



Protocol for the Examination of Specimens From Patients With Primary Carcinoma of the Uterine Cervix

Version: UterineCervix 4.0.0.1

Protocol Posting Date: June 2017

Includes pTNM requirements from the 8th Edition, AJCC Staging Manual and 2015 FIGO Cancer Report

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

Procedure	Description
Resection	Includes radical trachelectomy, radical hysterectomy, or pelvic exenteration
Tumor Type	Description
Carcinoma	
Carcinosarcoma	

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

Procedure
Biopsy, includes Excision (Cone/LEEP)
Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)
Cytologic specimens

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

Tumor Type
Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)
Sarcoma (consider Uterine Sarcoma protocol)

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With guidance from the CAP Cancer and CAP Pathology Electronic Reporting Committees.

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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 must 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 Uterine Cervix Protocol Summary of Changes

Version 4.0.0.1 errata:

Stromal Invasion

- **MODIFIED** Horizontal extent longitudinal/length (if applicable[#]) (millimeters): ___ mm
- **MODIFIED** Horizontal extent circumferential/width (if applicable[#]) (millimeters): ___ mm

[#]*Not applicable in larger tumors that can be measured grossly.*

Version 4.0.0.0

The following data elements were modified:

Pathologic Staging Classification (pTNM) has been updated per AJCC 8th Edition. Additional revisions to this protocol have been made to support the AJCC 8th Edition elements and prognostic factors important to the treatment of the patient.

Surgical Pathology Cancer Case Summary

Protocol posting date: June 2017

UTERINE CERVIX: Excision

Note: This case summary is recommended for reporting excision specimens, but is not required for accreditation purposes.

Select a single response unless otherwise indicated.

Procedure

- Cold knife cone excision
- Loop electrical excision procedure (LEEP)/large loop excision of the transformation zone (LLETZ)
- Other (specify): _____
- Not specified

+ Tumor Site (select all that apply) (Notes A, B, and C)

- + Left superior (anterior) quadrant (12 to 3 o'clock)
- + Left inferior (posterior) quadrant (3 to 6 o'clock)
- + Right inferior (posterior) quadrant (6 to 9 o'clock)
- + Right superior (anterior) quadrant (9 to 12 o'clock)
- + Other (specify): _____
- + Cannot be determined (explain): _____

Tumor Size (Note C)

- Greatest dimension (centimeters): ____ cm
- + Additional dimensions (centimeters): ____ x ____ cm
- Cannot be determined (explain): _____

Note: All dimensions are important; see definition for "superficially invasive squamous cell carcinoma" under T1a1/IA1.

Histologic Type (Note D)

- Squamous cell carcinoma, NOS
- Squamous cell carcinoma, keratinizing
- Squamous cell carcinoma, nonkeratinizing
- Squamous cell carcinoma, basaloid
- Squamous cell carcinoma, verrucous
- Squamous cell carcinoma, warty
- Squamous cell carcinoma, papillary
- Squamous cell carcinoma, lymphoepithelioma-like
- Squamous cell carcinoma, squamotransitional
- Endocervical adenocarcinoma, usual type
- Mucinous carcinoma, NOS
- Mucinous carcinoma, intestinal type
- Mucinous carcinoma, signet-ring cell type
- Mucinous carcinoma, gastric type
- Villoglandular carcinoma
- Endometrioid carcinoma
- Clear cell carcinoma
- Serous carcinoma
- Mesonephric carcinoma
- Adenocarcinoma admixed with neuroendocrine carcinoma
- Adenosquamous carcinoma
- Adenosquamous carcinoma, glassy cell variant
- Adenoid cystic carcinoma

+ 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.

- Adenoid basal carcinoma
- Small cell neuroendocrine carcinoma
- Large cell neuroendocrine carcinoma
- Undifferentiated carcinoma
- Carcinosarcoma
- Other histologic type not listed (specify): _____
- Carcinoma, type cannot be determined

Histologic Grade (Note E)

- G1: Well differentiated
- G2: Moderately differentiated
- G3: Poorly differentiated
- GX: Cannot be assessed
- Not applicable

Stromal Invasion (Note C)

- Depth of stromal invasion (millimeters): ____ mm
- Depth cannot be determined (explain): _____

- Horizontal extent longitudinal/length (if applicable[#]) (millimeters): ____ mm
- Extent cannot be determined (explain): _____

- Horizontal extent circumferential/width (if applicable[#]) (millimeters): ____ mm
- Extent cannot be determined (explain): _____

[#]Not applicable in larger tumors that can be measured grossly.

Margins (Note F)

Endocervical Margin

- Cannot be assessed (explain): _____
- Uninvolved by invasive carcinoma
 - + Distance of invasive carcinoma from margin (millimeters): ____ mm
 - + Specify location: _____
- Involved by invasive carcinoma
 - Specify location, if possible: _____
- Uninvolved by intraepithelial neoplasia
- Involved by high-grade squamous intraepithelial lesion (CIN 2-3)
 - + Specify location: _____
- Involved by adenocarcinoma in situ (AIS)
 - + Specify location: _____

Ectocervical Margin

- Cannot be assessed (explain): _____
- Uninvolved by invasive carcinoma
 - + Distance of invasive carcinoma from margin (millimeters): ____ mm
 - + Specify location: _____
- Involved by invasive carcinoma
 - Specify location, if possible: _____
- Uninvolved by intraepithelial neoplasia
- Involved by high-grade squamous intraepithelial lesion (CIN 2-3)
 - + Specify location: _____
- Involved by adenocarcinoma in situ (AIS)
 - + Specify location: _____

+ 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.

Deep Margin

- Cannot be assessed (explain): _____
- Uninvolved by invasive carcinoma
 - + Distance of invasive carcinoma from margin (millimeters): ____ mm
 - + Specify location: _____
- Involved by invasive carcinoma
 - Specify location, if possible: _____
- Uninvolved by intraepithelial neoplasia
- Involved by high-grade squamous intraepithelial lesion (CIN 2-3)
 - + Specify location: _____
- Involved by adenocarcinoma in situ (AIS)
 - + Specify location: _____

Lymphovascular Invasion (Note G)

- Not identified
- Present
- Cannot be determined

+ Additional Pathologic Findings (select all that apply)

- + None identified
- + Low-grade squamous intraepithelial lesion (CIN 1)
- + High-grade squamous intraepithelial lesion (CIN 2 or 3)
- + Inflammation
- + Other (specify): _____

+ Comment(s)

Surgical Pathology Cancer Case Summary

Protocol posting date: June 2017

UTERINE CERVIX: Resection**Select a single response unless otherwise indicated.****Procedure (select all that apply) (Notes A and H)**

- Trachelectomy
 Radical hysterectomy
 Simple hysterectomy
 Pelvic exenteration (specify included organs): _____
 Bilateral salpingo-oophorectomy
 Right salpingo-oophorectomy
 Left salpingo-oophorectomy
 Salpingo-oophorectomy, side not specified
 Right oophorectomy
 Left oophorectomy
 Oophorectomy, side not specified
 Bilateral salpingectomy
 Right salpingectomy
 Left salpingectomy
 Salpingectomy, side not specified
 Vaginal cuff resection
 Omentectomy
 Other (specify): _____

*Note: For information about lymph node sampling, please refer to the Regional Lymph Node section.***+ Hysterectomy Type**

- Abdominal
 Vaginal
 Vaginal, laparoscopic-assisted
 Laparoscopic
 Laparoscopic, robotic-assisted
 Other (specify): _____
 Not specified

Tumor Size (Note C)

- Greatest dimension (centimeters): ___ cm
 + Additional dimensions (centimeters): ___ x ___ cm
 Cannot be determined (explain): _____

*Note: All dimensions are important; see definition for "superficially invasive squamous cell carcinoma" under T1a1/IA1.***+ Tumor Site (select all that apply)**

- Left superior (anterior) quadrant (12 to 3 o'clock)
 Left inferior (posterior) quadrant (3 to 6 o'clock)
 Right inferior (posterior) quadrant (6 to 9 o'clock)
 Right superior (anterior) quadrant (9 to 12 o'clock)
 Other (specify): _____
 Not specified

Histologic Type (Note D)

- Squamous cell carcinoma, NOS
- Squamous cell carcinoma, keratinizing
- Squamous cell carcinoma, nonkeratinizing
- Squamous cell carcinoma, basaloid
- Squamous cell carcinoma, verrucous
- Squamous cell carcinoma, warty
- Squamous cell carcinoma, papillary
- Squamous cell carcinoma, lymphoepithelioma-like
- Squamous cell carcinoma, squamotransitional
- Endocervical adenocarcinoma, usual type
- Mucinous carcinoma, NOS
- Mucinous carcinoma, intestinal type
- Mucinous carcinoma, signet-ring cell type
- Mucinous carcinoma, gastric type
- Villoglandular carcinoma
- Endometrioid carcinoma
- Clear cell carcinoma
- Serous carcinoma
- Mesonephric carcinoma
- Adenocarcinoma admixed with neuroendocrine carcinoma
- Adenosquamous carcinoma
- Adenosquamous carcinoma, glassy cell variant
- Adenoid cystic carcinoma
- Adenoid basal carcinoma
- Small cell neuroendocrine carcinoma
- Large cell neuroendocrine carcinoma
- Undifferentiated carcinoma
- Carcinosarcoma
- Other histologic type not listed (specify): _____
- Carcinoma, type cannot be determined

Histologic Grade (Note E)

- G1: Well differentiated
- G2: Moderately differentiated
- G3: Poorly differentiated
- GX: Cannot be assessed
- Not applicable

Stromal Invasion (Note C)

Depth of stromal invasion (millimeters): ____ mm
 Depth cannot be determined (explain): _____

Horizontal extent longitudinal/length (if applicable[#]) (millimeters): ____ mm
 Extent cannot be determined (explain): _____

Horizontal extent circumferential/width (if applicable[#]) (millimeters): ____ mm
 Extent cannot be determined (explain): _____

[#]Not applicable in larger tumors that can be measured grossly.

Other Tissue/ Organ Involvement (select all that apply)

Note: Any organ not selected is either not involved or was not submitted.

- Not applicable
- Not identified
- Right parametrium

+ 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.

- Left parametrium
- Parametrium (side not specified)
- Vagina, upper two-thirds
- Vagina, lower one-third
- Vagina (location not specified)
- Right ovary
- Left ovary
- Ovary (side not specified)
- Right fallopian tube
- Left fallopian tube
- Fallopian tube (side not specified)
- Pelvic wall
- Bladder wall
- Bladder mucosa
- Rectal wall
- Bowel mucosa
- Omentum
- Other organs/tissue (specify): _____
- Cannot be determined (explain): _____

Margins (Note F)Ectocervical Margin

- Cannot be assessed (explain): _____
- Uninvolved by invasive carcinoma
 - + Distance of invasive carcinoma from margin (millimeters): ____ mm
 - + Specify location: _____
- Involved by invasive carcinoma
 - Specify location, if possible: _____
- Uninvolved by intraepithelial neoplasia
- Involved by high-grade squamous intraepithelial lesion (CIN 2-3)
 - + Specify location: _____
- Involved by adenocarcinoma in situ (AIS)
 - + Specify location: _____

Radial (Circumferential) Margin

- Cannot be assessed (explain): _____
- Uninvolved by invasive carcinoma
 - + Distance of invasive carcinoma from margin (millimeters): ____ mm
 - + Specify location: _____
- Involved by invasive carcinoma
 - Specify location(s), if possible: _____

Lymphovascular Invasion (Note G)

- Not identified
- Present
- Cannot be determined

Regional Lymph Nodes

Note: Lymph nodes designated as pelvic, parametrial, obturator, internal iliac (hypogastric), external iliac, common iliac, sacral, presacral and para-aortic are considered regional lymph nodes. Any other involved nodes should be categorized as metastases (pM1) and commented on in the distant metastasis section. Presence of isolated tumor cells no greater than 0.2 mm in regional lymph node(s) is considered NO(i+).

- No lymph nodes submitted or found

+ 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.

Lymph Node Examination (required only if lymph nodes are present in specimen)

Number of Nodes with Metastasis (excludes ITCs): _____
 ___ Number cannot be determined (explain): _____

Number of Nodes with Isolated Tumor Cells (ITCs) (0.2 mm or less) (if applicable)[#]: _____
 ___ Number cannot be determined (explain): _____

[#] Reporting the number of lymph nodes with isolated tumor cells is required only in the absence of metastasis greater than 0.2 mm in other lymph nodes.

Specify Lymph Node(s) with Tumor (if applicable)[#]: _____
[#] Note: Information should include location and laterality of lymph nodes with tumor.

Total Number of Nodes Examined (sentinel and non-sentinel): _____
 ___ Number cannot be determined (explain): _____
 Specify Site(s)[#]: _____

[#] Note: Information should include location and laterality of lymph nodes examined.

Number of Sentinel Nodes Examined: _____
 ___ Number cannot be determined (explain): _____

Pathologic Stage Classification (pTNM, AJCC 8th Edition) (Notes H, I, and J)

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: Cervical carcinoma confined to uterus (extension to corpus should be disregarded)
 ___ pT1a: Invasive carcinoma diagnosed by microscopy only. Stromal invasion with a maximum depth of 5.0 mm measured from the base of the epithelium and a horizontal spread of 7.0 mm or less. Vascular space involvement, venous or lymphatic, does not affect classification.
 ___ pT1a1: Measured stromal invasion of 3.0 mm or less in depth and 7.0 mm or less in horizontal spread
 ___ pT1a2: Measured stromal invasion of more than 3.0 mm and not more than 5.0 mm, with a horizontal spread of 7.0 mm or less
 ___ pT1b: Clinically visible lesion confined to the cervix or microscopic lesion greater than T1a2/IA2. Includes all macroscopically visible lesions, even those with superficial invasion.
 ___ pT1b1: Clinically visible lesion 4.0 cm or less in greatest dimension
 ___ pT1b2: Clinically visible lesion more than 4.0 cm in greatest dimension
 ___ pT2: Cervical carcinoma invading beyond the uterus but not to the pelvic wall or to lower third of the vagina
 ___ pT2a: Tumor without parametrial invasion
 ___ pT2a1: Clinically visible lesion 4.0 cm or less in greatest dimension
 ___ pT2a2: Clinically visible lesion more than 4.0 cm in greatest dimension
 ___ pT2b: Tumor with parametrial invasion
 ___ pT3: Tumor extending to the pelvic sidewall[#] and/or involving the lower third of the vagina and/or causing hydronephrosis or nonfunctioning kidney
 ___ pT3a: Tumor involving the lower third of the vagina but not extending to the pelvic wall
 ___ pT3b: Tumor extending to the pelvic wall and/or causing hydronephrosis or nonfunctioning kidney

+ 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.

___ pT4: Tumor invading the mucosa of the bladder or rectum and/or extending beyond the true pelvis (bullous edema is not sufficient to classify a tumor as T4)

[#] *The pelvic sidewall is defined as the muscle, fascia, neurovascular structures, and skeletal portions of the bony pelvis. On rectal examination, there is no cancer-free space between the tumor and pelvic sidewall.*

Note: The LAST definition of superficial invasive squamous cell carcinoma (SISCCA) conforms to T1a1.

Regional Lymph Nodes (pN) (select all that apply)

+ *Modifier*

- + ___ (sn)
- + ___ (sn)(i-)
- + ___ (sn)(i+)

Category (pN)

- ___ pNX: Regional lymph nodes cannot be assessed
- ___ pN0: No regional lymph node metastasis
- ___ pN0(i+): Isolated tumor cells in regional lymph node(s) no greater than 0.2 mm
- ___ pN1: Regional lymph node metastasis

Distant Metastasis (pM) (required only if confirmed pathologically in this case)

___ pM1: Distant metastasis (including peritoneal spread or involvement of the supraclavicular, mediastinal, or distant lymph nodes; lung; liver; or bone)

Specify site(s), if known: _____

+ FIGO Stage (2015 FIGO Cancer Report)

- + ___ I: Carcinoma is strictly confined to the cervix (extension to the uterine corpus should be disregarded)
- + ___ IA: Invasive cancer identified only microscopically. (All gross lesions even with superficial invasion are stage IB cancers.) Invasion is limited to measured stromal invasion with a maximum depth of 5 mm and no wider than 7 mm.[#]
- + ___ IA1: Measured invasion of stroma ≤3 mm in depth and ≤7 mm width.^{##}
- + ___ IA2: Measured invasion of stroma >3 mm and <5 mm in depth and ≤7 mm width.
- + ___ IB: Clinical lesions confined to the cervix, or preclinical lesions greater than stage IA.
- + ___ IB1: Clinical lesions ≤4 cm in size
- + ___ IB2: Clinical lesions >4cm in size
- + ___ II: The carcinoma extends beyond the uterus, but has not extended onto the pelvic wall or to the lower third of vagina.
- + ___ IIA: Involvement of up to the upper two-thirds of the vagina. No obvious parametrial involvement.
- + ___ IIA1: Clinically visible lesion ≤4 cm
- + ___ IIA2: Clinically visible lesion >4 cm
- + ___ IIB: Obvious parametrial involvement but not onto the pelvic sidewall.
- + ___ III: The carcinoma has extended onto the pelvic sidewall. On rectal examination, there is no cancer-free space between the tumor and pelvic sidewall and/or the tumor involves the lower third of the vagina. All cases of hydronephrosis or nonfunctioning kidney should be included unless they are known to be due to other causes.
- + ___ IIIA: Involvement of the lower third of the vagina but no extension onto pelvic sidewall.
- + ___ IIIB: Extension onto the pelvic sidewall, and/or causing hydronephrosis/nonfunctioning kidney.
- + ___ IV: Carcinoma has extended beyond the true pelvis or has clinically involved the mucosa of the bladder and/or rectum or spread to distant organs.
- + ___ IVA: Spread to adjacent pelvic organs, ie, tumor invading the mucosa of the bladder and/or rectum and/or extending beyond the true pelvis (bullous edema is not sufficient)
- + ___ IVB: Spread to distant organs.

[#]*Note: For FIGO IA cancers, the depth of invasion should not be more than 5 mm taken from the base of the epithelium, either surface or glandular, from which it originates. Vascular space invasion should not alter the staging.*

^{##}*The LAST definition of superficial invasive squamous cell carcinoma (SISCCA) conforms to FIGO IA1.*

+ 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.

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

- + None identified
- + Low-grade squamous intraepithelial lesion (CIN 1)
- + High-grade squamous intraepithelial lesion (CIN 2 or 3)
- + Inflammation
- + Other (specify): _____

+ **Ancillary Studies**

+ Specify: _____

+ p16 Immunohistochemistry

- + Positive
- + Negative

+ **Comment(s)**

Explanatory Notes

A. Specimen Orientation

If the specimen is the product of a cone biopsy or an excisional biopsy, it is desirable for the surgeon to orient the specimen to facilitate assessment of the resection margins (eg, stitch at 12 o'clock). The laterality of the specimen is in reference to the patient's perspective. Clock values refer to the cervix from the viewer's perspective (face on). However, specimens frequently are received without orientation. In these cases, the clock face orientation is designated by the pathologist and is arbitrary.

B. Specimen Handling (Cone/LEEP)

Specimens should have their margins inked and be step-sectioned with orientation by quadrant. For large, unfixed, cervical cone/loop electrical excision procedure (LEEP) specimens, the endocervical margin may be marked with ink and pinned on a corkboard with the mucosa facing up. Three hours of fixation before cutting is optimal. The specimen should be sectioned entirely at 1- to 3-mm intervals. Each tissue section may be marked with India ink or a dye such as eosin in order to orient embedding and facilitate evaluation of margins. For optimal evaluation, the sections are placed into separate cassettes, which are numbered consecutively.

C. Absence of Tumor

If no tumor or precursor lesion is present in a cytology or biopsy specimen, the adequacy of the specimen (ie, its content of both glandular and squamous epithelium) should receive comment. The absence of tumor or precursor lesions in resections must always be documented.

Tumor Size Measurement

Tumors should be measured in 3 dimensions in all cases, namely the depth of invasion and 2 measurements of horizontal extent (longitudinal/length and circumferential/width). Larger tumors are more accurately measured grossly, while smaller tumors and some larger tumors with a diffusely infiltrative pattern or with marked fibrosis are best measured microscopically. It is best to report only 1 set of tumor measurements based on a correlation of the gross and microscopic features to avoid confusion.

The depth of invasion is measured from its HSIL origin, that is, from the base of the epithelium either surface or glandular that is involved by HSIL to the deepest point of invasion. If the invasive focus or foci are not in continuity with the dysplastic epithelium, the depth of invasion should be measured from the deepest focus of tumor invasion to the base of the nearest dysplastic crypt or surface epithelium. If there is no obvious epithelial origin, the depth is measured from the deepest focus of tumor invasion to the base of the nearest surface epithelium, regardless of whether it is dysplastic or not. In situations where carcinomas are exclusively or predominantly exophytic, there may be little or no invasion of the underlying stroma. These should not be regarded as in situ lesions and the tumor thickness (from the surface of the tumor to the deepest point of invasion) should be measured in such cases. The depth of invasion below the level of the epithelial origin should not be provided in these cases as this may not truly reflect the biological potential of such tumors. If it is impossible to measure the depth of invasion, eg, in ulcerated tumors or in some adenocarcinomas, the tumor thickness may be measured instead, and this should be clearly stated on the pathology report along with an explanation for providing the thickness rather than the depth of invasion.

Horizontal extent: The longitudinal extent (length) of horizontal extent is measured in the superior-inferior plane (ie, from the endocervical to ectocervical aspects of the section), whereas the circumferential extent (width) is measured or calculated perpendicular to the longitudinal axis of the cervix. If the tumor involves only 1 block, the circumferential extent (width) will be 2.5 mm to 3 mm (thickness of 1 block). When more than 1 block is involved, it is the product of the number of consecutive blocks with tumor and thickness of a block.

The LAST definition of superficial invasive squamous cell carcinoma (SISCCA) conforms to T1a1/ FIGO 1A1. The LAST consensus recommends SISCCA to include multifocal disease and that reporting include presence, number, and size of independent multifocal carcinoma, however, no LAST recommendation was made on the methodology to measure multifocal disease. A recent publication by Day et al states that multifocal tumors should be defined as invasive foci separated by a tissue block within which there is no evidence of invasion or as

invasive foci in the same tissue block that are more than 2 mm apart, or as invasive foci on different cervical lips. They recommend that multifocal tumors should be staged based on the largest focus.

D. Histologic Type

For consistency in reporting, the histologic classification proposed by the World Health Organization (WHO) is recommended¹; other classification systems may be used, however.

WHO Histologic Classification of Cervical Carcinoma and Precursor Lesions

Epithelial Tumors and Related Lesions

Squamous lesions

- Squamous intraepithelial lesions/cervical intraepithelial neoplasia (SIL/CIN)
 - Low-grade squamous intraepithelial lesion [LSIL]/Mild dysplasia (CIN 1)
 - High-grade squamous intraepithelial lesion [HSIL]/Moderate dysplasia (CIN 2)
 - HSIL/Severe dysplasia (CIN 3)
 - HSIL/Carcinoma in situ (CIS)

- Squamous cell carcinoma, NOS
- Squamous cell carcinoma, keratinizing
- Squamous cell carcinoma, non-keratinizing
- Squamous cell carcinoma, basaloid
- Squamous cell carcinoma, verrucous
- Squamous cell carcinoma, warty
- Squamous cell carcinoma, papillary
- Squamous cell carcinoma, lymphoepithelioma-like
- Squamous cell carcinoma, squamotransitional

Endocervical adenocarcinoma, usual type

- Mucinous carcinoma, NOS
- Mucinous carcinoma, intestinal type
- Mucinous carcinoma, signet-ring cell type
- Mucinous carcinoma, gastric type

- Villoglandular carcinoma
- Endometrioid carcinoma
- Clear cell carcinoma
- Serous carcinoma
- Mesonephric carcinoma
- Adenocarcinoma admixed with neuroendocrine carcinoma
- Adenosquamous carcinoma
- Adenosquamous carcinoma, glassy cell variant
- Adenoid cystic carcinoma
- Adenoid basal carcinoma
- Small cell neuroendocrine carcinoma
- Large cell neuroendocrine carcinoma
- Undifferentiated carcinoma
- Carcinosarcoma

E. Histologic Grade

A wide variety of grading systems, including some that evaluate only the extent of cellular differentiation and others that assess additional features such as the appearance of the tumor margin, the extent of inflammatory cell infiltration, and vascular invasion, have been used for squamous cell carcinoma of the cervix. However, there is no consensus emerging from the literature that any of these systems are reproducible or that they provide useful prognostic information.

For the grading of invasive squamous tumors, it is suggested that 3 grades be used:

- GX Cannot be assessed
- G1 Well differentiated
- G2 Moderately differentiated
- G3 Poorly differentiated

In contrast to squamous cell carcinoma, most authors who grade cervical adenocarcinoma on the basis of its architecture (glandular and papillary versus solid areas) and its nuclear features have found the grade to have prognostic value.²⁻⁴

- G1 Small component of solid growth and mild to moderate nuclear atypia
- G2 Intermediate between grades 1 and 3
- G3 Solid pattern with severe nuclear atypia

Tumors with no differentiation or minimal differentiation that is discernible only in rare, tiny foci (undifferentiated carcinomas by WHO classification) are categorized as grade 4.

F. Resection Margins

Margins can be involved, negative, or indeterminate for carcinoma. If a margin is involved, whether endocervical, ectocervical, deep, or other, it should be specified. If indeterminate, the reason should be specified (eg, cautery artifact in electroexcision specimens may preclude evaluation of the status of the margin). The severity and extent of a precursor lesion (eg, focal or diffuse) involving a resection margin of a cone should be specified.

If an invasive tumor approximates but does not directly involve a resection margin, the distance between the tumor and the margin should be measured in millimeters. If the tumor involves the uterine corpus, a determination of whether the cervix or corpus is the primary site should be made.

G. Lymphovascular Invasion

Many gynecologists feel that the presence of vascular/lymphatic vessel invasion is important because it may change the extent of their surgical treatment. Specifically, the Society of Gynecologic Oncology (SGO) differs with the International Federation of Gynecology and Obstetrics (FIGO) in the definition of early invasive carcinoma. The SGO defines such tumors as being invasive to a depth <3 mm, with a width of <7 mm, but most importantly lacking lymphovascular invasion. At times, it may be difficult to determine whether vascular/lymphatic vessel invasion is present; in such cases, its presence should be categorized as indeterminate (cannot be determined).⁵

H. Examination of Bladder and Rectum

Currently, pelvic exenterations are rarely seen, but typically when performed indicate advanced tumor stage. In these cases, the extent of tumor involvement of the urinary bladder and rectum and the relation of the tumor to the cervical carcinoma should be described. To evaluate these features, sections of the rectum and bladder should be taken perpendicular to the mucosa directly overlying the tumor in the cervix. A method that provides excellent orientation of the tumor to adjacent structures consists of inflation of the urinary bladder and rectum with formalin and fixation of the specimen for several hours. The entire specimen can then be hemisected through the neoplasm, and appropriate sections can be obtained.

I. Pathologic Stage Classification

The TNM staging system for cervical cancer endorsed by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC), and the parallel system formulated by the International Federation of Gynecology and Obstetrics (FIGO), are recommended.⁶⁻¹⁰

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.

Of note, tumor size has been shown to have prognostic utility for stage I to stage II lesions, and the 2014FIGO staging classification has adopted T subclassifications for T2 lesions (cervical carcinoma spreading beyond the cervix but not to the pelvic side wall or lower one-third of the vagina), based on tumor size ≤ 4 cm (T2a1) and >4 cm (T2a2).^{6,10}

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.

Additional Descriptors

Residual Tumor (R)

Tumor remaining in a patient after therapy with curative intent (eg, surgical resection for cure) is categorized by a system known as R classification, shown below.

RX	Presence of residual tumor cannot be assessed
R0	No residual tumor
R1	Microscopic residual tumor
R2	Macroscopic residual tumor

For the surgeon, the R classification may be useful to indicate the known or assumed status of the completeness of a surgical excision. For the pathologist, the R classification is relevant to the status of the margins of a surgical resection specimen. That is, tumor involving the resection margin on pathologic examination may be assumed to correspond to residual tumor in the patient and may be classified as macroscopic or microscopic according to the findings at the specimen margin(s).

T Category Considerations

Lymphovascular Invasion (LVI)

LVI indicates whether microscopic lymphovascular invasion is identified. LVI includes lymphatic invasion, vascular invasion, or lymphovascular invasion. By AJCC/UICC convention, LVI does not affect the T category indicating local extent of tumor unless specifically included in the definition of a T category.

N Category Considerations

Isolated tumor cells (ITCs) are single cells or small clusters of cells not more than 0.2 mm in greatest dimension. Lymph nodes or distant sites with ITCs found by either histologic examination (eg, immunohistochemical evaluation for cytokeratin) or nonmorphological techniques (eg, flow cytometry, DNA analysis, polymerase chain reaction [PCR] amplification of a specific tumor marker) should be so identified. There is currently no guidance in the literature as to how these patients should be coded; until more data are available, they should be coded as "NO(i+)" with a comment noting how the cells were identified.

There is little data to assign risk for nonsentinel lymph node metastasis based on the size of the metastasis in the sentinel lymph node. However, the size criteria for micrometastasis and macrometastasis is adopted from the experience in breast carcinoma. Micrometastasis is defined as a metastasis measuring greater than 0.2 mm but less than 2 mm.

J. Examination of Parametria

The parametria may be measured grossly, but their width varies according to the elasticity of the tissue. Careful microscopic examination of the parametria is important for evaluation of the lateral margins and/or soft tissue extension.

K. Special Studies

p16 Immunohistochemistry

Immunohistochemistry has served as an important adjunct to the histologic diagnosis of CIN in difficult lesions, with p16 immunoreactivity being a good surrogate marker for high-risk human papillomavirus (HPV) infection.^{12,13} p16 immunostaining in the squamous epithelium, however, should be diffuse; strong nuclear and cytoplasmic staining, as focal strong p16 reactivity, may be identified not only in dysplastic squamous epithelium, but also in benign squamous epithelium (Table 1). p16 immunostaining is also considered a better candidate (rather than HPV in situ hybridization) for the initial assessment of cervical biopsies that are histologically indeterminate for dysplasia, given its wide availability, easy interpretation, and high sensitivity and specificity.¹⁴ Given the heterogeneous staining patterns seen in low-grade CIN lesions, however, immunohistochemistry for p16 is generally reserved for lesions that are morphologically suspicious or indeterminate for high-grade dysplasia. The LAST project proposed p16 be used in 3 specific situations. First, to distinguish inflammatory lesions from HSIL; second, to distinguish LSIL from HSIL; and third, to evaluate specimens such as endocervical curettage on patients who have previously had a recent HSIL diagnosis. ProEx C, an immunohistochemical assay targeting both topoisomerase II-alpha and minichromosome maintenance protein-2 (MMP-2), has recently been shown to have high sensitivity and specificity for HPV-associated lesions of the cervix, with similar staining patterns as those seen for p16 and MIB-1 (Ki-67).¹⁵

Immunohistochemistry: Endocervical versus Endometrial Adenocarcinoma

Immunohistochemistry can also be helpful in the differential diagnosis between endocervical and endometrial carcinoma, especially in curettage specimens, as endometrial carcinomas may show mucinous differentiation. A panel of antibodies, rather than a single antibody, is most useful; in most instances this includes vimentin, ER, p16, and monoclonal CEA.^{16,17}

Table 1. p16 Immunohistochemistry in the Differential Diagnosis of Squamous and Glandular Lesions of the Uterine Cervix

	p16 [#]	MIB-1 (Ki-67)
LSIL (CIN I)	+/-	increased
HSIL (CIN II-III)	+	increased (full thickness)
AIS	+	+
AIM	-/+	-/+
Reactive squamous or glandular atypia	-/+	+
Tubal metaplasia	+/-	-

LSIL, low-grade squamous intraepithelial neoplasia; HSIL, high-grade squamous intraepithelial neoplasia; CIN, cervical intraepithelial neoplasia; AIS, adenocarcinoma in situ; AIM, atypical immature metaplasia.

p16 expression (nuclear and cytoplasmic) is a surrogate marker of high-risk HPV (eg, HPV 16, 18). In LSIL, the p16 expression may be confined to the lower one-third/lower one-half of the squamous epithelium or show focal immunoreactivity (the latter being a pattern of expression, albeit cytoplasmic only, that may also be seen in reactive squamous epithelia). HSIL p16 immunoreexpression usually involves two-thirds or full thickness of the squamous epithelium (so-called block like positivity).¹⁸

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