

Protocol for the Examination of Biopsy Specimens From Patients With Carcinoma of the Ureter and Renal Pelvis

Version: Ureter and Renal Pelvis Biopsy 2.1.0.0 **Protocol Posting Date:** August 2019

Accreditation Requirements

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

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

Procedure	Description
Biopsy	Includes specimens designated biopsy
Tumor Type	Description
Carcinomas	Includes invasive carcinomas of the urinary tract, including urothelial carcinoma and its morphological variants (squamous cell carcinoma, adenocarcinoma, Müllerian carcinoma, neuroendocrine carcinoma, and sarcomatoid carcinoma)

The following should NOT be reported using this protocol:

Procedure
Resection (consider the Ureter and Renal Pelvis Resection protocol)
Cytologic specimens

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

Tumor Type
Lymphoma (consider the Hodgkin or non-Hodgkin Lymphoma protocols)
Sarcoma (consider the Soft Tissue protocol)

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Summary of Changes

Version 2.1.0.0:

Resection and biopsy case summaries separated into discrete cancer protocols

The following was modified:

Histologic Type

Surgical Pathology Cancer Case Summary

Protocol posting date: August 2019

URETER, RENAL PELVIS: Biopsy**Note: This case summary is recommended for reporting biopsy specimens, but is not required for accreditation purposes. Core data elements are bolded to help identify routinely reported elements.****Select a single response unless otherwise indicated.****Specimen (Note A)**

- Renal pelvis
 Ureter
 Other (specify): _____
 Not specified

Specimen Laterality

- Left
 Right
 Not specified

Histologic Type (select all that apply) (Note B)Urothelial

- Papillary urothelial carcinoma, noninvasive
 Papillary urothelial carcinoma, invasive
 Urothelial carcinoma in situ
 Urothelial carcinoma, invasive
 Urothelial carcinoma, nested (including large nested) variant
 Urothelial carcinoma, microcystic variant
 Urothelial carcinoma, micropapillary variant
 Urothelial carcinoma, lymphoepithelioma-like variant
 Urothelial carcinoma, plasmacytoid / signet ring / diffuse variant
 Urothelial carcinoma, sarcomatoid variant
 Urothelial carcinoma, giant cell variant
 Urothelial carcinoma, poorly differentiated variant
 Urothelial carcinoma, lipid-rich variant
 Urothelial carcinoma, clear cell variant
 Urothelial carcinoma with squamous differentiation
 Specify percentage of squamous differentiation: _____%
 Urothelial carcinoma with glandular differentiation
 Specify percentage of glandular differentiation: _____%
 Urothelial carcinoma with trophoblastic differentiation
 Specify percentage of trophoblastic differentiation: _____%
 Urothelial carcinoma with Müllerian differentiation
 Specify percentage of Müllerian differentiation: _____%

Squamous

- Squamous cell carcinoma
 Verrucous carcinoma
 Squamous cell carcinoma in situ (no invasive carcinoma identified)

Glandular

- Adenocarcinoma
 Adenocarcinoma, enteric
 Adenocarcinoma, mucinous
 Adenocarcinoma, mixed
 Adenocarcinoma in situ (no invasive carcinoma identified)

Tumors of Müllerian Type

- Clear cell carcinoma
 Endometrioid carcinoma

Neuroendocrine Tumors

- Small cell neuroendocrine carcinoma
 Specify percentage of small cell neuroendocrine component: _____%
 Large cell neuroendocrine carcinoma
 Specify percentage of large cell neuroendocrine component: _____%
 Well-differentiated neuroendocrine carcinoma
 Specify percentage of well-differentiated neuroendocrine component: _____%
 Other histologic type not listed (specify): _____

Associated Epithelial Lesions (select all that apply) (Note C)

- None identified
 Urothelial papilloma
 Urothelial papilloma, inverted type
 Papillary urothelial neoplasm, low malignant potential (PUNLMP)
 Urothelial proliferation of uncertain malignant potential
 Urothelial dysplasia
 Cannot be determined

Histologic Grade (Note C)*For urothelial carcinoma, other variants, or divergent differentiation*

- Low grade
 High grade

For squamous cell carcinoma or adenocarcinoma

- G1: Well differentiated
 G2: Moderately differentiated
 G3: Poorly differentiated
 GX: Cannot be assessed
 Other (specify): _____
 Cannot be assessed
 Not applicable

Tumor Configuration (select all that apply)

- Papillary
 Solid/nodule
 Flat
 Ulcerated
 Cannot be determined
 Other (specify): _____

Presence of Muscularis Propria for Determining T Category (Note D)

- Muscularis propria not identified
- Muscularis propria present
- Cannot be determined

Tumor Extension (Note E)

- Noninvasive papillary carcinoma
- Carcinoma in situ
- Tumor invades subepithelial connective tissue
- Tumor invades the muscularis
- Tumor invades beyond muscularis into peripelvic fat or the renal parenchyma (for renal pelvis only)
- Tumor invades beyond muscularis into periureteric fat (for ureter only)
- Tumor invades adjacent organs, or through the kidney into the perinephric fat
- Cannot be assessed

Additional Pathologic Findings (select all that apply)

- Inflammation/regenerative changes
- Therapy-related changes
- Cautery artifact
- Cystitis cystica et glandularis
- Keratinizing squamous metaplasia
- Intestinal metaplasia
- Other (specify): _____

Comment(s)

Explanatory Notes

A. History

A relevant history is important for interpretation of all upper urinary tract (renal pelvis and ureter) specimens. A history of renal stones, recent urinary tract procedures, infections, or obstruction can influence the interpretation of random biopsies obtained from patients with hematuria. Any neoplasms previously diagnosed should be specified, including the histologic type, primary site, and histologic grade. Primary tumors may be associated with hereditary nonpolyposis colon cancer (HNPCC) syndrome (Lynch syndrome II). Renal pelvic tumors are more often seen in analgesic abusers, who often have analgesic nephropathy, including papillary necrosis. If prior therapy has been given, it should be described (systemic or intravesical chemotherapy, immunotherapy, radiation, etc). The method of collection and date also should be specified in urine cytology specimens. Cytologic specimens from the ureter or renal pelvis may be over-interpreted if their site of sampling is not stated.

B. Histologic Type

Like the urinary bladder, the vast majority (more than 95%) of carcinomas of the renal pelvis and ureter are urothelial in origin.¹⁻⁷ The most recent 2016 World Health Organization (WHO) classification of tumors of the urothelial tract, including urethra, urinary bladder, ureter, and renal pelvis, is provided in this note. Benign tumors are included in this classification because, within the same patient, a spectrum of differentiation from benign to malignant tumors may be seen, either at the same time or over the clinical course of the disease. The full spectrum of invasive urothelial carcinoma and its variants as found in the urinary bladder may also be found in the upper tract. The distinction between a urothelial carcinoma with divergent squamous, glandular, or Müllerian differentiation, and a pure squamous cell carcinoma, adenocarcinoma or Müllerian is rather arbitrary. Most authorities, including the 2016 WHO classification, require a pure histology of squamous cell carcinoma, adenocarcinoma or Müllerian to designate a tumor as such, all others with recognizable papillary, invasive, or flat carcinoma in situ (CIS) urothelial component being considered as urothelial carcinoma with divergent differentiation. A malignant neoplasm with small cell neuroendocrine carcinoma component arising in the urinary tract is designated as small cell carcinoma.

Lynch syndrome, also known as hereditary nonpolyposis colorectal cancer, predisposes patients to urological cancer, particularly upper tract urothelial carcinoma. Upper tract urothelial carcinoma develops in up to 28% of patients with known Lynch syndrome. Therefore, pathologists should be aware of Lynch syndrome and their important role of identifying Lynch syndrome patients by considering appropriate tissue tests. Recently several guidelines have been published regarding when and what tissue testing is appropriate for screening patients with upper tract urothelial carcinoma.^{8,9}

2016 WHO Classification of Tumors of the Urothelial Tract

Urothelial tumors

Infiltrating urothelial carcinoma

- Nested, including large nested
- Microcystic
- Micropapillary
- Lymphoepithelioma-like
- Plasmacytoid/signet ring cell/diffuse
- Sarcomatoid
- Giant cell
- Poorly differentiated

Noninvasive urothelial lesions

- Urothelial carcinoma in situ
- Noninvasive papillary urothelial carcinoma, low grade
- Noninvasive papillary urothelial carcinoma, high grade
- Papillary urothelial neoplasm of low malignant potential
- Urothelial papilloma
- Inverted urothelial papilloma
- Urothelial proliferation of uncertain malignant potential

Urothelial dysplasia

Squamous cell neoplasms

Squamous cell carcinoma
Verrucous carcinoma
Squamous cell papilloma

Glandular neoplasms

Adenocarcinoma, NOS
 Enteric
 Mucinous
 Mixed
Villous adenoma

Tumors of Müllerian type

Clear cell carcinoma
Endometrioid carcinoma

Neuroendocrine tumors

Small cell neuroendocrine carcinoma
Large cell neuroendocrine carcinoma
Well-differentiated neuroendocrine tumor
Paraganglioma

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C. Histologic Grade

The grading system is identical to that for urinary bladder neoplasms. Flat intraepithelial lesions and papillary and invasive lesions are graded separately. There has been significant controversy in the classification of these lesions.¹ Due to variable classification systems and the need for a universally acceptable system, the World Health Organization/International Society of Urological Pathology (WHO/ISUP) consensus classification was proposed.² This system is utilized in the WHO 2004 classification,³ the 2004 Armed Forces Institute of Pathology (AFIP) fascicle,⁴ and 2016 WHO classification,⁵ and has been validated by many studies to be prognostically

significant. Other systems (that were being used previously) may still be used according to institutional preference. Urothelial carcinomas of the renal pelvis tend to more often be high grade^{6,7} compared to urinary bladder carcinomas.

Flat and papillary urothelial hyperplasia has been renamed as “urothelial proliferation of uncertain malignant potential” in 2016 WHO classification.

Squamous carcinomas and adenocarcinomas may be graded as well differentiated, moderately differentiated, and poorly differentiated.

References

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D. Extent of Invasion

Depth of invasion and pathologic stage are the most important prognostic indicators for patients with neoplasms of the upper urinary tract.^{1,2} A critical role of the surgical pathologist is to diagnose the depth and extent of invasion into the subepithelial connective tissue/lamina propria (pT1), muscularis propria (pT2), or beyond (pT3 or pT4). The patterns of invasion are similar to the urinary bladder, except that for renal pelvis carcinoma, the type of tumor involvement of the kidney, when present, impacts stage. Also, it is important to note that the lamina propria is absent beneath the urothelium lining the renal papillae in the pelvis and is thin along the minor calyces.³ As in the urinary bladder, in papillary tumors, invasion occurs most often at the base of the tumor and very infrequently in the stalk. Tumor infiltrating the lamina propria is pT1, and, like the urinary bladder, there is no accepted approach for assessing depth of lamina propria invasion. However, pathologists are encouraged to provide some assessment as to the extent of lamina propria invasion (ie, focal versus extensive, or depth in millimeters, or by level – above, at, or below muscularis mucosae). Designation of a tumor as merely muscle-invasive is inappropriate, but the type of muscle invasion, ie, muscularis mucosae (pT1 tumors) versus muscularis propria (pT2 tumors) invasion, needs to be clearly stated. Descriptive terminology, such as “urothelial carcinoma with muscle invasion, indeterminate for type of muscle invasion,” may be used when it is not possible to be certain whether the type of muscle invaded by the tumor is hypertrophic muscularis mucosae or muscularis propria. For renal pelvic tumors, in-situ extension of carcinoma into renal collecting ducts and renal tubules does not affect stage, while carcinoma invading into the renal parenchyma is pT3. Patients with upper tract urothelial carcinoma often present at higher stage compared to patients with urinary bladder carcinoma.^{4,5}

References

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