Protocol for the Examination of Cystectomy Specimens From Patients With Carcinoma of the Urinary Bladder

Version: 4.1.0.0
Protocol Posting Date: June 2021
CAP Laboratory Accreditation Program Protocol Required Use Date: March 2022

The changes included in this current protocol version affect accreditation requirements. The new deadline for implementing this protocol version is reflected in the above accreditation date.

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>Cystectomy</td>
<td>Includes specimens designated partial, total or radical cystectomy, radical</td>
</tr>
<tr>
<td></td>
<td>cystoprostatectomy (for bladder cancer), and anterior exenterations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinomas</td>
<td>Includes invasive carcinomas of the urinary tract, including urothelial</td>
</tr>
<tr>
<td></td>
<td>carcinoma, its morphological variants, and other carcinoma (squamous cell</td>
</tr>
<tr>
<td></td>
<td>carcinoma, adenocarcinoma, Müllerian carcinoma, neuroendocrine carcinoma,</td>
</tr>
<tr>
<td></td>
<td>and sarcomatoid carcinoma)</td>
</tr>
</tbody>
</table>

# This protocol is recommended for reporting noninvasive urothelial tumors (papillary and flat), but it is not required for accreditation purposes.

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

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy, transurethral resection of the bladder tumor* (TURBT), or</td>
</tr>
<tr>
<td>enucleations (consider Urinary Bladder Biopsy protocol)</td>
</tr>
<tr>
<td>Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)</td>
</tr>
<tr>
<td>Cytoplogic specimens</td>
</tr>
</tbody>
</table>

* Transurethral resection of a bladder tumor is NOT considered to be the definitive resection specimen, even though the entire cancer may be removed.

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

<table>
<thead>
<tr>
<th>Tumor Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urachal Carcinoma</td>
</tr>
<tr>
<td>Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)</td>
</tr>
<tr>
<td>Sarcoma (consider the Soft Tissue protocol)</td>
</tr>
</tbody>
</table>

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

* Denotes primary author.
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 as replacement for the synoptic report. In addition to but not as replacement for the synoptic report, all required elements must be in the synoptic portion of the report in the format defined above.

Summary of Changes
v 4.1.0.0

- General Reformatting
- Revised Margins Section
- Revised Lymph Nodes Section
- Added Distant Metastasis Section
- Removed pTX and pNX Staging Classification
- Reformat Tumor Extent Section
Reporting Template

Protocol Posting Date: June 2021
Select a single response unless otherwise indicated.

CASE SUMMARY: (URINARY BLADDER: Cystectomy, Anterior Exenteration)
Standard(s): AJCC-UICC 8
This protocol is recommended for reporting noninvasive urothelial tumors (papillary and flat), but it is not required for accreditation purposes.

SPECIMEN (Note A)

Procedure
___ Partial cystectomy
___ Radical cystectomy (total cystectomy)
___ Radical cystoprostatectomy
___ Anterior exenteration
___ Other (specify): ___________________
___ Not specified

TUMOR

Tumor Site (select all that apply)
___ Trigone
___ Right lateral wall
___ Left lateral wall
___ Anterior wall
___ Posterior wall
___ Dome
___ Other (specify): ___________________
___ Cannot be determined: ___________________

Histologic Type (Note B) (select all that apply)

Urothelial
___ Papillary urothelial carcinoma, noninvasive
___ Papillary urothelial carcinoma, invasive
___ Urothelial carcinoma in situ
___ Urothelial carcinoma, invasive
___ Urothelial carcinoma, nested (including large nested) variant
___ Urothelial carcinoma, micropapillary variant
___ Urothelial carcinoma, microcystic variant
___ Urothelial carcinoma, micropapillary variant
___ Urothelial carcinoma, lymphoepithelioma-like variant
___ Urothelial carcinoma, plasmacytoid / signet ring cell / diffuse
___ Urothelial carcinoma, sarcomatoid variant
___ Urothelial carcinoma, giant cell variant
___ Urothelial carcinoma, poorly differentiated variant
___ Urothelial carcinoma, lipid-rich variant
___ Urothelial carcinoma, clear cell variant
___ Urothelial carcinoma with squamous differentiation
   +Percentage of Squamous Differentiation
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Urothelial carcinoma with glandular differentiation
   +Percentage of Glandular Differentiation
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Urothelial carcinoma with trophoblastic differentiation
   +Percentage of Trophoblastic Differentiation
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Urothelial carcinoma with Müllerian differentiation
   +Percentage of Müllerian Differentiation
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined

Squamous
___ Squamous cell carcinoma
___ Verrucous carcinoma
___ Squamous cell carcinoma in situ (no invasive carcinoma identified)

Glandular
___ Adenocarcinoma
___ Adenocarcinoma, enteric
___ Adenocarcinoma, mucinous
___ Adenocarcinoma, mixed
___ Adenocarcinoma in situ (no invasive carcinoma identified)

Tumors of Müllerian type
___ Clear cell carcinoma
___ Endometrioid carcinoma

Neuroendocrine Tumors
___ Small cell neuroendocrine carcinoma
   +Percentage of Small Cell Neuroendocrine Component
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Large cell neuroendocrine carcinoma
   +Percentage of Large Cell Neuroendocrine Component
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Well-differentiated neuroendocrine tumor
   +Percentage of Well-differentiated Neuroendocrine Component
     ___ Specify percentage: _________________ %
     ___ Other (specify): _________________
     ___ Cannot be determined
___ Other histologic type not listed (specify): _________________
 Histologic Type Comment: __________________

Histologic Grade (Note C)
For urothelial carcinoma, other variants, or divergent differentiation
___ Low-grade
___ High-grade
For squamous cell carcinoma or adenocarcinoma
___ G1, well-differentiated
___ G2, moderately differentiated
___ G3, poorly differentiated
___ GX, cannot be assessed: ______________________
Other
___ Other (specify): ______________________
___ Cannot be assessed: ______________________
___ Not applicable

Tumor Size
___ Greatest dimension in Centimeters (cm): __________ cm
    +Additional Dimension in Centimeters (cm): ____ x ____ cm
___ Cannot be determined (explain): ______________________

Tumor Extent (Note D) (select all that apply)
___ Noninvasive papillary carcinoma
___ Urothelial carcinoma in situ
___ Invades lamina propria (subepithelial connective tissue)
___ Invades superficial muscularis propria (inner half)
___ Invades deep muscularis propria (outer half)
___ Invades perivesical soft tissue microscopically
___ Invades perivesical soft tissue macroscopically (extravesical mass)
___ Invades adjacent structure(s)#
    ___ Prostate (transmural invasion from the bladder tumor) (Note D, Fig. 1)(Note D)
    ___ Seminal vesicles
    ___ Uterus
    ___ Vagina
    ___ Adnexa
    ___ Pelvis wall
    ___ Abdominal wall
    ___ Rectum
    ___ Other (specify): ______________________
___ Cannot be determined: ______________________
___ No evidence of primary tumor
# Use the Urethral checklist for tumors that involve the urethral mucosa without invasion, tumors that involve the urethral mucosa with invasion of subepithelial connective tissue / prostate stroma, or tumors that involve prostatic ducts and acini with or without stromal invasion.

Lymphovascular Invasion (Note E)
___ Not identified
___ Present
___ Cannot be determined: ______________________
Tumor Configuration (select all that apply)
- Papillary
- Solid / nodule
- Flat
- Ulcerated
- Other (specify): ______________________
- Cannot be determined: ______________________

Tumor Comment: ______________________

Margins (Note F)
# For partial cystectomies, if the specimen is received unoriented precluding identification of specific margins, it should be denoted here.

Margin Status for Invasive Tumor
- All margins negative for invasive tumor

Closest Margin(s) to Invasive tumor (select all that apply)
- Right ureteral: ______________________
- Left ureteral: ______________________
- Urethral: ______________________
- Soft tissue: ______________________
- Other margin(s) (specify)#: ______________________

Distance from Invasive Tumor to Closest Margin
Specify in Millimeters (mm)
- Exact distance: ______________________ mm
- Other (specify): ______________________
- Cannot be determined: ______________________

Invasive tumor present at margin

Margin(s) Involved by Invasive Tumor (select all that apply)
- Right ureteral: ______________________
- Left ureteral: ______________________
- Urethral: ______________________
- Soft tissue: ______________________
- Other margin(s) (specify)#: ______________________
- Other (specify): ______________________
- Cannot be determined (explain): ______________________
- Not applicable

Margin Status for Carcinoma in situ / Noninvasive Papillary Urothelial Carcinoma
Non-invasive tumors include flat urothelial carcinoma in situ and non-invasive papillary urothelial carcinoma
- All margins negative for carcinoma in situ / noninvasive papillary urothelial carcinoma

Closest Margin(s) to Carcinoma in situ / Noninvasive Papillary Urothelial Carcinoma (select all that apply)
- Right ureteral: ______________________
- Left ureteral: ______________________
- Urethral: ______________________
- Soft tissue: ______________________
- Other (specify): ______________________
- Cannot be determined (explain): ______________________
- Not applicable
___ Carcinoma in situ / noninvasive papillary urothelial carcinoma present at margin
+Margin(s) Involved by Carcinoma in situ / Noninvasive Papillary Urothelial Carcinoma (select all that apply)
___ Right ureteral: _________________
___ Left ureteral: _________________
___ Urethral: _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________
___ Not applicable

+Margin Comment: _________________

REGIONAL LYMPH NODES

Regional Lymph Node Status
___ Not applicable (no regional lymph nodes submitted or found)
___ Regional lymph nodes present
___ All regional lymph nodes negative for tumor
___ Tumor present in regional lymph node(s)

Number of Lymph Nodes with Tumor
___ Exact number (specify): _________________
___ At least (specify): _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

+Size of Largest Nodal Metastatic Deposit
Specify in Centimeters (cm)
___ Exact size: _________________ cm
___ At least: _________________ cm
___ Greater than: _________________ cm
___ Less than: _________________ cm
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

+Nodal Site with Largest Metastatic Deposit (specify site): _________________

+Size of Largest Lymph Node with Tumor
Specify in Centimeters (cm)
___ Exact size: _________________ cm
___ At least: _________________ cm
___ Greater than: _________________ cm
___ Less than: _________________ cm
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

+Nodal Site with Largest Tumor (specify site): _________________
+Extranodal Extension (ENE)
   ___ Not identified
   ___ Present
   ___ Cannot be determined: _________________
   ___ Other (specify): _________________
   ___ Cannot be determined (explain): _________________

Number of Lymph Nodes Examined
   ___ Exact number (specify): _________________
   ___ At least (specify): _________________
   ___ Other (specify): _________________
   ___ Cannot be determined (explain): _________________

+Regional Lymph Node Comment: _________________

DISTANT METASTASIS

Distant Site(s) Involved, if applicable# (select all that apply)
   ___ Not applicable
   ___ Non-regional lymph node(s): _________________
   ___ Other site(s), excluding non-regional lymph nodes (specify): _________________
   ___ Cannot be determined: _________________

PATHOLOGIC STAGE CLASSIFICATION (pTNM, AJCC 8th Edition) (Note G)

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.

TNM Descriptors (select all that apply)
   ___ Not applicable: _________________
   ___ m (multiple primary tumors)
   ___ r (recurrent)
   ___ y (post-treatment)

pT Category
   ___ pT not assigned (cannot be determined based on available pathological information)
   ___ pT0: No evidence of primary tumor
   ___ pTa: Non-invasive papillary carcinoma
   ___ pTis: Urothelial carcinoma *in situ*: “flat tumor”
   ___ pT1: Tumor invades lamina propria (subepithelial connective tissue)
   ___ pT2: Tumor invades muscularis propria
   ___ pT2a: Tumor invades superficial muscularis propria (inner half)
   ___ pT2b: Tumor invades deep muscularis propria (outer half)
   ___ pT2 (subcategory cannot be determined)
   ___ pT3: Tumor invades perivesical soft tissue
   ___ pT3a: Tumor invades perivesical soft tissue microscopically
   ___ pT3b: Tumor invades perivesical soft tissue macroscopically (extravesicular mass)
   ___ pT3 (subcategory cannot be determined)
   ___ pT4: Extravesical tumor directly invades any of the following: prostatic stroma, seminal vesicles, uterus, vagina, pelvic wall, abdominal wall
____ pT4a: Extravesical tumor invades directly into prostatic stroma, uterus, or vagina
____ pT4b: Extravesical tumor invades pelvic wall, abdominal wall
____ pT4 (subcategory cannot be determined)

pN Category
____ pN not assigned (no nodes submitted or found)
____ pN not assigned (cannot be determined based on available pathological information)
____ pN0: No lymph node metastasis
____ pN1: Single regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node)
____ pN2: Multiple regional lymph node metastasis in the true pelvis (perivesical, obturator, internal and external iliac, or sacral lymph node)
____ pN3: Lymph node metastasis to the common iliac lymph nodes

pM Category (required only if confirmed pathologically)
____ Not applicable - pM cannot be determined from the submitted specimen(s)

pm1: Distant metastasis
____ pm1a: Distant metastasis limited to lymph nodes beyond the common iliacs
____ pm1b: Non-lymph-node distant metastases
____ pm1 (subcategory cannot be determined)

ADDITIONAL FINDINGS (Note C)

+ Associated Epithelial Lesions (select all that apply)
____ None identified
____ Urothelial papilloma
____ Urothelial papilloma, inverted type
____ Papillary urothelial neoplasm, low malignant potential (PUNLMP)
____ Urothelial proliferation of uncertain malignant potential
____ Urothelial dysplasia
____ Other (specify): __________________________
____ Cannot be determined: __________________________

+ Additional Findings (select all that apply)
____ Urothelial dysplasia
____ Adenocarcinoma of prostate (use checklist for carcinoma of prostate)
____ Inflammation / regenerative changes
____ Therapy-related changes (specify): __________________________
____ Cystitis cystica et glandularis
____ Keratinizing squamous metaplasia
____ Intestinal metaplasia
____ Other (specify): __________________________

COMMENTS

Comment(s): __________________________
Explanatory Notes

A. Sections for Microscopic Evaluation

Bladder
Sections of bladder for microscopic evaluation for cystectomy specimens, several representative sections of the tumor, including the macroscopically deepest penetration, should be sampled. Submit several sections of the mucosa remote from the carcinoma, especially if abnormal, including the lateral wall(s), dome, and trigone. Submit one section of ureteral margin, unless submitted separately as frozen section specimens, and 1 section of urethral margin. If a long segment of the ureter(s) is present, then additional sections from the mid-portion may be necessary, as urothelial cancer often is multifocal.

Prostate and Prostatic Urethra
Prostatic urethral involvement should be carefully investigated in cystectomy specimens. Sections should include the prostatic urethra, including at the margin and with the surrounding prostatic parenchyma. Representative sections of the peripheral zone, central zone, and seminal vesicles should be included. Close gross examination may help target sampling of selective abnormal-appearing areas.

Lymph Nodes
Submit one section from each grossly positive lymph node. All other lymph nodes should be entirely submitted, as presence of nodal disease may be used as an indication for adjuvant therapy. Lymph nodes may be grossly or microscopically detected in the perivesical fat.

Other Tissues
Submit one or more sections of uterus (as indicated) and one or more sections of vagina, seminal vesicles, and other organs (as indicated). If the tumor grossly appears to invade the prostate, uterus, or vagina, sections should be targeted, such that the relationship of the infiltrating tumor in the bladder wall and the adjacent viscus is clearly demonstrable.

B. Histologic Type
The vast majority (more than 95%) of carcinomas of the urinary bladder, renal pelvis, and ureter are urothelial cell in origin. The most recent 2016 World Health Organization (WHO) classification of tumors of the urothelial tract, including urethra, urinary bladder, ureter, and renal pelvis, is provided in this note. Benign tumors are included in this classification because, within the same patient, a spectrum of differentiation from benign to malignant tumors may be seen in the bladder, either at the same time or over the clinical course of the disease. Also, clinicians stage most tumors irrespective of histologic grade. The distinction between a urothelial carcinoma with divergent squamous, glandular, or Müllerian differentiation and a pure squamous cell carcinoma, adenocarcinoma or Müllerian is rather arbitrary. Most authorities, including the 2016 WHO classification, require a pure histology of squamous cell carcinoma, adenocarcinoma or Müllerian to designate a tumor as such, all others with recognizable papillary, invasive, or flat carcinoma in situ (CIS) urothelial component being considered as urothelial carcinoma with divergent differentiation. A malignant neoplasm with small cell neuroendocrine carcinoma component arising in the urinary tract is designated as small cell carcinoma.
2016 WHO Classification of Tumors of the Urothelial Tract

Urothelial tumors

*Infiltrating urothelial carcinoma*

- Nested, including large nested
- Microcystic
- Micropapillary
- Lymphoepithelioma-like
- Plasmacytoid/signet ring cell/diffuse
- Sarcomatoid
- Giant cell
- Poorly differentiated

*Noninvasive urothelial lesions*

- Urothelial carcinoma in situ
- Noninvasive papillary urothelial carcinoma, low grade
- Noninvasive papillary urothelial carcinoma, high grade
- Papillary urothelial neoplasm of low malignant potential
- Urothelial papilloma
- Inverted urothelial papilloma
- Urothelial proliferation of uncertain malignant potential
- Urothelial dysplasia

*Squamous cell neoplasms*

- Squamous cell carcinoma
- Verrucous carcinoma
- Squamous cell papilloma

*Glandular neoplasms*

- Adenocarcinoma, NOS
- Enteric
Mucinous
Mixed
Villous adenoma
Urachal carcinoma
Tumors of Mullerian type
Clear cell carcinoma
Endometrioid carcinoma
Neuroendocrine tumors
Small cell neuroendocrine carcinoma
Large cell neuroendocrine carcinoma
Well-differentiated neuroendocrine tumor
Paraganglioma

References
C. Histologic Grade
Flat intraepithelial lesions and papillary and invasive lesions are graded separately. There has been significant controversy in the classification of these lesions. Flat lesions were graded as mild, moderate, and severe dysplasia and carcinoma in situ; or atypical hyperplasia and carcinoma in situ; or dysplasia and carcinoma in situ. Papillary lesions were classified as papillomas (grade 0) and transitional cell carcinomas, grades I, II and III; or as papillomas, low-grade and high-grade transitional cell carcinomas. Due to variable classification systems and the need for a universally acceptable system, the World Health Organization/International Society of Urological Pathology (WHO/ISUP) consensus classification was proposed. This system is adopted in the WHO 2004 classification and 2004 Armed Forces Institute of Pathology (AFIP) fascicle, and has been validated by many studies to be prognostically significant. The 2016 WHO system used essentially the same classification with minor modification. Other systems (that were being used previously) may still be used according to institutional preference. Tumor grade according to both the WHO/ISUP (1998) / WHO (2004) system and the older WHO (1973) system may be concurrently used.

2004 WHO / ISUP Consensus Classification for Urothelial Lesions

Normal
- Normal

Hyperplasia
- Flat hyperplasia
- Papillary hyperplasia

Flat Lesions with Atypia
- Reactive (inflammatory) atypia
- Atypia of unknown significance
- Dysplasia (low-grade intraurothelial neoplasia)
- Carcinoma in situ (high-grade intraurothelial neoplasia)

Papillary Neoplasms
- Papilloma
- Inverted papilloma
- Papillary neoplasm of low malignant potential
- Papillary carcinoma, low-grade
- Papillary carcinoma, high-grade

Invasive Neoplasms
- Lamina propria invasion
- Muscularis propria (detrusor muscle) invasion

May include cases formerly diagnosed as “mild dysplasia.”
Flat and papillary urothelial hyperplasia has been renamed as “urothelial proliferation of uncertain malignant potential” in the 2016 WHO classification.

Squamous carcinomas and adenocarcinomas may be graded as well-differentiated, moderately differentiated, and poorly differentiated.

References

D. Extent of Invasion
A critical role of the surgical pathologist is to diagnose the depth and extent of invasion into the subepithelial connective tissue/lamina propria/submucosa (pT1), muscularis propria (pT2), or beyond (pT3 or pT4). In papillary tumors, invasion occurs most often at the base of the tumor and very infrequently in the stalk. In the urinary bladder, a tumor infiltrating the lamina propria (pT1) is sometimes overdiagnosed as vascular invasion; hence, caution should be exercised when diagnosing this feature, which in some cases may be supported by performing immunohistochemical studies for endothelial markers.

Involvement of the prostate gland may occur in several different patterns. Tumors (flat carcinoma in situ, papillary or invasive carcinoma) can first spread along the prostatic urethral mucosa and prostate glands and subsequently invade prostatic stroma (transurethral mucosal route) (Figure 1, B). Tumors may also invade through the bladder wall and the base of the prostate directly into the prostate gland (Figure 1, A, straight arrow). Tumors can also invade into extravesical fat and then extend back into the prostate gland.
The latter two routes are considered direct transmural invasion. The American Joint Committee on Cancer (AJCC) 8th edition staging manual defines direct extension of urinary bladder cancer into the prostate gland as T4 disease and excludes transurethral mucosal prostatic stroma invasion from the pT4a staging status. However, there is limited data on the best methodology to stage urothelial carcinoma that concurrently involves the urinary bladder and the prostatic urethra. In patients who have a large urinary bladder carcinoma that has invaded through the full thickness of the bladder wall and thereby secondarily involves the prostatic stroma, a T4 stage should be assigned per urinary bladder staging. In other circumstances in which involvement by urothelial carcinoma is seen in both sites, separate urinary bladder and prostatic urethral staging should be assigned. Transmucosal route into prostatic stroma from a bladder cancer without transmural prostatic stromal invasion is now categorized as pT2 per urethral cancer staging, and the concomitant bladder proper cancer is given a separate stage category according to the bladder cancer staging.

**Figure 1.** Prostatic invasion from urinary bladder cancer via direct transmural and extravesical route (A) and transurethral invasion (B). From: Patel AR, Cohn JA, El Latif AA, et al. Validation of new AJCC exclusion criteria for subepithelial prostatic stroma invasion from pT4a bladder urothelial carcinoma. *J Urol.* 2013;189:53-58. Reproduced with permission.

References

E. Lymphovascular Invasion

Urothelial carcinoma may invade blood vessels or lymphatic channels. Lymphovascular invasion has been shown to be an independent predictor of recurrence and decreased overall survival. In suspicious cases, blood vessels can be highlighted by immunohistochemical staining for factor VIII-related antigen, CD31 or CD34. Staining will not resolve the problem of differentiating lymphatic versus artifactual space entrapment by tumor cells, and as mentioned, this is frequently seen in urothelial tumors invading the lamina propria. Retraction artifact is also prominent in the “micropapillary variant” of urothelial carcinoma.

References


F. Margins

Resection margins, including those mentioned in Note A, should be carefully specified. Statements about deep soft tissue margins should specify whether peritoneal surfaces are involved by tumor. In cases of urachal adenocarcinoma in which partial cystectomy with excision of the urachal tract and umbilicus is performed, the margins of the urachal tract, ie, the soft tissue surrounding the urachus and the skin around the umbilical margin, should be specified.

G. TNM and Stage Groupings

The TNM Staging System for carcinomas of the urinary bladder of the AJCC is recommended. A cystoprostatectomy specimen may contain three separate primaries: carcinoma of the urinary bladder, carcinoma of the prostate and carcinoma of the urethra. Depending on the pathology in a given case, the number of protocols to be used in a cystoprostatectomy specimen will vary.

By AJCC 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.

Primary Tumor (T) (Figure 2)

The suffix “m” should be added to the appropriate T category to indicate multiple tumors. The suffix “is” may be added to any T to indicate the presence of associated carcinoma in situ.

**TNM Descriptors**

For identification of special cases of TNM or pTNM classifications, the “m” suffix and “y” and “r” 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.

**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).

References