



# Protocol for the Examination of Biopsy Specimens From Pediatric Patients With Ewing Sarcoma

Version: Ewing Sarcoma Biopsy 4.0.0.0

Protocol Posting Date: February 2019

## Accreditation Requirements

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

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

Procedure	Description
Biopsy	Includes specimens designated core needle biopsy, incisional biopsy, excisional biopsy, or other
Tumor Type	Description
Ewing sarcoma	Includes pediatric patients with osseous and extraosseous Ewing sarcoma family of tumors, including peripheral primitive neuroectodermal tumor

## The following should NOT be reported using this protocol:

Procedure
Resection (consider Pediatric Ewing Sarcoma Resection protocol)
Tumor Type
Adult Ewing sarcoma <sup>#</sup> (consider using bone or soft tissue protocols) Ewing-like sarcomas, including <i>CIC-</i> or <i>BCOR-</i> rearranged sarcomas (consider using Bone or Soft Tissue protocols)

<sup>#</sup>*Ewing sarcoma in adults may be treated differently than pediatric Ewing sarcoma, and use of the AJCC TNM staging system remains appropriate for these patients.*

## Authors

Erin Rudzinski, MD\*; Bruce Pawel, MD\*; Armita Bahrami, MD; M. John Hicks, MD

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

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

## Important Note (Note A)

First priority should always be given to formalin-fixed tissue for histomorphologic evaluation. Special studies (eg, cytogenetics, fluorescence in situ hybridization [FISH], reverse transcriptase polymerase chain reaction [RT-PCR], and less commonly next-generation sequencing, whole genome and exome analyses) are critical to the molecular workup of ES and require at least 100 mg of viable, fresh or snap-frozen tissue as the second priority for workup (Note A). Although molecular testing for FISH analysis of *EWSR1* rearrangement or for RT-PCR analysis of *EWSR1-FLI1*, *EWSR1-ERG*, and other ES translocations may be performed on formalin-fixed paraffin-embedded tissue, every attempt should be made to procure fresh tissue, as this may be a requirement for some treatment protocols.

This protocol is based on the experience of the Children’s Oncology Group. For more information, contact The Children’s Oncology Group Biopathology Center. Phone: (614) 722-2890 or (800) 347-2486.

## Summary of Changes

v4.0.0.0 - Biopsy and resection procedures separated into individual protocols

## Surgical Pathology Cancer Case Summary

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Protocol posting date: February 2019

### **EWING SARCOMA: Biopsy**

**Note: This case summary is recommended for reporting Ewing Sarcoma but is NOT REQUIRED for accreditation purposes. Core data elements are bolded to help identify routinely reported elements.**

**Select a single response unless otherwise indicated.**

#### **Procedure (Note B)**

- Core needle biopsy
- Incisional biopsy
- Excisional biopsy
- Other (specify): \_\_\_\_\_
- Not specified

#### **Tumor Site**

- Specify site (if known): \_\_\_\_\_
- Not specified

#### **Tumor Size (for excisional biopsy only)**

- Greatest dimension:(centimeters) \_\_\_ cm
- Additional dimensions:(centimeters) \_\_\_ x \_\_\_ cm
- Cannot be determined (explain): \_\_\_\_\_

#### **Margins (for excisional biopsy only) (Note C)**

- Cannot be assessed
- Uninvolved by tumor
- Distance of tumor from closest soft tissue margin (centimeters) (if applicable): \_\_\_ cm
- Distance of tumor from closest other (eg, parenchymal) margin (centimeters) (if applicable): \_\_\_ cm
- Involved by tumor
- Specify margin(s): \_\_\_\_\_

#### **Lymphovascular Invasion (Note D)**

- Not identified
- Present
- Cannot be determined

#### **Additional Pathologic Findings**

Specify: \_\_\_\_\_

**Ancillary Studies (select all that apply) (Note E)**

*Note: Results of these studies may not be available at the time of the final report*

Immunohistochemistry (specify): \_\_\_\_\_

**Cytogenetics Findings**

- Not performed
- Pending
- EWSR1 rearrangement present
  - Fusion partner not known
  - Fusion partner known
    - FLI1
    - ERG
    - Other (specify): \_\_\_\_\_
- Other (non-EWSR1 variant translocation) (specify): \_\_\_\_\_
- No rearrangement identified

**Method**

- Conventional karyotyping
- Fluorescent in situ hybridization (FISH)
- Reverse transcriptase polymerase chain reaction (RT-PCR)
- Other (specify): \_\_\_\_\_

Comment(s)

## Explanatory Notes

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### A. Tissue Handling

Tissue specimens optimally are received fresh/unfixed because of the importance of ancillary studies, such as cytogenetics and molecular testing, which require fresh tissue. First priority should always be given to formalin-fixed tissues for morphologic evaluation, followed by submission of fresh tissue for cytogenetics and/or snap freezing a minimum of 100 mg of viable tumor for potential molecular studies.<sup>1</sup> Molecular testing on formalin-fixed paraffin-embedded tissue may be performed for FISH evaluation of *EWSR1* rearrangement and for RT-PCR evaluation of *EWSR1-FLI1*, *EWSR1-ERG*, and other ES translocations. When the amount of tissue is limited, the pathologist can keep the frozen tissue aliquot used for frozen section (usually done to determine sample adequacy and viability) in a frozen state (-70°C is preferable). Translocations may be detected using RT-PCR on frozen or fixed paraffin-embedded tissue, or FISH on touch preparations made from fresh tissue or formalin-fixed paraffin-embedded tissue.

Note that classification of many subtypes of sarcoma is not always dependent upon special studies, such as cytogenetics or molecular genetics, but frozen tissue may be required to enter patients into treatment protocols. Discretion should be used in triaging tissue from sarcomas. Adequate tissue should be submitted for conventional light microscopy before tissue has been taken for cytogenetics, electron microscopy, or molecular analysis.

#### Reference

1. Qualman SJ, Morotti RA. Risk assignment in pediatric soft-tissue sarcoma: an evolving molecular classification. *Curr Oncol Rep.* 2002;4:123-130.

### B. Procedures

#### Cytologic Material

Cytological material is usually sufficient to diagnose ES (with supportive immunostains) (Note E). An important limitation of fine-needle aspiration is the limited amount of tissue for additional molecular diagnostic studies<sup>1</sup> and tissue banking (see Note A). Evaluation by a pathologist at the time of the fine-needle biopsy procedure is important to assess the adequacy of the specimen for routine histomorphologic diagnosis and for ancillary studies.

If cytologic material includes fluid, such as pleural effusions or fluid from a liquefactive tumor, the fluid should be centrifuged and the resulting pellet fixed with formalin prior to making a paraffin cell block. The resulting cell block allows for histopathologic examination and immunocytochemical, RT-PCR, and FISH analyses.

#### Biopsy (Needle, Incisional, Excisional)

Core needle biopsies can obtain sufficient material for special studies and histomorphologic diagnosis. Open incisional biopsy is generally the preferred and most widely used technique, because it consistently provides a larger sample of tissue and maximizes the opportunity for a specific pathologic diagnosis.<sup>2</sup> Excisional biopsy may not include an adequate margin of normal tissue, even with an operative impression of total gross removal.<sup>2</sup>

In cases of nonexcisional biopsy (eg, core biopsy, incisional biopsy), the tumor size cannot be determined on pathologic grounds; therefore, imaging data (computed tomography [CT], magnetic resonance imaging [MRI], etc) can be used instead.

#### References

1. Qualman SJ, Morotti RA. Risk assignment in pediatric soft-tissue sarcoma: an evolving molecular classification. *Curr Oncol Rep.* 2002;4:123-130.
2. Coffin CM, Dehner LP. Pathologic evaluation of pediatric soft tissue tumors. *Am J Clin Pathol.* 1998;109(suppl 1):S38-S52.

### C. Margins

The extent of resection (ie, gross residual disease versus complete resection with negative margins) has the strongest influence on local control of malignancy.<sup>1</sup> The definition of what constitutes a sufficiently “wide” margin of normal tissue in the management of ES and the significance of reactive and/or necrotic tissue at the margin are

current study questions for the Children's Oncology Group, and may evolve in the future. Currently, any tumor at the margin, whether viable, nonviable, or treated, is considered positive. The significance of treated tumor at the margin when there has been an excellent chemotherapeutic response (ie, greater than 90% tumor necrosis) remains unclear. There is currently no consensus as to whether margins involved by treated tumor require further treatment, and this is considered a negative margin on some studies. The presence of treated tumor at the margin should be reported, however, and can be included in the comment section of the checklist. The following margins are considered adequate:

- Bone margin: 2 to 5 cm
- Fascia, periosteum, and intermuscular septa: 2 mm
- Fat, muscle, and medullary bone: 5 mm

With Ewing sarcoma involving an encapsulated organ, surgical margins are considered to be negative if the organ's capsule is not surgically violated or breached by the tumor.

#### Reference

1. Fletcher C, Kempson RL, Weiss S. Recommendations for reporting soft tissue sarcomas. *Am J Clin Pathol.* 1999;111:594-598.

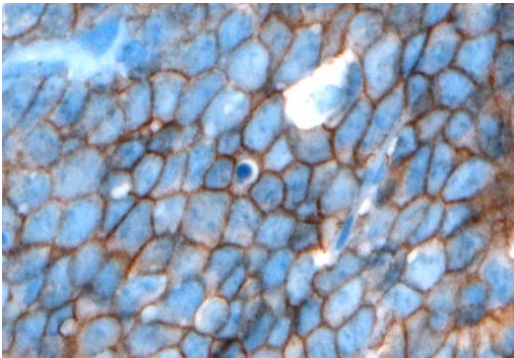
#### D. Lymphovascular Invasion (LVI)

Lymphovascular invasion (LVI) indicates whether microscopic lymphovascular invasion is identified in the pathology report. LVI includes lymphatic invasion, vascular invasion, or lymphovascular invasion. Evaluation of LVI may require immunohistochemical staining for endothelial markers (CD31, CD34, D240, etc). By American Joint Committee on Cancer (AJCC) and International Union Against Cancer (UICC) convention, LVI does not affect the T category indicating local extent of tumor unless specifically included in the definition of the T category.

#### E. Ancillary Studies

##### Immunohistochemistry

Immunohistochemistry with monoclonal antibodies against the cell surface glycoprotein CD99 is positive in virtually all cases of ES.<sup>1</sup> This glycoprotein is diffusely expressed in the vast majority of cases in a *membranous pattern* (Figure 2). The results of staining using monoclonal antibodies O13, HBA71, and 12E7 are similar, but individual tumors may exhibit better staining with one of these antibodies versus other antibodies.



**Figure 2.** CD99 staining in Ewing sarcoma shows strong, diffuse, membranous staining. (CD99 antibody O13 with hematoxylin counterstain.)

Lymphoblastic lymphomas/leukemias, rhabdomyosarcomas, synovial sarcomas, solitary fibrous tumors, rhabdoid tumors, neuroendocrine tumors, desmoplastic small round cell tumors, and mesenchymal chondrosarcomas may also demonstrate immunoreactivity to CD99. In some of these tumors, CD99 immunostaining is often weakly granular and intracytoplasmic; in others (lymphoblastic lymphoma/leukemia, occasional cases of poorly differentiated synovial sarcoma, alveolar rhabdomyosarcoma), distinct membrane staining is present, as seen in ES. Because these other tumors with small round cell morphology can exhibit CD99 expression, it is very important to consider including other immunohistochemical stains such as muscle markers (desmin, muscle-specific actin, myoD1, myogenin), S-100, epithelial markers (epithelial membrane antigen, cytokeratin), INI-1, and lymphoid markers (CD45, CD30, Tdt, T-cell and/or B-cell markers) when CD99 is performed to properly exclude

CD99-expressing tumors. Cytokeratin positivity may be seen in ES and may be diffusely positive in the adamantinoma-like variant of Ewing sarcoma.<sup>2,3</sup> Newer immunohistochemical antibodies, such as NKX2.2, may also be useful for the diagnosis of ES, although NKX2.2 staining may rarely be seen in other small round cell tumors.<sup>4</sup> The value of other immunohistochemical markers for diagnosis, such as Ki-67, p53, and C-kit (CD117), has not been established. ES is almost always vimentin immunopositive.

### Chromosomal Translocations

It is now generally accepted that Ewing sarcoma and PNET form a single group of bone and soft tissue tumors and the 2013 World Health Organization (WHO) classification of bone and soft tissue tumors uses the single terminology, *Ewing sarcoma*. The characteristic translocations involve the *EWSR1* gene at 22q12 and a member of the ETS family, most often either the *FLI1* gene at 11q24 or the *ERG* gene at 21q22. The presence of t(11;22) (*EWSR1-FLI1*) and t(21;22) (*EWSR1-ERG*) is strongly correlated with ES. The most common gene fusion is the *EWSR1-FLI1* (90%-95% of patients). It should be emphasized that there are numerous other *EWSR1* gene partners that occur in a minority (5%-10%) of ES. The failure to identify an *EWSR1-FLI1* or *EWSR1-ERG* translocation by RT-PCR or cytogenetics does not exclude ES from the diagnosis. Cytogenetic studies are important for identification of the less common and rare ES translocations and for discovering novel *EWSR1* translocations in ES. FISH analysis for *EWSR1* is helpful as a first step and may confirm the diagnosis in those tumors with histomorphologic features and immunohistochemical phenotypes of ES. Because other small round cell tumors of childhood can have *EWSR1* rearrangements with specific tumor-defining partners, *EWSR1* FISH positivity alone is not diagnostic of ES. Some of these tumors with *EWSR1* rearrangement include angiomatoid fibrous histiocytoma, clear cell sarcoma of soft parts, desmoplastic round cell tumor, and extraskelatal myxoid chondrosarcoma, as well as a subset of myxoid liposarcomas and myoepithelial carcinoma. This underscores the necessity for histologic and immunohistochemical correlation with FISH and/or cytogenetic data.<sup>5</sup>

Some of the less common ES translocations substitute *FUS* (ch16) for *EWSR1*, or involve other ETS partners including *ETV1*, *ETV4*, or *FEV*. Whether tumors with *EWSR1* fusion and a non-ETS partner (ie. *EWSR1-NFATC2*) represent Ewing sarcoma remains a matter of some debate. However, ES-like tumors with *CIC-DUX4* and *BCOR-CCNB3* are generally considered separate diagnostic entities and these tumors should not be reported using this protocol.<sup>6</sup>

The diagnosis of ES is not dependent upon identifying a “tumor-defining” translocation and may be rendered with the appropriate histomorphologic and immunohistochemical features. The specific *EWSR1* translocation and subtype based upon exon fusion type do not influence treatment, prognosis, or outcome.<sup>7</sup>

### References

1. Ambros IM, Ambros PF, Strehl S, Kovar H, Gardner H, Salzer-Kuntschik M. MIC2 is a specific marker for Ewing's sarcoma and peripheral primitive neuroectodermal tumor: evidence for a common histogenesis of Ewing's sarcoma and peripheral neuroectodermal tumors from MIC2 expression and specific chromosome aberration. *Cancer*. 1992;67:1886-1893.
2. Collini P, Sampietro G, Bertulli R, et al. Cytokeratin immunoreactivity in 41 cases of Ewing sarcoma/primitive neuroectodermal tumor confirmed by molecular diagnostic studies. *Am J Surg Pathol*. 2001;25:273-274.
3. Folpe AL, Goldblum JR, Rubin BP, Shehata BM, Liu W, Dei Tos AP, Weiss SW. Morphologic and immunophenotypic diversity in Ewing family tumors: a study of 66 genetically confirmed cases. *Am J Surg Pathol*. 2005;29:1025-1033.
4. Machado I, Yoshida A, Lopez-Guerrero JA, Nieto MG, Navarro S, Picci P, Llombart-Bosch A. Immunohistochemical analysis of NKX2.2, ETV4 and BCOR in a large series of genetically confirmed Ewing sarcoma family tumors. *Pathol Res Pract* 2017;213(9):1048-1053.
5. Tsokos M, Allagio RD, Dehner LP, et al. Ewing sarcoma/peripheral neuroectodermal tumor and related tumors. *Pediatr Dev Pathol*. 2012;15(1 suppl):108-126.
6. Antonescu C. Round cell sarcomas beyond Ewing: emerging entities. *Histopathology* 2014;64:26-37.
7. Van Doorninck JA, Ji L, Schaub B, et al. Current treatment protocols have eliminated the prognostic advantage of Type 1 fusions in Ewing sarcoma: a report from the Children's Oncology Group. *J Clin Oncol*. 2010;28:1989-1994.