COLLEGE of AMERICAN PATHOLOGISTS FOUNDATION

Webinar #3 Applying to the CAP Cancer Protocols: Featuring Colon an Prostate Use Cases
December 11, 2023
Submitted Questions with Responses

	Question	Response
Q1	What do you mean by the "Deep margin" in a colon resection?	I don't remember the exact context that I used deep but maybe I used it in reference to the radial margin in an APR or LAR.
Q2	Is IHC necessary for increased sensitivity in determining LN positivity?	I would say I do not use keratin IHC routinely to detect lymph node metastasis. I may on occasion use it if the primary tumor has signet ring cells but most times I would say careful examination by H&E is preferred. I do this especially since isolated tumor cells are not currently considered a positive lymph node by the most current AJCC edition for primary carcinomas of the colon. IHC many times raises more questions then it answers(positivity by keratin IHC but no H&E correlate etc.).
Q3	Are there different prognostic rates for lymphatic vs vascular invasion?	I think the biggest distinction is between small vessel(thin walled structures with endothelium without smooth muscle or an elastic layer) which includes lymphatics, capillaries and post capillary venules. Involvement of these structures are associated lymph node metastasis and worse outcomes. Large vessel venous (smooth muscle layer or elastic lamina) involvement is also associated with worse outcomes and liver metastasis. This is why we use the small vessel/large vessel distinction in the protocol used for primary carcinomas of the colon.
Q4	If the tumor is situated at caecum invading the appendix, how can we stage it, pT4b ?	If tumor traverses peritoneum of the caecum and then invades the peritoneum of the appendix it would qualify at pT4b. If tumor travels via the lumen without penetrating through the peritoneum it would not have the ability to qualify as pT4b.
Q5	Grading the colorectal adenocarcinoma, is cribriform pattern counted as gland formation?	I treat it as gland formation. I have not seen any literature to treat it otherwise.

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Q6	In non-treated colorectal adenocarcinoma, if the acellular mucin reaches serosa, is it interpreted as T4a?	I don't believe there is definitive published data on this. I believe you could make arguments to count it or not. I think whatever decision you make you document it in your report (and get multiple recuts before you do). AJCC does have a rule when a pathologist is uncertain about staging they should choose the lower stage. I try to follow this but I can not say I do it 100% of the time.
Q7	In non-treated colorectal adenocarcinoma, if the acellular mucin is present in lymph node, is it interpreted as positive lymph node?	Our subject matter experts agree with you that this is a gray area. The current recommendation is to call them negative, although good data is lacking. There was an abstract at one of the USCAP meetings few years ago with very few cases, one recent paper, and a study from Yale that will be presented at upcoming USCAP meeting that show that acellular mucin in this setting is closer to N0 than N1, although the number of cases are still small and the data is not 100% conclusive. **Click to view paper**. The preponderance of the available data (though not conclusive) supports staging as N0 provided the case is appropriately worked up. They suggest to stage them as N0 (after due diligence of levels and keratin stains if appropriate) and explain this in a note and possibly quote this paper.
Q8	How is it important for management or others to mention the precursor lesion?	We have made it optional in the protocol. I think does give some potential information (which colon carcinoma tumorigenesis pathway in being undertaken) but is not critical in my opinion for treatment since for many of these tumors additional testing is routinely performed (MMR, MSI, ect.) that help in clinically relevant classification.

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Q9	How to differentiated between mucinous adenocarcinoma with focal signet ring cells and mucinous adenocarcinoma with degenerated mucinous tumor cells floating in the mucin pool?	The distinction rests on the tumor cells. Signet ring cells should have intracytoplasmic mucin with displacement and moulding of the nucleus. Since these types of cells can be found in mucinous adenocarcinomas one must pay attention to the individual cell detail when classifying. Personally I also find it helpful to look at the background to help me in making the distinction (is there a background of degeneration, ischemia etc..).
Q10	Is mentioning distance greater than 10 mm important to the prognosis or management?	I have not seen outcome data suggesting different outcomes based on margins greater than 10 mm. However, the goal of recording the exact distance from the margin is to generate appropriate data as to what is relevant.
Q11	Does the number of tumor deposit matter?	Some studies have shown a linear relationship between the number of tumor deposits and survival. Citation: Prognostic value of tumor deposits for disease-free survival in patients with stage III colon cancer: a post hoc analysis of the IDEA France phase III trial (PRODIGE-GERCOR). J Clin Oncol. 2020; 38: 1702-1710
Q12	If there are 3 positive lymph nodes and 1 ITC LN; is it interpreted as pN1b to pN2a?	Based on current literature and staging rules it is reported as pN1b. However evolving data suggests that tumor deposits may be worse and the future staging may change.
Q13	Does extranodal extension matter and is it worth mentioned in colorectal cancer?	Some studies suggest that extranodal extension it is a negative prognostic factor in colon cancer. Currently it is not required element colon protocol.
Q14	How important is micrometastasis to be separately mentioned in the report?	Micrometastasis (0.2 mm-2.0 mm) in lymph nodes is considered involved by tumor. Current literature does not support it being separated out from larger lymph node metastasis for staging purposes.

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Q15	I currently have a case that I have never encountered before and would be glad to hear an expert´s opinion. It is about bladder which was augmented with a small bowel segment (vesica neurogenes), and now I have a carcinoma originating from the urothelium, with abundant squamous differentiation, also infiltrating the wall of the small bowel used for the augmentation. My question is, what pT is that? (pT4a - other organ?/or is that small bowel segment considered as a part of bladder wall and then just pT3b - because of fat infiltration that is evident macroscopically).	I think this should be staged as urothelial carcinoma and not CRC or small bowel carcinoma. The issue is that the staging systems are largely designed for the primary native organ or site, and not modified anatomy (except transplant). I am not sure if there is more clear answer for this from CAP or any other site synoptics.
Q16	How do we stage 'T' if there are two or more tumors in rectum?	Final stage is based on the most advanced tumor.
Q17	Is the presence of few fragmented elastic fibers sufficient for the diagnosis of large vessels invasion or it has to be circular to qualify for vascular invasion	I wish elastic stain always cleared things up but does increase the detection of large vessel invasion (LVI). I think context matters. Is this potential large vessel invasion focus paired with another vessel "orphan annie sign" or "protruding tongue sign"? I do not believe there is an accepted definition on what qualifies. I am not aware of a particular threshold used to make the diagnosis but I do use the elastic stain as a guide but not the end all be all when making the diagnosis. Elastic fibers can sometimes be obliterated in LVI and elastic fibers are not specific to just vessels.
Q18	How do you count matted nodes?	To the best of my and my PA's ability we try to discern the amount of lymph nodes. Whatever number I come up with I do report my reasoning for this number in a comment. Fortunately I have not come across this much.

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Q19	Do you record mets given in the clinical notes if you don't have a biopsy of the mets?	We have the following verbiage in any protocol where pathologic stage classification occurs: " Reporting of pT, pN, and (when applicable) pM categories is based on information available to the pathologist at the time the report is issued. As per the AJCC (Chapter 1, 8th Ed.) it is the managing physician's responsibility to establish the final pathologic stage based upon all pertinent information, including but potentially not limited to this pathology report."