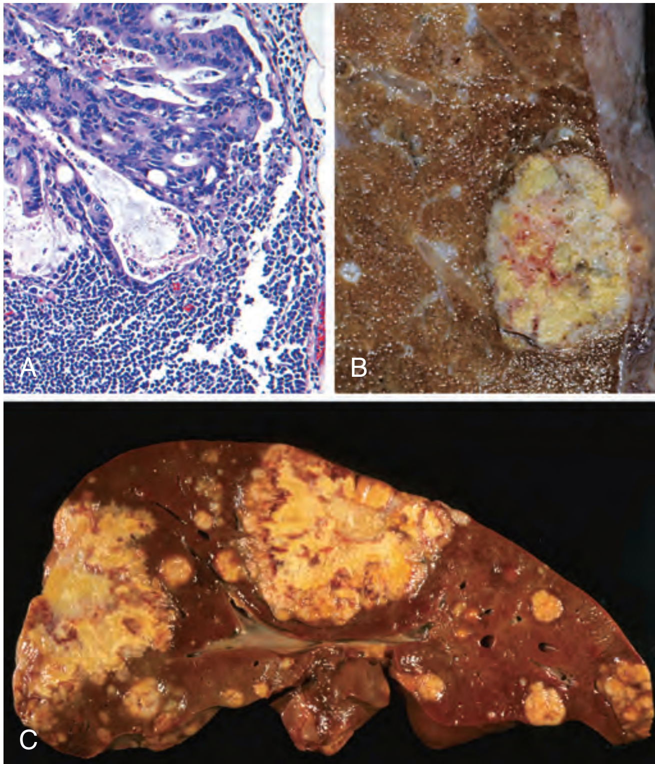

Figure 17-53 Metastatic colorectal carcinoma. **A,** Lymph node metastasis. Note the glandular structures within the subcapsular sinus. **B,** Solitary subpleural nodule of colorectal carcinoma metastatic to the lung. **C,** Liver containing two large and many smaller metastases. Note the central necrosis within metastases.

from 60% (Switzerland, Japan) to (40%) Poland. Overall survival rates are somewhat lower in other countries, such as China, India, the Philippines, and Thailand (30% to 42%). Sadly, the 5-year survival rate in Gambia is only 4%.

Table 17-12 American Joint Committee on Cancer (AJCC) TNM Classification of Colorectal Carcinoma

TNM	
Tumor	
Tis	In situ dysplasia or intramucosal carcinoma
T1	Tumor invades submucosa
T2	Tumor invades into, but not through, muscularis propria
T3	Tumor invades through muscularis propria
T3a	Invasion < 0.1 cm beyond muscularis propria
T3b	Invasion 0.1 to 0.5 cm beyond muscularis propria
T3c	Invasion > 0.5 to 1.5 cm beyond muscularis propria
T3d	Invasion > 1.5 cm beyond muscularis propria
T4	Tumor penetrates visceral peritoneum or invades adjacent organs
T4a	Penetration into visceral peritoneum
T4b	Invasion into other organs or structures
Regional Lymph Nodes	
NX	Lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in one to three regional lymph nodes
N1a	Metastasis in one regional lymph nodes
N1b	Metastasis in two or three regional lymph nodes
N1c	Tumor deposit(s) in the subserosa, mesentery, or nonperitonealized pericolic or perirectal tissues without regional nodal metastasis
N2	Metastasis in four or more regional lymph nodes
N2a	Metastasis in four to six regional lymph nodes
N2b	Metastasis in seven or more regional lymph nodes
Distant Metastasis	
MX	Distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis
M1a	Metastasis confined to one organ or site
M1b	Metastases in more than one organ/site or the peritoneum

Table 17-13 Colorectal Cancer Staging Systems

American Joint Committee on Cancer (AJCC) Stage				Astler-Coller Modification of Dukes Classification
	T	N	M	
I	T1	N0	M0	A
	T2	N0	M0	B1
IIA	T3	N0	M0	B2
IIB	T4a	N0	M0	B2
IIC	T4b	N0	M0	B3
IIIA	T1-T2	N1/N1c	M0	C1
	T1	N2a	M0	C1
IIIB	T3, T4a	N1 (any)	M0	C2
	T2, T3	N2a	M0	C1/C2
	T1, T2	N2b	M0	C1
IIIC	T4a	N2a	M0	C2
	T3, T4a	N2b	M0	C2
	T4b	N1, N2	M0	C3
IVA	Any T	Any N	M1a	D*
IVB	Any T	Any N	M1b	D*

*Stages not included in original Dukes classification; added later for comparison with AJCC staging.

KEY CONCEPTS

Benign and malignant proliferative lesions of the colon

- **Intestinal polyps** can be classified as nonneoplastic or neoplastic. The nonneoplastic polyps can be further defined as hyperplastic, inflammatory, or hamartomatous.
- **Hyperplastic polyps** are benign epithelial proliferations most commonly found in the left colon and rectum. They have no malignant potential, and must be distinguished from sessile serrated adenomas.
- **Inflammatory polyps** form as a result of chronic cycles of injury and healing.
- **Hamartomatous polyps** occur sporadically or as a part of genetic diseases. The latter include **juvenile polyposis** and **Peutz-Jeghers Syndrome**, which are associated with **increased risk of malignancy**.
- Benign epithelial neoplastic polyps of the intestines are termed **adenomas**. The hallmark of these lesions, which are the precursors of colonic adenocarcinomas, is cytologic dysplasia.
- In contrast to traditional adenomas, **sessile serrated adenomas** lack cytologic dysplasia and share morphologic features with hyperplastic polyps.

www.PTools.ir