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What's New in GU / Adrenal Pathology? (updated)
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What's New in Pathology?

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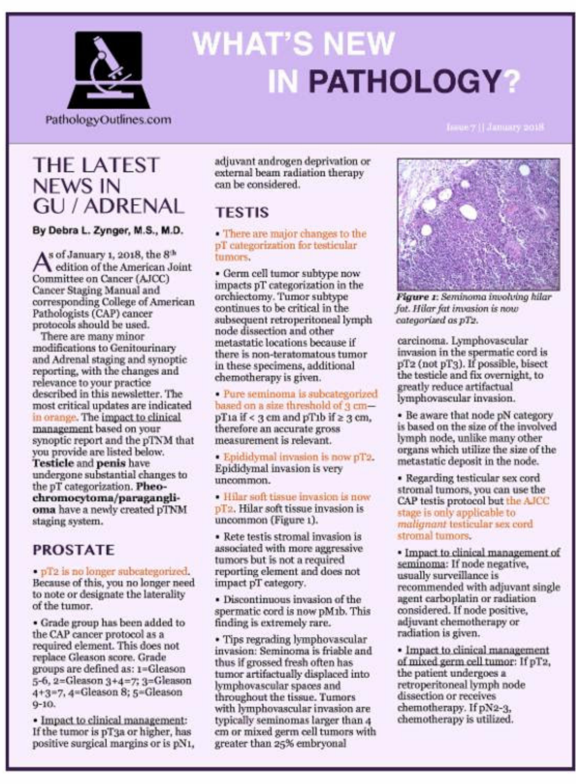

WHAT'S NEW IN PATHOLOGY?

PathologyOutlines.com

Issue 7 || January 2018

THE LATEST NEWS IN GU / ADRENAL

By Debra L. Zynger, M.S., M.D.

As of January 1, 2018, the 8th edition of the American Joint Committee on Cancer (AJCC) Cancer Staging Manual and corresponding College of American Pathologists (CAP) cancer protocols should be used.

There are many minor modifications to Genitourinary and Adrenal staging and synoptic reporting, with the changes and relevance to your practice described in this newsletter. The most critical updates are indicated in orange. The impact to clinical management based on your synoptic report and the pTNM that you provide are listed below. **Testicle** and **penis** have undergone substantial changes to the pT categorization. **Pheochromocytoma/paraganglioma** have a newly created pTNM staging system.

PROSTATE

- pT2 is no longer subcategorized. Because of this, you no longer need to note or designate the laterality of the tumor.
- Grade group has been added to the CAP cancer protocol as a required element. This does not replace Gleason score. Grade groups are defined as: 1=Gleason 5-6, 2=Gleason 3+4=7; 3=Gleason 4+3=7, 4=Gleason 8; 5=Gleason 9-10.
- Impact to clinical management: If the tumor is pT3a or higher, has positive surgical margins or is pN1, adjuvant androgen deprivation or external beam radiation therapy can be considered.

TESTIS

- There are major changes to the pT categorization for testicular tumors.
- Germ cell tumor subtype now impacts pT categorization in the orchiectomy. Tumor subtype continues to be critical in the subsequent retroperitoneal lymph node dissection and other metastatic locations because if there is non-teratomatous tumor in these specimens, additional chemotherapy is given.
- Pure seminoma is subcategorized based on a size threshold of 3 cm—pT1a if < 3 cm and pT1b if ≥ 3 cm, therefore an accurate gross measurement is relevant.
- Epididymal invasion is now pT2. Epididymal invasion is very uncommon.
- Hilar soft tissue invasion is now pT2. Hilar soft tissue invasion is uncommon (Figure 1).
- Rete testis stromal invasion is associated with more aggressive tumors but is not a required reporting element and does not impact pT category.
- Discontinuous invasion of the spermatic cord is now pM1b. This finding is extremely rare.
- Tips regrading lymphovascular invasion: Seminoma is friable and thus if grossed fresh often has tumor artifactually displaced into lymphovascular spaces and throughout the tissue. Tumors with lymphovascular invasion are typically seminomas larger than 4 cm or mixed germ cell tumors with greater than 25% embryonal carcinoma. Lymphovascular invasion in the spermatic cord is pT2 (not pT3). If possible, bisect the testicle and fix overnight, to greatly reduce artifactual lymphovascular invasion.
- Be aware that node pN category is based on the size of the involved lymph node, unlike many other organs which utilize the size of the metastatic deposit in the node.
- Regarding testicular sex cord stromal tumors, you can use the CAP testis protocol but the AJCC stage is only applicable to *malignant* testicular sex cord stromal tumors.
- Impact to clinical management of seminoma: If node negative, usually surveillance is recommended with adjuvant single agent carboplatin or radiation considered. If node positive, adjuvant chemotherapy or radiation is given.
- Impact to clinical management of mixed germ cell tumor: If pT2, the patient undergoes a retroperitoneal lymph node dissection or receives chemotherapy. If pN2-3, chemotherapy is utilized.

Figure 1: Seminoma involving hilar fat. Hilar fat invasion is now categorized as pT2.

By Debra L. Zynger, M.S., M.D.
PathologyOutlines.com Genitourinary and Adrenal Pathology Editor

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