



Protocol for the Examination of Radical Orchiectomy Specimens From Patients With Malignant Germ Cell and Sex Cord-Stromal Tumors of the Testis

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:

Procedure	Description
Radical Orchiectomy	Includes specimens designated orchiectomy and orchidectomy
Tumor Type	Description
Germ cell tumors	Includes seminoma and variants, all non-seminomatous germ cell tumors, mixed germ cell tumors, Leydig cell tumors, Sertoli cell tumors, granulosa cell tumors, and placental site trophoblastic tumors
Sex cord-stromal tumors	Includes Leydig cell tumors, Sertoli cell tumors, granulosa cell tumors, and mixed sex cord tumors

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

Procedure
Retroperitoneal lymphadenectomy (consider Testis Retroperitoneal Lymphadenectomy protocol)
Primary resection specimen with no residual cancer (eg, following neoadjuvant therapy)
Cytologic specimens

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

Tumor Type
Paratesticular malignancies (consider Soft Tissue protocol)
Non-testis germ cell tumors (consider Extragonadal Germ Cell protocol)
Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)
Sarcoma (consider the Soft Tissue protocol)

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

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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
- Added Histologic Types --- Yolk Sac Tumor and Mixed Germ Cell Tumor
- 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: (TESTIS: Radical Orchiectomy)

Standard(s): AJCC-UICC 8

CLINICAL

+Pre-Orchiectomy Serum Tumor Markers (Notes [A](#),[B](#)) (select all that apply)

- Unknown: _____
- Serum marker studies within normal limits
- Alpha-fetoprotein (AFP) elevation
- Beta-subunit of human chorionic gonadotropin (b-hCG) elevation
- Lactate dehydrogenase (LDH) elevation

+Post-Orchiectomy Serum Tumor Markers (Notes [A](#),[B](#)) (select all that apply)

- Unknown: _____
- Serum marker studies within normal limits
- Alpha-fetoprotein (AFP) elevation
- Beta-subunit of human chorionic gonadotropin (b-hCG) elevation
- Lactate dehydrogenase (LDH) elevation

+Serum Tumor Markers (S) (Note [B](#))

N indicates the upper limit of normal for the LDH assay

- SX (serum marker studies not available or performed)
- S0 (serum marker study levels within normal limits)
- | LDH || HCG (mIU / mL) || AFP (ng / mL)*
- S1 (|less than 1.5 x N | and | less than 5,000 | and | less than 1,000)
- S2 (|1.5-10 x N | or | 5,000-50,000 | or | 1,000-10,000)
- S3 (|greater than 10 X N | or | greater than 50,000 | or | greater than 10,000)

SPECIMEN

Specimen Laterality

- Right
- Left
- Not specified

TUMOR

Tumor Focality

- Unifocal
- Multifocal
- Cannot be determined: _____

Tumor Size

Greatest dimension of main tumor mass in Centimeters (cm): _____ cm

+Additional Dimension of Main Tumor Mass in Centimeters (cm): _____ x _____ cm

___ Cannot be determined (explain): _____

Additional Tumor Nodule(s) (may repeat for each nodule)

Greatest Dimension of Additional Tumor Nodule in Centimeters (cm)

- ___ Not applicable
- ___ Specify in Centimeters (cm): _____ cm
- ___ Cannot be determined (explain): _____

Histologic Type (Notes C,D,E) (select all that apply)

Intratubular germ cell neoplasia

- ___ Germ cell neoplasia in situ (GCNIS)
- ___ Other intratubular germ cell tumor (specify): _____

Seminoma

- ___ Seminoma
- ___ Seminoma with syncytiotrophoblastic cells

Non-seminomatous types

- ___ Embryonal carcinoma
- ___ Yolk sac tumor, postpubertal type
- ___ Choriocarcinoma
- ___ Mixed germ cell tumor
 - ___ Seminoma (specify percentage): _____ %
 - ___ Embryonal carcinoma (specify percentage): _____ %
 - ___ Yolk sac tumor, postpubertal type (specify percentage): _____ %
 - ___ Choriocarcinoma (specify percentage): _____ %
 - ___ Teratoma (specify percentage): _____ %
 - ___ Other (specify type and percentage): _____

Non-choriocarcinomatous trophoblastic tumors

- ___ Non-choriocarcinomatous trophoblastic tumor, NOS
- ___ Placental site trophoblastic tumor
- ___ Epithelioid trophoblastic tumor
- ___ Cystic trophoblastic tumor

Teratoma

- ___ Teratoma, postpubertal type
- ___ Teratoma with somatic-type malignancy (specify type): _____

Testicular scar / regressed germ cell tumor

- ___ Scar diagnostic of regressed germ cell tumor
- ___ Scar suspicious for regressed germ cell tumor

Germ Cell Tumors Unrelated to Germ Cell Neoplasia in situ

- ___ Spermatocytic tumor
- ___ Spermatocytic tumor with a sarcomatous component
- ___ Teratoma, prepubertal type
 - ___ Well-differentiated neuroendocrine tumor (monodermal teratoma)
 - ___ Other (specify): _____
- ___ Mixed teratoma and yolk sac tumor, prepubertal type
- ___ Yolk sac tumor, prepubertal type

Sex cord-stromal tumor

- ___ Leydig cell tumor
- ___ Leydig cell tumor, malignant
- ___ Sertoli cell tumor, NOS
- ___ Sertoli cell tumor, malignant
- ___ Sertoli cell tumor, large cell calcifying
- ___ Sertoli cell tumor, intratubular large cell hyalinizing

- Granulosa cell tumor, adult type
- Granulosa cell tumor, juvenile type
- Fibroma-thecoma
- Sex cord-stromal tumor, mixed type (specify components and approximate percentages): _____

- Sex cord-stromal tumor type, unclassified
Tumor Containing Both Germ Cell and Sex Cord-Stromal Elements
- Mixed germ cell-sex cord stromal tumor, gonadoblastoma
- Other histologic type not listed (specify): _____
- +Histologic Type Comment:** _____

Tumor Extent (Note F) (select all that apply)

- Germ cell neoplasia in situ only
- Limited to testis
- # See Note D for definition of rete testis invasion*
- Invades rete testis#
- Invades hilar soft tissue
- Invades epididymis
- Invades through tunica albuginea and perforates tunica vaginalis (mesothelial layer)
- Invades spermatic cord
- Invades scrotum
- Invades other structures (specify): _____
- Cannot be determined: _____
- No evidence of primary tumor

Lymphovascular Invasion (Note G)

- Not identified
- Present
- Cannot be determined: _____

+Tumor Comment: _____

MARGINS

Margin Status

- All margins negative for tumor
- Tumor present at margin
- Margin(s) Involved by Tumor (select all that apply)**
- Spermatic cord
- 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)

- Interaortocaval: _____
- Paraaortic: _____
- Paracaval: _____
- Preaortic: _____
- Precaval: _____
- Retroaortic: _____
- Retrocaval: _____
- Other (specify): _____
- Cannot be determined: _____
- Not applicable

+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: _____

+Nodal Site with Largest Metastatic Deposit (select all that apply)

- Interaortocaval: _____
- Paraaortic: _____
- Paracaval: _____
- Preaortic: _____
- Precaval: _____
- Retroaortic: _____
- Retrocaval: _____
- Other (specify): _____
- Cannot be determined: _____

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: _____

+Largest Lymph Node with Tumor (specify site): _____

Extranodal Extension

- Not identified
- Present
- Cannot be determined: _____

Histologic Subtype of Germ Cell Tumor in Involved Lymph Node(s) (select all that apply)

- Seminoma
- Seminoma with syncytiotrophoblastic cells
- Embryonal carcinoma
- Yolk sac tumor, postpubertal type
- Choriocarcinoma
- Mixed germ cell tumor (specify components and approximate percentages):

- Non-choriocarcinomatous trophoblastic tumors
- Placental site trophoblastic tumor
- Epithelioid trophoblastic tumor
- Cystic trophoblastic tumor
- Teratoma, postpubertal type
- Teratoma with somatic-type malignancy (specify type): _____
- Spermatocytic tumor
- Spermatocytic tumor with a sarcomatous component
- Well-differentiated neuroendocrine tumor (monodermal teratoma)
- Other histologic type not listed (specify): _____
- Not applicable

- 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-retroperitoneal lymph node(s): _____
- Lung: _____
- Other organ(s) or site(s) (specify): _____
- Cannot be determined: _____

PATHOLOGIC STAGE CLASSIFICATION (pTNM, AJCC 8th Edition) (Note [A](#))

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)
- r (recurrent)
- y (post-treatment)

pT Category

- pT not assigned (cannot be determined based on available pathological information)
- pT0: No evidence of primary tumor
- pTis: Germ cell neoplasia *in situ*
- pT1: Tumor limited to testis (including rete testis invasion) without lymphovascular invasion*
- # Subclassification of pT1 applies only to pure seminoma.*
- pT1a: Tumor smaller than 3 cm in size#
- pT1b: Tumor 3 cm or larger in size#
- pT1 (subcategory cannot be determined)
- pT2: Tumor limited to testis (including rete testis invasion) with lymphovascular invasion, or tumor invading hilar soft tissue or epididymis or penetrating visceral mesothelial layer covering the external surface of tunica albuginea with or without lymphovascular invasion
- pT3: Tumor directly invades spermatic cord soft tissue with or without lymphovascular invasion
- pT4: Tumor invades scrotum with or without lymphovascular invasion

pN Category

- 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 with a lymph node mass 2 cm or smaller in greatest dimension, and less than or equal to five nodes positive, none larger than 2 cm in greatest dimension
- pN2: Metastasis with a lymph node mass larger than 2 cm but not larger than 5 cm in greatest dimension, or more than five nodes positive, none larger than 5 cm; or evidence of extranodal extension of tumor
- pN3: Metastasis with a lymph node mass larger than 5 cm in greatest dimension

pM Category (required only if confirmed pathologically)

- Not applicable - pM cannot be determined from the submitted specimen(s)
- pM1: Distant metastasis*
- pM1a: Non-retroperitoneal nodal or pulmonary metastases
- pM1b: Non-pulmonary visceral metastases
- pM1 (subcategory cannot be determined)

ADDITIONAL FINDINGS (Note [H](#))

+Additional Findings (select all that apply)

- None identified
- Germ cell neoplasia in situ (GCNIS)
- Microlith
- Sertoli cell nodule (Pick's adenoma)
- Atrophy
- Other (specify): _____

COMMENTS

Comment(s): _____

Explanatory Notes

A. Staging

The protocol recommends staging according to the AJCC TNM staging system.¹ Additional criteria for staging seminomas according to a modification of the Royal Marsden system are also recommended.² Some studies suggest that the staging of patients with seminoma by the TNM system is less meaningful therapeutically than staging by a modification of the Royal Marsden method. Also, the data from a large Danish study of seminomas clinically limited to the testis do not support the conclusion that local staging of the primary tumor, as performed in the TNM system, provides useful prognostic information; rather, the most valuable prognostic indicator was the size of the seminoma.³ This protocol therefore encourages the use of the TNM system with optional use of the modified Royal Marsden staging system for patients with seminoma.

AJCC TNM and Stage Groupings

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.

References

1. Amin MB, Edge SB, Greene FL, et al, eds. AJCC Cancer Staging Manual. 8th ed. New York, NY: Springer; 2017.
2. Thomas G, Jones W, VanOosterom A, Kawai T. Consensus statement on the investigation and management of testicular seminoma 1989. Prog Clin Biol Res. 1990;357:285-294.
3. von der Maase H, Specht L, Jacobsen GK, et al. Surveillance following orchidectomy for stage I seminoma of the testis. Eur J Cancer. 1993;29A:1931-1934

B. Serum Markers

The protocol emphasizes the importance of relevant clinical information in the pathologic evaluation of specimens. Serum marker studies play a key role in the clinical management of patients with testicular germ cell tumors.^{1,2,3} The occurrence of elevated serum levels of alpha-fetoprotein (AFP) or the beta subunit of human chorionic gonadotropin (b-hCG) may indicate the need for additional sections of certain specimens if the initial findings do not account for such elevations. Information regarding serum marker status (lactate dehydrogenase [LDH], AFP, and b-hCG) is also important in the “S” categorization of the tumor for stage groupings. Postorchidectomy serum markers are important for the assignment of stage IS.

The serum tumor markers (S) category comprises the following:

- Alpha fetoprotein (AFP) – half-life 5 to 7 days
- Human chorionic gonadotropin (hCG) – half-life 1 to 3 days
- Lactate dehydrogenase (LDH)

References

1. Chisolm GG. Tumour markers in testicular tumours. Prog Clin Biol Res. 1985;203:81-91.
2. Javadpour N. Tumor markers in testicular cancer: an update. Prog Clin Biol Res. 1985;203:141-154.
3. Aass N, Klepp O, Cavallin-Stahl E, et al. Prognostic factors in unselected patients with nonseminomatous metastatic testicular cancer: a multicenter experience. J Clin Oncol. 1991;9:818-826.

C. Tissues Submitted for Microscopic Evaluation

The entire testicular tumor may be blocked if it requires 10 blocks or less (tissue may be retained for special studies); 10 blocks of larger tumors may be taken, unless the tumor is greater than 10 cm, in which case 1 block may be submitted for every 1 cm of maximum tumor dimension. Blocks must contain the interface with nontumorous testis, as well as the tunica albuginea, even away from the tumor, because lymphatic invasion is best appreciated in the peritumoral tissue, as well as in the vessels within and under/parallel to the tunica. When there are multifocal tumors (with greater than or equal to 2 separate tumor nodules), additional tumor nodule(s) should also be sampled. Tissues to be sampled include:

- Tumor, including interface with surrounding testis, and tunica albuginea
- All of the grossly different appearing areas in the tumor
- Testicular hilum/mediastinum testis
- Uninvolved testis, including tunica albuginea
- Epididymis
- Spermatic cord, including cord margin
- Other lesion(s)
- All identifiable lymph nodes#
- Other tissue(s) submitted with specimen

For large masses that have obliterated individual nodes, 1 section for every centimeter of maximum tumor dimension, including grossly different looking areas, is recommended.

The margins in a specimen resected for a malignant tumor of the testis, depending on the extent of the surgery, include spermatic cord margin, the parietal layer of tunica vaginalis, and scrotal skin.

D. Histologic Type

The protocol mainly applies to malignant tumors of the testis, the vast majority of which are of germ cell origin. It may also be applied to other malignant or potentially malignant tumors of the testis included in the classification shown below. [1.2.3.4.5.6.7.8.9.10.11.12](#) For hematolymphoid neoplasms involving the testis, refer to the corresponding CAP protocols.

World Health Organization (WHO) Histologic Classification of Testicular Tumors (2016)¹³

Germ Cell Tumors Derived From Germ Cell Neoplasia In Situ

Noninvasive germ cell neoplasia

 Germ cell neoplasia in situ

 Specific forms of intratubular germ cell neoplasia

Tumors of a single histologic type (pure forms)

 Seminoma

 Seminoma with syncytiotrophoblastic cells

Nonseminomatous germ cell tumors

 Embryonal carcinoma

 Yolk sac tumor, postpubertal type

 Trophoblastic tumors

 Choriocarcinoma

 Nonchoriocarcinomatous trophoblastic tumors

 Placental site trophoblastic tumor

 Epidermoid trophoblastic tumor

 Cystic trophoblastic tumor

 Teratoma, postpubertal type

 Teratoma with somatic-type malignancy

Nonseminomatous germ cell tumors of more than one histologic type

 Mixed germ cell tumor

Germ cell tumors of unknown type

 Regressed germ cell tumor

Germ Cell Tumors Unrelated to Germ Cell Neoplasia In Situ

Spermatocytic tumor

Teratoma, prepubertal type

 Dermoid cyst

 Epidermoid cyst

 Well-differentiated neuroendocrine tumor (monodermal teratoma)

 Yolk sac tumor, prepubertal type

Mixed teratoma and yolk sac tumor, prepubertal type

Yolk sac tumor, prepubertal type

Sex Cord-Stromal Tumors

Pure tumors

Leydig cell tumor

 Malignant Leydig cell tumor

Sertoli cell tumor

 Malignant Sertoli cell tumor

 Large cell calcifying Sertoli cell tumor

 Intratubular large cell hyalinizing Sertoli cell neoplasia

Granulosa cell tumor

 Adult granulosa cell tumor

 Juvenile granulosa cell tumor

Tumors in the fibroma-thecoma group

Mixed and unclassified sex cord stromal tumor

 Mixed sex cord-stromal tumor

 Unclassified sex cord-stromal tumor

Tumor Containing Both Germ Cell and Sex Cord-Stromal Elements

Gonadoblastoma

Miscellaneous

Ovarian epithelial-type tumors

 Serous cystadenoma

 Serous tumor of borderline malignancy

Serous cystadenocarcinoma

Mucinous cystadenoma

Mucinous borderline tumor

Mucinous cystadenocarcinoma

Endometrioid adenocarcinoma

Clear cell adenocarcinoma

Brenner tumor

Juvenile xanthogranuloma

Hemangioma

Hematolymphoid Tumors

Diffuse large B-cell lymphoma

Follicular lymphoma

Extranodal NI/T-cell lymphoma, nasal type

Plasmacytoma

Myeloid sarcoma

Rosai-Dorfman disease

Tumors of Collecting Duct and Rete Testis

Adenoma

Adenocarcinoma

Tumors of Paratesticular Structures

Adenomatoid tumor

Mesothelioma

Well-differentiated papillary mesothelioma

Epididymal tumors

Cystadenoma of the epididymis

Papillary cystadenoma

Adenocarcinoma of the epididymis

Squamous cell carcinoma

Melanotic neuroectodermal tumor

Nephroblastoma

Paraganglioma

Mesenchymal Tumors of the Spermatic Cord and Testicular Adnexa

Apipocytic tumors

- Lipoma
- Well-differentiated liposarcoma
- Dedifferentiated liposarcoma
- Myxoid liposarcoma
- Pleomorphic liposarcoma

References

1. Lawrence WD, Young RH, Scully RE. Sex cord-stromal tumors. In: Talerman A, Roth LM, eds. *Pathology of the Testis and Its Adnexa*. New York, NY: Churchill Livingstone; 1986:67-92.
2. Proppe KH, Scully RE. Large-cell calcifying Sertoli cell tumor of the testis. *Am J Clin Pathol*. 1980;74:607-619.
3. Young RH, Talerman A. Testicular tumors other than germ cell tumors. *Semin Diagn Pathol*. 1987;4:342-360.
4. Kim I, Young RH, Scully RE. Leydig cell tumors of the testis: a clinicopathological analysis of 40 cases and review of the literature. *Am J Surg Pathol*. 1985;9:177-192.
5. Mostofi FK, Price EBJ. *Tumors of the Male Genital System: Atlas of Tumor Pathology*. 2nd series. Fascicle 8. Washington DC: Armed Forces Institute of Pathology; 1973.
6. Eble JN, Sauter G, Epstein JI, Sesterhenn IA. *World Health Organization Classification of Tumours: Pathology and Genetics of Tumours of the Urinary System and Male Genital Organs*. Lyon, France: IARC Press; 2004.
7. Mostofi FK, Spaander P, Grigor K, Parkinson CM, Skakkebaek NE, Oliver RT. Consensus on pathological classifications of testicular tumours. *Prog Clin Biol Res*. 1990;357:267-276.
8. Young RH, Scully RE. *Testicular Tumors*. Chicago, IL: ASCP Press; 1990.
9. Ulbright TM. Testicular and paratesticular tumors. In: Mills SE, ed. *Sternberg's Diagnostic Surgical Pathology*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2004:2167-2232.
10. Ulbright TM, Amin MB, Young RH. *Tumors of the Testis, Adnexa, Spermatic Cord, and Scrotum*. Third Series. Fascicle 25. Washington, DC: Armed Forces Institute of Pathology; 1999.
11. Ro JY, Dexeus FH, El-Naggar A, Ayala AG. Testicular germ cell tumors: clinically relevant pathologic findings. *Pathol Annu*. 1991;26:59-87.
12. Ferry JA, Harris NL, Young RH, Coen J, Zietman A, Scully RE. Malignant lymphoma of the testis, epididymis, and spermatic cord: a clinicopathologic study of 69 cases with immunophenotypic analysis. *Am J Surg Pathol*. 1994;18:376-390.
13. Moch H, Humphrey PA, Ulbright TM, Reuter VE. *WHO Classification of Tumours of the Urinary System and Male Genital Organs*. Geneva, Switzerland: WHO Press; 2016.

E. Scar

Testicular scars, particularly in patients presenting with metastatic disease and clinically inapparent testicular primaries, may represent regressed, “burnt-out” testicular germ cell tumors. There are 2 established criteria to indicate a scar is diagnostic of a regressed germ cell tumor (GCT): a scar with associated germ cell neoplasia in situ (GCNIS) or a scar that contains coarse intratubular calcifications within expanded tubular profiles, which correspond to dystrophic calcifications that occurred in completely necrotic intratubular embryonal carcinoma. Features that are suspicious for, although not diagnostic of, regressed germ cell tumors include testicular atrophy, microlithiasis, and, in the scar, lymphoplasmacytic

infiltrates and prominent vascularity.¹ In otherwise pure seminoma, such partial regression may have clinically important implications, since it is possible that some of these scars may represent regression of a nonseminomatous germ cell tumor component of the tumor.

References

1. Balzer BL, Ulbright TM. Spontaneous regression of testicular germ cell tumors: an analysis of 42 cases. *Am J Surg Pathol.* 2006;30(7):858-865.

F. Invasion of the Rete Testis, Hilar/Mediastinal Soft Tissue, Epididymis or Tunica Vaginalis

Tumors invading the tunica vaginalis (perforating the mesothelial lining) (Figure 1, Tumor A) are considered category pT2 by the American Joint Committee on Cancer (AJCC) TNM staging system. Invasion of rete testis is not assigned a higher pT category than that for a tumor limited to the testis. Rete testis invasion has been reported by some to be associated with higher risk of relapse in clinical stage I seminoma.¹ Rete testis invasion is that the invasive tumor involves the rete testis stroma, with or without luminal involvement. Pagetoid extension of GCNIS into the rete testis should not be considered rete testis invasion. Hilar soft tissue invasion (Figure 1, Tumor B) is the predominant pathway of extratesticular extension for testicular tumors.^{2,3} There is evidence beginning to accumulate that rete testis and hilar soft tissue invasion have predictive value for metastatic disease in patients with nonseminomatous GCTs.³ Invasion of epididymis and hilar soft tissue is staged as pT2 by the 8th edition of AJCC TNM.⁴

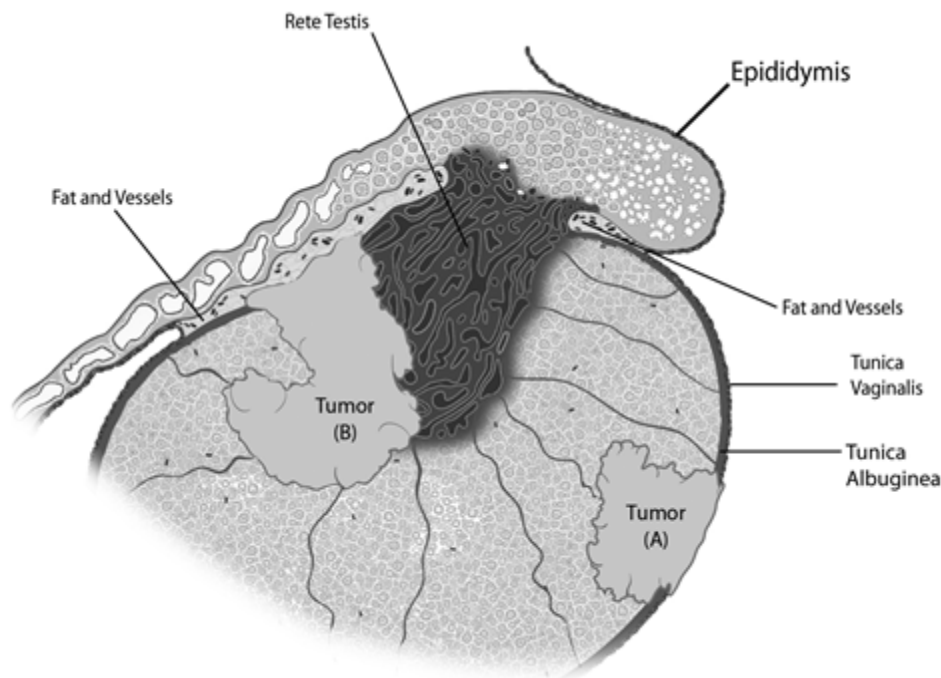


Figure 1. Diagrammatic representation of a tumor (Tumor A) invading tunica vaginalis, perforating through the mesothelium, and another tumor (Tumor B) partly involving the rete testis and invading the hilar soft tissue. Figure courtesy of Satish K. Tickoo, MD.

References

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G. Venous/Lymphatic Vessel Invasion

In several studies, the presence of vascular space invasion (usually lymphatic but possibly also capillary or venous invasion) has been correlated with a significantly elevated risk for distant metastasis.^{1,2,3,4,5,6,7} This observation, therefore, is most pertinent for patients who have clinical stage I disease, ie, those who have no evidence of spread beyond the testis by clinical examination (including radiographic and serum marker studies). Some clinicians manage the patients with clinical stage I disease who lack evidence of lymphatic or vascular invasion in their orchiectomy specimens (with possibly other favorable prognostic features, such as relatively small amounts of embryonal carcinoma) by close follow-up examinations rather than intervention.

According to the 8th edition AJCC TNM staging system, discontinuous involvement of the spermatic cord soft tissue via a vascular thrombus is better regarded as a metastatic deposit (pM1). Presence of only an intravascular tumor in the spermatic cord in the absence of parenchymal invasion is considered pT2.⁸

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H. Additional Findings

Important findings include Leydig cell hyperplasia, which may be correlated with b-hCG elevation; scarring, the presence of hemosiderin-laden macrophages, and coarse intratubular calcifications in expanded tubular profiles (distinct from microlithiasis), which may indicate regression of a tumor; testicular atrophy; sertoli cell nodules (Pick's adenoma), which most often are associated with undescended testes, and abnormal testicular development (eg, dysgenesis or androgen-insensitivity syndrome).^{1,2}

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I. Metastatic Tumor

Often the most important distinction in patients with metastatic testicular germ cell tumor following initial chemotherapy is the differentiation of metastatic residual teratoma from nonteratomatous types of germ cell tumor. Pure teratomatous metastasis is generally treated by surgical excision alone, whereas patients who have other residual germ cell tumor components are usually treated with additional chemotherapy.