ASCP STRONGERTOGETHER

COLLEGE of AMERICAN PATHOLOGISTS

Laboratory Workup of Lymphoma in Adults

Statements and Strengths of Recommendations

SUMMARY OF RECOMMENDATIONS

	Guideline Statement	Strength of Recommendation
1.	Clinical care providers should use surgical biopsy when feasible in a clinical setting where Hodgkin lymphoma is highly suspected.	Strong Recommendation
2.	Clinical care providers should obtain excisional or core needle biopsy (CNB) specimens in patients with high suspicion of lymphoma.	Strong Recommendation
3.	Clinical care providers should *not* use fine needle aspiration (FNA) cytomorphology alone without ancillary testing to achieve a definitive diagnosis of lymphoma. *Note:* Cytomorphology alone without ancillary studies has low sensitivity and low predictive value. *Note:* A defined subset of lymphoma requires architectural assessment and cannot be reliably diagnosed and subclassified by FNA.	Strong Recommendation
4.	Clinical care providers should follow-up patients with negative results for persistent signs and symptoms of lymphoma and pursue larger-volume biopsy when clinical suspicion for lymphoma persists.	Strong Recommendation
5.	Clinical care providers may use positron emission tomography (PET) with 2-deoxy-2-[fluorine-18]fluoro-D-glucose (FDG) to identify sites for biopsy in patients with suspected transformed/aggressive-histology lymphoma. As feasible, biopsies should be directed to the site of greatest FDG avidity.	Conditional Recommendation
6.	Clinical care providers may obtain bone marrow biopsies for the primary diagnosis in select patients with suspected lymphomas. *Note*: For certain lymphoma types (eg, splenic low-grade lymphomas, lymphoplasmacytic lymphomas) bone marrow biopsy may be preferred over more invasive surgical methods.	Conditional Recommendation
7.	Clinical care providers may use cerebrospinal fluid (CSF) for the evaluation of primary or secondary central nervous system (CNS) lymphoma in select patients.	Conditional Recommendation
8.	Clinical care providers should use a combined morphologic and flow cytometric evaluation of CSF in the investigation of possible primary or secondary CNS lymphoma in select patients.	Strong Recommendation

9.	Based on low negative predictive values, clinical care providers should follow-up patients with negative results for persistent signs and symptoms of CNS lymphoma and pursue repeat CSF examination or biopsy when clinical suspicion for lymphoma persists.	Strong Recommendation
10.	Clinical care providers should use immunophenotyping by flow cytometry and/or immunohistochemistry (IHC) in addition to morphology for the evaluation of specimens for the diagnosis and subclassification of lymphomas.	Strong Recommendation
11.	Clinical care providers may use fluorescence in situ hybridization (FISH) analysis when evaluating specimens in patients with suspected or confirmed lymphoma, or in the subclassification of lymphoma. FISH analysis is feasible on specimens obtained by FNA and may increase diagnostic yield. *Note:* Demonstration of the appropriate rearrangements is required for a diagnosis of high-grade B-cell lymphoma with MYC and BCL2 and/or BCL6 rearrangements. (eg, high-grade B-cell lymphoma with MYC and BCL2 and/or BCL6 rearrangements).	Conditional Recommendation
12.	Clinical care providers should not routinely use up-front PCR-based clonality studies of antigen receptor genes (ie, T-cell receptor and immunoglobulin) in the initial investigation of lymphoma. There may be a confirmatory role in certain settings for these studies.	Conditional Recommendation
13.	Clinical care providers may use molecular tests to aid in classification of lymphomas. For example, pathologists may use *MYD88* L265P to aid in the classification of indolent B-cell lymphoma. *Note:* This recommendation statement refers to non-FISH molecular tests.	Conditional Recommendation

Kroft SH, Sever CE, Bagg A, et al. Laboratory workup of lymphoma for adults: guideline from the American Society for Clinical Pathology and the College of American Pathologists. *Arch Pathol Lab Med*. 2021;145(3):269-290. doi: 10.5858/arpa.2020-0261-SA