Table of Contents

Hysterectomy Types

General Hysterectomy Types.................................................................3
Hysterectomy Types by Surgical Approach........................................4

Assigning Current Procedural Terminology Hysterectomy Codes

Flow Diagram for Assigning CPT Codes for Hysterectomy..................5
Chart for Determining CPT Code and Surgical Approach....................6
Laparoscopic Assisted Vaginal Hysterectomy vs. Laparoscopic Hysterectomy Algorithm........7

Hysterectomy Pathology

Pathology Report Format........................................................................8
Retroperitoneal Anatomy......................................................................12

Hysterectomy Variables & Definitions

List of Variables and Definitions.........................................................13
**Hysterectomy**
Hysterectomy is the surgical removal of the uterus. Commonly, it also involves the removal of the cervix, ovaries, fallopian tubes and other surrounding structures such as lymph nodes. Patients may have a hysterectomy for either benign or cancer indication(s) which is an important distinction to make when abstracting a hysterectomy case.

**Elements and Concepts of Understanding Hysterectomy**
- Uterine Structures
- Identifying Hysterectomy Type and Surgical Approach
- Pathology

**Uterine Structures**
There are 3 layers of the uterus. The inner lining is called the endometrium; the middle muscular layer is called the myometrium; and the outer layer is called the perimetrium. The SCQR will collect specimen pathology for the uterine tissue- endometrium and myometrium. When removed the fallopian tubes, ovaries, and cervix will also be collected. For MSQC, the perimetrium is included in the myometrium/uterus tissue site when abstracting specimen pathology so be sure to include if specific perimetrium findings are noted.
General Hysterectomy Types
Hysterectomies can be classified into one of three basic categories. Designation within a category depends on what organs and/or structures were surgically removed.

Radical Hysterectomy: The removal of the uterine fundus (body), cervix, the top portion of the vagina, and the parametria (tissue that surrounds the cervix). It may also include the removal of the pelvic lymph nodes.

Total Hysterectomy: may be identified as ‘Total Abdominal Hysterectomy’ (TAH), ‘Total Laparoscopic Hysterectomy (TLH) or ‘Laparoscopic Hysterectomy’. This is the removal of the uterine fundus (body) and cervix. This may include the removal of the tubes and/or ovaries and is described as salpingectomy (tubes only), oophorectomy (ovaries only), or salpingo-oophorectomy (tubes and ovaries).

Supracervical Hysterectomy: also called ‘Subtotal Hysterectomy’ or ‘Partial Hysterectomy’. This is the removal of the uterine fundus (body) but NOT the cervix.

The operative report frequently will include a description of the procedure type as a listing. Example: Procedure(s) Performed: DaVinci assisted total abdominal hysterectomy. Sometimes, however, the description under the procedure listing requires further deliberation. Example: DaVinci Assisted Total Abdominal hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and para aortic lymphadenectomy. Though not part of the listed description, this case qualifies as a radical hysterectomy.
Hysterectomy Types by Surgical Approach:
After determining what structures were removed (radical, total, or supracervical), surgical approach can be identified. Surgical approach is distinguished by the route or method of surgical detachment of uterus from its surrounding supportive structures (ligaments).

Open Hysterectomy: Often performed through a horizontal incision just within the pubic hairline. It can also be performed through a midline incision. The structures and supporting ligaments are detached by the surgeon through this incision.

Vaginal Hysterectomy: The procedure is completed through a circumferential incision around the cervix (frequently called the “colpotomy” in operative reports) and involves the removal of the cervix and uterine fundus. This type of hysterectomy is performed completely via a vaginal approach.

If a diagnostic laparoscopy is performed and then followed by a vaginal hysterectomy, the surgical approach is vaginal. If the ovaries and fallopian tubes are detached laparoscopically, but the hysterectomy is performed vaginally, list the surgical approach as a vaginal hysterectomy.

Laparoscopic Supracervical Hysterectomy (LSH): This is the laparoscopic detachment of the uterine fundus down to the uterine arteries. The uterine fundus is then separated from the cervix, hemostasis of the cervical stump is achieved and the endocervical canal is coagulated. The uterine body is removed abdominally. The cervix is not removed.

Robotic Supracervical Hysterectomy (RSH): A procedure similar to the laparoscopic supracervical hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms. This allows the surgeon to have enhanced dexterity and visualization.

*In the body of the operative report, look for a description of the robot being “docked” or “undocked”.

Laparoscopic Total Hysterectomy (Laparoscopic Hysterectomy): This is the laparoscopic ligament detachment of the uterine fundus and cervix. The uterus is often removed via the vagina, but alternatively, may be removed through the abdomen. Removal of the uterus may require bivalving, coring, or morcellating especially if the specimen is removed vaginally. The vaginal cuff may be closed either laparoscopically or vaginally.

Robotic Assisted Laparoscopic Hysterectomy (RALH): A procedure similar to a laparoscopic total hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms. This allows the surgeon to have enhanced dexterity and visualization.

*In the body of the operative report, look for a description of the robot being “docked” or “undocked”.

EFFECTIVE: Operation dates January 1, 2018 – December 31, 2018
Laparoscopic Assisted Vaginal Hysterectomy (LAVH): A combined laparoscopic and vaginal ligament detachment of the uterine fundus and cervix. Surgeons may use the following names of ligaments in operative reports: round ligament, broad ligament, cardinal ligament (includes the uterine vessels which is commonly referred to in OP reports), and/or uterosacral ligament.

Robotic Assisted Vaginal Hysterectomy (RAVH): A procedure similar to the laparoscopic assisted vaginal hysterectomy, except that the specialized laparoscopic instruments are connected to robotic arms. This allows the surgeon to have enhanced dexterity and visualization.

*In the body of the operative report, look for a description of the robot being “docked” or “undocked”.

*LAVH vs TLH (include robotic): Route of specimen removal or closure of the vaginal cuff is NOT a determining factor when identifying if the hysterectomy is a LAVH or TLH. When differentiating between these surgical approaches, the SCQR must identify in the operative report how the uterine ligament detachment was performed. (see page 7 for algorithm and tips)


Once it has been determined what structures were removed and the appropriate surgical approach, the next step is to select the CPT code and surgical approach in the data abstraction. Use the following resources to assist with this process.

**Resolution of Disagreement:**
If the description of the procedure and the listed procedure differ, use the description to assign a procedure code (description trumps listing).
If the pathology report and the operative report description differ, use the operative report description/listing to assign the procedure code. Example: op note states removal of lymph nodes but path report does not list lymph nodes or states lymph node specimen is not lymph tissue. Assign the CPT code that includes lymph node removal.
<table>
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<th>CPT Codes</th>
<th>Uterine Size</th>
<th>Tubes &amp;/or Ovaries</th>
<th>Removal of Cervix</th>
<th>Approach to Uterine Ligament Detatchment</th>
<th>Route of Tissue Removal</th>
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</tbody>
</table>

Note: For laparoscopic hysterectomy, the surgeon may also use a robot. Select the appropriate laparoscopic CPT code (there aren't specific robotic CPT codes). When selecting surgical approach, select the appropriate robotic option.
Laparoscopic (includes robotic) Assisted Vaginal Hysterectomy (LAVH) vs. Total Laparoscopic (includes robotic) Hysterectomy (TLH)

What approach was used to detach the uterine ligaments?

Laparoscopic (abdomen) and Vaginal

Laparoscopic (robotic) assisted vaginal hysterectomy

Tubes and/or Ovaries Removed?

Yes

Uterine Weight <= 250g CPT 58571

No

Uterine Weight > 250g CPT 58573

Laparoscopic (abdomen)

Laparoscopic (robotic) hysterectomy

Tubes and/or Ovaries Removed?

Yes

Uterine Weight <= 250g CPT 58552

No

Uterine Weight > 250g CPT 58554

All uterine ligment detachment occurs through the abdomen via laparoscopic approach

Clues to look for LAVH:
- A portion of the detachment performed laparoscopically and then the surgeon notes going "vaginally," "below" or "posteriorly" to complete or continue detachment
- Colpotomy timing: LAVH-performed prior to the vaginal detachment of the uterine ligaments vs. TLH-typically is last step prior to specimen removal
- Cul-de-sac: This is the space on the anterior and posterior side of the uterus important completing vaginal detachment of uterine ligaments
Pathology

Although pathology reports follow a general format, the dissimilarities between reports can make data capture of the pathology variables difficult and time-consuming. A way to minimize frustration with collection of these variables is to gain a general understanding of how a pathology report is structured and to know exactly where to look for pertinent information.

Pathology Report Format:

A surgical pathology report is divided into a minimum of four to five sections:

- Identifiers and clinical information
- Specimen section
- Gross description
- Microscopic description
- Diagnosis.

Identifiers and Clinical Information: This section of the pathology report lists the patient name, birthdate, other personal identifying information, surgeon, and pathologist information. It also includes the operation/procedure, pre-operative diagnosis, clinical history*, and post-operative diagnosis.

*Any pathology findings from a previous procedure or specimen biopsy should not be reported unless they are noted by the pathologist as a current finding, i.e. findings must be identified by the pathologist from the current procedure’s specimen. If
slides/specimens obtained from a recent/previous procedure were submitted to the pathologist for evaluation and reporting, alongside the current specimen, those findings are valid for reporting.

**Specimen Section:** This represents the portion of the pathology report providing details about the specimens received: location from which the tissue was removed, or what organ was submitted. Specific description and/or designation (left vs. right) can be found here. This section of the pathology report may be included as part of the clinical information section, have a heading of its own, or may be rolled into the *gross description* section of the pathology report.

**Example:**

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<td>Report:</td>
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<td>Physician(s):</td>
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</table>

**Clinical History**

(TOC: 1400) Endometrial cancer.

**Operative Diagnoses**

**Operation / Specimen**

A: Left and right per-ilio-lymph nodes, resection
B: Right pelvic lymph nodes, resection
C: Left pelvic lymph nodes, resection
D: Omentum, resection
E: Uterus, cervix, fallopian tubes and ovaries, resection

**Gross Description:** This section of the pathology report describes the specimen(s)’ appearance to the naked eye and details what tissue is to be examined under the microscope. Included in this section of the report is size, color, number of tissue sample, and specimen weight:

**Example #1 (brief description):**

GENERAL APPEARANCE:
A 9.5 cm distorted uterus with attached adnexal structures.
The Right Adnexa: 4 cm Fallopian Tube and 2 cm ovary.
The Left Adnexa: 3 cm Fallopian Tube and 6 cm ovary.
Weight of uterus with myomata: 69 g
Example #2 (longer description with more detail):

GROSS DESCRIPTION

Received in formalin labeled “uterus, cervix, right ovary and fallopian tube, left ovary and fallopian tube” is a uterus with attached cervix and attached bilateral fallopian tubes and ovaries. When trimmed of the fallopian tubes and ovaries, the uterus and cervix measures 7.0 cm in length, 6.1 cm laterally, 4.6 cm anterior to posterior, and weighs 78 grams. The serosal surface is tan-pink, smooth and glistening. Noted near the fundus is a pale white, ovoid focal area, measuring up to 0.6 cm in diameter. The uterine body is symmetrical. The ectocervix is pale tan, smooth and glistening, focally roughened, and measures 2.8 cm in greatest diameter. The os is patent, slit-like, and measures up to 1.0 cm in diameter. The endocervical canal measures 1.7 cm in length. The endometrial cavity measures 2.5 x 0.7 cm and is lined by gray-white, scarred endometrium, 0.2 cm in greatest thickness. The myometrium is tan-pink, trabeculated, and measures up to 2.3 cm in thickness. Cut sections through the myometrium reveal two gray-white intramural nodules, ranging in size from 0.2 to 1.5 cm in greatest diameter. Cut sections through these nodules reveal white, whorled, well-circumscribed cut surfaces. The attached right fallopian tube, which is identified by its fimbriated end, measures 6.3 cm in length by 0.6 cm in diameter. The serosa is tan-pink to purple, smooth and glistening. Serial sections reveal a pinpoint lumen. The attached right ovary is yellow-tan to pink-purple, multilocular, smooth and glistening, and grossly cystic, and measures 3.6 x 3.4 x 2.6 cm, and weighs 18 grams. Serial sections through this ovary reveal corpora albilcanta and corpora lutea. Also identified grossly are two cystic structures; one is filled with clear fluid and measures up to 1.4 cm in greatest diameter. The other is filled with yellow-green, mucoid material that measures up to 2.0 cm in greatest diameter. The serosa of the larger mucoid cystic structure has multiple yellow-tan, raised nodules attached to the wall. The ovary is totally submitted for microscopic examination.

The attached left fallopian tube, which is identified by its fimbriated end, measures 6.5 cm in length by 0.8 cm in diameter. The serosal surface is tan-pink to purple, smooth and glistening. Also noted near the fimbriated end is a smooth and glistening cystic structure consistent with a paratubal cyst that measures up to 1.0 cm in greatest diameter. Cut sections through the fallopian tube reveal a pinpoint lumen. The attached left ovary is yellow-tan to pink-purple, smooth and glistening, and grossly cystic, and measures 3.2 x 2.6 x 1.7 cm and weighs 7 grams. Serial sections reveal corpora albilcanta and corpora lutea. Also identified grossly in the ovary are three clear to hemorrhagic fluid-filled cysts ranging in size from 0.3 to 1.0 cm in greatest diameter. No lesions or nodules are grossly identified. Representative sections are submitted as follows: Posterior cervix cul-de-sac - 1A; anterior cervix cul-de-sac - 1B; posterior full-thickness endometrium - 1C, 1D; anterior full-thickness endometrium - 1E, 1F; focal area on fundus - 1G; intramural nodules - 1H; right fallopian tube - 1I; right ovary - 1J-1L, 10-12; left fallopian tube and paratubal cyst - 1M; left ovary 1N.

Microscopic Description: The microscopic description details how the specimen looks under the microscope and how it compares with normal cells. This section describes if the cancer has invaded nearby tissues. The microscopic description, gross description and clinical history are used by the pathologist to make the pathologic diagnosis. Findings from the microscopic examination of specimens are generally reported in the diagnosis section of the pathology report or immediately precede the diagnosis section of the pathology report.

Diagnosis Section: The diagnosis section of the pathology report represents the “bottom line” or the final medical diagnosis that is established after thorough examination of the specimen. This may be located at the beginning or the end of the report. Some diagnoses are very short while others may be quite lengthy, describing aspects of the cancer that will affect the patient’s treatment and outcome. In cancer cases, there will often be additional information included in the diagnosis:

- Type of cancer present
• Cancer grade (how the cancer looks)
• Cancer stage (spread of cancer)
• Other aspects of the cancer
  o Invasion of cancer (e.g., present in blood vessels, metastasis to bowel)
  o Surgical margins (do the edges/borders of the tumor contain cancer)

Example:

**MICROSCOPIC DIAGNOSIS**

**UTERUS, CERVIX, BILATERAL SALPINGO-OOPHORECTOMY:**
A. RIGHT OVARY EXHIBITING PAPILLARY SEROUS CYSTADENOCARCINOMA OF THE OVARY, GRADE 2. SEE SYNOPSIS REPORT.
B. LEFT OVARY WITH NO SIGNIFICANT HISTOPATHOLOGIC CHANGES. NEGATIVE FOR CARCINOMA.
C. LEFT AND RIGHT FALLOPIAN TUBES, NEGATIVE FOR MALIGNANCY.
D. UTERUS EXHIBITING INTRAMURAL LEIOMYOMATA.
   1. PROLIFERATIVE PHASE ENDOMETRIUM.
   2. MILD CHRONIC CYSTIC CERVICITIS.

**SYNOPTIC REPORT FOR OVARIAN CARCINOMA**

**SPECIMEN:** Bilateral ovaries, fallopian tubes, uterus and cervix.
**PROCEDURE:** Hysterectomy with bilateral salpingo-oophorectomy.
**LYMPH NODE SAMPLING:** Not performed.
**SPECIMEN INTEGRITY:** Right ovary is intact.
**PRIMARY TUMOR SITE:** Right ovary.
**OVARIAN SURFACE INVOLVEMENT:** Absent.
**TUMOR SIZE:** 3.6 x 3.4 x 2.6
**HISTOLOGIC TYPE:** Serous carcinoma.
**HISTOLOGIC GRADE:** Grade 2. Two-tier grading system is high grade.
**IMPLANTS:** Not sampled.
**EXTENT OF INVOLVEMENT OF OTHER TISSUES/ORGANS:** Right ovary only. Left ovary, right fallopian tube, left fallopian tubes, and uterus are all not involved.
Retroperitoneal Structures

Because operative report dictation most often provides description of disease involving specific viscera, it is essential to know what organs comprise the retroperitoneal structures. The variables Presence of Gross Abdominal Disease and Presence of Gross Residual Disease each request information about tumor disease location(s).

Retroperitoneal structures refer to viscera located in the abdominal cavity behind the peritoneum. Abdominal retroperitoneal viscera are:

- organs with peritoneum on the anterior surface
- organs not suspended by mesentery in the abdominal cavity
- organs lying between the parietal peritoneum and abdominal wall

Remembering the structures: this mnemonic may prove helpful.

- S-suprarenal (adrenal) gland
- A-aortic/inferior vena cava (IVC)
- D-duodenum (2nd & 3rd portion)
- P-pancreas (head & neck)
- U-ureters
- C-colon (ascending and descending)
- K-kidneys
- E-esophagus (thoracic portion)
- R-rectum
Variables and Definitions w/Section Locations

Preoperative Risk Factors Variables
   History of Cancer
   Prior Pelvic Surgery

Preoperative Processes Variables
   Parity
   Indication for Procedure
   Alternatives to Hysterectomy
   Workup for Hysterectomy

Surgery Factors Variables
   Endometriosis
   Bleeding Barrier
   Adhesion Barrier
   Vaginal Prep
   Intraoperative Complications
   Presence of Gross Abdominal Disease
   Presence of Gross Residual Disease
   Specimen Removal for Minimally Invasive Hysterectomy

Hysterectomy Variables
   Specimen Weight
   Specimen Pathology
   Endometrial Cancer Staging

Postoperative Occurrences Variables
   Hysterectomy Postoperative Occurrences