RECOMMENDATIONS FOR THE REPORTING OF LARYNGEAL CARCINOMA

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Introduction for ADASP reporting Guidelines

It has been evident for decades that pathology reports are very variable even within a single institution. Standardization of reporting is the optimal way to insure that information necessary for patient management, prognostic and predictive factor assessment, grading, staging, analysis of outcomes and tumor registries is included in pathology reports. In recent years, two societies (first ADASP and then the CAP), have undertaken to publish guidelines for the reporting of common cancers. The CAP assigned multidisciplinary groups of pathologists, surgeons, radiation and medical oncologists to develop the protocols. They were then reviewed by other pathologists and clinicians. After those reviews the protocols were reviewed by multiple CAP committees and finally approved by the Board of Governors.

The ADASP, in contrast, chose a pathologist expert in each field to assemble a group from within the pathology community (with clinician input if desired) to write specific cancer protocols. These were then approved by the ADASP council and subsequently by the membership. Even though both societies began the process at approximately the same time the streamlined approach adopted by the ADASP enabled them to publish years earlier in pathology journals frequented by anatomic pathologists. While the formats are somewhat different, the contents are essentially the same.

The American College of Surgery (ACS) Commission on Cancer (COC) accredits cancer centers in the USA. Recently, the COC decided to require elements, deemed as essential by the CAP, to be described in all pathology reports in their accredited cancer centers as of January 2004. Importantly they do not require that the specific CAP protocols or synoptic reports be utilized. ADASP has updated all of its protocols to comply with the COC requirements in the form of 37 uniform checklists. The checklists use the staging criteria sited in the American Joint Committee on Cancer (AJCC) 2002 staging manual (sixth edition) but include a variety of other references listed in each of the checklists. Moreover, the checklists are formatted for ease of use. They may be used as templates for uniform reporting and are designed to be compatible with voice activated transcription.

The different elements in these revised ADASP Diagnostic Checklists have been divided into *Required* and *Optional* . The term *Required* in this context only signifies compliance with the COC guidelines. ADASP realizes that specimens and practices vary and it will not be possible to report these elements in every case. However, ADASP hopes that pathologists will find these checklists to be useful in daily clinical practice, while facilitating compliance with the new COC requirements.

The checklists are in standard PDF file format, and may be easily downloaded from the ADASP website. They are not to be reproduced, altered or used for commercial purposes without consent from ADASP.

Features recommended to be included in the final report

1. Topography: Type of specimen(s) received (e.g. total or partial larynx, neck contents.

2. Procedure: Total or partial laryngectomy, e.g., supraglottic (horizontal) or hemilaryngectomy (vertical), radical neck dissection

3. Exact site of tumor: supraglottic, subglottic, glottic, see note 1

4. Histologic type: WHO classification recommended, see note 2; comment on no tumor present post-therapy.

5. Histologic grade as appropriate: check grading systems

6. Tumor extent: depth of invasion with respect to landmarks. Comment on neural, vascular, cartilage, pre-epiglottic space and extralaryngeal soft tissue (muscle soft tissue, cartilage) or tracheostomy involvement as well as multifocal growth.

7. Status of surgical margins

8. Lymph node metastases

- size of metastatic node
- number of involved nodes
- level of node involvement
- comment whether or not extranodal spread of tumor is found
- comment on keratin debris as evidence of previous tumor

9. Pre-operative treatment effects on nodes

Features optional for the final report

These are optional because they represent specific institutional preferences or are of inconclusive prognostic significance.

- Interface with stroma; infiltrating, pushing, superficial or deep invasion
- Extent of and location of any dysplasia (including grade)/CIS
- Results of ancillary investigations (i.e., flow cytometry)
- Type or density of inflammatory infiltrate
- Distance from surgical margins

Features contained in a good gross description

1. **How the specimen was received:** fresh, in formalin, opened by surgeon or pathologist, unopened, etc.
2. **How the specimen was identified:** labeled (with name, number) and anatomic site designation as, e.g., right partial vertical laryngectomy, modified neck dissection, etc.
3. **Describe portions of the larynx included with specimen including other structure that may be attached:** hyoid bone, adjacent, pharynx, thyroid and parathyroid glands and tracheal rings.

4. **Tumor description**

    - size (Greatest dimension is required by Commission on Cancer, 3 dimensions are recommended)
    - shape (ulcerating, exophytic, polypoid)
    - color
    - necrosis
    - multifocal growth

5. **Location of tumor:** Describe all anatomic structures involved including ventricles, which cords, right and/or left, true and/or false cord (specify clearly). Distance above and/or below false and true cords respectively. Involvement of aryepiglottic folds. Does tumor cross midline or extend more than 1 cm from below true vocal cord? If tumor crosses the midline, estimate the percentage of tumor on right and left sides. Is there submucosal spread?

6. **Depth of invasion, involvement of cartilage:** note specific cartilages involved

7. **Involvement of extralaryngeal structures, thyroid soft tissue, prelaryngeal (Delphian) lymph node, and parathyroid glands**

8. **Describe tracheotomy site if present.** Presence of absence of tumor.

9. **Lymph node dissection if included:**

    - Type: extended radical, radical, or modified radical or selective

- Inclusion of sternomastoid muscle/submandibular and/or parotid gland/jugular vein
- Palpable mass (solitary, matted)
- Size and location of gross invasion of adjacent soft tissues, muscle, and jugular vein
- Measure and described sternomastoid muscle, major salivary glands, and internal jugular vein
- Label lymph nodes as to levels as according to anatomic location in neck dissection.

References

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