Protocol for the Examination of Biopsy Specimens From Patients With Ductal Carcinoma In Situ (DCIS) of the Breast

Version: Breast DCIS Biopsy 1.0.0.1  Protocol Posting Date: February 2020

The use of this protocol is recommended for clinical care purposes but is not required for accreditation purposes.

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy</td>
<td>Includes specimens designated needle biopsy, fine needle aspiration</td>
</tr>
<tr>
<td></td>
<td>and others (for excisional biopsy, see below)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ductal carcinoma in situ without invasive carcinoma or microinvasion</td>
<td></td>
</tr>
<tr>
<td>Paget disease of the nipple not associated with invasive breast carcinoma</td>
<td></td>
</tr>
<tr>
<td>Encapsulated papillary carcinoma without invasive carcinoma</td>
<td></td>
</tr>
<tr>
<td>Solid papillary carcinoma without invasive carcinoma</td>
<td></td>
</tr>
</tbody>
</table>

The following should NOT be reported using this protocol:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resection (consider Breast DCIS Resection protocol)</td>
<td></td>
</tr>
<tr>
<td>Excisional biopsy (consider Breast DCIS Resection protocol)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any tumor with invasive carcinoma (consider the Breast Invasive Carcinoma Biopsy protocol)</td>
<td></td>
</tr>
<tr>
<td>Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)</td>
<td></td>
</tr>
<tr>
<td>Sarcoma (consider the Soft Tissue protocol)</td>
<td></td>
</tr>
</tbody>
</table>

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

* Denotes primary author. All other contributing authors are listed alphabetically.

Accreditation Requirements
The use of this biopsy case summary is recommended for clinical care purposes, but is not required for accreditation purposes. The core and conditional data elements are routinely reported for biopsy specimens. Non-core data elements are included to allow for reporting information that may be of clinical value.

Summary of Changes
v1.0.0.1
Added Architectural Pattern
Updated the Background Documentation (Notes)

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Surgical Pathology Cancer Case Summary

Protocol posting date: February 2020

DCIS OF THE BREAST: Biopsy

Notes:
This case summary is recommended for reporting biopsy specimens but is NOT REQUIRED for accreditation purposes. Core data elements are bolded to help identify routinely reported elements.

Select a single response unless otherwise indicated.

Procedure
___ Needle biopsy
___ Fine needle aspiration
___ Other (specify): ____________________________
___ Not specified

Specimen Laterality
___ Right
___ Left
___ Not specified

Tumor Site (select all that apply)
___ Upper outer quadrant
___ Lower outer quadrant
___ Upper inner quadrant
___ Lower inner quadrant
___ Central
___ Nipple
___ Clock position (specify): _____o’clock
___ Distance from nipple (centimeters): ______cm
___ Other (specify): _____________________
___ Not specified

Histologic Type (Note A)
___ Ductal carcinoma in situ (DCIS)
___ Paget disease
___ Encapsulated papillary carcinoma without invasive carcinoma
___ Solid papillary carcinoma without invasive carcinoma

Architectural Patterns (select all that apply) (Note B)
___ Comedo
___ Paget disease (DCIS involving nipple skin)
___ Cribriform
___ Micropapillary
___ Papillary
___ Solid
___ Other (specify: ________________________)

Nuclear Grade (Note C)
___ Grade I (low)
___ Grade II (intermediate)
___ Grade III (high)

The routinely reported core data elements are bolded.
Necrosis (Note D)
___ Not identified
___ Present, focal (small foci or single cell necrosis)
___ Present, central (expansive “comedo” necrosis)

Additional Pathologic Findings (Note E)
Specify: __________________________

Microcalcifications (select all that apply) (Note F)
___ Not identified
___ Present in DCIS
___ Present in non-neoplastic tissue
___ Other (specify): __________________________

Ancillary Studies
Note: For hormone receptor and HER2 reporting, the CAP Breast Biomarker Template should be used.
www.cap.org/cancerprotocols.

Biomarker Studies
___ Pending

Comment(s)
A. Histologic Type
This protocol applies only to cases of DCIS. The protocol for invasive carcinoma of the breast applies if invasion or microinvasion (less than or equal to 1 mm) is present. Pleomorphic lobular carcinoma in situ (LCIS) has overlapping features with DCIS and may be treated similarly, but at present there is insufficient evidence to establish definitive recommendations for treatment. Thus, pleomorphic LCIS is not currently included in the pTis classification.

When DCIS involves nipple skin only, without underlying invasive carcinoma or DCIS, the classification is DCIS (ie, pTis [Paget]). The majority of these cases are strongly positive for HER2.

B. Architectural Pattern
The architectural pattern has been reported traditionally for DCIS.\(^1\)\(^2\) However, nuclear grade and the presence of necrosis are more predictive of clinical outcome.

References

C. Nuclear Grade
The nuclear grade of DCIS is determined using 6 morphologic features (Table 1).\(^1\)\(^2\)

Table 1. Nuclear Grade of Ductal Carcinoma In Situ

<table>
<thead>
<tr>
<th>Feature</th>
<th>Grade I (Low)</th>
<th>Grade II (Intermediate)</th>
<th>Grade III (High)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleomorphism</td>
<td>Monotonous (monomorphic)</td>
<td>Intermediate</td>
<td>Markedly pleomorphic</td>
</tr>
<tr>
<td>Size</td>
<td>1.5 to 2 x the size of a normal RBC or a normal duct epithelial cell nucleus</td>
<td>Intermediate</td>
<td>&gt;2.5 x the size of a normal RBC or a normal duct epithelial cell nucleus</td>
</tr>
<tr>
<td>Chromatin</td>
<td>Usually diffuse, finely dispersed chromatin</td>
<td>Intermediate</td>
<td>Usually vesicular with irregular chromatin distribution</td>
</tr>
<tr>
<td>Nucleoli</td>
<td>Only occasional</td>
<td>Intermediate</td>
<td>Prominent, often multiple</td>
</tr>
<tr>
<td>Mitoses</td>
<td>Only occasional</td>
<td>Intermediate</td>
<td>May be frequent</td>
</tr>
<tr>
<td>Orientation</td>
<td>Polarized toward luminal spaces</td>
<td>Intermediate</td>
<td>Usually not polarized toward the luminal space</td>
</tr>
</tbody>
</table>

Definition: RBC, red blood cell.

References

D. Necrosis
The presence of necrosis\(^1\) \(^2\) is correlated with the finding of mammographic calcifications (ie, most areas of necrosis will calcify). DCIS that presents as mammographic calcifications often recurs as calcifications. Necrosis can be classified as follows:

- **Central ("comedo")**: The central portion of an involved ductal space is replaced by an area of expansive necrosis that is easily detected at low magnification. Ghost cells and karyorrhectic debris are generally
present. Although central necrosis is generally associated with high-grade nuclei (i.e., comedo DCIS), it can also occur with DCIS of low or intermediate nuclear grade. This type of necrosis often correlates with a linear and/or branching pattern of calcifications on mammography.

- **Focal (punctate):** Small foci, indistinct at low magnification, or single cell necrosis.

Necrosis should be distinguished from secretory material, which can also be associated with calcifications, cytoplasmic blebs, and histiocytes, but does not include nuclear debris.

References

E. **Additional Pathologic Findings**
If the biopsy was performed for a benign lesion and the DCIS is an incidental finding, this should be documented. An example would be the finding of DCIS in an excision for a palpable fibroadenoma. In some cases, other pathologic findings are important for the clinical management of patients.

F. **Microcalcifications**
DCIS found in biopsies performed for microcalcifications will almost always be at the site of the calcifications or in close proximity.\(^1\,\!\!^2\,\!\!^3\) The presence of the targeted calcifications in the specimen should be confirmed by specimen radiography. The pathologist must be satisfied that the specimen has been sampled in such a way that the lesion responsible for the calcifications has been examined microscopically. The relationship of the radiologic calcifications to the DCIS should be indicated.

References