Protocol for the Examination of Biopsy Specimens From Patients With Primary Tumors of Bone

Version: 4.1.0.1
Protocol Posting Date: November 2021
The use of this protocol is recommended for clinical care purposes but is not required for accreditation purposes.

This protocol may be used for the following procedures AND tumor types:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy</td>
<td>Includes specimens designated Core needle biopsy, curettage, excisional biopsy, and others</td>
</tr>
<tr>
<td>Tumor Type</td>
<td>Description</td>
</tr>
<tr>
<td>Primary malignant bone tumors</td>
<td>Includes chondrogenic tumors, osteogenic tumors, fibrogenic tumors, osteoclastic giant cell rich tumors, notochordal tumors, vascular tumors, myogenic tumors, lipogenic tumors, undifferentiated small round cell sarcomas and other mesenchymal tumors arising in bone.</td>
</tr>
</tbody>
</table>

The following should NOT be reported using this protocol:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resection (consider Bone Resection protocol)</td>
<td></td>
</tr>
<tr>
<td>Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)</td>
<td></td>
</tr>
<tr>
<td>Cytologic specimens</td>
<td></td>
</tr>
<tr>
<td>Tumor Type</td>
<td>Description</td>
</tr>
<tr>
<td>Plasma cell neoplasms (consider the Plasma Cell Neoplasms protocol)</td>
<td></td>
</tr>
<tr>
<td>Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)</td>
<td></td>
</tr>
<tr>
<td>Pediatric Ewing sarcoma (consider the Ewing Sarcoma protocol)</td>
<td></td>
</tr>
<tr>
<td>Soft tissue sarcoma (consider the Soft Tissue protocol)</td>
<td></td>
</tr>
</tbody>
</table>

Authors
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With guidance from the CAP Cancer and CAP Pathology Electronic Reporting Committees.
* Denotes primary author.
Accreditation Requirements
The use of this biopsy case summary is recommended for clinical care purposes, but is not required for accreditation purposes. The core and conditional data elements are routinely reported for biopsy specimens. Non-core data elements are included to allow for reporting information that may be of clinical value.

Summary of Changes

v 4.1.0.1
- The CAP made no changes to Cancer Protocol content. We updated metadata only for the electronic Cancer Checklists (eCC), requiring a version number change for the Word and PDF Cancer Protocols.
Reporting Template

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

CASE SUMMARY: (BONE: Biopsy)
Standard(s): AJCC-UICC 8
This case summary is recommended for reporting biopsy specimens, but is not required for accreditation purposes.

CLINICAL (Note A)

+Radiographic Findings (Note B)
   ___ Specify: _________________
   ___ Not available

SPECIMEN

Procedure (Note C)
   ___ Core needle biopsy
   ___ Curettage
   ___ Excisional biopsy
   ___ Other (specify): _________________
   ___ Not specified

TUMOR

Tumor Site (Note D)
   ___ Appendicular skeleton (specify bone, if known): _________________
   ___ Spine (specify bone, if known): _________________
   ___ Pelvis (specify bone, if known): _________________
   ___ Not specified

Tumor Location and Extent (Note B) (select all that apply)
   ___ Epiphysis or apophysis
   ___ Metaphysis
   ___ Diaphysis
   ___ Cortex
   ___ Medullary cavity
   ___ Surface
   ___ Involves joint
   ___ Extends into soft tissue
   ___ Cannot be determined: _________________

Histologic Type (World Health Organization [WHO] Classification of Malignant Bone Tumors) (Note E)
   ___ Chondrogenic Tumors
      ___ Chondrosarcoma
      ___ Dedifferentiated chondrosarcoma
___ Periosteal chondrosarcoma
___ Clear cell chondrosarcoma
___ Mesenchymal chondrosarcoma

___ Osteogenic Tumors
___ Low grade central osteosarcoma
___ Osteosarcoma NOS
___ Conventional osteosarcoma
___ Telangiectatic osteosarcoma
___ Small cell osteosarcoma
___ Parosteal osteosarcoma
___ Periosteal osteosarcoma
___ High grade surface osteosarcoma
___ Secondary osteosarcoma

+Precipitating Factor for Secondary Osteosarcoma: _________________

___ Undifferentiated Small Round Cell Sarcomas
___ Ewing sarcoma
___ Round cell sarcoma with EWSR1-non ETS fusions
___ CIC-rearranged sarcoma
___ Sarcoma with BCOR genetic alterations

___ Fibrogenic Tumors - Fibrosarcoma of bone

___ Malignancy in giant cell tumor of bone

___ Notochordal Tumors
___ Chordoma NOS
___ Chondroid chordoma
___ Poorly differentiated chordoma
___ Dedifferentiated chordoma

___ Vascular Tumors
___ Epithelioid hemangioendothelioma
___ Angiosarcoma

___ Other Mesenchymal Tumors
___ Leiomyosarcoma of bone
___ Adamantinoma
___ Dedifferentiated adamantinoma
___ Undifferentiated high-grade pleomorphic sarcoma

___ Cannot be determined: _________________

___ Other histologic type not listed (specify): _________________

+Histologic Type Comment: _________________

Histologic Grade (Note F)
___ G1, well differentiated, low grade
___ G2, moderately differentiated, high grade
___ G3, poorly differentiated, high grade
___ GX, cannot be assessed: _________________
___ Not applicable
+Mitotic Rate (Note G)
   ___ Specify mitotic rate per mm²: _________________ mitoses per mm²
   ___ Specify mitotic rate per 10 high-power fields (HPF): _______ mitoses per 10 high-power fields (HPF)
   ___ Cannot be determined (explain): ____________________

Necrosis (Note C)
   ___ Not identified
   ___ Present
       Extent of Necrosis
          ___ Specify percentage: _________________ %
          ___ Cannot be determined (explain): ____________________
          ___ Cannot be determined

+Lymphovascular Invasion (Note H)
   ___ Not identified
   ___ Present
   ___ Cannot be determined: ____________________

+Tumor Comment: ________________

ADDITIONAL FINDINGS

+Additional Findings (specify): ________________

SPECIAL STUDIES

Immunohistochemistry
   ___ Specify: ________________
   ___ Not performed: ________________
   ___ Not applicable

Cytogenetics
   ___ Specify: ________________
   ___ Not performed: ________________
   ___ Not applicable

Molecular Pathology
   ___ Specify: ________________
   ___ Not performed: ________________
   ___ Not applicable

COMMENTS

Comment(s): ____________________
Explanatory Notes

A. Scope of Guidelines
These recommendations are used for all primary malignant tumors of bone except hematopoietic neoplasms, ie, lymphoma and plasma cell neoplasms.

B. Tumor Location and Extent
Radiographic imaging plays an especially critical role in the diagnosis of bone tumors. Close collaboration with an experienced musculoskeletal radiologist and orthopedic surgeon is recommended.

Figure 1 is a diagrammatic representation of the “anatomic” regions of a long bone. These locations are very important in classifying bone tumors. For instance, chondroblastomas almost always arise in the epiphysis. Epiphyses and apophyses are secondary ossification centers and therefore are embryonic equivalents. The greater and lesser trochanters are apophyses, while the epiphyses are at the ends of long bones.

Figure 1. Important anatomic landmarks for tumor diagnosis in long bones. Adapted from Gray’s Anatomy.1

References

C. Procedure / Tissue Processing
The following is a list of guidelines to be used in defining what type of procedure has been performed. This is based on the surgeon’s intent and not based on the pathologic assessment of the margins.

- **Intralesional Resection**: Leaving gross tumor behind. Partial debulking or curettage are examples.
- **Marginal Resection**: Removing the tumor and its pseudocapsule with a relatively small amount of adjacent tissue. There is no gross tumor at the margin; however, microscopic tumor may be
present. Note that occasionally, a surgeon will perform an “excisional” biopsy, which effectively accomplishes the same thing as a marginal resection.

- **Segmental/Wide Resection**: An intracompartmental resection. A single piece of bone is resected, including the lesion and a cuff of normal bone.
- **Radical Resection**: The removal of an entire bone, or the excision of the adjacent muscle groups if the tumor is extracompartmental

**Fixation**

Tissue specimens from bone tumors optimally are received fresh/unfixed in case fresh tissue for ancillary studies, such as cytogenetics or molecular studies, needs to be collected. All tissue should be processed in a manner that would allow molecular studies to be undertaken successfully. Decalcification using harsh acid reagents may be detrimental for nucleic acid-based molecular studies and therefore utilization of EDTA as decalcifying agent has been recommended. Freezing a portion of the sample and/or fixing soft portions of the lesion in buffered formalin is encouraged.

**Tissue Submission for Histologic Evaluation**

One section per centimeter of maximum dimension is usually recommended, although fewer sections are needed for very large tumors, especially if they are homogeneous. Tumors known to be high grade from a previous biopsy do not require as many sections as those that were previously diagnosed as low grade, as documentation of a high-grade component will change stage and prognosis in the latter case. Sections should be taken of grossly heterogeneous areas, and there is no need to submit more than 1 section of necrotic tumor (always with a transition to viable tumor), with the exception of specimens obtained to assess chemotherapy effect on osteosarcomas and Ewing sarcoma. Occasionally, gross pathology can be misleading, and areas that appear to be grossly necrotic may actually be myxoid or edematous. When this happens, additional sections of these areas should be submitted for histologic examination. When estimates of gross necrosis exceed those of histologic necrosis, the greater percentage of necrosis should be recorded on the surgical pathology report. In general, most tumors require 12 sections or fewer, excluding margins. Tumors with greater areas of heterogeneity may need to be sampled more thoroughly.

**Molecular Studies**

Additionally, it may be important to snap freeze a small portion of tissue as availability of frozen tissue may be a requirement for patient enrollment in clinical trials. Approximately 1 cm$^3$ of fresh tissue (less is acceptable for small specimens, including core biopsies) should be cut into small, 0.2-cm fragments, reserving sufficient tissue for histologic examination. This frozen tissue should ideally be stored at minus (-)70°C and can be shipped on dry ice to facilities that perform molecular analysis. Discretion should be used in triaging tissue from bone sarcomas. Adequate tissue should be submitted for conventional light microscopy before tissue has been taken for cytogenetics, electron microscopy, or molecular analysis.

**References**

D. Tumor Site
Given the strong association between the primary anatomic site and outcome, the 8th edition of the AJCC Cancer Staging Manual uses the following site groups for staging purposes:

- Appendicular skeleton, including trunk, skull, and facial bones
- Pelvis
- Spine

This site grouping is reflected by the provision of separate definitions for the primary tumor (T) for each anatomic site.

References

E. Classification of Bone Tumors
Intraoperative Consultation

Histologic classification of bone tumors is sufficiently complex that, in many cases, it is unreasonable to expect a precise classification of these tumors based on an intraoperative consultation. A complete understanding of the surgeon’s treatment algorithm is recommended before rendering a frozen section diagnosis. In the case of primary bone tumors, an intraoperative diagnosis of benign versus malignant will generally guide the immediate decision to curette, excise, or wait for permanent sections, and certain therapeutic options may be lost if the wrong path is pursued. Intraoperative consultation is useful in assessing if “lesional” tissue is present and whether or not this tissue is necrotic, and in constructing a differential diagnosis that can direct the proper triage of tissue for flow cytometry (lymphoma), electron microscopy, and molecular studies/cytogenetics. Tissue triage optimally is performed at the time of frozen section. In many cases, it is important that a portion of tissue be submitted for ancillary studies, even from fine-needle aspiration (FNA) and core needle biopsy specimens, once sufficient tissue has been submitted for histologic evaluation.

Tumor Classification from Biopsies

It is not always possible to classify bone tumors precisely based on biopsy material, especially FNA and core needle biopsy specimens. Although pathologists should make every attempt to classify lesions in small biopsy specimens, on occasion, stratification into very basic diagnostic categories, such as lymphoma, carcinoma, melanoma, and sarcoma, is all that is possible. In some cases, precise classification is only possible in open biopsies or resection specimens.

Histologic Classification of Treated Lesions

Due to extensive treatment effects, such as necrosis, fibrosis, and chemotherapy-induced and radiation-induced pleomorphism, it may not be possible to classify some lesions that were either never biopsied or
where the biopsy was insufficient for a precise diagnosis. In problematic cases, the grade of the pretreatment specimen (if available) should take precedence.

WHO Classification of Malignant Bone Tumors

Classification of tumors should be made according to the 2020 World Health Organization (WHO) classification of bone tumors.\(^1\) As part of the WHO classification system, soft tissue tumors are divided into 4 categories: benign, intermediate (locally aggressive), intermediate (rarely metastasizing), and malignant. Primary malignant lymphomas and plasma cell neoplasms are not staged using the AJCC system for malignant bone tumors.

References


F. Grading

The grading of bone tumors is largely driven by the histologic diagnosis, and traditionally grading has been based on the system advocated by Broders, which assesses cellularity and nuclear features/degree of anaplasia.\(^1\) The eighth edition of the AJCC Cancer Staging Manual recommends a 2-tiered system (low vs high grade) for recording grading.\(^2\) Histologic grading uses a 3-tiered system: Grade 1 is considered low grade, and Grade 2 and Grade 3 are grouped together as high grade for biological grading. In bone sarcomas, the histologic subtype often determines the clinical behaviour and grade. Therefore, a more pragmatic approach to grading aggressive and malignant primary tumors of bone can be used.\(^3\)

Two bone tumors that are locally aggressive and metastasize infrequently, and thus are usually low grade, are low-grade central osteosarcoma and parosteal osteosarcoma. Periosteal osteosarcoma is generally regarded as a grade 2 osteosarcoma. Primary bone tumors that are generally high grade include malignant giant cell tumor, Ewing sarcoma, angiosarcoma, dedifferentiated chondrosarcoma, conventional osteosarcoma, telangiectactic osteosarcoma, small cell osteosarcoma, secondary osteosarcoma, and high-grade surface osteosarcoma.

Grading of conventional chondrosarcoma is based on cellularity, cytologic atypia, and mitotic figures, following the grading system proposed by Evans et al.\(^4\) Grade 1 (low-grade) chondrosarcoma is hypocellular and similar histologically to enchondroma. Grade 2 (intermediate-grade) chondrosarcoma is more cellular than grade 1 chondrosarcoma; has more cytologic atypia, greater hyperchromasia and nuclear size; or has extensive myxoid stroma. Grade 3 (high-grade) chondrosarcoma is hypercellular, pleomorphic, and contains prominent mitotic activity.

Mesenchymal chondrosarcoma, fibrosarcoma, leiomyosarcoma, liposarcoma, undifferentiated high-grade pleomorphic sarcoma of bone and other “soft tissue-type” sarcomas that rarely occur in bone can be graded according to the French Federation of Cancer Centers Sarcoma Group (FNCLCC) grading system\(^5\) (see College of American Pathologists protocol for soft tissue tumors\(^6\)).

Chordomas are locally aggressive lesions with a propensity for metastasis late in their clinical course and are not graded. Adamantinomas tend to have a low-grade clinical course, but this is variable. Fortunately, they are very rare. According to the 2020 WHO classification of tumors of bone, adamantinomas are not graded.\(^3\)

**Bone Tumor Grades (Summary)**

**Grade 1 (Low Grade)**

Low-grade intramedullary (central) osteosarcoma
Parosteal osteosarcoma
Grade I chondrosarcoma
Clear cell chondrosarcoma

**Grade 2**
Periosteal osteosarcoma
Grade II chondrosarcoma

**Grade 3 (High Grade)**
Ewing sarcoma
Conventional osteosarcoma
Telangiectatic osteosarcoma
Mesenchymal chondrosarcoma
Small cell osteosarcoma
Secondary osteosarcoma
High-grade surface osteosarcoma
Dedifferentiated chondrosarcoma
Dedifferentiated chordoma
Malignancy in giant cell tumor
Grade III chondrosarcoma
Soft-tissue type sarcomas (eg, leiomyosarcoma)
Undifferentiated high-grade pleomorphic sarcoma

**TNM Grading**
The 8th edition of the American Joint Committee on Cancer (AJCC) and International Union Against Cancer (UICC) staging system for bone tumors includes a 3-grade system but effectively collapses into high grade and low grade. Grading in the TNM grading system is based on differentiation only and does not generally apply to sarcomas.

**GX** Grade cannot be assessed

**G1** Well differentiated, low grade

**G2** Moderately differentiated, high grade

**G3** Poorly differentiated, high grade

For purposes of using the AJCC staging system, 3-grade systems can be converted to a 2-grade (TNM) system as follows: grade 1 = low-grade; grade 2 and grade 3 = high-grade.

**References**
G. Mitotic Rate

Mitotic rate is determined by counting mitotic figures in the most mitotically active area, away from areas of necrosis, in either 10 consecutive high-power fields (HPF) (use the X40 objective) (1 HPF x 400 = 0.1734 mm²) or in the appropriate number of HPF to encompass 1 mm² based on each individual microscope.

The area of 1 HPF originally used measured 0.1734 mm². However, the area of 1 HPF using most modern microscopes with wider 40x lenses will most likely be higher. Pathologists are encouraged to determine the field area of their 40x lenses and divide 0.1734 by the obtained field area to obtain a conversion factor. The number of mitotic figures in 10 HPF multiplied by the obtained conversion factor and rounded to the nearest whole number should be used for reporting purposes.

An important change in the 5th Edition of the WHO Classification of Tumours series is the conversion of mitotic count from the traditional denominator of 10 HPFs to a defined area expressed in mm², as an attempt to standardize the area used for mitotic count. Table 1 shows the approximate number of fields required to encompass 1 mm² based on the field diameter and its corresponding area.

Table 1. Approximate number of fields per 1 mm² based on field diameter and its corresponding area

<table>
<thead>
<tr>
<th>Field diameter (mm)</th>
<th>Area (mm²)</th>
<th>Approximate number of fields per 1 mm²</th>
</tr>
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<tbody>
<tr>
<td>0.40</td>
<td>0.126</td>
<td>8</td>
</tr>
<tr>
<td>0.41</td>
<td>0.132</td>
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<tr>
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<tr>
<td>0.43</td>
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<tr>
<td>0.44</td>
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<tr>
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<tr>
<td>0.46</td>
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<tr>
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<tr>
<td>0.65</td>
<td>0.332</td>
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</table>
H. Lymphovascular Invasion
Lymphovascular invasion (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.

References