COLLEGE of AMERICAN PATHOLOGISTS FOUNDATION

Webinar #2 Applying the CAP Cancer Protocols: Featuring Breast Use Cases
September 13, 2023
Submitted Questions with Responses

	Question	Response
Q6	Kindly clarify how pathological nodal status should be assigned if nodal clearance is inadequate?	You assign pathological N category based on what is evaluated. In a comment you can state why you consider that this nodal clearance maybe inadequate and therefore the assigned N category may not be accurate.
Q9	How do we measure the margin status of DCIS in microscopy?	For DCIS margins: If DCIS is present at the margin, the extent of margin involvement is associated with the likelihood of residual disease. Please review the CAP protocol on DCIS for details. However, briefly, important points are, State if margin is positive (DCIS is at the ink). If margin is negative give exact distance from each margin or report as greater than or less than in mm. If negative, we report as > 2mm or < 1mm from the inked margin. If margin is positive or < 1mm we indicate if it is: Focal: DCIS at the margin in a <1 mm area in 1 block; Minimal/moderate: between focal and extensive; Extensive: DCIS at the margin in an area ≥15 mm or in 5 or more low-power fields and/or in 8 or more blocks.
Q13	How is the liver resection (HCC) report used for clinical decisions in the US? Is it used for any adjuvant therapy?	Positive margins do change management requiring additional local or systemic therapy. A positive margin does change treatment - in the past, that may have been local therapy or consideration of systemic therapy on a case-by-case basis. However, there is new adjuvant data from the IMBrave 050 study - giving a year of Atezolizumab and Bevacizumab to patients with a high risk of recurrence. The study was positive and presented this spring - not yet published. Doctors think it will be practice changing. Doctors have started to offer it to their patients with a high risk for recurrence.

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Q14	Are there plans to have templates for Cytopathology reporting other than cervical Pap tests that is presently available?	An updated template for the reporting of anal cytology specimens will be released in December. The current anal cytology reporting template can be found here Cytopathology Committee Topic Center. https://www.cap.org/member-resources/councils-committees/cancer-topic-center/cytopathology-topic-center There is ongoing discussion on development of reporting templates for non-gynecological specimens.
Q16	How important is it to provide photomicrographs in the reports; for the breast Onco surgeons; esp. in a resource limited setting?	Our subject matter experts don't think providing photomicrographs in the report is very important. Including photomicrographs might be helpful in selected cases when there is something unusual that the pathologist wants to draw attention to, but they don't see how doing it routinely for all cases is going to help the surgeons. It may be a useful marketing tool in making the path report look more impressive, but it's unlikely to help clinicians much and isn't worth the effort in resource-constrained laboratories.
Q18	What are standard practice to identify single cell metastasis in LN. Because as usual we don't do it routinely. What are the CAP recommendations?	Evaluating lymph nodes: At least 1 representative hematoxylin-and-eosin (H&E) level must be examined. Additional methods of sampling, such as additional H&E levels or immunohistochemical studies, may detect isolated tumor cells or micro metastases. However, the clinical impact outcome of these small metastases is minimal and therefore not mandatory. Please See explanatory note M of breast invasive CAP protocol.

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Q19	In the US, do the collected data using the CAP protocols get gathered together for statistical analyses?	The eCP data is aggregated by some healthcare institutions and also by cancer registries. In the latter case, the data workflow is still far from optimal. In the former case, some institutions do a great job with their eCP data internally, but it is not commonly shared with other institutions. There are some prominent exceptions in Canada, where they are far ahead of the US in aggregating/sharing eCP data. Some of our Canadian colleagues have also published a few papers with that data.
Q20	In post NA breast cancer, how can we assess the tumor size if we have extensive areas of fibrosis with individual here and there tumor cells areound?	This was discussed during Webinar #2 with schematic diagram and example. Based on AJCC /CAP guidelines, measure and assign T category based on the largest contiguous focus of invasive cancer without including intervening fibrosis and give the number of residual invasive foci and add suffix (m) to indicate multiple foci of residual invasive carcinoma. If only individual residual cancer cells are present, state so and give rough size estimate of largest microinvasive focus of invasive carcinoma. The RCB burden would be useful additional information to provide.
Q21	a mixed carcinoma(IDC with ILC-70 percent) , how to go ahead with the grading?	In mixed carcinomas, assign a single overall grade if the grade of both components is similar. Mitotic score in based on the most mitotically active part of the tumor. If a portion of the tumor is of higher grade (pleomorphic lobular component for example), indicate that in the diagnosis and in note or comment.

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Q22	Do we have to use 2 different forms for 2 synchronous carcinoma?	If there are multiple invasive carcinomas, size, grade, histologic type, and the results of studies for estrogen receptor (ER), progesterone receptor (PgR), and HER2 should pertain to the largest invasive carcinoma. If smaller invasive carcinomas differ in any of these features, this information may be included in the "Comments" section. Two separate forms are not required.
Q23	Since biomarker status in breast cancer is based according to the greatest focus, is it necessary to explore the sescond focus, keeping in mind that we are a low income country?	When multiple invasive foci are present, the largest invasive focus should be tested. Testing smaller invasive carcinomas is also recommended if they are of different histologic type or higher grade. This is because biomarker status may be different which will influence treatment decision.
Q24	extensive DCIS with multiple focal invasion, how to determine the size for T staging?	Assign T category based on the largest contiguous focus of invasive cancer, in a note indicate that there are multiple foci ranging in size from ** to ***, estimate and give number of invasive foci & use m suffix to indicate multiple foci of invasive carcinoma. Please review Explanatory note F of the CAP protocol for details.
Q25	Invasion of lymphatics in a node capsule is considered as metastasis?	LVI in nodal capsule alone is not metastasis, however it will be prudent to get additional deeper levels to check if a metastasis is seen in the nodal parenchyma in a deeper level.
Q26	Is there still a category referred to as close margins for primary tumor or are there only positive and negative margins?	Margin status is to be first reported as positive or negative. However, for negative margins it is optional to give exact distance or greater than or less than in mm distance from the carcinoma. In our institution we indicate if margin is > 2mm or < 1mm for invasive carcinoma and DCIS.

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Q27	extensive DCIS with multiple foci of invasion. and distance between the invasive foci is less than 5mm. how to determine the size	From the question, individual foci of invasion are more likely to be microinvasive and should be reported as multiple foci of microinvasive carcinoma. For other scenarios, Please review explanatory note F on single or multiple foci of invasive carcinoma of the Breast invasive resection CAP protocol.