Protocol for the Examination of Specimens From Patients With Neuroendocrine Tumors (Carcinoid Tumors) of the Jejunum and Ileum

Version: Jejunum/IleumNET 1.0.0.1  Protocol Posting Date: June 2017
Includes pTNM requirements from the 8th Edition, AJCC Staging Manual

For accreditation purposes, this protocol should be used for the following procedures AND tumor types:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resection</td>
<td>Includes specimens designated segmental resection – small intestine and ileocelecity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-differentiated tumor of the jejunum and ileum</td>
<td></td>
</tr>
</tbody>
</table>

This protocol is NOT required for accreditation purposes for the following:

<table>
<thead>
<tr>
<th>Procedure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy</td>
<td></td>
</tr>
<tr>
<td>Primary resection specimen with no residual cancer (e.g., following neoadjuvant therapy)</td>
<td></td>
</tr>
<tr>
<td>Recurrent tumor</td>
<td></td>
</tr>
<tr>
<td>Cytologic specimens</td>
<td></td>
</tr>
</tbody>
</table>

The following tumor types should NOT be reported using this protocol:

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-differentiated tumor of the duodenum and ampulla (consider the Duodenum and Ampulla Carcinoma protocol)</td>
<td></td>
</tr>
<tr>
<td>Poorly differentiated neuroendocrine carcinoma including small cell and large cell neuroendocrine carcinoma (consider the Small Intestine protocol)</td>
<td></td>
</tr>
<tr>
<td>Other epithelial tumors including mixed adenoneuroendocrine carcinoma (consider the Small Intestine protocol)</td>
<td></td>
</tr>
<tr>
<td>Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal stromal tumor (GIST) (consider the GIST protocol)</td>
<td></td>
</tr>
<tr>
<td>Non-GIST sarcoma (consider the Soft Tissue protocol)</td>
<td></td>
</tr>
</tbody>
</table>

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With guidance from the CAP Cancer and CAP Pathology Electronic Reporting Committees.
* Denotes primary author. All other contributing authors are listed alphabetically.
Accreditation Requirements
This protocol can be utilized for a variety of procedures and tumor types for clinical care purposes. For accreditation purposes, only the definitive primary cancer resection specimen is required to have the core and conditional data elements reported in a synoptic format.

- **Core data elements** are required in reports to adequately describe appropriate malignancies. For accreditation purposes, essential data elements must be reported in all instances, even if the response is “not applicable” or “cannot be determined.”

- **Conditional data elements** are only required to be reported if applicable as delineated in the protocol. For instance, the total number of lymph nodes examined must be reported, but only if nodes are present in the specimen.

- **Optional data elements** are identified with “+” and although not required for CAP accreditation purposes, may be considered for reporting as determined by local practice standards.

The use of this protocol is not required for recurrent tumors or for metastatic tumors that are resected at a different time than the primary tumor. Use of this protocol is also not required for pathology reviews performed at a second institution (ie, secondary consultation, second opinion, or review of outside case at second institution).

Synoptic Reporting
All core and conditionally required data elements outlined on the surgical case summary from this cancer protocol must be displayed in synoptic report format. Synoptic format is defined as:

- Data element: followed by its answer (response), outline format without the paired “Data element: Response” format is NOT considered synoptic.

- The data element should be represented in the report as it is listed in the case summary. The response for any data element may be modified from those listed in the case summary, including “Cannot be determined” if appropriate.

- Each diagnostic parameter pair (Data element: Response) is listed on a separate line or in a tabular format to achieve visual separation. The following exceptions are allowed to be listed on one line:
  - Anatomic site or specimen, laterality, and procedure
  - Pathologic Stage Classification (pTNM) elements
  - Negative margins, as long as all negative margins are specifically enumerated where applicable

- The synoptic portion of the report can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all Data element: Responses must be listed together in one location. Organizations and pathologists may choose to list the required elements in any order, use additional methods in order to enhance or achieve visual separation, or add optional items within the synoptic report. The report may have required elements in a summary format elsewhere in the report IN ADDITION TO but not as replacement for the synoptic report i.e. all required elements must be in the synoptic portion of the report in the format defined above.

CAP Laboratory Accreditation Program Protocol Required Use Date: March 2018*
* Beginning January 1, 2018, the 8th edition AJCC Staging Manual should be used for reporting pTNM.

CAP Jejunum/Ileum NET Protocol Summary of Changes

**Version 1.0.0.1**
Corrected Notes for area on table to 2mm²

**Version 1.0.0.0**
The Small Intestine NET protocol was divided into 2 separate new protocols: Duodenum/Ampulla NET and Jejunum/Ileum NET protocols.
Surgical Pathology Cancer Case Summary

Protocol posting date: June 2017

JEJUNUM AND ILEUM NEUROENDOCRINE TUMOR

Select a single response unless otherwise indicated.

Procedure
___ Segmental resection, small intestine
___ Ileocolic resection
___ Other (specify): _________________________
___ Not specified

Tumor Site (Notes A and B)
___ Jejunum
___ Ileum
___ Small intestine, not otherwise specified
___ Other (specify): __________________________

Tumor Size (Note C)
Greatest dimension (centimeters): ___ cm (specify size of largest tumor if multiple tumors are present)
+ Additional dimensions (centimeters): ___ x ___ cm
___ Cannot be determined (explain): __________________________

Tumor Focality
___ Unifocal
___ Multifocal (specify number of tumors): ______
___ Cannot be determined

Histologic Type and Grade (Notes D and E)
___ G1: Well-differentiated neuroendocrine tumor
___ G2: Well-differentiated neuroendocrine tumor
___ G3: Well-differentiated neuroendocrine tumor
___ Other (specify): __________________________
___ GX: Well-differentiated neuroendocrine tumor, grade cannot be assessed
___ Not applicable

Note: For poorly differentiated (high-grade) neuroendocrine carcinomas arising in the jejunum or ileum, the College of American Pathologists (CAP) protocol for carcinoma of the small intestine should be used.¹

Mitotic rate and/or Ki-67 labeling index is required to determine histologic grade

Mitotic Rate (Note E)
___ <2 mitoses/2mm²
___ 2-20 mitoses/2mm²
   + Specify mitoses per 2mm²: ______
___ >20 mitoses per 2mm²
   + Specify mitoses per 2mm²: ______
___ Cannot be determined (explain): __________________________
___ Not applicable

¹ Mitotic rate should be reported as number of mitoses per 2 mm², by evaluating at least 10 mm² in the most mitotically active part of the tumor (eg, if using a microscope with a field diameter of 0.55 mm, count 42 high-power fields [10 mm²] and divide the resulting number of mitoses by 5 to determine the number of mitoses per 2 mm² needed to assign tumor grade).

+ Data elements preceded by this symbol are not required for accreditation purposes. These optional elements may be clinically important but are not yet validated or regularly used in patient management.
Ki-67 Labeling Index (Note E)

___ <3%
___ 3% to 20%
   + Specify Ki-67 percentage: ____%
___ >20%
   + Specify Ki-67 percentage: ____%
___ Cannot be determined (explain): __________________________
___ Not applicable

Tumor Extension

___ No evidence of primary tumor
___ Tumor invades the lamina propria
___ Tumor invades the submucosa
___ Tumor invades the muscularis propria
___ Tumor invades through the muscularis propria into subserosal tissue without penetration of overlying serosa
___ Tumor invades visceral peritoneum (serosa)
___ Tumor invades other organs or adjacent structures (specify): _____________________
___ Cannot be assessed

Margins

Note: Use this section only if all margins are uninvolved and all margins can be assessed.

___ All margins are uninvolved by tumor
   
  Margins examined: _________________________
   
Note: Margins may include proximal, distal, radial or mesenteric, and others.
   
+ Distance of tumor from closest margin (millimeters or centimeters): ___ mm or ___ cm
   
+ Specify closest margin: __________________________

Individual margin reporting required if any margins are involved or margin involvement cannot be assessed

Proximal Margin

___ Cannot be assessed
___ Uninvolved by tumor
___ Involved by tumor

Distal Margin

___ Cannot be assessed
___ Uninvolved by tumor
___ Involved by tumor

Radial or Mesenteric Margin (Note F)

___ Cannot be assessed
___ Uninvolved by tumor
___ Involved by tumor

Other Margin(s) (required only if applicable)

Specify margin(s): ________________________________

___ Cannot be assessed
___ Uninvolved by tumor
___ Involved by tumor

Lymphovascular Invasion

___ Not identified
___ Present
___ Cannot be determined

+ Data elements preceded by this symbol are not required for accreditation purposes. These optional elements may be clinically important but are not yet validated or regularly used in patient management.
Perineural Invasion
+ Not identified
+ Present
+ Cannot be determined

Large Mesenteric Masses (>2 cm) (Note G)
+ Not identified
+ Present
+ Specify number: ____
+ Cannot be determined

Regional Lymph Nodes
+ No lymph nodes submitted or found

Lymph Node Examination (required only if lymph nodes are present in the specimen)
Number of Lymph Nodes Involved: ____
+ Number cannot be determined (explain): ______________________

Number of Lymph Nodes Examined: ____
+ Number cannot be determined (explain): ______________________

Pathologic Stage Classification (pTNM, AJCC 8th Edition) (Note G)
Note: Reporting of pT, pN, and (when applicable) pM categories is based on information available to the pathologist at the time the report is issued. Only the applicable T, N, or M category is required for reporting; their definitions need not be included in the report. The categories (with modifiers when applicable) can be listed on 1 line or more than 1 line.

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#: Invades the lamina propria or submucosa and less than or equal to 1 cm in size
+ pT2#: Invades the muscularis propria or greater than 1 cm in size
+ pT3#: Invades through the muscularis propria into subserosal tissue without penetration of overlying serosa
+ pT4#: Invades visceral peritoneum (serosal) or other organs or adjacent structures

# Note: For any T, add (m) for multiple tumors [TX(#) or TX(m), where X = 1–4, and # = number of primary tumors identified##]; for multiple tumors with different T, use the highest.

## Example: If there are 2 primary tumors, only 1 of which invades through the muscularis propria into subserosal tissue without penetration of overlying serosa (jejunal or ileal), we define the primary tumor as either T3(2) or T3(m).

Regional Lymph Nodes (pN)
+ pNX: Regional lymph nodes cannot be assessed
+ pN0: No regional lymph node metastasis has occurred
+ pN1: Regional lymph node metastasis less than 12 nodes
+ pN2: Large mesenteric masses (>2 cm) and/or extensive nodal deposits (12 or greater), especially those that encase the superior mesenteric vessels

+ Data elements preceded by this symbol are not required for accreditation purposes. These optional elements may be clinically important but are not yet validated or regularly used in patient management.
Distant Metastasis (pM) (required only if confirmed pathologically in this case)
___ pM1: Distant metastasis
___ pM1a: Metastasis confined to liver
___ pM1b: Metastasis in at least one extrahepatic site (eg, lung, ovary, nonregional lymph node, peritoneum, bone)
    Specify site(s), if known: __________________________
___ pM1c: Both hepatic and extrahepatic metastases
    Specify site(s), if known: __________________________

+ Additional Pathologic Findings (select all that apply) (Note H)
+ ___ None identified
+ ___ Tumor necrosis
+ ___ Mesenteric tumor deposit(s) ≤2 cm
+ ___ Mesenteric vascular elastosis
+ ___ Other (specify): __________________________

+ Comment(s)
Explanatory Notes

A. Application and Tumor Location
This protocol applies to well-differentiated neuroendocrine tumors (carcinoid tumors) of the jejunum and ileum. Poorly differentiated neuroendocrine carcinomas (small cell carcinomas and large cell neuroendocrine carcinomas) and tumors with mixed glandular/neuroendocrine differentiation are not included.1 Neuroendocrine tumors of the duodenum and ampulla of Vater use a separate CAP cancer protocol.2

Because of site-specific similarities in histology, immunohistochemistry, and histochemistry, neuroendocrine tumors of the digestive tract have traditionally been subdivided into those of foregut, midgut, and hindgut origin (Table 1). In general, the distribution pattern along the gastrointestinal (GI) tract parallels that of the progenitor cell type, and the anatomic site of origin of GI neuroendocrine tumors is an important predictor of clinical behavior.3

Table 1. Site of Origin of Gastrointestinal Neuroendocrine Tumors

<table>
<thead>
<tr>
<th>Site</th>
<th>Foregut Tumors</th>
<th>Midgut Tumors</th>
<th>Hindgut Tumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach, Proximal Duodenum</td>
<td>Jejunum, Ileum, Appendix, Proximal Colon</td>
<td>Distal Colon, Rectum</td>
<td></td>
</tr>
<tr>
<td>Immunohistochemistry</td>
<td>Chromogranin A</td>
<td>Synaptophysin</td>
<td>Serotonin</td>
</tr>
<tr>
<td>86%-100% +</td>
<td>82%-92% +</td>
<td>40%-58% +</td>
<td></td>
</tr>
<tr>
<td>50% +</td>
<td>95%-100% +</td>
<td>94%-100% +</td>
<td></td>
</tr>
<tr>
<td>33% +</td>
<td>86% +</td>
<td>45%-83% +</td>
<td></td>
</tr>
<tr>
<td>Other Immunohistochemical Markers</td>
<td>Rarely, + for pancreatic polypeptide, histamine, gastrin, vasoactive intestinal peptide (VIP), or adrenocorticotropic hormone (ACTH)</td>
<td>Prostatic acid phosphatase + in 20%-40%</td>
<td>Prostatic acid phosphatase + in 20%-82%</td>
</tr>
</tbody>
</table>

B. Site-Specific Features
The small intestine is the most common primary site for neuroendocrine tumors.4-6 Most small intestine neuroendocrine tumors occur in the distal ileum. Multiple tumors are found in 25% to 40% of cases and may be associated with a worse outcome.7 Primary jejunal and ileal tumors are often small and asymptomatic. However, extensive fibrosis can form when they invade deep soft tissue (eg, mesenteric soft tissue), causing small bowel obstruction and small bowel ischemia due to encasement of the superior mesenteric vessels. In addition, about 50% of patients with jejunoileal neuroendocrine tumor have liver metastasis as the initial presentation, and patients with liver metastasis can have carcinoid syndrome (eg, flushing, diarrhea, and wheezing). Metastatic risk is increased by tumor size >2 cm, involvement of the muscularis propria, and mitotic activity.3

C. Tumor Size
For neuroendocrine tumors in any part of the gastrointestinal tract, size greater than 2.0 cm is associated with a higher risk of lymph node metastasis. For jejunoileal tumors, nodal metastases occur in about 12% of patients with tumors smaller than 1.0 cm and in most patients with tumors larger than 1.0 cm.3 Thus, treatment for small intestine neuroendocrine tumor includes complete resection with regional lymphadenectomy.

D. Histologic Type
The World Health Organization (WHO) classifies neuroendocrine neoplasms as well-differentiated neuroendocrine tumors (either the primary tumor or metastasis) and poorly differentiated neuroendocrine carcinomas.8 Historically, well-differentiated neuroendocrine tumors have been referred to as “carcinoid tumors,” a term which may cause confusion because clinically a carcinoid tumor is a serotonin-producing tumor associated with functional manifestations of carcinoid syndrome. The use of the term “carcinoid” for neuroendocrine tumor reporting is therefore discouraged for these reasons.
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.

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, synaptophysin, and CD56. Because of their relative sensitivity and specificity, chromogranin A and synaptophysin are recommended.

E. Histologic Grade
Cytologic atypia in well-differentiated neuroendocrine tumors has no impact on clinical behavior of these tumors. The WHO classification and others use mitotic rate and/or Ki-67 index as one of the criteria for potential for aggressive behavior. Mitotic rate should be reported as number of mitoses per 2 mm², by evaluating at least 10 mm² in the most mitotically active part of the tumor. Only clearly identifiable mitotic figures should be counted; hyperchromatic, karyorrhectic, or apoptotic nuclei are excluded. Because of variations in field size, the number of high-power field (HPF) (at 40X magnification) for 10 mm² (thereby 2 mm²) must be determined for each microscope (Table 2). For example, if using a microscope with a field diameter of 0.55 mm, count 42 HPF and divide the resulting number of mitoses by 5 to determine the number of mitoses per 2 mm² needed to assign tumor grade.

**Table 2. Number of HPF Required for 10 mm² Using Microscopes With Different Field Diameter**

<table>
<thead>
<tr>
<th>Field Diameter (mm)</th>
<th>Area (mm²)</th>
<th>Number of HPF for 10 mm²</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.40</td>
<td>0.125</td>
<td>80</td>
</tr>
<tr>
<td>0.41</td>
<td>0.132</td>
<td>75</td>
</tr>
<tr>
<td>0.42</td>
<td>0.139</td>
<td>70</td>
</tr>
<tr>
<td>0.43</td>
<td>0.145</td>
<td>69</td>
</tr>
<tr>
<td>0.44</td>
<td>0.152</td>
<td>65</td>
</tr>
<tr>
<td>0.45</td>
<td>0.159</td>
<td>63</td>
</tr>
<tr>
<td>0.46</td>
<td>0.166</td>
<td>60</td>
</tr>
<tr>
<td>0.47</td>
<td>0.173</td>
<td>58</td>
</tr>
<tr>
<td>0.48</td>
<td>0.181</td>
<td>55</td>
</tr>
<tr>
<td>0.49</td>
<td>0.189</td>
<td>53</td>
</tr>
<tr>
<td>0.50</td>
<td>0.196</td>
<td>50</td>
</tr>
<tr>
<td>0.51</td>
<td>0.204</td>
<td>49</td>
</tr>
<tr>
<td>0.52</td>
<td>0.212</td>
<td>47</td>
</tr>
<tr>
<td>0.53</td>
<td>0.221</td>
<td>45</td>
</tr>
<tr>
<td>0.54</td>
<td>0.229</td>
<td>44</td>
</tr>
<tr>
<td>0.55</td>
<td>0.238</td>
<td>42</td>
</tr>
<tr>
<td>0.56</td>
<td>0.246</td>
<td>41</td>
</tr>
<tr>
<td>0.57</td>
<td>0.255</td>
<td>39</td>
</tr>
<tr>
<td>0.58</td>
<td>0.264</td>
<td>38</td>
</tr>
<tr>
<td>0.59</td>
<td>0.273</td>
<td>37</td>
</tr>
<tr>
<td>0.60</td>
<td>0.283</td>
<td>35</td>
</tr>
</tbody>
</table>
Ki-67 index is reported as percent positive tumor cells in area of highest nuclear labeling (“hot spot”), although the precise method of assessment has not been standardized. A number of methods have been used to assess Ki-67 index, including automatic counting and “eyeballing.” Automated counting is not widely available and requires careful modification of the software to circumvent the inaccuracies. Eye-balling can be used for most tumors; however, for tumors with Ki-67 index close to grade cut-offs, it is recommended to perform the manual count on the print of camera-captured image of the hot spot. It has been recommended that a minimum of 500 tumor cells be counted to determine the Ki-67 index, and a notation is made if less cells are available. Grade assigned based on Ki-67 index is typically higher than that based on mitotic count, and the case is assigned to the higher of the 2 if both methods are performed.

It is important to note that there are a small group of well-differentiated neuroendocrine tumors with a Ki-67 index >20% and a mitotic rate usually <20 per 10 HPF. In WHO-2010, these tumors were considered as G3 poorly differentiated neuroendocrine carcinomas. However, they have typical morphology of well-differentiated tumors. Previous studies (most on pancreatic neuroendocrine tumors) have demonstrated that these tumors have a worse prognosis than grade 2 (Ki-67=3-20% and mitosis <20/10 HPF) neuroendocrine tumors, but they are not as aggressive as poorly differentiated neuroendocrine carcinomas. In addition, these tumors do not have the genetic abnormalities seen in poorly differentiated neuroendocrine carcinomas. Furthermore, unlike poorly differentiated neuroendocrine carcinomas, they are less responsive to platinum-based chemotherapy. In the WHO-2017 blue book of endocrine tumors and AJCC 8th edition, those with typical morphology of well-differentiated tumors are classified as “well differentiated neuroendocrine tumor” but as grade 3. Here, the updated classification for “endocrine” tumors is adapted, and following grading scheme is recommended to grade well-differentiated gastroenteropancreatic neuroendocrine tumors (Table 3).

Table 3
Recommended Grading System for Well-Differentiated Gastroenteropancreatic Neuroendocrine Tumors

<table>
<thead>
<tr>
<th>Grade</th>
<th>Mitotic Rate (per 2mm²)</th>
<th>Ki-67 Index (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-differentiated neuroendocrine tumor, G1</td>
<td>&lt;2</td>
<td>&lt;3</td>
</tr>
<tr>
<td>Well-differentiated neuroendocrine tumor, G2</td>
<td>2 to 20</td>
<td>3 to 20</td>
</tr>
<tr>
<td>Well-differentiated neuroendocrine tumor, G3</td>
<td>&gt;20</td>
<td>&gt;20</td>
</tr>
</tbody>
</table>

F. Circumferential (Radial or Mesenteric) Margin
In addition to addressing the proximal and distal margins, assessment of the circumferential (radial) margin is necessary for any segment of gastrointestinal tract either unencased (Figure, C) or incompletely encased by peritoneum (Figure, B). The circumferential 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 positive if the tumor is present at the inked 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, jejunum and ileum) (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.

G. Pathologic Stage Classification

The TNM staging system for neuroendocrine tumors of the jejunum and ileum of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) is recommended.15

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.

N Category Considerations
For ileal and jejunal tumors, the regional lymph nodes are the cecal (for tumors arising in the terminal ileum), superior mesenteric, and mesenteric nodes. Metastases to celiac nodes are considered distant metastases.

Mesenteric masses are defined as discrete but irregular mesenteric tumor nodules frequently located adjacent to neurovascular bundles and discontinuous from the primary neoplasm. Mesenteric masses are often associated with dense fibrosis, causing ecasement of large mesenteric vessels. The presence of mesenteric masses has also been associated with frequent liver metastasis and a poor prognosis.

**M Category Considerations**

The liver is the most common metastatic site. Metastases to extrahepatic sites, such as lung, ovary, peritoneum, and bone, are rare. Involvement of the celiac, para-aortic, and other nonregional lymph nodes is also considered M1 disease. In the AJCC 8th edition, M is subcategorized into M1a (hepatic only), M1b (extrahepatic only), and M1c (both hepatic and extrahepatic).

**H. Additional Pathologic Findings**

Mesenteric vascular changes (elastic vascular sclerosis) associated with midgut carcinoids may produce arterial luminal narrowing due to concentric accumulation of elastic tissue in the adventitia. These vascular changes may lead to intestinal ischemia and frank necrosis.

**References**


