obstruction
- [ ] Perforation
- [ ] Both
- [ ] Unknown

**Residual Tumour (see reverse)**
- [ ] 0
- [ ] 1
- [ ] 2
- [ ] Unknown

**Radial Margin**
- [ ] Positive or ≤ 1 mm
- [ ] > 1 mm
- [ ] Unknown

**# Nodes Removed**
- [ ] ________
- [ ] None
- [ ] N/A
- [ ] Unknown

**# Nodes Positive**
- [ ] ________
- [ ] None
- [ ] N/A
- [ ] Unknown

**Synchronous CRC Cancer**
- [ ] Yes
- [ ] No
- [ ] Not Evaluated

Completed by: ___________________________ Date: ____________ (dd/mm/yyyy)

Diagnosis/Stage Amended to:__________________________________________________________

Reason: ________________________________________________________________

By: ___________________________ Date: ____________ (dd/mm/yyyy)

NOTIFY DATA QUALITY & REGISTRY IF STAGE/DIAGNOSIS IS AMENDED
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
T1 Tumour invades submucosa
T2 Tumour invades muscularis propria
T3 Tumour invades through the muscularis propria into the subserosa or into non-peritonealized pericolonic or perirectal tissues
T4 Tumour directly invades other organs or structures and/or perforates visceral peritoneum
T4a Tumour perforates visceral peritoneum
T4b Tumour directly invades or is adherent to other organs or structures

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 tumors in a retroperitoneal or subteritoneal 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 pericolonic 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 discontinuous 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.