Sponsored by

Endometrial Cancer Histopathology Reporting Guide

Family/Last name

Given name(s)

Date of birth DD – MM – YYYY

Patient identifiers

Date of request DD – MM – YYYY

Accession/Laboratory number

Elements in **black text** are CORE. Elements in **grey text** are NON-CORE.

☐ indicates multi-select values ◯ indicates single select values

SCOPE OF THIS DATASET

CLINICAL INFORMATION (select all that apply)

- ◯ Information not provided
- ☐ Family history of cancer or cancer-associated syndrome, *specify*
- ☐ Previous history of cancer, *specify*
- ☐ Previous therapy, *specify*
- ☐ Other clinical information, *specify*

OPERATIVE PROCEDURE (select all that apply)

- ◯ Not specified
- ☐ Hysterectomy
  - ◯ Simple
  - ◯ Simple supracervical/subtotal
  - ◯ Radical
  - ◯ Type not specified
- ☐ Other, *specify*

SPECIMEN(S) SUBMITTED (select all that apply)

- ◯ Not specified
- ☐ Fallopian tube — ☐ Left ☐ Right ◯ Laterality not specified
- ☐ Ovary — ☐ Left ☐ Right ◯ Laterality not specified
- ☐ Parametrium — ☐ Left ☐ Right ◯ Laterality not specified
- ☐ Vaginal cuff
- ☐ Vaginal nodules
- ☐ Omentum
- ☐ Peritoneal biopsies
- ☐ Peritoneal washings/peritoneal fluid
- ☐ Lymphadenectomy specimen(s)
  - ☐ Sentinel node(s) — ☐ Left ☐ Right ◯ Laterality not specified
  - ☐ Regional node(s): pelvic — ☐ Left ☐ Right ◯ Laterality not specified
  - ☐ Regional node(s): para-aortic
  - ☐ Non-regional node(s): inguinal — ☐ Left ☐ Right ◯ Laterality not specified
  - ☐ Other node group, *specify*
- ☐ Other, *specify*

TUMOUR SITE (select all that apply)

- ☐ Isthmus/lower uterine segment
- ☐ Fundus
- ☐ Body
- ☐ Other, *specify*

MAXIMUM TUMOUR DIMENSION

mm

OMENTUM DIMENSIONS

mm x mm x mm

BLOCK IDENTIFICATION KEY

(List overleaf or separately with an indication of the nature and origin of all tissue blocks)

HISTOLOGICAL TUMOUR TYPE (select all that apply)

(Value list based on the World Health Organization Classification of Female Genital Tumours (2020))

- ☐ Endometrioid carcinoma
- ☐ Serous carcinoma
- ☐ Clear cell carcinoma
- ☐ Carcinoma, undifferentiated
- ☐ Mixed cell carcinoma
- ☐ Mesonephric carcinoma
- ☐ Squamous cell carcinoma
- ☐ Mucinous carcinoma, gastrointestinal type
- ☐ Mesonephric-like carcinoma
- ☐ Neuroendocrine carcinomas
  - Specify subtype
- ☐ Carcinosarcoma NOS → % Epithelial AND % Sarcomatous
  - ◯ Homologous
  - ◯ Heterologous
- ☐ Other, *specify*

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HISTOLOGICAL TUMOUR GRADE

- ◯ Not applicable
- ◯ Cannot be assessed
- ◯ Grade 1 (low)
- ◯ Grade 2 (low)
- ◯ Grade 3 (high)

MYOMETRIAL INVASION

◯ Not identified ◯ <50% ◯ ≥50%

Pattern of myometrial invasion, *specify*

Absolute percentage of myometrial wall thickness invaded by carcinoma ____ %

Distance of myoinvasive tumour to serosa ____ mm

LYMPHOVASCULAR INVASION

- ◯ Indeterminate
- ◯ Not identified
- ◯ Present
  - **Extent of lymphovascular invasion**
    - ◯ Focal
    - ◯ Extensive/Substantial

CERVICAL SURFACE OR CRYPT

- ◯ Not involved
- ◯ Involved

LOWER UTERINE SEGMENT

- ◯ Not involved
- ◯ Involved

CERVICAL STROMA

- ◯ Indeterminate
- ◯ Not involved
- ◯ Involved
  - **Depth of cervical stromal invasion** ____ mm
  - **Percentage of cervical stromal invasion** ____ %

PARAMETRIA[a]

- ◯ Not involved
- ◯ Involved

VAGINA[a]

- ◯ Not involved
- ◯ Involved

OMENTUM[a]

- ◯ Not involved
- ◯ Involved

[a] *If submitted.*

PERITONEAL BIOPSIES[a]

- ◯ Not involved
- ◯ Involved
  - **Site(s) of involvement** (select all that apply)
    - ☐ Pelvic ☐ Abdominal
    - Specify site

PERITONEAL CYTOLOGY

- ◯ Positive
- ◯ Negative
- ◯ Atypical/suspicious

UTERINE SEROSA

- ◯ Not involved
- ◯ Involved

ADNEXA[a]

- ◯ Not involved
- ◯ Involved
  - **Site(s) of involvement** (select all that apply)
    - ☐ Ovary(ies)
      - ☐ Left ☐ Right ◯ Laterality not specified
    - ☐ Fallopian tube(s)
      - ☐ Left ☐ Right ◯ Laterality not specified
    - Describe involvement (e.g., musocal)

[a] *If submitted.*

MARGIN STATUS

(Applicable only if appropriate anatomical structures submitted)

Paracervical soft tissue margin

- ◯ Cannot be assessed
- ◯ Not involved
  - Distance of tumour to closest margin ____ mm
- ◯ Involved

Ectocervical/vaginal cuff margin

- ◯ Cannot be assessed
- ◯ Not involved
  - Distance of tumour to closest margin ____ mm
- ◯ Involved

BACKGROUND ENDOMETRIUM (select all that apply)

- ☐ Cyclical
- ☐ Atrophic/inactive
- ☐ Hyperplasia without atypia
- ☐ Atypical hyperplasia/endometrioid intraepithelial neoplasia
- ☐ Other, *specify*

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LYMPH NODE STATUS

- ◯ Cannot be assessed
- ◯ No nodes submitted or found

Maximum dimension of largest deposit in regional node

mm

Extranodal spread

- ◯ Not identified
- ◯ Present

Lymph node type	Laterality	Number of lymph nodes[b]	Number of lymph nodes with isolated tumour cells[b,c]	Number of lymph nodes with micrometastasis[b,d]	Number of lymph nodes with macrometastasis[b,d]
Sentinel node(s)	**Left**				
	Right				
Regional node(s): pelvic	**Left**				
	Right				
Regional node(s): para-aortic					

[b] *If the actual number of lymph nodes examined or the number of positive nodes cannot be determined due, for example, to fragmentation, then this should be indicated in the response.*

[c] *Isolated tumour cells (≤0.2 mm and ≤200 cells).*

[d] *Micrometastasis (>0.2 mm and ≤2 mm); Macrometastasis (>2 mm).*

ANCILLARY STUDIES

- ◯ Not performed
- ◯ Performed (select all that apply)
  - ☐ Mismatch repair testing, *specify*
  - ☐ Immunohistochemistry, *specify test(s) and result(s)*
  - ☐ Molecular findings, *specify test(s) and result(s)*
  - ☐ TCGA-based molecular classification, *specify*
  - ☐ Other, *record test(s), methodology and result(s)*

Representative blocks for ancillary studies, *specify those blocks best representing tumour and/or normal tissue for further study*

PATHOLOGICALLY CONFIRMED DISTANT METASTASIS

(Report when tissue submitted for evaluation)

- ◯ Not identified
- ◯ Present, *specify site(s)*

PROVISIONAL PATHOLOGICAL STAGING

FIGO (2023 edition)[c,d,e]

- ◯ I Confined to the uterine corpus and ovary[f]
  - ◯ IA Disease limited to the endometrium OR non-aggressive histological type, i.e., low grade endometrioid, with invasion of less than half of myometrium with no or focal lymphovascular space involvement (LVSI) OR good prognosis disease
    - ◯ IA1 Non-aggressive histological type limited to an endometrial polyp OR confined to the endometrium
    - ◯ IA2 Non-aggressive histological types involving less than half of the myometrium with no or focal LVSI
    - ◯ IA3 Low grade endometrioid carcinomas limited to the uterus and ovary[f]
  - ◯ IB Non-aggressive histological types with invasion of half or more of the myometrium, and with no or focal LVSI[g]
  - ◯ IC Aggressive histological types[h] limited to a polyp or confined to the endometrium
- ◯ II Invasion of cervical stroma with extrauterine extension OR with substantial LVSI OR aggressive histological types with myometrial invasion
  - ◯ IIA Invasion of the cervical stroma of non-aggressive histological types
  - ◯ IIB Substantial LVSI[g] of non-aggressive histological types
  - ◯ IIC Aggressive histological types[h] with any myometrial involvement
- ◯ III Local and/or regional spread of the tumour of any histological subtype
  - ◯ IIIA Invasion of uterine serosa, adnexa, or both by direct extension or metastasis
    - ◯ IIIA1 Spread to ovary or fallopian tube (except when meeting stage IA3 criteria)[f]
    - ◯ IIIA2 Involvement of submesothelial fibroconnective tissue or the mesothelial layer[i] or spread through the uterine serosa
  - ◯ IIIB Metastasis or direct spread to the vagina and/or to the parametria or pelvic peritoneum
    - ◯ IIIB1 Metastasis or direct spread to the vagina and/or the parametria
    - ◯ IIIB2 Metastasis to the pelvic peritoneum

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PROVISIONAL PATHOLOGICAL STAGING CONT.

FIGO (2023 edition)[c,d,e] cont.

- ◯ IIIC Metastasis to the pelvic or para-aortic lymph nodes or both[j]
  - ◯ IIIC1 Metastasis to the pelvic lymph nodes
    - ◯ IIIC1i Micrometastasis
    - ◯ IIIC1ii Macrometastasis
  - ◯ IIIC2 Metastasis to para-aortic lymph nodes up to the renal vessels, with or without metastasis to the pelvic lymph nodes
    - ◯ IIIC2i Micrometastasis
    - ◯ IIIC2ii Macrometastasis
- ◯ IV Spread to the bladder mucosa and/or intestinal mucosa and/or distance metastsis
  - ◯ IVA Invasion of the bladder mucosa and/or the intestinal/bowel mucosa
  - ◯ IVB Abdominal peritoneal metastasis beyond the pelvis
  - ◯ IVC Distant metastasis, including metastasis to any extra- or intra-abdominal lymph nodes above the renal vessels, lungs, liver, brain, or bone

[c] *Reprinted from Int J Gynaecol Obstet., DOI: 10.1002/ijgo.14923), Berek JS, Matias-Guiu X, Creutzberg C, Fotopoulou C, Gaffney D, Kehoe S, Lindemann K, Mutch D and Concin N, FIGO staging of endometrial cancer:2023, pages 1-12, 2023, with permission from Wiley.*

[d] *Endometrial cancer is surgically staged and pathologically examined. In all stages, the grade of the lesion, the histological type and LVSI must be recorded. If available and feasible, molecular classification testing (POLEmut, MMRd, NSMP, p53abn) is encouraged in all patients with endometrial cancer for prognostic risk-group stratification and as factors that might influence adjuvant and systemic treatment decisions.*

[e] *In early endometrial cancer, the standard surgery is a total hysterectomy with bilateral salpingo-oophorectomy via a minimally invasive laparoscopic approach. Staging procedures include infracolic omentectomy in specific histological subtypes, such as serous and undifferentiated endometrial carcinoma, as well as carcinosarcoma, due to the high risk of microscopic omental metastases. Lymph node staging should be performed in patients with intermediate-high/high-risk patients. Sentinel lymph node (SLN) biopsy is an adequate alternative to systematic lymphadenectomy for staging proposes. SLN biopsy can also be considered in low-/low-intermediate-risk patients to rule out occult lymph node metastases and to identify disease truly confined to the uterus. Thus, the ESGO-ESTRO-ESP guidelines allow an approach of SLN in all patients with endometrial carcinoma, which is endorsed by FIGO. In assumed early endometrial cancer, an SLN biopsy in an adequate alternative to systematic lymphadenectomy in high-intermediate and high-risk cases for the purpose of lymph node staging and can also be considered in low-/intermediate-risk disease to rule out occult lymph node metastases. An SLN biopsy should be done in association with thorough (ultrastaging) staging as it will increase the detection of low-volume disease in lymph nodes.*

[f] *Low grade EECs involving both the endometrium and the ovary are considered to have a good prognosis, and no adjuvant treatment is recommended if all the below criteria are met. Disease limited to low grade endometrioid carcinomas involving the endometrium and ovaries (Stage IA3) must be distinguished from extensive spread of the endometrial carcinoma to the ovary (Stage IIIA1), by the following criteria: (1) no more than superficial myometrial invasion is present (<50%); (2) absence of extensive/substantial LVSI; (3) absence of additional metastases; and (4) the ovarian tumour is unilateral, limited to the ovary, without capsule invasion/rupture (equivalent to pT1a).*

[g] *LVSI as defined in WHO 2021: extensive/substantial, ≥5 vessels involved.*

[h] *Grade and histological type.*

[i] *The consensus of the dataset authors was to replace 'uterine subserosa' with 'submesothelial fibroconnective tissue or the mesothelial layer'.*

[j] *Micrometastases are considered to be metastatic involvement (pN1 (mi)). The prognostic significance of isolated tumour cells (ITCs) is unclear. The presence of ITCs should be documented and is regarded as pN0(i+). According to TNM8, macrometastases are >2 mm in size, micrometastases are >0.2–2 mm and/or >200 cells, and isolated tumour cells are ≤0.2 mm and ≤200 cells. Based on staging established by FIGO and the American Joint Committee on Cancer (AJCC). AJCC Cancer Staging Manual. 8th ed. New York: Springer, 2017.*

TNM Staging (UICC TNM 8th edition 2016)[k]

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

- ☐ m - multiple primary tumours
- ☐ r - recurrent
- ☐ y - post-therapy

Primary tumour (pT)

- ◯ TX[l] Primary tumour can not be assessed
- ◯ T0 No evidence of primary tumour
- ◯ T1 Tumour confined to the corpus uteri[m]
  - ◯ T1a Tumour limited to endometrium or invading less than half of myometrium
  - ◯ T1b Tumour invades one half or more of myometrium
- ◯ T2 Tumour invades cervical stroma, but does not extend beyond the uterus
- ◯ T3 Local and/or regional spread as specified here:
  - ◯ T3a Tumour invades the serosa of the corpus uteri or adnexae (direct extension or metastasis)
  - ◯ T3b Vaginal or parametrial involvement (direct extension or metastasis)
- ◯ T4 Tumour invades bladder/bowel mucosa[n]

Regional lymph nodes (pN)

- ◯ NX[l] Regional lymph nodes cannot be assessed
- ◯ N0 No regional lymph node metastasis
- ◯ N1 Metastasis to pelvic lymph nodes[o]
- ◯ N2 Metastasis to para-aortic lymph nodes with or without metastasis to pelvic lymph nodes[o]

[k] *Reproduced with permission. Source: UICC TNM Classification of Malignant Tumours, 8th Edition, eds by James D. Brierley, Mary K. Gospodarowicz, Christian Wittekind. 2016, Publisher Wiley (incorporating any errata published up until 8th July 2024).*

[l] *TX and NX should be used only if absolutely necessary.*

[m] *Endocervical glandular involvement only should be considered as Stage I.*

[n] *The presence of bullous oedema is not sufficient evidence to classify as T4.*

[o] *Positive cytology has to be reported separately without changing the stage.*

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