Protocol for the Examination of Resection Specimens from Patients with Invasive Carcinoma of Renal Tubular Origin

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>Nephrectomy</td>
<td>Includes specimens designated partial, total, or radical nephrectomy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal cell carcinomas</td>
<td>Includes all renal cell carcinoma variants</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy (needle, incisional or wedge)</td>
</tr>
<tr>
<td>Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)</td>
</tr>
<tr>
<td>Cytologic specimens</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Tumor Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urothelial tumors (consider Ureter, Renal Pelvis protocol)</td>
</tr>
<tr>
<td>Wilm’s tumors (Consider Wilm’s Tumor protocol)</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>

Authors
John R. Srigley, MD*; Gladell P. Paner, MD*; Ming Zhou, MD, PhD*; Lara R. Harik, MD; Robert Allan, MD; Mahul B. Amin, MD; Steven C. Campbell, MD; Anthony Chang, MD; Brett Delahunt, MD; David J. Grignon, MD; Peter A. Humphrey, MD, PhD; Bradley C. Leibovich, MD; Rodolfo Montironi, MD; Jason Pettus, MD; Victor E. Reuter, MD.

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 IN ADDITION TO but not as replacement for the synoptic report ie, 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
Reporting Template

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

CASE SUMMARY: (KIDNEY: Nephrectomy)
Standard(s): AJCC-UICC 8

SPECIMEN (Note A)

Procedure
___ Partial nephrectomy
___ Radical nephrectomy
___ Total nephrectomy
___ Other (specify): _________________
___ Not specified

Specimen Laterality
___ Right
___ Left
___ Not specified

TUMOR

Tumor Focality
___ Unifocal
___ Multifocal: _________________

+Tumor Site (select all that apply)
___ Upper pole
___ Middle
___ Lower pole
___ Other (specify): _________________
___ Not specified

Tumor Size
If multiple tumors present, document the size of the largest tumor.
___ Greatest dimension in Centimeters (cm): _________________ cm
   +Additional Dimension in Centimeters (cm): ____ x ____ cm
___ Cannot be determined (explain): _________________

Histologic Type (Note B)
___ Clear cell renal cell carcinoma
___ Multilocular cystic clear cell renal cell neoplasm of low malignant potential
___ Papillary renal cell carcinoma
___ Papillary renal cell carcinoma, type 1
___ Papillary renal cell carcinoma, type 2
___ Chromophobe renal cell carcinoma
___ Collecting duct carcinoma
___ Renal medullary carcinoma
___ Mit family translocation renal cell carcinoma
___ Xp11 translocation renal cell carcinoma
___ t(6;11) renal cell carcinoma
___ Mucinous tubular and spindle renal cell carcinoma
___ Tubulocystic renal cell carcinoma
___ Acquired cystic disease associated renal cell carcinoma
___ Clear cell papillary renal cell carcinoma
___ Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma
___ Succinate dehydrogenase (SDH) deficient renal carcinoma
___ Renal cell carcinoma, unclassified
___ Other histologic type not listed (specify): _________________

+Histologic Type Comment: _________________

Histologic Grade (WHO / ISUP) (Note C)
___ G1 (nucleoli absent or inconspicuous and basophilic at 400x magnification)
___ G2 (nucleoli conspicuous and eosinophilic at 400x magnification, visible but not prominent at 100x magnification)
___ G3 (nucleoli conspicuous and eosinophilic at 100x magnification)
___ G4 (extreme nuclear pleomorphism and / or multi-nuclear giant cells and / or rhabdoid and / or sarcomatoid differentiation)
___ GX (cannot be assessed)
___ Not applicable: _________________

Tumor Extent (Notes D,E) (select all that apply)
___ Limited to kidney
___ Extends into perinephric tissue (beyond renal capsule)
___ Extends into renal sinus
___ Extends beyond Gerota's fascia
___ Extends into major vein (renal vein or its segmental branches, inferior vena cava)
___ Extends into pelvicalyceal system
___ Directly invades adrenal gland (T4)
___ Involves adrenal gland non-contiguously (M1)
___ Extends into other organ(s) / structure(s) (specify): _________________
___ Cannot be determined: _________________
___ No evidence of primary tumor

Sarcomatoid Features (Note F)
___ Not identified
___ Present

+Percentage of Sarcomatoid Element
___ Specify percentage: _________________ %
___ Other (specify): _________________
___ Cannot be determined
___ Cannot be determined: _________________

Rhabdoid Features (Note F)
___ Not identified
___ Present
___ Cannot be determined: _________________
Tumor Necrosis (Note G)
___ Not identified
___ Present

+Percentage of Tumor Necrosis
___ Specify percentage: ____________________%
___ Other (specify): ____________________
___ Cannot be determined
___ Cannot be determined: ____________________

Lymphovascular Invasion (excluding renal vein and its segmental branches and inferior vena cava)
___ Not identified
___ Present
___ Cannot be determined: ____________________

+Tumor Comment: ____________________

MARGINS (Note H)

Margin Status
___ All margins negative for invasive carcinoma
___ Invasive carcinoma present at margin

Margin(s) Involved by Invasive Carcinoma (select all that apply)
# For partial nephrectomy only
___ #Renal parenchymal: ____________________
___ #Renal capsular: ____________________
___ Perinephric fat: ____________________
___ Renal sinus soft tissue: ____________________
___ Gerota's fascia: ____________________
___ Renal vein: ____________________
___ Ureteral: ____________________
___ 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): _________________

+**Nodal Site(s) with Tumor (select all that apply)**
   ___ Hilar: _________________
   ___ Precaval: _________________
   ___ Interaortocaval: _________________
   ___ Paracaval: _________________
   ___ Retrocaval: _________________
   ___ Preaortic: _________________
   ___ Paraaortic: _________________
   ___ Retroaortic: _________________
   ___ Other (specify): _________________

+**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): _________________

+**Largest Lymph Node with Tumor (specify site): _________________**
   ___ 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
___ Not applicable
___ Specify site(s): ______________________
___ Cannot be determined: ____________________

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

Primary Tumor (pT)
___ pT not assigned (cannot be determined based on available pathological information)
___ pT0: No evidence of primary tumor
___ pT1: Tumor less than or equal to 7 cm in greatest dimension, limited to the kidney
   ___ pT1a: Tumor less than or equal to 4 cm in greatest dimension, limited to the kidney
   ___ pT1b: Tumor greater than 4 cm but less than or equal to 7 cm in greatest dimension limited to the kidney
___ pT1 (subcategory cannot be determined)
___ pT2: Tumor greater than 7 cm in greatest dimension, limited to the kidney
   ___ pT2a: Tumor greater than 7 cm but less than or equal to 10 cm in greatest dimension, limited to the kidney
   ___ pT2b: Tumor greater than 10 cm, limited to the kidney
   ___ pT2 (subcategory cannot be determined)
___ pT3: Tumor extends into major veins or perinephric tissues, but not into the ipsilateral adrenal gland and not beyond Gerota’s fascia
   ___ pT3a: Tumor extends into the renal vein or its segmental branches, or invades the pelvicalyceal system, or invades perirenal and / or renal sinus fat but not beyond Gerota’s fascia
   ___ pT3b: Tumor extends into the vena cava below the diaphragm
   ___ pT3c: Tumor extends into the vena cava above the diaphragm or invades the wall of the vena cava
   ___ pT3 (subcategory cannot be determined)
___ pT4: Tumor invades beyond Gerota’s fascia (including contiguous extension into the ipsilateral adrenal gland)

Regional Lymph Nodes (pN)
___ pN not assigned (no nodes submitted or found)
___ pN not assigned (cannot be determined based on available pathological information)
___ pN0: No regional lymph node metastasis
___ pN1: Metastasis in regional lymph node(s)

Distant Metastasis (pM)
___ Not applicable - pM cannot be determined from the submitted specimen(s)
___ pM1: Distant metastasis
ADDITIONAL FINDINGS (Note J)

Additional Findings in Nonneoplastic Kidney (select all that apply)
___ Insufficient tissue
___ None identified
___ Glomerular disease (specify type): __________________
___ Tubulointerstitial disease (specify type): __________________
___ Vascular disease (specify type): __________________
___ Other (specify): __________________

+Additional Findings (select all that apply)
___ Cyst(s) (specify type): __________________
___ Tubular (papillary) adenoma(s): __________________
___ Other (specify): __________________

COMMENTS

Comment(s): __________________
Explanatory Notes

A. Specimen Type
A standard radical nephrectomy specimen consists of the entire kidney including the calyces, pelvis, and a variable length of ureter. The adrenal gland is usually removed en bloc with the kidney. The entire perirenal fatty tissue is removed to the level of Gerota’s fascia, a membranous structure that is similar to the consistency of the renal capsule that encases the kidney in perirenal fat. Variable lengths of the major renal vessels at the hilus are submitted.

Regional lymphadenectomy is not generally performed even with a radial nephrectomy. A few lymph nodes may occasionally be seen in the renal hilus around major vessels. Other regional lymph nodes (eg, paracaval, para-aortic, and retroperineal) may be submitted separately.

A partial nephrectomy specimen may vary from a simple enucleation of the tumor to part of a kidney containing variable portions of calyceal or renal pelvic collecting system. The perirenal fat immediately overlying the resected portion of the kidney but not to a level of Gerota’s fascia is usually included.

B. Histologic Type
The current World Health Organization (WHO) classification (2016) is based on the International Society of Urological Pathology (ISUP) Vancouver Classification of Renal Neoplasia 2012.1,2

- Clear cell renal cell carcinoma
- Multilocular clear cell renal cell neoplasm of low malignant potential
- Papillary renal cell carcinoma
  - Type 1
  - Type 2
- Chromophobe renal cell carcinoma
- Collecting duct carcinoma
- Renal medullary carcinoma
- MiT family translocation renal cell carcinoma
- Mucinous tubular and spindle cell carcinoma
- Tubulocystic renal cell carcinoma
- Acquired cystic disease associated renal cell carcinoma
- Clear cell papillary/tubulopapillary renal cell carcinoma
- Hereditary leiomyomatosis and renal cell carcinoma-associated renal cell carcinoma
- Succinate dehydrogenase (SDH) deficient renal carcinoma
- Renal cell carcinoma, unclassified
- Papillary adenoma
- Renal oncocytoma

Many subtypes of renal cell carcinoma, including many newly described variants, have differing clinical behaviors and prognosis.1,2,3,4 Additionally the usage of adjuvant therapy is related to tumor subtype.5 The concept of an emerging/provisional category of renal cell carcinoma was introduced in the 2012 ISUP Vancouver classification.2 These tumors, while appearing distinctive, had not been fully characterized morphologically or by ancillary techniques. This category in the 2016 WHO classification includes the following entities: oncocytoid renal cell carcinoma (RCC) postneuroblastoma, thyroid-like follicular RCC, anaplastic lymphoma kinase (ALK) rearrangement-associated RCC, and RCC with (angio) leiomyomatous stroma.1 For the purpose of the protocol, these emerging tumors should be classified under "other" and the name specified.
Occasionally more than 1 histologic type of carcinoma occurs within the same kidney specimen. Each tumor type should be separately recorded along with its associated prognostic factors.8

References

C. Histologic Grade
The WHO/ISUP grading system has supplanted the Fuhrman system as the grading standard.12 This grading system has been validated for both clear cell and papillary renal cell carcinoma; however, it has not been validated for other RCC subtypes.14 Nevertheless, the WHO/ISUP grade may be included for descriptive purposes. Currently it is recommended that chromophobe renal cell carcinoma not be graded with the WHO/ISUP system. Details are shown below:

Not applicable
Grade X- Cannot be assessed
Grade 1 - Nucleoli absent or inconspicuous and basophilic at 400x magnification
Grade 2 - Nucleoli conspicuous and eosinophilic at 400x magnification, visible but not prominent at 100x magnification
Grade 3 - Nucleoli conspicuous and eosinophilic at 100x magnification
Grade 4 - Extreme nuclear pleomorphism and/or multinuclear giant cells and/or rhabdoid and/or sarcomatoid differentiation

Although the grading system does reference the tinctorial characteristics of the nucleoli, the determining feature is the nucleolar prominence. Grade should be assigned based on the single high-power field showing the greatest degree of pleomorphism.

References
D. Macroscopic Extent of Tumor
A careful gross analysis and description of tumor extension in a nephrectomy specimen is important and should guide blocking of tissue samples for histologic assessment. Careful documentation of the tumor extension beyond kidney into perinephric fat and Gerota’s fascia provides important staging information. Renal sinus involvement in renal cell carcinoma is an under-recognized phenomenon. The renal sinus is an important pathway of spread of renal cell carcinoma (Figure 1, A and B). The renal sinus should be carefully assessed and generously sampled in order to detect renal sinus fat and vessel involvement. There is evolving literature suggesting that renal sinus involvement predicts a more aggressive outcome than peripheral perinephric fat invasion. If a tumor thrombus is present in the renal vein it is important to determine if the tumor is confined to the renal vein (pT3a) or whether it extends into inferior vena cava (pT3b/c). When renal carcinoma involves adrenal gland, it is important to document whether the involvement is contiguous spread of tumor or a separate (noncontiguous) nodule of carcinoma, the latter representing metastatic disease (pM1) (Figure 2).

Figure 1. A, Diagram showing the renal sinus fat (S) and its rich venous system that envelops the collecting system. The renal capsule terminates (arrow) just inside the vestibule of the hilus. B, A renal malignancy is constrained by the renal capsule (arrow), yet no fibrous capsule impedes its growth into the vascular tissue of the renal sinus (curved arrows). From Bonsib et al. Reproduced with permission of the American Journal of Surgical Pathology. © 2000 Wolters Kluwer Health.
Figure 2. Diagram showing relationship between local tumor extension and pT designation. When a tumor shows direct invasion into the perirenal fat or renal sinus fat, it is designated as pT3a. A tumor that directly invades the adrenal gland is designated as pT4, while a tumor that shows discontinuous (noncontiguous) involvement of the adrenal gland is considered metastatic (M1).

References

E. Microscopic Tumor Extension
The microscopic documentation of extrarenal extension is critical in assigning a pT category in renal cell carcinoma. Invasion of perirenal fat is considered pT3a and invasion beyond Gerota’s fascia is a feature of pT4 disease.

The renal sinus is an anatomical compartment separating the renal parenchyma from the upper collecting system (renal pelvis and calyces). In this area abundant adipose tissue, lymphatics, and thin walled veins are noted in the renal sinus. Clear cell renal cell carcinomas ≥7 cm in diameter show renal sinus invasion in greater than 90% of cases. In recent years, the definition of renal sinus involvement has been clarified and includes the following: (1) tumor in contact with renal sinus fat, (2) tumor in loose connective tissue of sinus clearly beyond the renal parenchyma, and (3) involvement of endothelial lined spaces (with or without mural smooth muscle), including lymphatics.
Involvement of the renal vein or segmental branches is generally identified macroscopically and is definitional for the pT3a category. It is important to document renal involvement microscopically.

Direct spread of tumor into the adrenal gland (if present) is considered pT4 disease. However, if there is a discrete separate nodule in the adrenal gland, this would be considered pM1 disease. Additionally, the presence of metastatic disease in any other accompanying organs would be considered pM1 disease for the purpose of the TNM system.

References

F. Sarcomatoid and Rhabdoid Features
Sarcomatoid carcinoma is not a specific morphogenetic subtype of renal cell carcinoma but is considered as a pattern of dedifferentiation. Sarcomatoid change in a renal cell carcinoma is associated with an adverse outcome. Sarcomatoid morphology may be found in any histologic subtypes of renal cell carcinomas, including clear cell, papillary, chromophobe, collecting duct, and other rare and unclassified subtypes. When the background carcinoma subtype is recognized, it should be specified under histologic type (see Note A). Pure sarcomatoid carcinoma or sarcomatoid carcinoma associated with epithelial elements that do not conform to usual renal carcinoma cell types should be considered as unclassified renal cell carcinoma. Sarcomatoid morphology is also incorporated into the WHO/ISUP grading system as grade 4.

There is some indication that the percentage of sarcomatoid component in a renal cell carcinoma has prognostic importance.

Rhabdoid features, like sarcomatoid, are a characteristic of high-grade disease. Rhabdoid cells have abundant eosinophilic cytoplasm with an eccentric nucleus often with a prominent nucleolus. Rhabdoid changes are associated with an adverse outcome and in cases with rhabdoid morphology, about 25% of them also show sarcomatoid features. Rhabdoid morphology is an important component of the new WHO/ISUP grading system (grade 4).

References

G. Necrosis
Tumor necrosis is an important prognostic factor in renal cell carcinoma.\textsuperscript{1,2,3} It is recommended that both macroscopic and microscopic (coagulative) necrosis be recorded. The prognostic significance of necrosis independent of tumor stage has been identified in clear cell and chromophobe renal cell carcinoma.\textsuperscript{2} The prognostic significance of necrosis in papillary renal cell carcinoma is controversial. Large papillary carcinomas not uncommonly display cystic necrosis and yet don’t exhibit extra renal spread. Tumor necrosis as a prognostic factor cannot be assessed in a situation where patients have undergone presurgical arterial embolization.

At present, the prognostic significance of the extent of necrosis is unclear; however, it is recommended that this be recorded as a percentage.\textsuperscript{3}

References

H. Margins
In a partial nephrectomy specimen, the renal parenchymal margin should be inked and histologically assessed.\textsuperscript{1} Most partial nephrectomy specimens also contain a portion of perinephric fat overlying the tumor site. The perirenal fat margin should also be assessed. In situations where no perirenal fat is present, the renal capsular margin should be inked and examined histologically.\textsuperscript{1}

In radical nephrectomy specimens the ureteric, major vascular (renal vein, renal artery) and soft tissue (Gerota’s fascia, renal sinus) margins should be examined and documented in the report.

References
I. TNM and Stage Groupings
The TNM staging system of the American Joint Committee on Cancer (AJCC) for renal cell carcinoma is recommended.1

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.

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

The “a” prefix designates the stage determined at autopsy: aTNM.

Additional Descriptors
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).

Lymphovascular Invasion
By AJCC convention, vessel invasion (lymphatic or venous) does not affect the T category indicating local extent of tumor unless specifically included in the definition of a T category. In all other cases, lymphatic and venous invasion by tumor are coded separately.
References


J. Additional Findings in Nonneoplastic Kidney

It is important to recognize that medical kidney diseases may be present in nonneoplastic renal tissue in nephrectomy and nephroureterectomy specimens. Arterionephrosclerosis (or hypertensive nephropathy) and diabetic nephropathy are seen in approximately 30% and 20% of cases, respectively. Other medical renal diseases that have been identified include thrombotic microangiopathy, focal segmental glomerulosclerosis, and IgA nephropathy. The findings of greater than 20% global glomerulosclerosis or advanced diffuse diabetic glomerulosclerosis are predictive of significant decline in renal function 6 months after radical nephrectomy. Evaluation for medical renal disease should be performed in each case; PAS and/or Jones methenamine silver stains should applied if necessary. Consultation with a nephropathologist should be pursued as needed.

However, no studies have specifically measured peritumoral-related changes in the renal cortex. Some tumors have no peritumoral changes. Oncocytoma is the best example. While some large tumors often have a large zone of peritumoral changes compared with smaller tumors. The pseudocapsule may contain sclerotic glomeruli, tubular atrophy and show fibrointimal thickening of arteries, followed by a zone of several millimeters of acute tubular injury, none of which is representative of the cortex elsewhere. A judgement whether the amount of nonneoplastic renal parenchyma is sufficient for evaluation of medical kidney diseases should be made on a case by case basis. Two studies have used 1 mm to 5 mm as the cut-off for insufficient renal parenchyma. Five millimeters of nonneoplastic renal parenchyma is a reasonable recommendation.

References