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## Protocol for the Examination of Specimens From Patients With Neuroendocrine Tumors (Carcinoid Tumors) of the Appendix

**Protocol applies to well-differentiated neuroendocrine tumors of the appendix. Goblet cell carcinoids, poorly differentiated carcinomas with neuroendocrine features, and small cell carcinomas are not included.**

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**Based on AJCC/UICC TNM, 7<sup>th</sup> Edition**

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### Procedures

- Excision (Appendectomy)
- Appendectomy With Segmental Resection (Right Hemicolectomy)

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## CAP Appendix NET Protocol Revision History

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### Version Code

The definition of the version code can be found at [www.cap.org/cancerprotocols](http://www.cap.org/cancerprotocols).

**Version:** AppendixNET 3.2.0.0

### Summary of Changes

The following changes have been made since the February 2011 release.

### Excision (Appendectomy) or Resection

#### Procedure

Deleted "Length" elements.

#### Histologic Type; Alternate Histologic Classification; Histologic Grade

These three reporting elements were combined into one, and the word "checklist" was changed to "protocol" as follows:

#### Histologic Type and Grade<sup>#</sup>

- Not applicable
- Well-differentiated neuroendocrine tumor; GX: Grade cannot be assessed
- Well-differentiated neuroendocrine tumor; G1: Low grade (carcinoid)
- Well-differentiated neuroendocrine tumor; G2: Intermediate grade (atypical carcinoid)
- Other (specify): \_\_\_\_\_

<sup>#</sup> For poorly differentiated (high-grade) neuroendocrine carcinomas (G3), the College of American Pathologists (CAP) protocol for carcinoma of the appendix should be used.

#### Margins

Reporting on distal margin was removed. "Not applicable" was added under mesenteric (mesoappendiceal) margin. Reporting on circumferential (radial) margin was removed. Reporting on other margins was added, as follows:

Other Margin(s) (required only if applicable)

Specify margin(s): \_\_\_\_\_

- Cannot be assessed
- Uninvolved by neuroendocrine tumor
- Involved by neuroendocrine tumor

#### Pathologic Staging (pTNM)

Primary Tumor (pT)

pT1 was changed from a selectable to a nonselectable element.

#### Ancillary Studies

Reporting on Ki-67 was updated, changing >2% to 3% and adding "specify," as follows:

- +  Ki-67 labeling index (specify: \_\_\_\_\_)
- +  ≤2%
- +  3% to 20%
- +  >20%

### **Explanatory Notes**

"Neoplasms" was changed to "tumors."

#### **A. Application and Tumor Location**

The first sentence was modified to clarify that the protocol encompasses tumors "of any size."

#### **C. Histologic Type**

The second paragraph was changed to the following:

Alternate classification schemes based upon the World Health Organization (WHO) classification categorize neuroendocrine neoplasms as well-differentiated neuroendocrine tumors (either the primary tumor or metastasis) and poorly differentiated neuroendocrine carcinomas.<sup>6-9</sup> Classification of neuroendocrine tumors is based upon size, functionality, site, and invasion, and tumor proliferative activity (mitosis and Ki67 index). Functioning tumors are those associated with clinical manifestations of hormone production or secretion of measurable amounts of active hormone; immunohistochemical demonstration of hormone production is not equivalent to clinically apparent functionality.

#### **Alternative Classification Based Upon WHO Classification: Neuroendocrine Tumors of the Appendix**

This section was deleted.

#### **D. Histologic Grade**

"Mitotic count" was changed to "mitotic rate."

Ki-67 Index (%): >2 was changed to 3.

The second to last paragraph was changed to:

This grading system, while based upon that proposed by European Neuroendocrine Tumour Society (ENETS) and the WHO, differs from their system in the designation of G2 tumors as showing mitotic rates of up to 10 per 10 HPF, rather than 20 per 10 HPF,<sup>8</sup> in order to harmonize criteria for "atypical carcinoid" tumors as proposed in the seventh edition of the *AJCC TNM Cancer Staging Manual*<sup>2</sup> with criteria for G2 designation.

In the last paragraph, the word "checklist" was changed to "protocol."

### **References**

Reference #8 was updated.

## Surgical Pathology Cancer Case Summary

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Protocol web posting date: June 2012

### APPENDIX: Excision (Appendectomy) or Resection

Select a single response unless otherwise indicated.

#### Specimen (select all that apply) (Note A)

- Appendix
- Cecum
- Right colon
- Terminal ileum
- Other (specify): \_\_\_\_\_
- Not specified

#### Procedure

- Appendectomy
- Appendectomy and right colectomy
- Other (specify): \_\_\_\_\_

#### Specimen Integrity

- Intact
- Fragmented
  - + Number of pieces in fragmented specimens: \_\_\_\_
- Other (specify): \_\_\_\_\_

#### + Specimen Size

+ Specify: \_\_\_\_ (length) x \_\_\_\_ x \_\_\_\_ cm

#### Tumor Site

- Proximal half of appendix
- Distal half of appendix
- Diffusely involving appendix
- Appendix, not otherwise specified
- Unknown
- Other (specify): \_\_\_\_\_

#### Tumor Size (Note B)

- Greatest dimension: \_\_\_\_ cm
- + Additional dimensions: \_\_\_\_ x \_\_\_\_ cm
- Cannot be determined (see "Comment")

**Histologic Type and Grade (Notes C and D)#**

- Not applicable  
 Well-differentiated neuroendocrine tumor; GX: Grade cannot be assessed  
 Well-differentiated neuroendocrine tumor; G1: Low grade (carcinoid)  
 Well-differentiated neuroendocrine tumor; G2: Intermediate grade (atypical carcinoid)  
 Other (specify): \_\_\_\_\_

# For poorly differentiated (high-grade) neuroendocrine carcinomas (G3), the College of American Pathologists (CAP) protocol for carcinoma of the appendix<sup>1</sup> should be used.

**Mitotic Rate (Note D)**

- Specify: \_\_\_ /10 high-power fields (HPF)  
 Cannot be determined

**Microscopic Tumor Extension**

- Cannot be assessed  
 No evidence of primary tumor  
 Tumor invades lamina propria  
 Tumor invades submucosa  
 Tumor invades muscularis propria  
 Tumor invades subserosal tissue without involvement of visceral peritoneum  
 Tumor extends into mesoappendix  
 Tumor penetrates serosa (visceral peritoneum)  
 Tumor directly invades adjacent structures (specify: \_\_\_\_\_)  
 Tumor penetrates to the surface of the visceral peritoneum (serosa) and directly invades adjacent structures (specify: \_\_\_\_\_)

**Margins (select all that apply) (Note E)**

- If all margins uninvolved by neuroendocrine tumor:  
 Distance of tumor from closest margin: \_\_\_ mm or \_\_\_ cm  
 Specify margin: \_\_\_\_\_

Proximal Margin

- Cannot be assessed  
 Uninvolved by tumor  
 Involved by tumor

Mesenteric (Mesoappendiceal) Margin

- Not applicable  
 Cannot be assessed  
 Uninvolved by tumor  
 Distance of tumor from closest mesenteric margin: \_\_\_ mm or \_\_\_ cm  
 Involved by tumor

Other Margin(s) (required only if applicable)

- Specify margin(s): \_\_\_\_\_  
 Cannot be assessed  
 Uninvolved by neuroendocrine tumor  
 Involved by neuroendocrine tumor

+ Data elements preceded by this symbol are not required. However, these elements may be clinically important but are not yet validated or regularly used in patient management.

**Lymph-Vascular Invasion**

- Not identified  
 Present  
 Indeterminate

**+ Perineural Invasion**

- +  Not identified  
 +  Present  
 +  Indeterminate

**Pathologic Staging (pTNM) (Note F)**

TNM Descriptors (required only if applicable) (select all that apply)

- m (multiple primary tumors)  
 r (recurrent)  
 y (posttreatment)

Primary Tumor (pT)

- pTX: Primary tumor cannot be assessed  
 pT0: No evidence of primary tumor  
 pT1: Tumor 2 cm or less in greatest dimension  
 pT1a: Tumor 1 cm or less in greatest dimension  
 pT1b: Tumor more than 1 cm but not more than 2 cm  
 pT2: Tumor more than 2 cm but not more than 4 cm or with extension to the cecum  
 pT3: Tumor more than 4 cm or with extension to the ileum  
 pT4: Tumor directly invades other adjacent organs or structures, eg, abdominal wall and skeletal muscle

Regional Lymph Nodes

- Cannot be assessed  
 pN0: No regional lymph node metastasis  
 pN1: Metastasis in regional lymph nodes  
  
 No nodes submitted or found

*Number of Lymph Nodes Examined*

- Specify:  \_\_\_\_\_  
 Number cannot be determined (explain): \_\_\_\_\_

*Number of Lymph Nodes Involved*

- Specify:  \_\_\_\_\_  
 Number cannot be determined (explain): \_\_\_\_\_

Distant Metastasis

- Not applicable  
 pM1: Distant metastasis  
     + Specify site(s), if known: \_\_\_\_\_

**+ Ancillary Studies (select all that apply) (Notes D and G)**

- +  Ki-67 labeling index (specify: \_\_\_\_\_)
  - +   $\leq 2\%$
  - +  3% to 20%
  - +   $> 20\%$
- +  Other (specify): \_\_\_\_\_
- +  Not performed

**+ Additional Pathologic Findings (select all that apply) (Note H)**

- +  Tumor necrosis
- +  Acute appendicitis
- +  Other (specify): \_\_\_\_\_

**+ Comment(s)**

## Explanatory Notes

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### A. Application and Tumor Location

This protocol applies to well-differentiated neuroendocrine tumors (carcinoid tumors) of the appendix of any size. Poorly differentiated neuroendocrine carcinomas, small cell carcinomas, and goblet cell carcinoids are not included.

The appendix is a common site of gastrointestinal neuroendocrine tumors, usually presenting as small solitary lesions incidentally discovered after appendectomy. A separate staging system for appendiceal neuroendocrine tumors (NETs) is included in the *AJCC Cancer Staging Manual*<sup>2</sup> because of the substantial differences in behavior between appendiceal carcinomas and NETs and between appendiceal NETs and other gastrointestinal (GI) NETs. Neuroendocrine tumors arising in the appendix have no *in situ* state and arise in the deep mucosa or submucosa. Unlike for adenocarcinomas, for appendiceal NETs, tumor size is a more important predictor of patient outcome than depth of tumor invasion.

### B. Tumor Size

Appendiceal neuroendocrine tumors smaller than 1.0 cm do not recur or metastasize, whereas those between 1.0 and 2.0 cm rarely do.<sup>3</sup> Tumor size >2.0 cm and mesoappendiceal invasion<sup>4</sup> have been correlated with nodal metastasis, but not with poor outcome.<sup>5</sup> For these reasons, appendectomy is sufficient for tumors 1.0 cm or smaller, as well as many tumors between 1.0 and 2.0 cm. More extensive procedures (eg, right hemicolectomy) are usually reserved for patients with tumors larger than 2.0 cm or with invasion beyond the muscularis propria.

### C. Histologic Type

Most appendiceal NETs are low grade, with few mitoses and no necrosis, and have traditionally been classified as “carcinoids.” While the term “atypical carcinoid” is not well defined for GI NETs, the *AJCC Cancer Staging Manual*<sup>2</sup> recommends using this terminology for appendiceal NETs with a mitotic rate of 2 to 10 mitoses per 10 high-power fields and/or focal necrosis. Although the term “carcinoid tumor” remains in widespread use, this term may cause confusion for clinicians, who might view a carcinoid tumor as a serotonin-producing tumor associated with functional manifestations of carcinoid syndrome.

Alternate classification schemes based upon the World Health Organization (WHO) classification categorize neuroendocrine neoplasms as well-differentiated neuroendocrine tumors, well-differentiated neuroendocrine carcinomas, and poorly differentiated neuroendocrine carcinomas.<sup>6-9</sup> Classification of neuroendocrine tumors is based upon size, functionality, site, and invasion. Functioning tumors are those associated with clinical manifestations of hormone production or secretion of measurable amounts of active hormone; immunohistochemical demonstration of hormone production is not equivalent to clinically apparent functionality.

### Alternative Classification Based Upon WHO Classification: Neuroendocrine Tumors of the Appendix

#### Well-Differentiated Neuroendocrine Tumor

*Benign:* Nonfunctioning cytologically bland tumors measuring not more than 1 cm in greatest dimension, without extension into mesoappendix.

*Uncertain malignant potential:* Nonfunctioning cytologically bland tumors measuring 1 to 2 cm with extension into mesoappendix.

#### Well-Differentiated Neuroendocrine Carcinoma

*Low-grade malignant potential:* Nonfunctioning tumors measuring greater than 2 cm and deeply invading the mesoappendix; functioning tumors of any type.

### Histologic Patterns

Although specific histologic patterns in well-differentiated neuroendocrine neoplasms, such as trabecular, insular, and glandular, roughly correlate with tumor location,<sup>10</sup> these patterns have not been clearly shown independently to predict response to therapy or risk of nodal metastasis and are rarely reported in clinical practice.

Most appendiceal neuroendocrine tumors are derived from enterochromaffin cells. Rarely, L-cell neuroendocrine tumors of the appendix are encountered; because of their distinctive growth pattern of tear-dropped shaped tubules embedded in a fibrous stroma,<sup>11</sup> these lesions are sometimes called tubular neuroendocrine tumors. It should be noted that these tumors are negative for chromogranin A but express enteroglucagon, peptide YY, and pancreatic polypeptide. Tubular neuroendocrine tumors are usually small lesions confined to the appendix and are found in female patients. These lesions exhibit benign behavior and should not be confused with adenocarcinoma.

### D. Histologic Grade

Cytologic atypia in low-grade neuroendocrine tumors has no impact on clinical behavior of these tumors. The following grading system is recommended:

Grade	Mitotic Rate (per 10 HPF) #	Ki-67 Index (%)##
G1	<2	≤2
G2	2 to 10	3 to 20
G3	>10	>20

# Mitotic rate should be based upon counting 50 high-power (40x objective) fields and in the area of highest mitotic activity, and reported as number of mitoses per 10 HPF.

## Ki-67 index is reported as percent positive tumor cells in area of highest nuclear labeling. It has been recommended that 2000 tumor cells be counted to determine the Ki-67 index<sup>12</sup>; however, this practice may not be practical for routine clinical purposes, and it is acceptable to estimate the labeling index.

This grading system, while based upon that proposed by European Neuroendocrine Tumour Society (ENETS) and the WHO, differs from their system in the designation of G2 tumors as showing mitotic rates of up to 10 per 10 HPF, rather than 20 per 10 HPF,<sup>8,13</sup> in order to harmonize criteria for "atypical carcinoid" tumors as proposed in the seventh edition of the *AJCC TNM Cancer Staging Manual*<sup>2</sup> with criteria for G2 designation.

G1 and G2 are well-differentiated tumors with diffuse intense chromogranin/synaptophysin positivity. Punctate necrosis is more typical of G2 tumors. G3 tumors are high-grade neuroendocrine carcinomas (the CAP carcinoma protocol for appendiceal carcinoma<sup>1</sup> should be used for poorly differentiated neuroendocrine carcinomas of appendix).

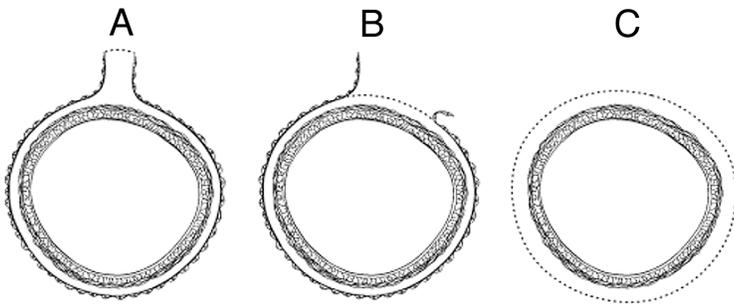
### E. Margins

Margins in a simple appendectomy specimen include the proximal and mesenteric or radial margin. It is recommended that the proximal margin on a simple appendectomy specimen should be taken en face in order to evaluate the entire appendiceal mucosa and muscularis circumferentially. In the vast majority of cases, the appendix is entirely peritonealized, and the closest distance between the invasive carcinoma and the mesenteric resection margin represents the radial margin and should be measured. Even retrocecal appendices are usually invested by peritoneum but have adhered to the posterior cecum, either because of inflammation or tumor. Exceptionally, a retrocecal appendix may be retroperitoneal, in which case the distance between the tumor and the nonperitonealized radial resection margin is the "surgical clearance" and should be measured.

In general, the circumferential (radial) margin must be assessed for any segment of gastrointestinal tract either incompletely encased or unencased by peritoneum (Figure, B and C). The posterior surface of

the ascending colon portion of a right hemicolectomy specimen lacks a peritoneal covering and thus constitutes a circumferential margin, which in rare cases may be relevant in right hemicolectomy specimens resected for treatment of appendiceal neuroendocrine tumors. The circumferential (radial) margin represents the adventitial soft tissue margin closest to the deepest penetration of tumor and is created surgically by blunt or sharp dissection of the retroperitoneal or subperitoneal aspect, respectively. The distance between the tumor and circumferential (radial) margin should be reported, if applicable. The circumferential (radial) margin is considered negative if the tumor is more than 1 mm from the inked nonperitonealized surface, but should be recorded as positive if the tumor is located 1 mm or less from the nonperitonealized surface. This assessment includes tumor within a lymph node as well as direct tumor extension, but if circumferential (radial) margin positivity is based solely on intranodal tumor, this should be so stated.

The mesenteric resection margin is the only relevant circumferential margin in segments completely encased by peritoneum (eg, appendix and cecum) (Figure, A). Involvement of this margin should be reported even if tumor does not penetrate the serosal surface.



A, Mesenteric margin in viscus completely encased by peritoneum (dotted line). B, Circumferential (radial) margin (dotted line) in viscus incompletely encased by peritoneum. C, Circumferential (radial) margin (dotted line) in viscus completely unencased by peritoneum. Reproduced with permission from Washington et al.<sup>15</sup> Copyright 2008. College of American Pathologists.

#### F. TNM and Anatomic Stage/Prognostic Groupings

The TNM staging system for appendiceal NETs of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) is recommended.<sup>2</sup>

By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination. pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions. Clinical classification (cTNM) is usually carried out by the referring physician before treatment during initial evaluation of the patient or when pathologic classification is not possible.

Pathologic staging is usually performed after surgical resection of the primary tumor. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed. If a biopsied tumor is not resected for any reason (eg, when technically unfeasible) and if the highest T and N categories or the M1 category of the tumor can be confirmed microscopically, the criteria for pathologic classification and staging have been satisfied without total removal of the primary cancer.

**TNM Descriptors**

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

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

The “y” prefix indicates those cases in which classification is performed during or following initial multimodality therapy (ie, neoadjuvant chemotherapy, radiation therapy, or both chemotherapy and radiation therapy). The cTNM or pTNM category is identified by a “y” prefix. The ycTNM or ypTNM categorizes the extent of tumor actually present at the time of that examination. The “y” categorization is not an estimate of tumor prior to multimodality therapy (ie, before initiation of neoadjuvant therapy).

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

The “a” prefix designates the stage determined at autopsy: aTNM.

**T Category Considerations**

Tumor that is adherent to other organs or structures, macroscopically, is classified T4. However, if no tumor is present in the adhesion, microscopically the classification should be pT1 to pT3.

**N Category Considerations**

The regional lymph nodes for the appendix are the ileocolic lymph nodes.

**pTNM Pathological Classification**

The pT, pN, and pM categories correspond to the T, N, and M categories except that pM0 (no distant metastasis) does not exist as a category.

**pN0.** Histologic examination of a regional lymphadenectomy specimen will ordinarily include 12 or more lymph nodes. If the lymph node results are negative, but the number ordinarily examined is not met, classify as pN0.

**Histopathologic Grading**

Histologic grading is not required for carcinoid tumors, but a mitotic rate of 2 to 10 per 10 HPF and/or focal necrosis are features of atypical carcinoids (well-differentiated neuroendocrine carcinomas), a type seen much more commonly in the lung than in the appendix.

Goblet cell carcinoids are classified according to the carcinoma scheme.

**TNM Anatomic Stage/Prognostic Groupings**

Stage I	T1	N0	M0
Stage II	T2 or T3	N0	M0
Stage III	T4	N0	M0
	Any T	N1	M0
Stage IV	Any T	Any N	M1

**G. Ancillary Studies**

Immunohistochemistry and other ancillary techniques are generally not required to diagnose well-differentiated neuroendocrine tumors. Specific markers that may be used to establish neuroendocrine differentiation include chromogranin A, neuron-specific enolase, synaptophysin, and CD56.<sup>9</sup> Because of their relative sensitivity and specificity, chromogranin A and synaptophysin are recommended. It should be noted that hindgut neuroendocrine tumors often do not express appreciable amounts of

chromogranin A. Rectal neuroendocrine tumors express prostatic acid phosphatase, a potential diagnostic pitfall for tumors arising in male patients.<sup>14</sup>

Immunohistochemistry for Ki-67 may be useful in establishing tumor grade (Note D) and prognosis<sup>12</sup> but is not currently considered standard of care.<sup>9</sup>

#### H. Additional Pathologic Findings

Coagulative tumor necrosis, usually punctate, may indicate more aggressive behavior<sup>13</sup> and should be reported. Appendiceal NETs are often an incidental finding in specimens removed for acute appendicitis.

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