Protocol for the Examination of Specimens From Patients With Uveal Melanoma

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>Resection</td>
<td>Includes local resection, enucleation, and partial or complete exenteration</td>
</tr>
<tr>
<td>Tumor Type</td>
<td>Description</td>
</tr>
<tr>
<td>Uveal melanoma</td>
<td>Limited to melanoma of the iris, ciliary body, and choroid</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cutaneous melanoma</td>
<td>(consider Skin Melanoma protocol)</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
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 Clinical Section
- Revised Tumor Site Section
- Added Tumor Sampling for Molecular Studies
- Added Discrete Tumor Deposits to Orbit
- Removed pTX and pNX Staging Classification
- Added Special Studies Section
Reporting Template

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

CASE SUMMARY: (UVEAL MELANOMA)
Standard(s): AJCC-UICC 8

CLINICAL

*Treatment History
___ No known preoperative therapy
___ Preoperative therapy given (specify, if known): _________________
___ Not specified

SPECIMEN (Note A)

Procedure (select all that apply)
___ Local resection
___ Enucleation
___ Limited exenteration
___ Complete exenteration
___ Other (specify): _________________
___ Not specified

Tumor Sampling for Molecular Studies
___ Yes
___ No
___ Not known

Specimen Laterality
___ Right
___ Left
___ Not specified

TUMOR

Tumor Site (macroscopic examination / transillumination) (Note B) (select all that apply)
___ Superotemporal quadrant of globe
___ Superonasal quadrant of globe
___ Inferotemporal quadrant of globe
___ Inferonasal quadrant of globe
___ Superior quadrant of globe
___ Inferior quadrant of globe
___ Nasal quadrant of globe
___ Temporal quadrant of globe
___ Anterior chamber
___ Other (specify): _________________
___ Cannot be determined: _________________
**Tumor Site after Sectioning (Note C) (select all that apply)**
- ___ Superonasal
- ___ Inferonasal
- ___ Superotemporal
- ___ Inferotemporal
- ___ Superior quadrant of globe
- ___ Inferior quadrant of globe
- ___ Nasal quadrant of globe
- ___ Temporal quadrant of globe
- ___ Anterior chamber
- ___ Other (specify): ____________________
- ___ Cannot be determined: ____________________

+**Distance from Anterior Edge of Tumor to Limbus at Cut Edge**

  *Specify in Millimeters (mm)*
- ___ Exact distance: ____________________ mm
- ___ At least: ____________________ mm
- ___ Less than 1 mm
- ___ Other (specify): ____________________
- ___ Cannot be determined: ____________________

+**Distance from Posterior Margin of Tumor Base to Edge of Optic Disc**

  *Specify in Millimeters (mm)*
- ___ Exact distance: ____________________ mm
- ___ At least: ____________________ mm
- ___ Less than 1 mm
- ___ Other (specify): ____________________
- ___ Cannot be determined: ____________________

**Tumor Size after Sectioning (Note D)**
- ___ Cannot be determined: ____________________
- ___ Size can be determined

  **Greatest Basal Diameter of Tumor**

  *Specify in Millimeters (mm)*
- ___ Exact measurement: ____________________ mm
- ___ At least: ____________________ mm
- ___ Less than 1 mm
- ___ Other (specify): ____________________
- ___ Cannot be determined: ____________________

+**Basal Diameter at Cut Edge of Tumor**

  *Specify in Millimeters (mm)*
- ___ Exact measurement: ____________________ mm
- ___ At least: ____________________ mm
- ___ Less than 1 mm
- ___ Other (specify): ____________________
- ___ Cannot be determined: ____________________

**Greatest Thickness of Tumor**

  *Specify in Millimeters (mm)*
- ___ Exact measurement: ____________________ mm
- ___ At least: ____________________ mm
- ___ Less than 1 mm
Thicknness at Cut Edge of Tumor
Specify in Millimeters (mm)
- Exact measurement: ________________ mm
- At least: ________________ mm
- Less than 1 mm
- Other (specify): ________________
- Cannot be determined: ________________

Tumor Growth Pattern (select all that apply)
- Solid mass
- Cavitary
- Dome shape
- Mushroom shape
- Diffuse (ciliary body ring)
- Diffuse (flat)
- Other (specify): ________________
- Cannot be determined: ________________

Tumor Size in Microscopic Sections (Note D)
- Cannot be determined: ________________
- Size can be determined

Greatest Basal Diameter of Tumor (microscopic)
Specify in Millimeters (mm)
- Exact measurement: ________________ mm
- At least: ________________ mm
- Less than 1 mm
- Other (specify): ________________
- Cannot be determined: ________________

Greatest Thickness of Tumor (microscopic)
Specify in Millimeters (mm)
- Exact measurement: ________________ mm
- At least: ________________ mm
- Less than 1 mm
- Other (specify): ________________
- Cannot be determined: ________________

Histologic Type (Note E)
- Spindle cell melanoma (greater than 90% spindle cells)
- Mixed cell melanoma (greater than 10% epithelioid cells and less than 90% spindle cells)
- Epithelioid cell melanoma (greater than 90% epithelioid cells)
- Other histologic type not listed (specify): ________________
- Cannot be determined: ________________

Histologic Type Comment: ________________

Other Ocular Structures Involved by Tumor (select all that apply)
- Sclera (direct invasion)
- Sclera (within intrascleral emissarial canals)
- Vortex vein(s)
- Optic nerve head
___ Vitreous
___ Choroid
___ Ciliary body
___ Iris
___ Lens
___ Anterior chamber
___ Extrascleral extension (anterior)
___ Extrascleral extension (posterior)
___ Angle / Schlemm's canal
___ Optic nerve
___ Retina
___ Other (specify): _____________________
___ Cannot be determined: _____________________

+Tumor Location (select all that apply)
___ Anterior margin between ciliary body and iris (sulcus)
___ Anterior margin between equator and ciliary body
___ Anterior margin between disc and equator
___ Posterior margin between ciliary body and iris (sulcus)
___ Posterior margin between equator and ciliary body
___ Posterior margin between disc and equator
___ Other (specify): _____________________
___ Cannot be determined: _____________________

Scleral Involvement
___ Not identified
___ Intrascleral, within intrascleral emissarial canals
___ Intrascleral, direct invasion
___ Extrascleral, less than or equal to 5mm in largest diameter
___ Extrascleral, greater than 5mm in largest diameter
___ Cannot be determined: _____________________

+Tumor Comment: _____________________

MARGINS

Margin Status
___ All margins negative for melanoma
___ Extrascleral extension of melanoma present (for enucleation specimens)
___ Other (specify): _____________________
___ Cannot be determined: _____________________

+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
Discrete Tumor Deposits in Orbit
___ Not identified
___ Present
___ Cannot be determined: ______________________
___ 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): ______________________
___ 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): ______________________

Largest Diameter of Largest Distant Metastasis
___ Specify in Centimeters (cm): ______________ cm
___ Less than or equal to 3 cm
___ 3.1 to 8.0 cm
___ Greater than or equal to 8.1 cm
___ Cannot be determined: ______________________
___ Cannot be determined: ______________________

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

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 Descriptions (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

Iris
___ pT1: Tumor limited to the iris
___ pT1a: Tumor limited to the iris not more than 3 clock hours in size
pT1b: Tumor limited to the iris more than 3 clock hours in size
pT1c: Tumor limited to the iris with secondary glaucoma
pT1 (subcategory cannot be determined)

pT2: Tumor confluent with or extending into the ciliary body, choroid, or both
pT2a: Tumor confluent with or extending into the ciliary body, without secondary glaucoma
pT2b: Tumor confluent with or extending into the ciliary body and choroid, without secondary glaucoma
pT2c: Tumor confluent with or extending into the ciliary body, choroid, or both, with secondary glaucoma
pT2 (subcategory cannot be determined)

pT3: Tumor confluent with or extending into the ciliary body, choroid, or both, with scleral extension
pT4: Tumor with extrascleral extension
pT4a: Tumor with extrascleral extension less than or equal to 5 mm in largest diameter
pT4b: Tumor with extrascleral extension greater than 5 mm in largest diameter
pT4 (subcategory cannot be determined)

Iris melanomas originate from, and are predominantly located in, this region of the uvea. If less than half the tumor volume is located within the iris, the tumor may have originated in the ciliary body, and consideration should be given to classifying it accordingly.

Ciliary Body and Choroid

pT1: Tumor size category 1
pT1a: Tumor size category 1 without ciliary body involvement and extraocular extension
pT1b: Tumor size category 1 with ciliary body involvement
pT1c: Tumor size category 1 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in largest diameter
pT1d: Tumor size category 1 with ciliary body involvement and extraocular extension less than or equal to 5 mm in largest diameter
pT1 (subcategory cannot be determined)

pT2: Tumor size category 2
pT2a: Tumor size category 2 without ciliary body involvement and extraocular extension
pT2b: Tumor size category 2 with ciliary body involvement
pT2c: Tumor size category 2 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in largest diameter
pT2d: Tumor size category 2 with ciliary body involvement and extraocular extension less than or equal to 5 mm in largest diameter
pT2 (subcategory cannot be determined)

pT3: Tumor size category 3
pT3a: Tumor size category 3 without ciliary body involvement and extraocular extension
pT3b: Tumor size category 3 with ciliary body involvement
pT3c: Tumor size category 3 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in largest diameter
pT3d: Tumor size category 3 with ciliary body involvement and extraocular extension less than or equal to 5 mm in largest diameter
pT3 (subcategory cannot be determined)

pT4: Tumor size category 4
pT4a: Tumor size category 4 without ciliary body involvement and extraocular extension
pT4b: Tumor size category 4 with ciliary body involvement
pT4c: Tumor size category 4 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in largest diameter
pT4d: Tumor size category 4 with ciliary body involvement and extraocular extension less than or equal to 5 mm in largest diameter
pT4e: Any tumor size category with extraocular extension greater than 5 mm in largest diameter
pT4 (subcategory cannot be determined)
Primary ciliary body and choroidal melanomas are classified according to the four tumor size categories defined in Figure 3 (CAP Cancer Protocol Explanatory Notes).
In clinical practice, the largest tumor basal diameter may be estimated in optic disc diameters (DD; average: 1 DD = 1.5 mm), and tumor thickness may be estimated in diopters (average: 2.5 diopters = 1 mm). Ultrasonography and fundus photography are used to provide more accurate measurements.
When histopathologic measurements are recorded after fixation, tumor diameter and thickness may be underestimated because of tissue shrinkage.

**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: Regional lymph node metastasis or discrete tumor deposits in the orbit_
  - _pN1a: Metastasis in one or more regional lymph node(s)_
  - _pN1b: No regional lymph nodes are positive, but there are discrete tumor deposits in the orbit that are not contiguous to the eye (choroidal and ciliary body)_
- _pN1 (subcategory cannot be determined)_

**PM Category (required only if confirmed pathologically)**
- _Not applicable - pM cannot be determined from the submitted specimen(s)_
- _pM1: Distant metastasis_
  - _pM1a: Largest diameter of the largest metastasis less than or equal to 3 cm_
  - _pM1b: Largest diameter of the largest metastasis 3.1-8.0 cm_
  - _pM1c: Largest diameter of the largest metastasis greater than or equal to 8.1 cm_
  - _pM1 (subcategory cannot be determined)_

**ADDITIONAL FINDINGS (Note G)**

- **+Additional Findings (select all that apply)**
  - _None identified_
  - _Mitotic rate (number of mitoses per 40 fields determined by using a 40X objective with a field area of 0.152 mm²) (specify): __________ mitoses per 40 high-power fields (HPF)_
  - _Vasculogenic mimicry patterns (extracellular closed loops and networks, the latter defined as at least 3 back-to-back closed loops, is associated with death from metastatic disease)_
  - _Vascular invasion (tumor vessels or other vessels)_
  - _Degree of pigmentation (specify): ___________
  - _Tumor infiltrating lymphocytes_
  - _Tumor infiltrating macrophages_
  - _Drusen_
  - _Retinal detachment_
  - _Rupture of Bruch's membrane_
  - _Nevus_
  - _Hemorrhage (specify site): ___________
  - _Neovascularization_
  - _Other (specify): ___________

**SPECIAL STUDIES**

- **+Gene Expression Profile (GEP)**
  - _Class 1A_
  - _Class 1B_
  - _Class 2_
+TCGA Classification
___ Group A
___ Group B
___ Group C
___ Group D

+BAP1 Result by Immunohistochemistry
___ Intact nuclear expression
___ Loss of nuclear expression
___ Cannot be determined (explain): _________________

+BAP1 Mutational Analysis
___ No mutation detected
___ Mutation(s) identified: _________________

+PRAME Expression Status
___ Positive
___ Negative

COMMENTS

Comment(s): _________________
Explanatory Notes

A. Fixative
The minimum recommended fixation time for whole globes with intraocular tumors is 24 to 48 hours. The globe should be fixed in an adequate volume of fixative, with a 10:1 ratio of fixative volume to specimen volume recommended. Incisions or windows in the globe are not necessary for adequate penetration of fixative and are not recommended. Injection of fixative into the globe is also not recommended.

B. Orientation
The orientation of a globe may be determined by identification of extraocular muscle insertions, the optic nerve, and other landmarks, as illustrated in Figure 1. The terms temporal and nasal are generally used in place of lateral and medial with reference to ocular anatomy.

Figure 1. Anatomic landmarks of the posterior aspect of the globe (right eye). The position of the inferior oblique muscle relative to the optic nerve is most helpful in orienting the globe. The inferior oblique muscle insertion is located temporal (lateral) to the optic nerve on the sclera, and its fibers travel inferonasally from its insertion. The long posterior ciliary artery is often seen as a blue-gray line in the sclera on either side of the optic nerve and marks the horizontal meridian of the globe. Reprinted with permission from WB Saunders Company.

C. Sectioning the Globe
The globe is generally sectioned in the meridian to include the largest (or the most informative) portion of the tumor, with care to include the pupil and optic nerve in the section to be submitted for microscopic examination, as illustrated in Figure 2. Alternative methods of sectioning have been described.1,2,3
Figure 2. The most common methods of sectioning a globe. After transillumination, the tumor base is marked, if possible, and included in the pupil-optic (p-o) nerve section and submitted for processing. If tumor is found in either of the calottes, these may also be submitted for sectioning. The meridian in which the globe was sectioned should be included in the gross description of the pathology report. It is not uncommon to induce an artifactitious retinal detachment while sectioning the globe. This can be minimized by gentle handling and by avoiding a sawing motion with the blade. When a scleral window has been created to retrieve fresh tumor, this window should be included in one of the calottes to allow for an intact PO section. Reprinted with permission from WB Saunders Company.

References

D. Tumor Size
Tumor greatest basal diameter is measured as the greatest arc of contact of the tumor base with the sclera. The tumor height is measured perpendicular to the sclera from the base of the tumor to its apex. See Figure 3. Tumor size can be also measured on a microscopic slide in accordance with the same guidelines. In general, the largest dimensions (either gross or microscopic) are recorded for T category.\textsuperscript{1}
Tumor size has prognostic significance. Many studies of choroidal and ciliary body melanoma have defined small tumors as being less than 10 mm in greatest diameter. More recently, an ongoing study started in 1986, the Collaborative Ocular Melanoma Study, defined the following size classification based on clinical measurements.

- **Small tumors**: Smaller than medium or large tumors defined below
- **Medium tumors**: Greater than or equal to 2.5 mm, less than or equal to 10 mm in height, and less than or equal to 16 mm in basal diameter
- **Large tumors**: Greater than 10 mm in height or Greater than 2 mm in height and greater than 16 mm in basal diameter or Greater than 8 mm in height with optic nerve involvement

*Small tumors have a more favorable prognosis.*

Since then, the AJCC TNM system defined empirically 4 tumor sizes (Figure 3) – small (T1), medium (T2), large (T3), and very large (T4) – that differ significantly in survival prognosis. This size classification was externally validated and is now recommended.

References


### E. Histologic Type

The modified Callender classification shown below is used for determining cell type but has prognostic significance only for tumors of the choroid and ciliary body, not those of the iris, which generally have a benign course unless they invade the chamber angle. The American Joint Committee on Cancer (AJCC) defined the histopathologic types as follows:

- **Spindle cell melanoma** (>90% spindle cells)
- **Mixed cell melanoma** (>10% epithelioid cells and <90% spindle cells)
- **Epithelioid cell melanoma** (>90% epithelioid cells)

Spindle cell melanomas have the most favorable prognosis, and epithelioid cell melanomas the least favorable in terms of survival.

#### Histologic Grade (G)

<table>
<thead>
<tr>
<th>G</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>GX</td>
<td>Grade cannot be assessed</td>
</tr>
<tr>
<td>G1</td>
<td>Spindle cell melanoma (&gt;90% spindle cells)</td>
</tr>
<tr>
<td>G2</td>
<td>Mixed cell melanoma (&gt;10% epithelioid cells and &lt;90% spindle cells)</td>
</tr>
<tr>
<td>G3</td>
<td>Epithelioid cell melanoma (&gt;90% epithelioid cells)</td>
</tr>
</tbody>
</table>

*Note: Because of the lack of universal agreement regarding which proportion of epithelioid cells classifies a tumor as mixed or epithelioid, some ophthalmic pathologists currently combine grades 2 and 3 (nospindle, ie, epithelioid cells detected) and contrast them with grade 1 (spindle, ie, no epithelioid cells detected) or even tumors that have no epithelioid cells with those that have any epithelioid cells.*

### References


### F. Pathologic Stage Classification

The American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) TNM staging systems for uveal melanoma of the iris, ciliary body, and choroid are shown below.
By AJCC/UICC 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**

**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).
T Category Considerations
Iris melanomas originate from, and are predominantly located in, this region of the uvea. If less than half of the tumor volume is located within the iris, the tumor may have originated in the ciliary body, and consideration should be given to classifying it accordingly.

Ciliary Body and Choroid
Primary ciliary body and choroidal melanomas are classified according to the 4 tumor size categories below:

![Figure 3](image)

Figure 3. In clinical practice, the largest tumor basal diameter may be estimated in optic disc diameters (dd, average: 1 dd = 1.5 mm). Tumor thickness may be estimated in diopters (average: 2.5 diopters = 1 mm). However, techniques such as ultrasonography and fundus photography are used to provide more accurate measurements. Ciliary body involvement can be evaluated by the slit-lamp, ophthalmoscopy, gonioscopy, and transillumination. However, high-frequency ultrasonography (ultrasound biomicroscopy) is used for more accurate assessment. Extension through the sclera is evaluated visually before and during surgery, and with ultrasonography, computed tomography, or magnetic resonance imaging.

When histopathologic measurements are recorded after fixation, tumor diameter and thickness may be underestimated because of tissue shrinkage.

Lymph-Vascular Invasion (LVI)
LVI indicates whether microscopic lymph-vascular invasion is identified in the pathology report. LVI includes lymphatic invasion, vascular invasion, or lymph-vascular 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. It should be noted that regional lymph node involvement is rare in uveal melanoma, but metastasis to the liver and direct extension into the orbit are more common.

Stage Grouping

<table>
<thead>
<tr>
<th>Stage</th>
<th>T Category</th>
<th>N Category</th>
<th>M Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>T1a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T1b-d</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T2a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T2b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3a</td>
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<td>M0</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>T2c-d</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3b-c</td>
<td>N0</td>
<td>M0</td>
</tr>
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<tr>
<td>Stage IIIIB</td>
<td>T3d</td>
<td>N0</td>
<td>M0</td>
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<tr>
<td></td>
<td>T4b-c</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIC</td>
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G. Other Pathologic Features of Prognostic Significance

Other histologic features with prognostic significance in choroidal and ciliary body melanoma include the number of mitoses in 40 high-powered fields, pigmentation, tumor infiltrating lymphocytes, tumor infiltrating macrophages, growth pattern (diffuse choroidal melanomas and ring melanomas of the ciliary body have a much less favorable prognosis), location of anterior margin of tumor, degree and patterns of vascularity, blood vessel invasion (both tumor vessels and normal vessels), tumor necrosis, extraocular extension, optic nerve involvement, and lack of nuclear BAP1 immunostaining.

References


