

Protocol for the Examination of Specimens From Patients With Carcinomas of the Larynx

Protocol applies to all invasive carcinomas of the larynx, including supraglottis, glottis, and subglottis. Mucosal melanoma is included. Lymphomas and sarcomas are not included.

Based on AJCC/UICC TNM, 7th edition
Protocol web posting date: October 2013

Procedures

- Biopsy
- Resection

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CAP Larynx Protocol Revision History

Version Code

The definition of the version code can be found at www.cap.org/cancerprotocols.

Version: Larynx 3.3.0.0

Summary of Changes

The following changes have been made since the June 2012 release.

Entire Document

"Mucosal malignant melanoma" was changed to "Mucosal melanoma."

Excisional Biopsy, Resection

Procedure

"Incisional biopsy" was deleted.

Histologic Type

Neuroendocrine Carcinoma

"Large cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma)" was added.

Carcinomas of Minor Salivary Glands

Low, intermediate, and high grade were added to adenoid cystic carcinoma, and Adenocarcinoma, not otherwise specified, was added, as follows:

- Adenoid cystic carcinoma
 - Low grade
 - Intermediate grade
 - High grade
- Mucoepidermoid carcinoma
 - Low grade
 - Intermediate grade
 - High grade
- Adenocarcinoma, not otherwise specified
 - Low grade
 - Intermediate grade
 - High grade

Margins

Reporting on margins was updated, as follows:

- Cannot be assessed
- Margins uninvolved by invasive carcinoma
 - Distance from closest margin:
Specify distance: ___ mm
 - Cannot be determined
 - Specify location of closest margin, per orientation, if possible: _____
 - + Location and distance of other close margins (Note D): _____
- Margins involved by invasive carcinoma
 - Specify margin(s), per orientation, if possible: _____
- Margins uninvolved by carcinoma in situ (includes moderate and severe dysplasia#) (Note D)
 - Distance from closest margin:
Specify distance: ___ mm
 - Cannot be determined

Specify location of closest margin, per orientation, if possible: _____

___ Margins involved by carcinoma in situ (includes moderate and severe dysplasia#) (Note D)

Specify margin(s), per orientation, if possible: _____

Applicable only to squamous cell carcinoma and histologic variants.

Pathologic Staging (pTNM)

Regional Lymph Nodes (pN)

Number of Lymph Nodes Involved

Size was changed from "largest positive lymph node" to largest metastatic focus in the lymph node."

Extracapsular extension was added, as follows:

Extracapsular Extension

___ Not identified

___ Present

+ Distance from lymph node capsule: _____ mm

___ Indeterminate

Distant Metastasis (pM)

Deleted "Source of pathologic metastatic specimen (specify)."

Explanatory Notes

Scope of Guidelines: First sentence: "oral cancer including the lip" was changed to "laryngeal cancer." Third to last sentence: "oral cavity" was changed to "larynx."

B. Histologic Type

Neuroendocrine carcinoma: added "Large cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma)."

C. Histologic Grade

D. Surgical Margins

E. Orientation of Specimen

F. Perineural Invasion

G. Extracapsular Extension

K. Lymph Nodes

N. Ancillary Testing

Edits were made to these notes.

References: References were updated.

Surgical Pathology Cancer Case Summary

Protocol web posting date: October 2013

LARYNX (SUPRAGLOTTIS, GLOTTIS, SUBGLOTTIS): Excisional Biopsy, Resection

Select a single response unless otherwise indicated.

Specimen (select all that apply) (Note A)

- Larynx, supraglottis
- Larynx, glottis
- Larynx, subglottis
- Other (specify): _____
- Not specified

Received:

- Fresh
- In formalin
- Other (specify): _____

Procedure (select all that apply)

- Excisional biopsy
- Resection
 - Endolaryngeal excision
 - Transoral laser excision (glottis)
 - Supraglottic laryngectomy
 - Supracricoid laryngectomy
 - Vertical hemilaryngectomy (specify side): _____
 - Partial laryngectomy (specify type): _____
 - Total laryngectomy
- Neck (lymph node) dissection (specify): _____
- Other (specify): _____
- Not specified

+ Specimen Integrity

- + Intact
- + Fragmented

Laryngectomy (required only if applicable)

- Open
- Unopened

Specimen Size

- Greatest dimensions: ___ x ___ x ___ cm
- + Additional dimensions (if more than one part): ___ x ___ x ___ cm

Tumor Site (select all that apply) (Note A)

- Larynx, supraglottis
 Epiglottis
 Lingual aspect
 Laryngeal aspect
 Aryepiglottic folds
 Arytenoid(s)
 False vocal cord
 Ventricle
 Larynx, glottis
 True vocal cord
 Anterior commissure
 Posterior commissure
 Larynx, subglottis
 Other (specify): _____
 Not specified

Transglottic:

- Yes
 No

Tumor Laterality (select all that apply)

- Right
 Left
 Midline
 Not specified

Tumor Focality

- Single focus
 Bilateral
 Multifocal (specify): _____

Tumor Size

- Greatest dimension: ___ cm
 + Additional dimensions: ___ x ___ cm
 Cannot be determined (see Comment)

+ Tumor Description (select all that apply)

- + Gross subtype:
 + Polypoid
 + Exophytic
 + Endophytic
 + Ulcerated
 + Sessile
 + Other (specify): _____

+ Macroscopic Extent of Tumor

- + Specify: _____

Histologic Type (select all that apply) (Note B)Squamous Cell Carcinoma Squamous cell carcinoma, conventional*Variants of Squamous Cell Carcinoma* Acantholytic squamous cell carcinoma Adenosquamous carcinoma Basaloid squamous cell carcinoma Papillary squamous cell carcinoma Spindle cell squamous cell carcinoma Verrucous carcinoma Giant cell carcinoma Lymphoepithelial carcinoma (non-nasopharyngeal)Neuroendocrine Carcinoma Typical carcinoid tumor (well differentiated neuroendocrine carcinoma) Atypical carcinoid tumor (moderately differentiated neuroendocrine carcinoma) Large cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma) Small cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma) Combined (or composite) small cell carcinoma, neuroendocrine type with (specify type):
_____ Mucosal melanomaCarcinomas of Minor Salivary Glands Adenoid cystic carcinoma Low grade Intermediate grade High grade Mucoepidermoid carcinoma Low grade Intermediate grade High grade Adenocarcinoma, not otherwise specified Low grade Intermediate grade High grade Other (specify): _____ Carcinoma, type cannot be determined**Histologic Grade (Note C)** Not applicable GX: Cannot be assessed G1: Well differentiated G2: Moderately differentiated G3: Poorly differentiated Other (specify): _____**+ Microscopic Tumor Extension** + Specify: _____

Margins (select all that apply) (Notes D and E)

- Cannot be assessed
- Margins uninvolved by invasive carcinoma
Distance from closest margin:
Specify distance: ___ mm
 Cannot be determined
Specify location of closest margin, per orientation, if possible: _____
+ Location and distance of other close margins (Note D): _____
- Margins involved by invasive carcinoma
Specify margin(s), per orientation, if possible: _____
- Margins uninvolved by carcinoma in situ (includes moderate and severe dysplasia#) (Note D)
Distance from closest margin:
Specify distance: ___ mm
 Cannot be determined
Specify location of closest margin, per orientation, if possible: _____
- Margins involved by carcinoma in situ (includes moderate and severe dysplasia#) (Note D)
Specify margin(s), per orientation, if possible: _____

Applicable only to squamous cell carcinoma and histologic variants.

Lymph-Vascular Invasion

- Not identified
- Present
- Indeterminate

Perineural Invasion (Note F)

- Not identified
- Present
- Indeterminate

+ Treatment Effect (applicable to carcinomas treated with neoadjuvant therapy)

- + Not identified
- + Present (specify): _____
- + Indeterminate

Pathologic Staging (pTNM) (Note H)

Note: The phrases in italics include clinical findings required for AJCC staging. This clinical information may not be available to the pathologist. However, if known, these findings should be incorporated into the pathologic staging.

TNM Descriptors (required only if applicable) (select all that apply)

- m (multiple primary tumors)
- r (recurrent)
- y (posttreatment)

Primary Tumor (pT)

- pTX: Cannot be assessed
- pT0: No evidence of primary tumor
- pTis: Carcinoma in situ

For All Carcinomas Excluding Mucosal Melanoma**Primary Tumor (pT): Supraglottis**

- ___ pT1: Tumor limited to one subsite of supraglottis *with normal vocal cord mobility*
- ___ pT2: Tumor invades mucosa of more than one adjacent subsite of supraglottis or glottis or region outside the supraglottis (eg, mucosa of base of tongue, vallecula, medial wall of pyriform sinus) *without fixation of the larynx*
- ___ pT3: Tumor limited to larynx *with vocal cord fixation* and/or invades any of the following: postcricoid area, preepiglottic space, paraglottic space, and/or inner cortex of thyroid cartilage
- ___ pT4a: Moderately advanced local disease. Tumor invades through the thyroid cartilage and/or invades tissues beyond the larynx (eg, trachea, soft tissues of neck including deep extrinsic muscle of tongue, strap muscles, thyroid, or esophagus)
- ___ pT4b: Very advanced local disease. Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Primary Tumor (pT): Glottis

- ___ pT1: Tumor limited to the vocal cord(s) (may involve anterior or posterior commissure) *with normal mobility*
- ___ pT1a: Tumor limited to one vocal cord
- ___ pT1b: Tumor involves both vocal cords
- ___ pT2: Tumor extends to supraglottis and/or subglottis *and/or with impaired vocal cord mobility*
- ___ pT3: Tumor limited to the larynx *with vocal cord fixation* and/or invades paraglottic space and/or minor thyroid cartilage erosion (eg, inner cortex) (Note H)
- ___ pT4a: Moderately advanced local disease. Tumor invades through the outer cortex of the thyroid cartilage and/or invades tissues beyond the larynx (eg, trachea, soft tissues of neck including deep extrinsic muscle of the tongue, strap muscles, thyroid, or esophagus) (Note H)
- ___ pT4b: Very advanced local disease. Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Primary Tumor (pT): Subglottis

- ___ pT1: Tumor limited to subglottis
- ___ pT2: Tumor extends to vocal cord(s) *with normal or impaired mobility*
- ___ pT3: Tumor limited to larynx *with vocal cord fixation*
- ___ pT4a: Moderately advanced local disease. Tumor invades cricoid or thyroid cartilage and/or invades tissues beyond the larynx (eg, trachea, soft tissues of neck including deep extrinsic muscles of the tongue, strap muscles, thyroid, or esophagus)
- ___ pT4b: Very advanced local disease. Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Regional Lymph Nodes (pN)# (Notes I through L)

- pNX: Cannot be assessed
- pN0: No regional lymph node metastasis
- pN1: Metastasis in a single ipsilateral lymph node, 3 cm or less in greatest dimension
- pN2: Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension, or in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension, or in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
- pN2a: Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension
- pN2b: Metastasis in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension
- pN2c: Metastasis in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
- pN3: Metastasis in a lymph node more than 6 cm in greatest dimension
- No nodes submitted or found

Number of Lymph Nodes Examined

Specify: _____

 Number cannot be determined (explain): _____*Number of Lymph Nodes Involved*

Specify: _____

+ Size (greatest dimension) of the largest metastatic focus in the lymph node: _____ cm (Note K)

 Number cannot be determined (explain): _____*Extracapsular Extension (Note G)* Not identified Present

+ Distance from lymph node capsule: _____ mm

 Indeterminate*# Superior mediastinal lymph nodes are considered regional lymph nodes (level VII). Midline nodes are considered ipsilateral nodes.*Distant Metastasis (pM) Not applicable pM1: Distant metastasis

+ Specify site(s), if known: _____

For Mucosal MelanomaPrimary Tumor (pT) pT3: Mucosal disease pT4a: Moderately advanced disease. Tumor involving deep soft tissue, cartilage, bone, or overlying skin pT4b: Very advanced disease. Tumor involving brain, dura, skull base, lower cranial nerves (IX, X, XI, XII), masticator space, carotid artery, prevertebral space, or mediastinal structuresRegional Lymph Nodes (pN) pNX: Regional lymph nodes cannot be assessed pN0: No regional lymph node metastases pN1: Regional lymph node metastases present

+ Data elements preceded by this symbol are not required. However, these elements may be clinically important but are not yet validated or regularly used in patient management.

Distant Metastasis (pM) Not applicable pM1: Distant metastasis present

+ Specify site(s), if known: _____

+ Additional Pathologic Findings (select all that apply)+ None identified+ Keratinizing dysplasia (Note M)+ Mild+ Moderate+ Severe (carcinoma in situ)+ Nonkeratinizing dysplasia (Note M)+ Mild+ Moderate+ Severe (carcinoma in situ)+ Inflammation (specify type): _____+ Squamous metaplasia+ Epithelial hyperplasia+ Colonization+ Fungal+ Bacterial+ Other (specify): _____**+ Ancillary Studies (Note N)**

+ Specify type(s): _____

+ Specify result(s): _____

+ Clinical History (select all that apply)+ Neoadjuvant therapy+ Yes (specify type): _____+ No+ Indeterminate+ Other (specify): _____**+ Comment(s)**

Explanatory Notes

Scope of Guidelines

The reporting of laryngeal cancer is facilitated by the provision of a case summary illustrating the features required for comprehensive patient care. However, there are many cases in which the individual practicalities of applying such a case summary may not be straightforward. Common examples include finding the prescribed number of lymph nodes, trying to determine the levels of the radical neck dissection, and determining if isolated tumor cells in a lymph node represent metastatic disease. Case summaries have evolved to include clinical, radiographic, morphologic, immunohistochemical, and molecular results in an effort to guide clinical management. Adjuvant and neoadjuvant therapy can significantly alter histologic findings, making accurate classification an increasingly complex and demanding task. This case summary tries to remain simple while still incorporating important pathologic features as proposed by the American Joint Committee on Cancer (AJCC) cancer staging manual, the World Health Organization classification of tumors, the TNM classification, the American College of Surgeons Commission on Cancer, and the International Union on Cancer (UICC). This protocol is to be used as a guide and resource, an adjunct to diagnosing and managing cancers of the larynx in a standardized manner. It should not be used as a substitute for dissection or grossing techniques and does not give histologic parameters to reach the diagnosis. Subjectivity is always a factor, and elements listed are not meant to be arbitrary but are meant to provide uniformity of reporting across all the disciplines that use the information. It is a foundation of practical information that will help to meet the requirements of daily practice to benefit both clinicians and patients alike.

A. Anatomical Sites and Subsites for the Larynx (Figure 1)

Supraglottis

- Epilarynx, including marginal zone
 - Suprahyoid epiglottis, including tip, lingual (anterior) and laryngeal surfaces
 - Aryepiglottic fold, laryngeal aspect
 - Arytenoid
- Supraglottis, excluding epilarynx
 - Infrahyoid epiglottis
 - Ventricular bands (false cords)
 - Ventricle

Glottis

- Vocal cords
- Anterior commissure
- Posterior commissure

Subglottis

The protocol applies to all carcinomas arising at these sites.¹ The piriform sinus represents part of the hypopharynx which expands bilaterally and forward around the sides of the larynx and lies between the larynx and the thyroid cartilage. Cancers of the piriform sinus are included in the protocol on pharynx cancers.

Anatomic Compartments (Figure 1)

The anatomic compartments of the larynx include:

1. Supraglottic larynx extending from the tip of the epiglottis to a horizontal line passing through the apex of the ventricle; structures included in this compartment are the epiglottis (lingual and laryngeal aspects), aryepiglottic folds, arytenoids, false vocal cords and the ventricle.

2. Glottic region, which extends from the ventricle to approximately 0.5 to 1.0 cm below the free level of the true vocal cord and includes the anterior and posterior commissures and the true vocal cord.
3. Subglottic larynx, which extends approximately 1.0 cm below the level of the true vocal cord to the inferior rim of the cricoid cartilage.
4. The paraglottic space is a potential space deep to the ventricles and saccules filled with adipose tissue and connective tissue (Figure 2). It is bounded by the conus elasticus inferiorly, the thyroid cartilage laterally, the quadrangular membrane medially, and the piriform sinus posteriorly.² Like the paraglottic space, the pre-epiglottic space is filled with adipose tissue and connective tissue (Figure 3); it is triangular in shape and is bounded by the thyroid cartilage and thyrohyoid membrane anteriorly, the epiglottis and thyroepiglottic ligament posteriorly, and the hyoepiglottic ligament at its base (Figures 1 and 2).² The paraglottic and preglottic spaces contain lymphatics and blood vessels but no lymph nodes.²

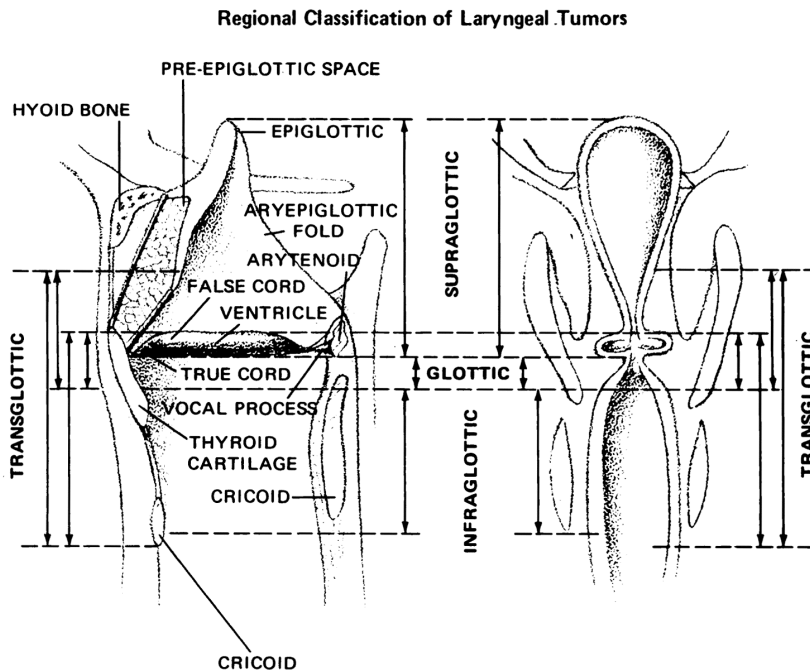


Figure 1. Anatomic compartments of the larynx. From Cocke EW Jr, Wang CC. Part I - Cancer of the larynx: selecting optimum treatment. *CA Cancer J Clin.* 1976;26:194-200. Figure by J.H. Ogura, MD.

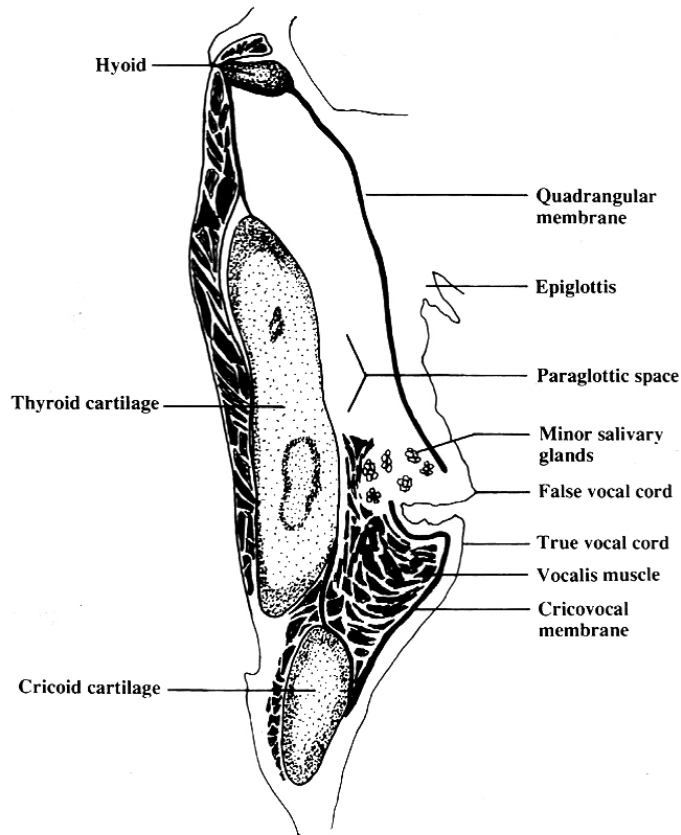


Figure 2. The paraglottic space. From *World Health Organization Classification of Tumours: Pathology and Genetics of Head and Neck Tumours*. Lyon, France: IARC Press; 2005. Reproduced with permission.

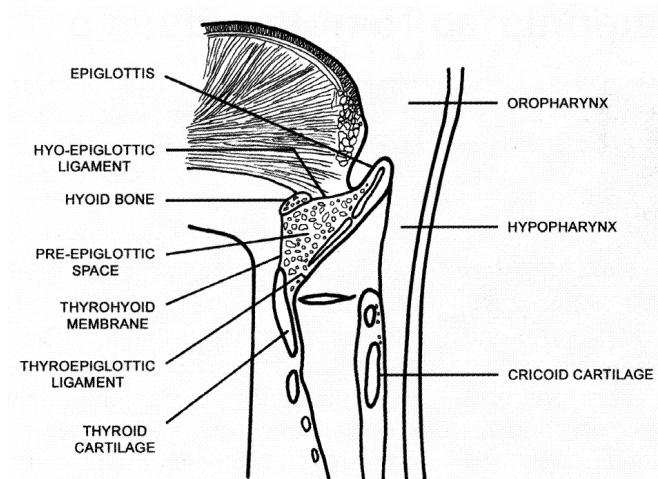


Figure 3. The pre-epiglottic space. From *World Health Organization Classification of Tumours: Pathology and Genetics of Head and Neck Tumours*. Lyon, France: IARC Press; 2005. Reproduced with permission.

Site-Specific Carcinomas

1. Supraglottic squamous cell carcinoma represents a squamous cell carcinoma that involves the structures of the supraglottic larynx, including the epiglottis (laryngeal and lingual surfaces), aryepiglottic folds, arytenoids, false vocal cords and ventricles.

2. Glottic squamous cell carcinoma represents a squamous cell carcinoma that involves the structures of the glottis, including the true vocal cords, and the anterior and posterior commissures.
3. Subglottic squamous cell carcinoma represents a squamous cell carcinoma that involves the subglottis which begins 1 cm below the apex of the ventricle to its inferior border represented by the rim of the cricoid cartilage.
4. Transglottic carcinomas represent a carcinoma that crosses the ventricles in a vertical direction arising in either the glottic or supraglottic larynx

B. Histological Type

A modification of the World Health Organization (WHO) classification of carcinomas of the larynx is shown below.³ This list may not be complete. This protocol applies to carcinomas and melanomas and does not apply to lymphomas or sarcomas.

Carcinomas of Larynx

Squamous cell carcinoma

Conventional

Variants of squamous cell carcinoma

Acantholytic squamous cell carcinoma

Adenosquamous carcinoma

Basaloid squamous cell carcinoma

Papillary squamous cell carcinoma

Spindle cell squamous cell carcinoma

Verrucous carcinoma

Giant cell carcinoma

Lymphoepithelial carcinoma

Neuroendocrine carcinoma

Typical carcinoid tumor (well differentiated neuroendocrine carcinoma)

Atypical carcinoid tumor (moderately differentiated neuroendocrine carcinoma)

Small cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma)

Large cell carcinoma, neuroendocrine type (poorly differentiated neuroendocrine carcinoma)

Combined (or composite) small cell carcinoma, neuroendocrine type[#]

[#] Represents a carcinoma showing combined features of small cell neuroendocrine carcinoma associated with a squamous or adenocarcinomatous component.⁴

Carcinomas of Minor Salivary Glands

Adenoid cystic carcinoma

Mucoepidermoid carcinoma

Adenocarcinoma, not otherwise specified

Other[#]

Mucosal Melanoma

[#] Please refer to the CAP protocol for major salivary glands for detailed listing of other tumor types.

C. Histologic Grade

For histologic types of carcinomas that are amenable to grading, 3 histologic grades are suggested, as shown below. For conventional squamous cell carcinoma, histologic grading as a whole does not perform well as a prognosticator.⁵ Nonetheless, it should be recorded when applicable as it is a basic

tumor characteristic. Selecting either the most prevalent grade or the highest grade for this synoptic protocol is acceptable. Variants of squamous cell carcinoma (ie, verrucous, basaloid, etc), have an intrinsic biologic potential and currently do not appear to require grading.

Grade 1	Well differentiated
Grade 2	Moderately differentiated
Grade 3	Poorly differentiated
Grade X	Cannot be assessed

The histologic (microscopic) grading of salivary gland carcinomas has been shown to be an independent predictor of behavior and plays a role in optimizing therapy.⁶⁻¹¹ Further, there is often a positive correlation between histologic grade and clinical stage. Most salivary carcinomas have a biologic behavior defined by their categorization and do not require grading.¹¹ The 3 major categories that are amenable to grading include adenoid cystic carcinoma, mucoepidermoid carcinoma (the 2 most frequent histologic types seen in larynx) and adenocarcinoma, not otherwise specified.^{6,8,12}

Generally, 3 histologic grades are suggested, as follows:

Grade 1	Well differentiated = Low-grade
Grade 2	Moderately differentiated = Intermediate-grade
Grade 3	Poorly differentiated = High-grade
Grade X	Cannot be assessed

In some carcinomas, histologic grading may be based on growth pattern, such as in adenoid cystic carcinoma, for which a histologic high-grade variant has been recognized based on the percentage of solid growth.⁸ Those adenoid cystic carcinomas showing 30% or greater of solid growth pattern are considered to be histologically high-grade carcinomas. The histologic grading of mucoepidermoid carcinoma includes a combination of growth pattern characteristics (e.g., cystic, solid, neurotropism) and cytomorphologic findings (eg, anaplasia, mitoses, necrosis).¹³⁻¹⁵ Adenocarcinomas, not otherwise specified do not have a formalized grading scheme and are graded intuitively, based on cytomorphologic features.¹¹

D. Surgical Margins

The definition of a positive margin is somewhat controversial given the varied results from prior studies.^{16,17} However, overall, several studies support the definition of a positive margin to be invasive carcinoma *or* carcinoma in situ/high grade dysplasia present at margins (microscopic cut-through of tumor).¹⁶ Furthermore, reporting of surgical margins should also include information regarding the distance of invasive carcinoma, carcinoma in situ, or high-grade dysplasia (moderate to severe) from the surgical margin. Tumors with “close” margins also carry an increased risk for local recurrence.^{16,18,19} The definition of a “close” margin is not standardized as the effective cut-off varies between studies and between anatomic subsites. Commonly used cut points to define close margins are 5 mm in general, and 2 mm with respect to glottis larynx.¹⁶ However, values ranging from 3 to 7 mm have been used with success,^{16,20} and for glottic tumors, as low as 1 mm.²¹ Thus distance of tumor from the nearest margin should be recorded.

Reporting of surgical margins for carcinomas of the minor salivary glands should follow those used for squamous cell carcinoma of oral cavity.

Keratinizing Dysplasia

The types of intraepithelial dysplasia of the upper aerodigestive tract (UADT) include nonkeratinizing (“classic”) dysplasia and keratinizing dysplasia. Of the 2 types of dysplasias, the keratinizing dysplasias are significantly more common than the nonkeratinizing dysplasias. For both types of UADT intraepithelial dysplasias, grading includes mild, moderate, and severe forms, with the latter category

being synonymous with carcinoma in situ. It must be noted that in the setting of keratinizing dysplasia, full thickness dysplasia of the surface epithelium, representing the histologic definition for carcinoma in situ, is an uncommon occurrence. Nevertheless, there are keratinizing dysplasias that lack full thickness dysplasia and yet carry a significant risk to invasive carcinoma.^{5,22} Since invasive carcinoma develops from keratinizing dysplasia in which there is an absence of full thickness dysplasia, the grading of UADT dysplasias is problematic and lacks reproducibility among pathologists (see below under Note M). Since there is no significant statistical difference in the risk to invasive carcinoma between the category of keratinizing moderate dysplasia and keratinizing severe dysplasia,²² the suggestion has been entertained of adopting a Bethesda-like classification to keratinizing dysplasias of the UADT, including a low-grade category limited to keratinizing mild dysplasia and a high-grade category to include keratinizing moderate and severe dysplasias.²³ As such, it must be recognized that keratinizing severe dysplasia, even if not “full thickness,” should for all intents and purposes be dealt with in a similar manner as classically defined carcinoma in situ so that in evaluating surgical margins for the presence or absence of dysplasia/carcinoma in situ, keratinizing moderate and severe dysplasias should be viewed as a single category relative to risk of progression to invasive carcinoma. Such a risk does not include keratinizing mild dysplasia. In summary, the presence of keratinizing mild dysplasia at (or near) a surgical margin should not be viewed/reported as a positive margin, whereas the presence of keratinizing moderate or severe dysplasia at (or near) a surgical margin should be viewed/reported as a positive margin.

E. Orientation of Specimen

Complex specimens should be examined and oriented with the assistance of the operating surgeon(s). Direct communication between the surgeon and pathologist is a critical component in specimen orientation and proper sectioning. Whenever possible, the tissue examination request form should include a drawing or photograph of the resected specimen showing the extent of the tumor and its relation to the anatomic structures of the region. The lines and extent of the resection can be depicted on preprinted adhesive labels and attached to the surgical pathology request forms.

F. Perineural Invasion

Traditionally, the presence of perineural invasion (neurotropism) is an important predictor of poor prognosis in head and neck cancer of virtually all sites.²⁴ The presence of perineural invasion (neurotropism) in the primary cancer is associated with poor local disease control and regional control, as well as being associated with metastasis to regional lymph nodes.²⁴ Further, perineural invasion is associated with decrease in disease-specific survival and overall survival.²⁴ There is conflicting data relative to an association between the presence of perineural invasion and the development of distant metastasis, with some studies showing an increased association with distant metastasis, while other studies showing no correlation with distant metastasis.²⁴ The relationship between perineural invasion and prognosis is independent of nerve diameter.²⁵ Additionally, emerging evidence suggests that extratumoral perineural invasion may be more prognostically relevant.²⁶ Although perineural invasion of small unnamed nerves may not produce clinical symptoms, the reporting of perineural invasion includes nerves of all sizes including small peripheral nerves (ie, less than 1 mm in diameter). Aside from the impact on prognosis, the presence of perineural invasion also guides therapy. Concurrent adjuvant chemoradiation therapy has been shown to improve outcomes in patients with perineural invasion (as well as in patients with extranodal extension and bone invasion).^{27,28} Given the significance relative to prognosis and treatment, perineural invasion is a required data element in the reporting of head and neck cancers.

G. Extracapsular Extension

The status of cervical lymph nodes is the single most important prognostic factor in aerodigestive cancer. All macroscopically negative or equivocal lymph nodes should be submitted in toto. Grossly positive nodes may be partially submitted for microscopic documentation of metastasis. Reporting of lymph nodes containing metastasis should include whether there is presence or absence of extranodal

extension (EE). This finding consists of extension of metastatic tumor, present within the confines of the lymph node, through the lymph node capsule into the surrounding connective tissue, with or without associated stromal reaction. A distance of extension from the native lymph node capsule is optional and has not yet been shown to have a definitive impact on prognosis or treatment for head and neck subsites. If macroscopic examination suggests EE, this tissue should be submitted for microscopic confirmation. EE is a predictor of regional relapse and a criterion for postoperative radiotherapy.²⁹⁻³²

H. TNM and Stage Groupings

The protocol recommends the TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) for larynx cancer.^{1,33} Of note in the 7th edition of the AJCC staging of head and neck cancers¹ is the division of T4 lesions into T4a (moderately advanced local disease) and T4b (very advanced local disease), leading to the stratification of stage IV into stage IVA (moderately advanced local/regional disease), stage IVB (very advanced local/regional disease), and stage IVC (distant metastatic disease). Relative to supraglottic and glottic cancers, the determination between a T3 cancer with "minor thyroid cartilage erosion" versus a T4a cancer with "invasion through thyroid cartilage" can be problematic as there is no specific definition whether "invasion through thyroid cartilage" means complete infiltration through and through the cartilage or whether tumors invading short of completely through the thyroid cartilage (eg, half way through, other) qualify as a pT4a cancer. When confronted with this issue, review of the operative report and imaging studies, as well as direct communication with the surgeon may provide insight or consensus of opinion. Generally, if the tumor invades at least into the center of the cartilage but not "through," most authorities would stage such a lesion as a T4a cancer.

The 7th edition of the AJCC staging of head and neck cancers includes mucosal melanomas.¹ Approximately two-thirds of mucosal melanomas arise in the sinonasal tract, one-quarter are found in the oral cavity, and the remainder occur only sporadically in other mucosal sites of the head and neck.¹ Even small cancers behave aggressively with high rates of recurrence and death.¹ To reflect this aggressive behavior, primary cancers limited to the mucosa are considered T3 lesions. Advanced mucosal melanomas are classified as T4a and T4b. The anatomic extent criteria to define *moderately advanced* (T4a) and *very advanced* (T4b) disease are given below. The AJCC staging for mucosal melanomas does not provide for the histologic definition of a T3 lesion; as the majority of mucosal melanomas are invasive at presentation, mucosal based melanomas (T3 lesions) include those lesions that involve either the epithelium and/or lamina propria of the involved site. Rare examples of *in situ* mucosal melanomas occur, but *in situ* mucosal melanomas are excluded from staging, as they are extremely rare.¹

For All Carcinomas Excluding Mucosal Melanoma

Primary Tumor: Supraglottis

TX	Cannot be assessed
T0	No evidence of primary tumor
Tis	Carcinoma in situ
T1	Tumor limited to one subsite of supraglottis <i>with normal vocal cord mobility</i>
T2	Tumor invades mucosa of more than one adjacent subsite of supraglottis or glottis or region outside the supraglottis (eg, mucosa of base of tongue, vallecula, medial wall of pyriform sinus) <i>without fixation of the larynx</i>
T3	Tumor limited to larynx <i>with vocal cord fixation</i> and/or invades any of the following: postcricoid area, pre-epiglottic space, paraglottic space, and/or minor thyroid cartilage erosion (eg, inner cortex)
T4a	Moderately advanced local disease. Tumor invades through the thyroid cartilage and/or invades tissues beyond the larynx (eg, trachea, soft tissues of neck including deep extrinsic muscle of tongue, strap muscles, thyroid, or esophagus)

T4b Very advanced local disease. Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Primary Tumor: Glottis

TX Cannot be assessed
 T0 No evidence of primary tumor
 Tis Carcinoma in situ
 T1 Tumor limited to the vocal cord(s) (may involve anterior or posterior commissure) *with normal mobility*
 T1a Tumor limited to one vocal cord
 T1b Tumor involves both vocal cords
 T2 Tumor extends to supraglottis and/or subglottis *and/or with impaired vocal cord mobility*
 T3 Tumor limited to the larynx *with vocal cord fixation* and/or invasion of paraglottic space, and/or inner cortex of thyroid cartilage
 T4a Tumor invades through the outer cortex of the thyroid cartilage and/or invades tissues beyond the larynx (eg, trachea, soft tissues of neck including deep extrinsic muscle of the tongue, strap muscles, thyroid, or esophagus)
 T4b Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Primary Tumor: Subglottis

TX Cannot be assessed
 T0 No evidence of primary tumor
 Tis Carcinoma in situ
 T1 Tumor limited to subglottis
 T2 Tumor extends to vocal cord(s) *with normal or impaired mobility*
 T3 Tumor limited to larynx *with vocal cord fixation*
 T4a Tumor invades cricoid or thyroid cartilage and/or invades tissues beyond the larynx (e.g., trachea, soft tissues of neck including deep extrinsic muscles of the tongue, strap muscles, thyroid, or esophagus)
 T4b Tumor invades prevertebral space, encases carotid artery, or invades mediastinal structures

Regional Lymph Nodes[#]

NX Cannot be assessed
 N0 No regional lymph node metastasis
 N1 Metastasis in a single ipsilateral lymph node, 3 cm or less in greatest dimension
 N2 Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension, or in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension, or in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
 N2a Metastasis in a single ipsilateral lymph node, more than 3 cm but not more than 6 cm in greatest dimension
 N2b Metastasis in multiple ipsilateral lymph nodes, none more than 6 cm in greatest dimension
 N2c Metastasis in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension
 N3 Metastasis in a lymph node more than 6 cm in greatest dimension

[#] Superior mediastinal lymph nodes are considered regional lymph nodes (level VII).
 Midline nodes are considered ipsilateral nodes.

Distant Metastasis

M0 No distant metastasis
 M1 Distant metastasis

For Mucosal MelanomaPrimary Tumor

T3	Mucosal disease
T4a	Moderately advanced disease. Tumor involving deep soft tissue, cartilage, bone, or overlying skin
T4b	Very advanced disease. Tumor involving brain, dura, skull base, lower cranial nerves (IX, X, XI, XII), masticator space, carotid artery, prevertebral space, or mediastinal structures

Regional Lymph Nodes

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastases
N1	Regional lymph node metastases present

Distant Metastasis

M0	No distant metastasis
M1	Distant metastasis present

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 (e.g., 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.

T Category Considerations

Supraglottis. Normal vocal cord mobility (T1), fixation of the larynx (T2), and vocal cord fixation (T3) may only be determined clinically.

Glottis. Normal vocal cord mobility (T1), impaired vocal cord mobility (T2), and vocal cord fixation (T3) may only be determined clinically.

Subglottis. Normal or impaired vocal cord mobility (T2) and vocal cord fixation (T3) may only be determined clinically.

Stage Groupings: Supraglottis, Glottis, and Subglottis - For All Cancers Except Mucosal Melanoma

Stage 0	Tis	N0	M0
Stage I	T1	N0	M0
Stage II	T2	N0	M0
Stage III	T1	N1	M0
	T2	N1	M0
	T3	N0,N1	M0

Stage IVA	T1,T2,T3	N2	M0
	T4a	N0,N1,N2	M0
Stage IVB	T4b	Any N	M0
	Any T	N3	M0
Stage IVC	Any T	Any N	M1

Stage Groupings – For Mucosal Melanoma

Stage III	T3	N0	M0
Stage IVA	T4a	N0	M0
	T3-T4a	N1	M0
Stage IVB	T4b	Any N	M0
Stage IVC	Any T	Any N	M1

TNM Descriptors

For identification of special cases of TNM or pTNM classifications, the “m” suffix and “y” and “r” 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 (i.e., 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.

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).

I. Classification of Neck Dissection

1. Radical neck dissection
2. Modified radical neck dissection, internal jugular vein and/or sternocleidomastoid muscle spared

3. Selective neck dissection (SND), as specified by the surgeon (Figure 4), defined by dissection of less than the 5 traditional levels of a radical and modified radical neck dissection. The following dissections are now under this category³⁴⁻³⁶:
 - a. Supraomohyoid neck dissection
 - b. Posterolateral neck dissection
 - c. Lateral neck dissection
 - d. Central compartment neck dissection
4. Superselective neck dissection (SSND), a relatively new term defined by dissection of the fibrofatty elements of 2 or less levels³⁷
5. Extended radical neck dissection, as specified by the surgeon

J. Regional Lymph Nodes (pN0): Isolated Tumor Cells

Isolated tumor cells (ITCs) are single cells or small clusters of cells not more than 0.2 mm in greatest dimension. While the generic recommendation is that for lymph nodes with ITCs found by either histologic examination, immunohistochemistry, or nonmorphologic techniques (eg, flow cytometry, DNA analysis, polymerase chain reaction [PCR] amplification of a specific tumor marker) they should be classified as N0 or M0, respectively,^{33,38} evidence for the validity of this practice in head and neck squamous cell carcinoma and other histologic subtypes is lacking. In fact, rare studies relevant to head and neck sites indicate that isolated tumor cells may actually be a poor prognosticator in terms of local control.³⁹

For purposes of pathologic evaluation, lymph nodes are organized by levels as shown in Figure 4.⁴⁰



Figure 4. The six sublevels of the neck for describing the location of lymph nodes within levels I, II, and V. Level IA, submental group; level IB, submandibular group; level IIA, upper jugular nodes along the carotid sheath, including the subdigastric group; level IIB, upper jugular nodes in the submuscular recess; level VA, spinal accessory nodes; and level VB, the supraclavicular and transverse cervical nodes. From: Flint PW, et al, eds. *Cummings Otolaryngology: Head and Neck Surgery*. 5th ed. Philadelphia, PA; Saunders: 2010. Reproduced with permission © Elsevier.

In order for pathologists to properly identify these nodes, they must be familiar with the terminology of the regional lymph node groups and with the relationships of those groups to the regional anatomy. Which lymph node groups surgeons submit for histopathologic evaluation depends on the type of neck dissection they perform. Therefore, surgeons must supply information on the types of neck dissections that they perform and the details of the local anatomy in the specimens they submit for examination or, in other manners, orient those specimens for pathologists.

If it is not possible to assess the levels of lymph nodes (for instance, when the anatomic landmarks in the excised specimens are not specified), then the lymph node levels may be estimated as follows: level II, upper third of internal jugular (IJ) vein or neck specimen; level III, middle third of IJ vein or neck specimen; level IV, lower third of IJ vein or neck specimen, all anterior to the sternocleidomastoid muscle.

Level I. Submental Group (Sublevel IA)

Lymph nodes within the triangular boundary of the anterior belly of the digastric muscles and the hyoid bone.

Level I. Submandibular Group (Sublevel IB)

Lymph nodes within the boundaries of the anterior and posterior bellies of the digastric muscle and the body of the mandible. The submandibular gland is included in the specimen when the lymph nodes within this triangle are removed.

Level II. Upper Jugular Group (Sublevels IIA and IIB)

Lymph nodes located around the upper third of the internal jugular vein and adjacent spinal accessory nerve extending from the level of the carotid bifurcation (surgical landmark) or hyoid bone (clinical landmark) to the skull base. The posterior boundary is the posterior border of the sternocleidomastoid muscle, and the anterior boundary is the lateral border of the stylohyoid muscle.

Level III. Middle Jugular Group

Lymph nodes located around the middle third of the internal jugular vein extending from the carotid bifurcation superiorly to the omohyoid muscle (surgical landmark), or cricothyroid notch (clinical landmark) inferiorly. The posterior boundary is the posterior border of the sternocleidomastoid muscle, and the anterior boundary is the lateral border of the sternohyoid muscle.

Level IV. Lower Jugular Group

Lymph nodes located around the lower third of the internal jugular vein extending from the omohyoid muscle superiorly to the clavicle inferiorly. The posterior boundary is the posterior border of the sternocleidomastoid muscle, and the anterior boundary is the lateral border of the sternohyoid muscle.

Level V. Posterior Triangle Group (Sublevels VA and VB)

This group comprises predominantly the lymph nodes located along the lower half of the spinal accessory nerve and the transverse cervical artery. The supraclavicular nodes are also included in this group. The posterior boundary of the posterior triangle is the anterior border of the trapezius muscle, the anterior boundary of the posterior triangle is the posterior border of the sternocleidomastoid muscle, and the inferior boundary of the posterior triangle is the clavicle.

Level VI. Anterior (Central) Compartment

Lymph nodes in this compartment include the pre- and paratracheal nodes, precricoid (Delphian) node, and the perithyroidal nodes, including the lymph nodes along the recurrent laryngeal nerve. The superior boundary is the hyoid bone, the inferior boundary is the suprasternal notch, the lateral boundaries are the common carotid arteries, and the posterior boundary by the prevertebral fascia.

Level VII. Superior Mediastinal Lymph Nodes

Metastases at level VII are considered regional lymph node metastases; all other mediastinal lymph node metastases are considered distant metastases.

Lymph node groups removed from areas not included in the above levels, e.g., scalene, suboccipital, and retropharyngeal, should be identified and reported from all levels separately. Midline nodes are considered ipsilateral nodes.

K. Lymph Nodes

Lymph Node Number

Histological examination of a selective neck dissection specimen will ordinarily include 6 or more lymph nodes. Histological examination of a radical or modified radical neck dissection specimen will ordinarily include 10 or more lymph nodes in the untreated neck.

Measurement of Tumor Metastasis

The cross-sectional diameter of the largest lymph node metastasis (not the lymph node itself) is measured in the gross specimen at the time of macroscopic examination or, if necessary, on the histologic slide at the time of microscopic examination.^{24,34}

L. Special Procedures for Lymph Nodes

The risk of regional (cervical neck) nodal spread from cancers varies based on anatomic subsite. At the current time, no additional special techniques are required other than routine histology for the assessment of nodal metastases. Immunohistochemistry and PCR to detect isolated tumor cells are considered investigational techniques at this time.

M. Dysplasia of the Upper Aerodigestive Tract (UADT)

In contrast to the uterine cervix in which the nonkeratinizing ("classic") form of epithelial dysplasia is most common resulting in a reproducible and clinically useful grading scheme of mild, moderate, and severe dysplasia (ie, carcinoma in situ), the majority of the UADT mucosal lesions fall under the designation of keratinizing dysplasias. The criteria for evaluating keratinizing dysplasias are less well defined, and the diagnosis of severe keratinizing (intraepithelial) dysplasia remains controversial. In particular, the definition of severe dysplasia in the setting of keratosis is broader than the highly reproducible pattern seen in the uterine cervix and includes a microscopically heterogeneous group of lesions. In the setting of keratinizing dysplasia where surface maturation is retained with only partial replacement of the epithelium by atypical cells, severe dysplasia includes those lesions in which the epithelial alterations are so severe that there would be a high probability for the progression to an invasive carcinoma if left untreated. The evaluation of keratinizing dysplasia includes cellular abnormalities (ie, cytomorphology) and maturation abnormalities (ie, architectural alterations). At present, the preferred grading for keratinizing dysplasias of the UADT include mild, moderate, and severe dysplasia, depending on the degree and extent of cellular and maturation alterations that are present.⁴¹ Using the definition of carcinoma in situ (CIS) as applied to the uterine cervix requires loss of maturation of squamous epithelium; therefore, by this definition most keratotic lesion cannot be CIS because keratosis shows maturation of the squamous epithelium. Therefore, the use of the specific term CIS in keratinizing dysplasias of the UADT has been questioned and is likely inappropriate in this setting; a more appropriate designation is keratinizing severe dysplasia.

Several points should be stressed relative to keratinizing dysplasia of the UADT:

- Invasive carcinoma develops from dysplasia limited in extent including only to the lower third (basal zone region) of the surface epithelium in the absence of full thickness dysplasia (ie, "classic" carcinoma in situ).
- Keratinizing severe dysplasia is often multifocal and frequently occurs adjacent to or near synchronous foci of invasive carcinoma.
- Keratinizing severe dysplasia has a rate of progression to invasive carcinoma that is greater than that of "classic" carcinoma in situ.

- A diagnosis of severe dysplasia requires therapeutic intervention, as well as clinical evaluation of the entire upper aerodigestive tract to exclude the possible presence of additional foci of dysplasia or carcinoma that may exist from field effect.

The end point for the grading of dysplasia is to convey to the clinician what is the potential biologic behavior of a given epithelial lesion. Keratotic epithelium without dysplasia carries a very low risk of developing subsequent carcinoma with reported incidences of 4% to 5%.²² In contrast, keratotic epithelium with dysplasia is associated with an increased risk for the subsequent progression or development of premalignant or overtly carcinomatous changes varying from 16% to 19%.²² This risk of malignant transformation represents a 3 to 5 fold increase as compared to carcinoma arising in keratotic lesions without atypia.²² The risk for progression to invasive carcinoma in lesions diagnosed as keratosis with dysplasia varies depending on the degree of atypia/dysplasia.²²

- for mild dysplasia – approximately 6%
- for moderate dysplasia – approximately 20%
- for severe dysplasia – approximately 24%

Given the absence of statistical significance in progression to invasive carcinoma between keratinizing moderate dysplasia and severe dysplasia, there may be merits in employing the 2-grade system currently in use for uterine cervical dysplasias (Bethesda classification) for keratinizing dysplasias of the UADT to include:

- Low-grade squamous intraepithelial lesion/neoplasia for mild dysplasia
- High-grade squamous intraepithelial lesion/neoplasia for moderate and severe dysplasias

Such a grading scheme for upper aerodigestive tract keratinizing dysplasias is not currently established or universally accepted.

N. Ancillary Testing

It is now well established that human papillomavirus (HPV) plays a pathogenic role in a subset of head and neck cancers, termed HPV-associated head and neck squamous cell carcinoma (HPV-HNSCC).^{42,43} HPV, in particular the high risk type 16 (HPV-16), is present in most oropharyngeal carcinomas.⁴² These carcinomas arise predominantly from the palatine tonsil and lingual tonsils of the oropharynx (ie, tonsil or base of tongue) and are nonkeratinizing carcinomas characterized by a somewhat basaloid morphology recapitulating tonsillar crypt epithelium (not to be confused with the specific variant basaloid squamous cell carcinoma).⁴⁴ A similar association has been suggested but not confirmed for oral cavity carcinoma. To date, there are no data linking HPV with laryngeal carcinoma, and the utility of testing for the presence of HPV in laryngeal carcinomas is unproven.

References

1. Patel S, Shah JP. Larynx. In: Edge SB, Byrd DR, Carducci MA, Compton CA, eds. *AJCC Cancer Staging Manual*. 7th ed. New York: Springer; 2009:57-68.
2. Barnes L, Tse LLY, Hunt JL, et al. Tumours of the hypopharynx, larynx and trachea: introduction. In: Barnes L, Eveson JW, Reichart P, Sidransky D, eds. *Pathology and Genetics of Head and Neck Tumours*. Lyon, France: IARC Press; 2005:111-116. *World Health Organization Classification of Tumours*.
3. Barnes L, Eveson JW, Reichart P, Sidransky D. WHO histological classification of tumours of the hypopharynx, larynx and trachea. In: Barnes L, Eveson JW, Reichart P, Sidransky D, eds. *Pathology and Genetics of Head and Neck Tumours*. Lyon, France: IARC Press; 2005:108. *World Health Organization Classification of Tumours*.
4. Barnes L. Neuroendocrine tumors. In: Barnes L, Eveson JW, Reichart P, Sidransky D, eds. *World Health Organization Classification of Tumours: Pathology and Genetics of Head and Neck Tumours*. Lyon, France: IARC Press; 2005:135-139.

5. Conventional squamous cell carcinoma. In: Mills SE, Stelow EB, Hunt JL, eds. *Tumors of the Upper Aerodigestive Tract and Ear*. Silver Spring, MD: ARP Press; 2012:41-80. *AFIP Atlas of Tumor Pathology*. Series 4, Vol. 17.
6. Ellis GL, Auclair PL, eds. *Tumors of the Salivary Glands*. Silver Spring, MD: ARP Press; 2008. *AFIP Atlas of Tumor Pathology*. Series 4, Vol. 9.
7. Spiro RH, Huvos AG, Strong EW: Adenocarcinoma of salivary origin: clinicopathologic study of 204 patients. *Am J Surg*. 1982;144(4):423-431.
8. Szanto PA, Luna MA, Tortoledo ME, White RA. Histologic grading of adenoid cystic carcinoma of the salivary glands. *Cancer*. 1984;54(6):1062-1069.
9. Spiro RH, Thaler HT, Hicks WF, Kher UA, Huvos AH, Strong EW. The importance of clinical staging of minor salivary gland carcinoma. *Am J Surg*. 1991;162(4):330-336.
10. Kane WJ, McCaffrey TV, Olsen KD, Lewis JE. Primary parotid malignancies: a clinical and pathologic review. *Arch Otolaryngol Head Neck Surg*. 1991;117(3):307-315.
11. Seethala RR. Histologic grading and prognostic biomarkers in salivary gland carcinomas. *Adv Anat Pathol*. 2011;18(1):29-45.
12. Grimm EE, Rulyak SJ, Sekijima JH, Yeh MM. Canalicular adenoma arising in the esophagus. *Arch Pathol Lab Med*. 2007;131(10):1595-1597.
13. Auclair PL, Goode RK, Ellis GL. Mucoepidermoid carcinoma of intraoral salivary glands: evaluation and application of grading criteria in 143 cases. *Cancer*. 1992;69(8):2021-2030.
14. Brandwein MS, Ivanov K, Wallace DI, et al. Mucoepidermoid carcinoma: a clinicopathologic study of 80 patients with special reference to histological grading. *Am J Surg Pathol*. 2001;25(7):835-845.
15. Seethala RR, Dacic S, Ciepły K, Kelly LM, Nikiforova MN. A reappraisal of the MECT1/MAML2 translocation in salivary mucoepidermoid carcinomas. *Am J Surg Pathol*. 2010;34(8):1106-1121.
16. Hinni ML, Ferlito A, Brandwein-Gensler MS, et al. Surgical margins in head and neck cancer: a contemporary review. *Head Neck*. 2012 Sep 3. [Epub ahead of print]
17. Brandwein-Gensler M, Teixeira MS, Lewis CM, et al. Oral squamous cell carcinoma: histologic risk assessment, but not margin status, is strongly predictive of local disease-free and overall survival. *Am J Surg Pathol*. 2005;29(2):167-178.
18. Alicandri-Ciuffelli M, Bonali M, Piccinini A, et al. Surgical margins in head and neck squamous cell carcinoma: what is 'close'? *Eur Arch Otorhinolaryngol*. 2012 Dec 28. [Epub ahead of print]
19. Bradley PJ, MacLennan K, Brakenhoff RH, Leemans CR. Status of primary tumour surgical margins in squamous head and neck cancer: prognostic implications. *Curr Opin Otolaryngol Head Neck Surg*. 2007;15(2):74-81.
20. Liao CT, Chang JT, Wang HM, et al. Analysis of risk factors of predictive local tumor control in oral cavity cancer. *Ann Surg Oncol*. 2008;15(3):915-922.
21. Ansarin M, Santoro L, Cattaneo A, et al. Laser surgery for early glottic cancer: impact of margin status on local control and organ preservation. *Arch Otolaryngol Head Neck Surg*. 2009;135(4):385-390.
22. Barnes L. Disease of the larynx, hypopharynx and trachea. In: Barnes L, ed. *Surgical Pathology of the Head and Neck*. New York: Informa Healthcare; 2009:109-201.
23. Wenig BM. Squamous cell carcinoma of the upper aerodigestive tract: precursors and problematic variants. *Mod Pathol*. 2002;15(3):229-254.
24. Smith BD, Haffty BG. Prognostic factoris in patients with head and neck cancer. In: Harrison LB, Sessions RB, Hong WK, eds. *Head and Neck Cancer: A Multidisciplinary Approach*. Philadelphia: Lippincott Williams and Wilkins; 2009:51-75.
25. Fagan JJ, Collins B, Barnes L, D'Amico F, Myers EN, Johnson JT. Perineural invasion in squamous cell carcinoma of the head and neck. *Arch Otolaryngol Head Neck Surg*. 1998;124(6):637-640.
26. Miller ME, Palla B, Chen Q, et al. A novel classification system for perineural invasion in noncutaneous head and neck squamous cell carcinoma: histologic subcategories and patient outcomes. *Am J Otolaryngol*. 2012;33(2):212-215.

27. Cooper JS, Pajak TF, Forastiere AA, et al. Postoperative concurrent radiotherapy and chemotherapy for high-risk squamous-cell carcinoma of the head and neck. *N Engl J Med.* 2004;350(19):1937-1944.
28. Bernier J, Dommenege C, Ozsahin M, et al. Postoperative irradiation with or without concomitant chemotherapy for locally advanced head and neck cancer. *N Engl J Med.* 2004;350(19):1945-1952.
29. Woolgar J, Triantafyllou A. Neck dissections: a practical guide for the reporting histopathologist. *Curr Diag Pathol.* 2007;13:499-511.
30. Leemans CR, Tiwari R, Nauta JJ, van der Waal I, Snow GB. Regional lymph node involvement and its significance in the development of distant metastases in head and neck carcinoma. *Cancer.* 1993;71(2):452-456.
31. Woolgar JA, Rogers SN, Lowe D, Brown JS, Vaughan ED. Cervical lymph node metastasis in oral cancer: the importance of even microscopic extracapsular spread. *Oral Oncol.* 2003;39(2):130-137.
32. Johnson JT, Myers EN, Bedetti CD, Barnes EL, Schramm VL Jr, Thearle PB. Cervical lymph node metastases. Incidence and implications of extracapsular carcinoma. *Arch Otolaryngol.* 1985;111(8):534-537.
33. Sobin LH, Gospodarowicz MK, Wittekind CH, eds. *TNM Classification of Malignant Tumours.* New York: Wiley-Liss; 2009.
34. Seethala RR. Current state of neck dissection in the United States. *Head Neck Pathol.* 2009;3(3):238-245.
35. Robbins KT, Shaha AR, Medina JE, et al. Consensus statement on the classification and terminology of neck dissection. *Arch Otolaryngol Head Neck Surg.* 2008;134(5):536-538.
36. Ferlito A, Robbins KT, Shah JP, et al. Proposal for a rational classification of neck dissections. *Head Neck.* 2011;33(3):445-450.
37. Suarez C, Rodrigo JP, Robbins KT, et al. Superselective neck dissection: rationale, indications, and results. *Eur Arch Otorhinolaryngol.* 2013 Jan 16. [Epub ahead of print]
38. Singletary SE, Greene FL, Sobin LH. Classification of isolated tumor cells: clarification of the 6th edition of the American Joint Committee on Cancer Staging Manual. *Cancer.* 2003;98(12):2740-2741.
39. Broglie MA, Haerle SK, Huber GF, Haile SR, Stoeckli SJ. Occult metastases detected by sentinel node biopsy in patients with early oral and oropharyngeal squamous cell carcinomas: Impact on survival. *Head Neck.* 2013;35(5):660-666.
40. Flint PW, Haughey BH, Lund VJ, et al, eds. *Cummings Otolaryngology - Head And Neck Surgery.* 5th ed. Philadelphia: Saunders; 2010.
41. Gale N, Pilch BZ, Sidransky D, Westra WH, Califano JA. Epithelial precursor lesions. In: Barnes L, Eveson JW, Reichart P, Sidransky D, eds. *Pathology and Genetics of Head and Neck Tumours.* Lyon, France: IARC Press; 2005:140-143. *World Health Organization Classification of Tumours.*
42. Chung CH, Gillison ML. Human papillomavirus in head and neck cancer: its role in pathogenesis and clinical implications. *Clin Cancer Res.* 2009;15(22):6758-6762.
43. IARC Working Group on the Evaluation of Carcinogenic Risks to Humans. Human papillomaviruses. *IARC Monogr Eval Carcinog Risks Hum.* 2007;90:1-636.
44. Lewis JS Jr, Khan RA, Masand RP, et al. Recognition of nonkeratinizing morphology in oropharyngeal squamous cell carcinoma - a prospective cohort and interobserver variability study. *Histopathology.* 2012;60(3):427-436.