Protocol for the Examination of Resection Specimens From Patients With Primary Carcinoma of the Uterine Cervix

Version: 5.0.0.0  
Protocol Posting Date: October 2020  
CAP Laboratory Accreditation Program Protocol Required Use Date: July 2021

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 radical trachelectomy, radical hysterectomy, or pelvic exenteration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tumor Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carcinoma</td>
<td></td>
</tr>
<tr>
<td>Carcinosarcoma</td>
<td></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, includes Excision (Cone/LEEP) (consider Uterine Cervix Excision protocol)</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>Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)</td>
</tr>
<tr>
<td>Sarcoma (consider Uterine Sarcoma protocol)</td>
</tr>
</tbody>
</table>

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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
v5.0.0.0

- WHO 5th Edition Histologic Types
- Addition of “Equivocal” to Lymphovascular Invasion
- Margins Section Modifications
- Lymph Node Section (driven by new AJCC pN Staging Classification)
- Addition of Separate Distant Metastasis Section
- AJCC 9th Version pTNM Staging Classification
- Alternate Verbiage for pTX and pNX as Approved by AJCC
- FIGO 2018 Staging Corrigendum
- Updated Explanatory Notes for Histologic Type, Silva Pattern, Lymphovascular Invasion
### Reporting Template

**Protocol Posting Date: October 2020**

*Note: + Data elements preceded by this symbol are not required for accreditation purposes. These optional elements may be clinically important but are not yet validated or regularly used in patient management.*

Select a single response unless otherwise indicated.

#### CASE SUMMARY: (UTERINE CERVIX: Resection)

**Standard(s):** FIGO Cancer Report 2018, ACS.AJCC.Protocol.CervixUteri.2021.v09.00.00

**SPECIMEN (Note A)**

**Procedure (select all that apply)**

- ___ Trachelectomy
- ___ Total hysterectomy and bilateral salpingo-oophorectomy
- ___ Radical hysterectomy
- ___ Simple hysterectomy
- ___ Pelvic exenteration (specify included organs): _________________
- ___ Bilateral salpingo-oophorectomy
- ___ Right salpingo-oophorectomy
- ___ Left salpingo-oophorectomy
- ___ Salpingo-oophorectomy, side not specified
- ___ Right oophorectomy
- ___ Left oophorectomy
- ___ Oophorectomy, side not specified
- ___ Bilateral salpingectomy
- ___ Right salpingectomy
- ___ Left salpingectomy
- ___ Salpingectomy, side not specified
- ___ Vaginal cuff resection
- ___ Omentectomy
- ___ Other (specify): _________________

*Note: For information about lymph node sampling, please refer to the Regional Lymph Node section.*

#### +Hysterectomy Type

- ___ Abdominal
- ___ Vaginal
- ___ Vaginal, laparoscopic-assisted
- ___ Laparoscopic
- ___ Laparoscopic, robotic-assisted
- ___ Other (specify): _________________
- ___ Not specified

#### TUMOR

**+Tumor Site (select all that apply)**

- ___ Left superior (anterior) quadrant (12 to 3 o’clock)
- ___ Left inferior (posterior) quadrant (3 to 6 o’clock)
- ___ Right inferior (posterior) quadrant (6 to 9 o’clock)
- ___ Right superior (anterior) quadrant (9 to 12 o’clock)
__ Other (specify): _________________
__ Not specified

Tumor Size (Note B)
__ Greatest dimension in Centimeters (cm): _________________ cm
+Additional Dimension in Centimeters (cm): _____ cm
+Additional Dimension in Centimeters (cm): _____ cm
__ Cannot be determined (explain): _________________

Note: All dimensions are important; see definition for “superficially invasive squamous cell carcinoma” under T1a1 / IA1.
Note: Per AJCC Staging Manual, Tumor Size is reported in Centimeters.

Histologic Type (Note C)
__ Squamous cell carcinoma, HPV-associated
__ Squamous cell carcinoma, HPV-independent
__ Squamous cell carcinoma, NOS (acceptable when p16 or HPV testing is not available)
__ Adenocarcinoma, NOS
__ Adenocarcinoma, HPV-associated
__ Adenocarcinoma, HPV-independent, NOS
__ Adenocarcinoma, HPV-independent, gastric type
__ Adenocarcinoma, HPV-independent, clear cell type
__ Adenocarcinoma, HPV-independent, mesonephric type
__ Endometrioid adenocarcinoma, NOS
__ Carcinosarcoma
__ Adenosquamous carcinoma
__ Adenoid basal carcinoma
__ Mucoepidermoid carcinoma
__ Carcinoma, unclassifiable (undifferentiated carcinoma)
__ Neuroendocrine tumor, NOS
__ Neuroendocrine tumor, grade 1
__ Neuroendocrine tumor, grade 2
__ Small cell neuroendocrine carcinoma, high grade
__ Large cell neuroendocrine carcinoma, high grade
__ Neuroendocrine carcinoma, NOS
__ Mixed neuroendocrine non-neuroendocrine carcinoma
__ Other histologic type not listed (specify): _________________
__ Carcinoma, type cannot be determined: _________________
+Histologic Type Comments: _________________

Histologic Grade (Note D)
__ G1: Well differentiated
__ G2: Moderately differentiated
__ G3: Poorly differentiated
__ GX: Cannot be assessed: _________________
__ Not applicable
Stromal Invasion (Note B)

Depth of Stromal Invasion in Millimeters (mm)
___ Specify in Millimeters (mm): _________________ mm
___ At least in Millimeters (mm): _________________ mm
___ Cannot be determined (explain): _________________

+Depth of Stromal Invasion
___ Superficial one-third
___ Middle one-third
___ Deep one-third

+Horizontal Extent of Stromal Invasion in Millimeters (mm)
___ Not applicable (in larger tumors that can be measured grossly)
___ Specify in Millimeters (mm): _________________ mm
___ Estimated as less than or equal to 7 Millimeters (mm)
Specify Number of Blocks Involved: _________________
___ Estimated as greater than 7 Millimeters (mm)
Specify Number of Blocks Involved: _________________
___ Cannot be determined (explain): _________________

+Silva Pattern of Invasion#
#Silva System- applicable only to invasive endocervical adenocarcinomas
___ Not applicable
___ Pattern A
___ Pattern B
___ Pattern C

Other Tissue / Organ Involvement (select all that apply)
___ Not applicable
___ Not identified
___ Right parametrium
___ Left parametrium
___ Parametrium (side not specified)
___ Vagina, upper two-thirds
___ Vagina, lower one-third
___ Vagina (location not specified)
___ Right ovary
___ Left ovary
___ Ovary (side not specified)
___ Right fallopian tube
___ Left fallopian tube
___ Fallopian tube (side not specified)
___ Pelvic wall
___ Bladder wall
___ Bladder mucosa#
___ Rectal wall
___ Bowel mucosa#
___ Omentum
___ Other organs / tissue (specify): _________________
___ Cannot be determined (explain): _________________

#Note: Tumor should involve the mucosal surface Note: Any organ not selected is either not involved or was not submitted.
Lymphovascular Invasion (Note E)
___ Not identified
___ Present
___ Equivocal (explain): __________________
___ Cannot be determined

MARGINS (Note F)

Margin Status for Invasive Carcinoma
___ All margins negative for invasive carcinoma
+Closest Margin(s) to Invasive Carcinoma (select all that apply)
   ___ Ectocervical (specify location, if possible): _________________
   ___ Radial/circumferential (specify location, if possible): _________________
   ___ Endocervical/lower uterine segment (specify location, if possible): _________________
   ___ Vaginal cuff: _________________
   ___ Other (specify): _________________
   ___ Cannot be determined

+Distance of Invasive Carcinoma to Closest Margin
   Specify in Millimeters (mm)
   ___ Exact distance: _________________ mm
   ___ Greater than: _________________ mm
   ___ At least: _________________ mm
   ___ Less than: _________________ mm
   ___ Less than 1 mm
   ___ Other (specify): _________________
   ___ Cannot be determined

___ Invasive carcinoma present at margin
Margin(s) Involved by Invasive Carcinoma (select all that apply)
   ___ Ectocervical (specify location, if possible): _________________
   ___ Radial/circumferential (specify location, if possible): _________________
   ___ Endocervical/lower uterine segment (specify location, if possible): _________________
   ___ Vaginal cuff: _________________
   ___ Other (specify): _________________
   ___ Cannot be determined
   ___ Other (specify): _________________
   ___ Cannot be determined (explain): _________________
   ___ Not applicable

Margin Status for HSIL/AIS#
___ All margins negative for high-grade squamous intraepithelial lesion (HSIL) and/or adenocarcinoma in situ (AIS)
___ High-grade squamous intraepithelial lesion (HSIL) present at margin
Margin(s) Involved by HSIL (select all that apply)
   ___ Ectocervical (specify location, if possible): _________________
   ___ Endocervical/lower uterine segment (specify location, if possible): _________________
   ___ Vaginal cuff: _________________
   ___ Other (specify): _________________
   ___ Cannot be determined
   ___ Other (specify): _________________
   ___ Cannot be determined (explain): _________________
   ___ Not applicable
___ Adenocarcinoma in situ (AIS) present at margin
Margin(s) Involved by AIS (select all that apply)

___ Ectocervical (specify location, if possible): __________________
___ Endocervical/lower uterine segment (specify location, if possible): ______________
___ Other (specify): __________________
___ Cannot be determined
___ Other (specify): __________________
___ Cannot be determined (explain if possible): ______________
___ Not applicable

Reporting high-grade squamous intraepithelial lesion (CIN 2-3 or VAIN 2-3) and/or AIS is not required if margin is involved by invasive carcinoma.

Margins Comments: ______________

REGIONAL LYMPH NODES (Note E)

Regional Lymph Node Status#

# Note: Lymph nodes designated as pelvic (parametrial, obturator, internal iliac (hypogastric), external iliac, common iliac, sacral, presacral) and para-aortic are considered regional lymph nodes. Any other involved nodes should be categorized as metastases (pM1) and reported in the distant metastasis section. Presence of isolated tumor cells no greater than 0.2 mm in regional lymph node(s) is considered N0 (i+).

___ No lymph nodes submitted or found
___ All regional lymph nodes negative for tumor cells
___ Tumor present in pelvic lymph node(s)

Note: Macrometastases (greater than 2 mm), Micrometastases (greater than 0.2 mm to 2 mm), Isolated Tumor Cells (ITC: less than or equal to 0.2 mm or single cells or clusters of cells less than or equal to 200 cells in a single lymph node cross section). If pelvic and/or para-aortic lymph nodes are submitted and positive for tumor cells, reporting the number of nodes with or without macrometastases and micrometastases is required. Reporting isolated tumor cells is required only in the absence of macrometastasis or micrometastasis.

Pelvic Lymph Nodes (required only if present)

Total Number of Pelvic Nodes with Macrometastasis (greater than 2 mm) (sentinel and non-sentinel)

___ Exact number: ______________
___ At least: ______________
___ Other (specify): ______________
___ Cannot be determined (explain): ______________

+Number of Pelvic Sentinel Nodes with Macrometastasis

___ Exact number: ______________
___ At least: ______________
___ Other (specify): ______________
___ Cannot be determined (explain): ______________

Total Number of Pelvic Nodes with Micrometastasis (greater than 0.2 mm up to 2 mm and/or greater than 200 cells) (sentinel and non-sentinel)

___ Exact number: ______________
___ At least: ______________
___ Other (specify): ______________
___ Cannot be determined (explain): ______________
+Number of Pelvic Sentinel Nodes with Micrometastasis
   ___ Exact number: ____________________
   ___ At least: ____________________
   ___ Other (specify): ____________________
   ___ Cannot be determined (explain): ____________________

Total Number of Pelvic Nodes with Isolated Tumor Cells# (0.2 mm or less and not more than 200 cells)
# Note: Reporting the number of lymph nodes with isolated tumor cells is required only in the absence of macrometastasis or micrometastasis in other lymph nodes.
   ___ Not applicable
   ___ Exact number: ____________________
   ___ At least: ____________________
   ___ Other (specify): ____________________
   ___ Cannot be determined (explain): ____________________

+Number of Pelvic Sentinel Nodes with ITCs
   ___ Exact number: ____________________
   ___ At least: ____________________
   ___ Other (specify): ____________________
   ___ Cannot be determined (explain): ____________________

Laterality of Pelvic Node(s) with Tumor Cells
# Note: Right/Left applies only to non-sentinel pelvic lymph nodes.
   ___ Not applicable
   ___ Right sentinel: ____________________
   ___ Right#: ____________________
   ___ Left sentinel: ____________________
   ___ Left#: ____________________
   ___ Cannot be determined

+Size of Largest Pelvic Nodal Metastatic Deposit (specify in Millimeters) : ________ mm

___ Tumor present in para-aortic lymph node(s)

Para-aortic Nodes (required only if present)
   Total Number of Para-aortic Nodes with Macrometastasis (greater than 2 mm)
   (sentinel and non-sentinel)
      ___ Not applicable
      ___ Exact number: ____________________
      ___ At least: ____________________
      ___ Other (specify): ____________________
      ___ Cannot be determined (explain): ____________________

+Number of Para-aortic Sentinel Nodes with Macrometastasis
   ___ Exact number: ____________________
   ___ At least: ____________________
   ___ Other (specify): ____________________
   ___ Cannot be determined (explain): ____________________
Total Number of Para-aortic Nodes with Micrometastasis (greater than 0.2 mm up to 2 mm and/or greater than 200 cells) (sentinel and non-sentinel)
___ Not applicable
___ Exact number: _________________
___ At least: _________________
___ Cannot be determined (explain): _________________

+Number of Para-aortic Sentinel Nodes with Micrometastasis
___ Exact number: _________________
___ At least: _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

Total Number of Para-aortic Nodes with Isolated Tumor Cells# (0.2 mm or less and not more than 200 cells)
# Note: Reporting the number of lymph nodes with isolated tumor cells is required only in the absence of macrometastasis or micrometastasis in other lymph nodes.
___ Not applicable
___ Specify number: _________________
___ At least: _________________
___ Cannot be determined (explain): _________________

+Number of Para-aortic Sentinel Nodes with ITCs
___ Exact number: _________________
___ At least: _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

Laterality of Para-aortic Node(s) with Tumor Cells
# Note: Right/Left applies only to non-sentinel para-aortic lymph nodes.
___ Not applicable
___ Right sentinel: _________________
___ Right#
___ Left sentinel: _________________
___ Left#
___ Cannot be determined

+Size of Largest Para-aortic Nodal Metastatic Deposit (specify in Millimeters) : ___ mm
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

Lymph Nodes Examined
Total Number of Pelvic Nodes Examined (sentinel and non-sentinel)
___ Exact number: _________________
___ At least: _________________
___ Other (specify): _________________
___ Cannot be determined (explain): _________________

Number of Pelvic Sentinel Nodes Examined
___ Not applicable
___ Exact number: _________________
### Total Number of Para-aortic Nodes Examined (sentinel and non-sentinel)

- **Exact number:** _________________
- **At least:** _________________
- **Other (specify):** _________________
- **Cannot be determined (explain):** _________________

### Number of Para-aortic Sentinel Nodes Examined

- **Not applicable**
- **Exact number:** _________________
- **At least:** _________________
- **Other (specify):** _________________
- **Cannot be determined (explain):** _________________

### DISTANT METASTASIS

**Distant Site(s) Involved, if applicable#** (select all that apply)

- **Not applicable**
- **Uterine serosa:** _________________
- **Adnexa involvement:** _________________
- **Inguinal lymph nodes:** _________________
- **Intraperitoneal disease:** _________________
- **Lung:** _________________
- **Liver:** _________________
- **Bone:** _________________
- **Other (specify):** _________________
- **Cannot be determined**

### PATHOLOGIC STAGE CLASSIFICATION (pTNM, AJCC 9th Version)(Note G)

**TNM Descriptors**

- **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

**pT1:** Carcinoma is strictly confined to the cervix (extension to the corpus should be disregarded)

**pT1a:** Invasive carcinoma that can be diagnosed only by microscopy with maximum depth of invasion less than or equal to 5 mm

#The LAST definition of superficial invasive squamous cell carcinoma (SISCCA) conforms to T1a1.

**pT1a1:** Measured stromal invasion less than or equal to 3 mm in depth#
___ pT1a2: Measured stromal invasion greater than 3 mm and less than or equal to 5 mm in depth
___ pT1a (subcategory cannot be determined)

pT1b: Invasive carcinoma with measured deepest invasion >5 mm (greater than stage IA); lesion limited to the cervix uteri with size measured by maximum tumor diameter. Note: The involvement of vascular/lymphatic spaces should not change the staging. The lateral extent of the lesion is no longer considered.

___ pT1b1: Invasive carcinoma greater than 5 mm depth of stromal invasion and less than or equal to 2 cm in greatest dimension
___ pT1b2: Invasive carcinoma greater than 2 cm and less than or equal to 4 cm in greatest dimension
___ pT1b3: Invasive carcinoma greater than 4 cm in greatest dimension
___ pT1b (subcategory cannot be determined)
___ pT1 (subcategory cannot be determined)

pT2: Carcinoma invades beyond the uterus, but has not extended onto the lower third of the vagina or to the pelvic wall

___ pT2a1: Invasive carcinoma less than or equal to 4 cm in greatest dimension
___ pT2a2: Invasive carcinoma greater than 4 cm in greatest dimension
___ pT2a (subcategory cannot be determined)
___ pT2b: With parametrial invasion but not up to the pelvic wall
___ pT2 (subcategory cannot be determined)

pT3: Carcinoma involves the lower third of the vagina and/or extends to the pelvic wall and/or causes hydronephrosis or nonfunctioning kidney. Note: The pelvic wall is defined as the muscle, fascia, neurovascular structures, and skeletal portions of the bony pelvis. Cases with no cancer-free space between the tumor and pelvic wall by rectal examination are FIGO III.

___ pT3a: Carcinoma involves lower third of the vagina, with no extension to the pelvic wall
___ pT3b: Extension to the pelvic wall and/or hydronephrosis or nonfunctioning kidney (unless known to be due to another cause)
___ pT3 (subcategory cannot be determined)

Tumor should involve the mucosal surface.

___ pT4: Carcinoma has involved (biopsy-proven) the mucosa of the bladder or rectum, or has spread to adjacent organs. (Bullous edema, as such, does not permit a case to be assigned to stage 4.)##

Regional Lymph Nodes Modifier

#The suffix (sn) is added to the N category when metastasis is identified only by sentinel lymph node biopsy.
___ Not applicable
___ (sn)#
___ (sn)(i-)
___ (sn)(i+)

##The suffix (f) is added to the N category when metastasis is identified only by FNA or core biopsy.
___ (f)##

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
___ pN0(i+): Isolated tumor cells in regional lymph node(s) less than or equal to 0.2 mm, or single cells or clusters of cells less than or equal to 200 cells in a single lymph node cross section

pN1: Regional lymph node metastasis to pelvic lymph nodes only
___ pN1mi: Regional lymph node metastasis (greater than 0.2 mm but less than or equal to 2.0 mm) to pelvic lymph nodes
___ pN1a: Regional lymph node metastasis (greater than 2.0 mm diameter) to pelvic lymph nodes
___ pN1 (subcategory cannot be determined)

pN2: Regional lymph node metastasis to para-aortic lymph nodes, with or without positive pelvic lymph nodes
pN2mi: Regional lymph node metastasis to para-aortic lymph nodes (greater than 0.2 mm but less than or equal to 2.0 mm), with or without positive pelvic lymph nodes

pN2a: Regional lymph node metastasis to para-aortic lymph nodes (greater than 2.0 mm in diameter), with or without positive pelvic lymph nodes

pN2 (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 (includes metastasis to inguinal lymph nodes, intraperitoneal disease, lung, liver, or bone) (excludes metastasis to pelvic or para-aortic lymph nodes, or vagina). Uterine serosa and adnexa involvement are considered M1 disease.

FIGO STAGE (Note G)

+FIGO Stage (2018 FIGO Cancer Report) (Note G)

Please note that this section includes the Corrigendum to Revised FIGO staging for carcinoma of the cervix uteri. See the appropriate reference in Note G.

IA: Carcinoma is strictly confined to the cervix (extension to the uterine corpus should be disregarded)

IB: Invasive carcinoma with measured stromal invasion greater than 5.0 mm (greater than stage IA) and limited to the uterus

IB1: Invasive carcinoma with measured stromal invasion greater than 5.0 mm and 2 cm or less in greatest dimension

IB2: Invasive carcinoma greater than 2 cm but 4 cm or less in greatest dimension

IB3: Invasive carcinoma greater than 4 cm in greatest dimension

II: Carcinoma extends beyond the uterus but has not extended onto the pelvic sidewall or to the lower third of vagina

IIA: Carcinoma involves the upper two-thirds of the vagina without parametrial invasion

IIA1: Invasive carcinoma 4 cm or less in greatest dimension

IIA2: Invasive carcinoma greater than 4 cm in greatest dimension

IIB: Parametrial involvement but not involving the pelvic sidewall

III: Carcinoma involves the lower third of the vagina and/or extends to the pelvic sidewall and/or causes hydronephrosis or nonfunctioning kidney and/or involves pelvic and/or para-aortic lymph nodes

IIIA: Involvement of the lower third of the vagina but no extension onto pelvic sidewall

IIIB: Extension onto the pelvic sidewall, and/or causing hydronephrosis or nonfunctioning kidney (unless known to be due to another cause)

IIIC: Involvement of pelvic and/or para-aortic lymph nodes (including micrometastases), irrespective of tumor size and extent (with r and p notations)

IIIC1: Pelvic lymph node metastasis only

IIIC2: Para-aortic lymph node metastasis

IV: Carcinoma extends beyond the true pelvis or involves (biopsy proven) the mucosa of the bladder and/or rectum (bullous edema is not sufficient) or spread to distant organs
___ IVA: Spread to adjacent organs, i.e., tumor invading the mucosa of the bladder and / or rectum (biopsy proven) and / or extending beyond the true pelvis (bullous edema is not sufficient)
___ IVB: Spread to distant organs

ADDITIONAL FINDINGS

+Additional Findings (select all that apply)
   ___ None identified
   ___ Low-grade squamous intraepithelial lesion (CIN 1)
   ___ High-grade squamous intraepithelial lesion (CIN 2 or 3)
   ___ Inflammation
   ___ Endocervical adenocarcinoma in situ
   ___ Other (specify): ____________________

SPECIAL STUDIES

+Ancillary Studies (specify) (Note H):
   ____________________

+ p16 Immunohistochemistry
   ___ Positive
   ___ Negative

Comment(s): ____________________

Explanatory Notes

A. Procedure
   Specimen Orientation
   If the specimen is the product of a cone biopsy or an excisional biopsy, it is desirable for the surgeon to orient the specimen to facilitate assessment of the resection margins (eg, stitch at 12 o’clock). The laterality of the specimen is in reference to the patient’s perspective. Clock values refer to the cervix from the viewer’s perspective (face on). However, specimens frequently are received without orientation. In these cases, the clock face orientation is designated by the pathologist and is arbitrary.

   Examination of Bladder and Rectum
   Currently, pelvic exenterations are rarely seen, but typically when performed indicate advanced tumor stage. In these cases, the extent of tumor involvement of the urinary bladder and rectum and the relation of that tumor to the cervical carcinoma should be described. To evaluate these features, sections of the rectum and bladder should be taken perpendicular to the mucosa directly overlying the tumor in the cervix. A method that provides excellent orientation of the tumor to adjacent structures consists of inflation of the urinary bladder and rectum with formalin and fixation of the specimen for several hours. The entire specimen can then be hemisected through the neoplasm, and appropriate sections can be obtained.

B. Tumor Size
   Tumor Size Measurement
   Larger tumors are more accurately measured grossly, while smaller tumors and some larger tumors with a diffusely infiltrative pattern or with marked fibrosis are best measured microscopically. It is best to report only one set of tumor measurements based on a correlation of the gross and microscopic features to avoid confusion. According to the 2018 FIGO staging system for all stages the size of the primary tumor can be assessed by clinical evaluation (pre- or intraoperative), imaging, and/or pathological
The depth of invasion is required for the sub-staging of Stage 1 carcinomas in the latest FIGO staging system (2018)\(^1\) and in the latest AJCC system (2020).\(^2\) The depth of invasion is measured from its HSIL origin, that is, from the base of the epithelium, whether epithelial surface or an endocervical gland that is involved by HSIL to the deepest point of invasion. If the invasive focus or foci are not in continuity with the dysplastic epithelium, the depth of invasion should be measured from the deepest focus of tumor invasion to the base of the nearest dysplastic crypt or surface epithelium. If there is no obvious epithelial origin, the depth is measured from the deepest point of tumor invasion to the base of the nearest surface epithelium, regardless of whether it is dysplastic or not. In situations where carcinomas are exclusively or predominantly exophytic, there may be little or no invasion of the underlying stroma. These should not be regarded as in situ lesions and the tumor thickness (from the surface of the tumor to the deepest point of invasion) should be measured. The depth of invasion below the level of the epithelial origin should not be provided in these cases, as this may not truly reflect the biological potential of these tumors. If it is impossible to measure the depth of invasion, eg, in ulcerated tumors or in some adenocarcinomas, the tumor thickness may be measured instead, and this should be clearly stated on the pathology report along with an explanation for providing the thickness rather than the depth of invasion.

The depth of stromal invasion in fractional thirds in resections is a data point in the NCCN guidelines that guides clinical management.\(^3\),\(^4\)

**Horizontal Extent**

This is now an optional element in the synoptic template. It is no longer included in the AJCC staging update and is no longer used for sub-staging of Stage I carcinomas in the 2018 FIGO staging system.\(^3\) However, some still feel that horizontal spread may have prognostic significance in early stage cervical cancer. The collection of horizontal spread data is encouraged to create an opportunity for future analysis and individual clinicians may request a horizontal extent for their practice.

The horizontal extent may be the longitudinal extent (length) measured in the superior-inferior plane (ie, from the endocervical to ectocervical aspects of the section), or it may be the circumferential extent (width) that is measured or calculated perpendicular to the longitudinal axis of the cervix. When a gross lesion is not identified, the measurement accuracy of horizontal extent may be limited. If the extent is measured on a single glass slide, this may underestimate the true horizontal extent, because the tumor may involve multiple blocks and may have a greater “width” than “length”. The thickness of sections of the cervix, which are often taken as “wedges” of a cone may be variable and may range from less than 1.0 mm to greater than 3.0 mm. In addition, adding thicknesses of adjacent sections where the sections are taken as a cone are measuring the circumference rather than a linear “width”. Estimates using a thickness of 2.5 mm to 3.0 mm may overestimate the true tumor extent.\(^5\),\(^6\) The pathologist should report the maximum horizontal extent (when it on a single block) and where multiple blocks are involved, they should report the number of blocks involved and if it is estimated as less than or equal to 7.0 mm or greater than 7.0 mm.

To summarize, horizontal extent data is an optional element and has been excluded from the staging update. However, the collection of horizontal spread data is encouraged.

The Lower Anogenital Squamous Terminology (LAST)\(^7\) definition of superficial invasive squamous cell carcinoma (SISSCA) conforms to T1a1/ FIGO IA1 and defines what would have been previously reported as “microinvasive” squamous cell carcinoma. The LAST consensus recommends that SISCCA include multifocal disease and that reporting include the presence, number, and size of independent multifocal carcinoma. However, LAST makes no recommendation on the methodology to measure multifocal disease. Multifocal tumors should be defined as invasive foci separated by a tissue block within which there is no evidence of invasion, as invasive foci in the same tissue block that are more than 2.0 mm apart, or as invasive foci on different cervical lips. They recommend that multifocal tumors should be staged based on the largest focus.\(^7\)
Silva Pattern of Invasion

Accurately measuring the depth of stromal invasion can be challenging in some endocervical adenocarcinomas. The Silva system of classification stratifies cases of invasive endocervical adenocarcinomas into three groups on the basis of the morphologic pattern of invasion and is predictive of the risk for LN metastasis. Briefly, Pattern A shows well-demarcated glands with rounded contours, frequently forming groups with no destructive stromal invasion, no single cells or cell detachment and no LVI. Complex intraglandular growth such as cribriform or papillary architecture is acceptable but there is no solid growth. Pattern B shows localized (limited, early) destructive stromal invasion. There are individual or small groups of tumor cells, separated from the rounded gland, in a focally desmoplastic or inflamed stroma. There is no solid growth and LVI may or may not be present. Pattern C shows diffuse destructive stromal invasion. There are diffusely infiltrative glands with associated extensive desmoplastic response. Growth pattern is confluent or solid and LVI may or may not be present. Pattern A cases were all stage I with negative lymph nodes and no recurrences. Pattern B tumors rarely had metastatic lymph nodes and only 23.8% of cases with pattern C had lymph node metastases.

<table>
<thead>
<tr>
<th>Silva Pattern</th>
<th>Histologic Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Demarcated, complete, rounded glands, frequently forming groups on low power</td>
</tr>
<tr>
<td></td>
<td>• Cribriform and papillary growth is possible, but solid (nonglandular) growth is not</td>
</tr>
<tr>
<td></td>
<td>• No desmoplastic stroma</td>
</tr>
<tr>
<td></td>
<td>• Lacks single or detached cells</td>
</tr>
<tr>
<td></td>
<td>• No lymphovascular invasion</td>
</tr>
<tr>
<td></td>
<td>• Relationship of tumor to large cervical vessels and depth of tumor are not relevant to</td>
</tr>
<tr>
<td></td>
<td>pattern</td>
</tr>
<tr>
<td>B</td>
<td>Localized or limited destructive (desmoplastic) stromal invasion arising in Pattern A</td>
</tr>
<tr>
<td></td>
<td>• Buds of small glands or individual cells from rounded glands (often in an inflamed or</td>
</tr>
<tr>
<td></td>
<td>focally desmoplastic stroma), often with increased cytoplasm or maturation</td>
</tr>
<tr>
<td></td>
<td>• Single, multiple or linear (base of tumor) foci are acceptable</td>
</tr>
<tr>
<td></td>
<td>• No solid growth pattern</td>
</tr>
<tr>
<td></td>
<td>• Lymphovascular invasion may or may not be present</td>
</tr>
<tr>
<td>C</td>
<td>Diffuse growth pattern with destructive (often extensive desmoplastic) stromal</td>
</tr>
<tr>
<td></td>
<td>invasion</td>
</tr>
<tr>
<td></td>
<td>• Confluent growth of glands, papillae, or mucin lakes filling 4X field (5 mm)</td>
</tr>
<tr>
<td></td>
<td>• Angulated, often incomplete or discontinuous glands (breaks opening into the stroma)</td>
</tr>
<tr>
<td></td>
<td>• Canalicular (labyrinthine, interconnected glandular) pattern with occasional open</td>
</tr>
<tr>
<td></td>
<td>glands</td>
</tr>
<tr>
<td></td>
<td>• Solid or poorly differentiated component (high grade); nuclear grade is disregarded</td>
</tr>
<tr>
<td></td>
<td>• Lymphovascular invasion may or may not be present</td>
</tr>
</tbody>
</table>

References

2. Olawaiye AB, Hagemann I, Otis C et al. Cervix Uteri. Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging System (2020).


C. Histologic Type
For consistency in reporting, the histologic classification proposed by the World Health Organization (WHO) is recommended; other classification systems may be used, however. A majority of cervical squamous cell carcinomas are HPV-associated. p16 testing and/or molecular HPV typing is recommended before making the diagnosis of HPV-associated cervical SCC. If these results are not available, the NOS category should be used. There is now a general consensus that most or all serous carcinomas detected in the cervix represent metastasis or direct extension from adnexal or endometrial serous carcinomas, although conclusive studies to support this have yet to be published.

References

D. Histologic Grade
A wide variety of grading systems, including some that evaluate only the extent of cellular differentiation and others that assess additional features such as the appearance of the tumor margin, the extent of inflammatory cell infiltration, and vascular invasion, have been used for squamous cell carcinoma of the cervix. However, there is no consensus emerging from the literature that any of these systems are reproducible or that they provide useful prognostic information, so no particular system is recommended. For the grading of invasive squamous tumors, it is suggested that three grades be used:

- **GX** Cannot be assessed
- **G1** Well differentiated
- **G2** Moderately differentiated
- **G3** Poorly differentiated

It is uncertain whether grading has independent prognostic value in cervical ACA. Whilst a correlation between higher grade and adverse outcomes has been reported, at least for poorly differentiated tumors, this has not been a universal finding. Most grading systems are based on the tumor architecture (glandular and papillary versus solid areas) and its nuclear features. In contrast to squamous cell carcinoma, most authors who grade cervical adenocarcinoma have found the grade to have prognostic value.12,34

- **G1** Small component of solid growth and mild to moderate nuclear atypia
- **G2** Intermediate between grades 1 and 3
- **G3** Solid pattern with severe nuclear atypia

Tumors with no differentiation or minimal differentiation that is discernible only in rare, tiny foci (undifferentiated carcinomas by WHO classification) are categorized as Grade 4.
Neuroendocrine tumors of the cervix have a separate grading system mirroring neuroendocrine tumors of other body sites. The 2020 WHO classifies uterine cervix neuroendocrine tumors into two categories: low-grade neuroendocrine tumor (including grades 1 and 2) and high-grade neuroendocrine carcinoma (including small cell neuroendocrine carcinoma and large cell neuroendocrine carcinoma), along with a “mixed” category with other carcinoma. By definition, the high-grade tumors are Grade 3.\textsuperscript{1,2,3} High-grade neuroendocrine tumors of the cervix are typically HPV-associated, most frequently HPV subtypes 16 or 18.

References

E. Lymphovascular Invasion
Many gynecologists feel that the presence of vascular/lymphatic vessel invasion is important because it may change the extent of their surgical treatment and may be an independent risk factor for recurrence.\textsuperscript{1,2,3,4} At times, it may be difficult to evaluate a specimen for vascular/lymphatic vessel invasion, as in cases with crush artifact or suboptimal fixation. In these cases, it can be categorized as “cannot be determined”. At other times, it may be difficult to be definitive whether vascular/lymphatic vessel invasion is present. This can include cases where retraction artifact or artifactual transfer of tumor cells is a consideration. In other cases, foci may be suspicious but not definitive for invasion. All of these situations can be categorized as “equivocal for invasion”. In cases where one cannot be definitive, a qualifying note explaining the interpretive difficulty and the extent of possible involvement is recommended, since it may help to direct medical management.\textsuperscript{1,2,5,6,7}

References


**F. Resection Margins**

Margins can be involved, negative, or indeterminate for carcinoma. If a margin is involved, whether endocervical, ectocervical, deep, or other, it should be specified. If indeterminate, the reason should be specified (e.g., cautery artifact in electroexcision specimens may preclude evaluation of the status of the margin). The severity and extent of a precursor lesion (e.g., focal or diffuse) involving a resection margin of a cone should be specified.

If an invasive tumor approximates but does not directly involve a resection margin, the distance between the tumor and the margin should be measured in millimeters. If the tumor involves the uterine corpus, a determination of whether the cervix or corpus is the primary site should be made.

In hysterectomy or trachelectomy specimens, the lateral radial margin may consist of parametrial soft tissue, which should be measured if present. If a parametrectomy has been performed, a measurement from the side of the uterus to the lateral edge of each unstretched parametrium (lateral extent) should be recorded and calculated into the margin evaluation. If parametrectomy has been performed, careful microscopic examination of the parametria is important for evaluation of the lateral margins and/or soft tissue extension. Fragments of paracervical/parametrial soft tissue that may be present in sections of cervix from a simple hysterectomy do not represent a formal parametrectomy. Anterior and posterior radial/deep stromal margins in a hysterectomy specimen will consist of cervical stromal tissue.

**References**


**G. Pathological Classification**

The TNM categories for cervical cancer endorsed by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC), and the parallel system formulated by the International Federation of Gynecology and Obstetrics (FIGO), are recommended. By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathological classification of the TNM, as opposed to the clinical ‘c’ 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.

Pathological classification is usually performed after surgical resection of the primary tumor. Pathological classification 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 (e.g., when technically infeasible) and if the highest T and N categories or the M1 category of the tumor can be confirmed microscopically, the criteria for pathological classification and staging have been satisfied without total removal of the primary cancer.

Of note, tumor size has been shown to have prognostic utility for stage I to stage II lesions, and the 2018 FIGO staging classification uses tumor size for the subclassification of stage I and stage IIA tumors.

**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 total number of primary tumors may be (optionally) reported in parentheses after the (m) pT(m)(2)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.

**T Category Considerations**

**Lymphovascular Invasion (LVI)**

LVI indicates whether microscopic lymphovascular invasion is identified. LVI includes lymphatic invasion, vascular invasion, or lymphovascular invasion. By AJCC/UICC convention, LVI does not affect the T category indicating local extent of tumor unless specifically included in the definition of a T category.

**N Category Considerations**

Sentinel lymph node sampling in cervical carcinoma has been recently implemented. Sentinel nodes should be sliced at 2.0 mm intervals. The sentinel nodes should undergo ultrastaging. Currently, there is no universal ultrastaging protocol. However, all institutions undertaking sentinel lymph node examination should have a standard procedure in place for sentinel lymph nodes. One protocol is as follows: For any section that is negative on initial H&E section, 2 sections are taken from each of two levels that are 50 µm apart, with one for H&E and the second for pankeratin immunohistochemistry.

There is little data to assign risk for nonsentinel lymph node metastasis based on the size of the metastasis in the sentinel lymph node. However, the size criteria for micrometastasis and macrometastasis is adopted from the experience in breast carcinoma. Micrometastasis is defined as a metastasis measuring greater than 0.2 mm but less than or equal to 2.0 mm.

Isolated tumor cells (ITCs) are single cells or small clusters of cells not more than 0.2 mm in greatest dimension, or single cells or clusters of cells less than or equal to 200 cells in a single lymph node cross section. Lymph nodes or distant sites with ITCs found by either histologic examination (eg, immunohistochemical evaluation for cytokeratin) or nonmorphological techniques (eg, flow cytometry, DNA analysis, polymerase chain reaction [PCR] amplification of a specific tumor marker) should be so identified. There is currently no guidance in the literature as to how these patients should be coded; until more data are available, they should be coded as “N0(i+)” with a comment noting how the cells were identified.

**Examination of Parametria**

The parametria may be measured grossly, but their width varies according to the elasticity of the tissue. Careful microscopic examination of the parametria is important for evaluation of the lateral margins and/or soft tissue extension.

**References**

1. Used with permission of the American College of Surgeons, Chicago, Illinois. The original source for this information is the AJCC Cancer Staging System (2020).

H. Special Studies
p16 Immunohistochemistry
Immunohistochemistry (IHC) serves as an important adjunct to the histologic diagnosis of high grade squamous intraepithelial lesion (HSIL) in difficult cases, with p16 immunoreactivity serving as a surrogate marker for high-risk human papillomavirus (HPV) infection. Squamous epithelial p16 immunostaining should be diffuse and strong in both nuclei and cytoplasm to support HPV etiology. Focally strong nuclear and cytoplasmic p16 staining may be identified not only in dysplastic squamous epithelium, but also in benign squamous epithelium. p16 immunostaining is also considered a better candidate (rather than HPV in situ hybridization) for the initial assessment of cervical biopsies that are histologically indeterminate for HSIL, given its wide availability, easy interpretation, and high sensitivity and specificity. However, due to the heterogeneous staining patterns seen in low-grade squamous intraepithelial lesions (LSIL), p16 immunohistochemistry is generally reserved for lesions that are morphologically suspicious or indeterminate for HSIL. The LAST project proposed that p16 be used in 3 specific situations. First, to distinguish inflammatory lesions from HSIL; second, to distinguish LSIL from HSIL; and third, to evaluate specimens such as endocervical curettage in patients who have previously had a recent HSIL diagnosis. It should not be used if the biopsy shows identifiable LSIL or HSIL. ProEx C, an immunohistochemical assay targeting both topoisomerase II-alpha and minichromosome maintenance protein-2 (MMP-2), has been shown to have high sensitivity and specificity for HPV-associated lesions of the cervix, with similar staining patterns as those seen for p16 and MIB-1 (Ki-67).

Immunohistochemistry: Endocervical versus Endometrial Adenocarcinoma
Immunohistochemistry can also be helpful in the differential diagnosis between endocervical and endometrial carcinoma, especially in curettage specimens, since endometrial carcinomas may show mucinous differentiation. A panel of antibodies, rather than a single antibody, is most useful; in most instances this includes vimentin, ER, p16, and monoclonal CEA. Typically, endometrioid adenocarcinoma is positive for vimentin and ER, whereas endocervical adenocarcinoma is positive for p16 and mCEA, but exceptions occur.

References


