KEMENTERIAN KESIHATAN MALAYSIA
PERKHIDMATAN PATOLOGI

HOSPITAL .....

REPORTING PROFORMA FOR ENDOMETRIAL CANCER

NAME :
HPE NO :
NRIC :

CLINICAL INFORMATION:

Age, menopausal status
Symptoms & ultrasound findings
Relevant previous history, previous biopsy
Hormonal status
Other clinical information

1.0 MACROSCOPIC DESCRIPTION:

Specimen labelled as:

1.1 Type of specimen:

- □ Not specified
- □ Hysterectomy
  - o Simple
  - o Simple supracervical/subtotal
  - o Radical
  - o Type not specified
- □ Other procedure, specify type:_____

1.2 Specimen integrity:

- □ Intact
- □ Opened
- □ Morcellated
- □ Other:_____

1.3 Weight of specimen:

1.4 Measurements:

Uterus: (length x transverse x anteroposterior)
Cervix:
Right fallopian tube:
Right ovary:
Left fallopian tube:
Left ovary:
Vaginal cuff (if available):
Parametrium (if available):

1.5 Tumour assessment (Uterus)

Site: Isthmus/ Lower uterine segment/ Fundus/ Body/ Others:____

(Anatomically, the lower uterine segment begins where the body funnels towards the cervix and ends at the internal os. The fundus is that part of the uterus above the origin of the fallopian tubes. Endometrial carcinoma involving the lower uterine segment has several implications. Tumours originating in this location are more frequently associated with mismatch repair (MMR) protein deficiencies. Lower uterine segment involvement in early endometrial carcinoma is predictive of lymph node metastasis and is an independent poor prognostic factor for distant recurrence and death.)

Size of tumour:_____(largest dimension & macroscopic or microscopic assessment or the combination of both)

Appearance of tumour:

- □ Endophytic
- □ Exophytic
- □ Haemorrhagic
- □ Necrotic

Involvement of myometrium by tumour:

- □ <50%
- □ >50%

Greatest depth of tumour invasion:_____ mm

Total myometrial thickness:_____ mm

Thickness of normal (uninvolved) myometrial wall:_____mm

Sampling: one section per 10 millimetres. An alternative, when dealing with large tumours, at least four blocks of tumour. However, the entire endometrium and underlying inner myometrium should be submitted for microscopic examination in the setting of a preoperative endometrial specimen demonstrating malignancy, when no gross lesion is seen in the hysterectomy specimen. Submit at least one section that depicts any exophytic

component, the most myoinvasive component, and an adjacent non-involved endomyometrial junction.

1.6 Cervix: specify if in continuity with endometrial lesions

- □ Maximum depth of cervical stroma invasion:_____mm
- □ Distance from inferior surgical margin:_____mm

1.7 Attached anatomical structures:

- □ Right Ovary:_____
- □ Left ovary:_____
- □ Right fallopian tube: _____
- □ Left fallopian tube: _____
- □ Right parametrium: _____
- □ Left parametrium:_____

1.8 Omentum: _____(Dimension)

The omentum should be cut at 5 millimetre intervals to detect small lesions. Obvious lesions can be sampled in one or two blocks but if no lesion is seen then at least four blocks are recommended.

1.8 Peritoneal biopsy: Yes:_____mm / No

1.9. Involvement of other organs/ tissues: if yes please specify: _____

1.10 Other lesions/ abnormalities:

- □ Polyp
- □ Adenomyosis
- □ Leiomyoma
- □ Endometriosis
- □ Others:_____

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

MICROSCOPIC

2.0 MICROSCOPIC DESCRIPTION:

2.1 Histological Tumour Type (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 _____% Sarcomatous (Homologous/ Heterologous)

- □ Other:_____

2.2 Histological Tumour Grade:

- □ Not applicable (Entities that are high grade by definition)
- □ Cannot be assessed. (Histological grade may be difficult to apply for cases (especially hysterectomy specimens) in which the specimen was inappropriately fixed and/or the tumour is autolysed)
- □ Grade 1 (low)
- □ Grade 2 (low)

- □ Grade 3 (high)

2.3 Myometrial invasion:

- □ Not identified
- □ <50%
- □ ≥50%

Distance of myoinvasive tumour to serosa: _____ mm

2.4 Lymphovascular invasion:

- □ Indeterminate
- □ Not identified
- □ Present (extent of lymphovascular invasion:
  - □ Focal (<5 vessels)
  - □ Extensive/ substantial (≥ 5 vessels; WHO Female Genital Tumours, 5th edition)

2.5 Involvement of:

- Lower uterine segment:

- □ Not involved
- □ Involved
- □ Indeterminate:_____

- Uterine serosa: (*tumour infiltrating the full myometrial thickness and reaching the submesothelial fibroconnective tissue or the mesothelial layer)*

- □ Not involved
- □ Involved
- □ Indeterminate:_____

- Cervical stroma:
- □ Not involved
- □ Involved (Depth of cervical stromal invasion/ inner half/ outer half)
- □ Indeterminate:_____

- Vagina:

- □ Not applicable/ not submitted
- □ Not involved
- □ Involved

- Adnexa :
- □ Not applicable/ not submitted
- □ Not involved
- □ Involved:

  - Ovary: site (right/ left/ laterality not specified)
  - Fallopian tube(s) (right/left): site(s) of involvement: serosal/ mucosal)

- Parametrium:

□ Not applicable/ not submitted
□ Not involved
□ Involved

- Omentum:

□ Not applicable/ not submitted
□ Not involved
□ Involved

- Peritoneal biopsies:

□ Not applicable/ not submitted
□ Not involved
□ Involved (site(s) of involvement- pelvic/ abdominal

2.5 Margin status (applicable if cervix and/ or parametrium/ paracervix is involved):

It is important to record the status of paracervical soft tissue and ectocervical/vaginal cuff margins, and this is a core reporting element. The term paracervical soft tissue refers to the small part of the parametrium that is included in simple hysterectomy specimens, which is the common surgical procedure for endometrial carcinoma

- Parametrial/ paracervical soft tissue margin:
  - □ Not applicable/ cannot be assessed
  - □ Not involved (distance of tumour to closest margin:____ mm)
  - □ Involved
- Ectocervical/ vaginal cuff margin:
  - □ Not applicable/ cannot be assessed
  - □ Not involved (distance of tumour to closest margin:____ mm)
  - □ Involved

2.6 Background endometrium:

□ Cyclical
□ Atrophic or inactive
□ Hyperplasia without atypia
□ Atypical hyperplasia/ endometrioid intraepithelial neoplasia
□ Others: _____

2.7 Lymph node status (Total retrieved/ Involvement by malignancy):

- Right pelvic lymph nodes:

□ Cannot be assessed/ No nodes submitted
□ Negative:
□ Positive:
(maximum dimension of largest deposit in regional node:____ mm)

Grossing of the lymph nodes is an important step for a thorough histologic evaluation. Lymph nodes up to 2 mm are embedded whole. If lymph nodes are larger than 2 mm, they should be sliced perpendicular to the long axis at 2 to 3 mm intervals and entirely submitted.

- Left pelvic lymph nodes:
□ Cannot be assessed/ No nodes submitted
□ Negative:
□ Positive:
(maximum dimension of largest deposit in regional node:____ mm)

- Other lymph nodes:_____
□ Cannot be assessed/ No nodes submitted
□ Negative:
□ Positive:
(maximum dimension of largest deposit in regional node:____ mm)

(Macrometastases: >2mm, Micrometastases: >0.2-2mm and/or >200 cells, presence of isolated tumour cells <0.2mm and <200 tumour cells in regional lymph node(s) are not considered metastatic, not included in FIGO 2023 and in TNM are regarded as pN0(i+))

2.8 Ancillary studies: Performed/ Not performed (Block no)

- Mismatch repair testing: _____
- Immunohistochemistry:_____
- Molecular findings:_____
- TCGA-based molecular classification:_____
- Other:_____

Testing for MMR status/microsatellite instability (MSI) in endometrial carcinoma patients has been shown to be important for four key reasons:

1. *Diagnostic, since MMRd/MSI is helpful to diagnose endometrioid carcinomas (as opposed to serous carcinoma or human papillomavirus (HPV)-associated cervical carcinoma);*
2. *It is part of the screening algorithm to identify potential patients with Lynch syndrome;[6]*
3. *Prognostic, as part of the TCGA surrogate molecular classification;[7] and*
4. *Therapeutically as a predictive biomarker for potential utility of immune checkpoint inhibitor therapy.[8]*

In an attempt to bring the TCGA molecular-based classification into clinical practice, different groups have proposed a surrogate (simplified) algorithm precluding comprehensive tumour profiling.[7,29,30] The algorithm includes three immunohistochemical markers (p53, MSH6 and PMS2) and one molecular test (mutation analysis of POLE).

2.9 Pathologically confirmed distant metastasis: (Report when has tissue submitted for evaluation) :

- □ Not applicable
- □ Not identified
- □ Present: specify site:_____

3.0 Provisional pathological staging: (depending on respective gynaeoncology requirement):

FIGO 2009:

- □ IA / IB
- □ II
- □ IIIA / IIIB / IIIC1/ IIIC2
- □ IVA / IVB

FIGO 2023:

- □ IA/ IB / IC
- □ IIA / IIB / IIC
- □ IIIA / IIIB / IIIC
- □ IVA / IVB / IVC

INTERPRETATION:

3.1 Tumour Type:

3.2 Tumour Grade:

3.3 Status MMR and p53: (if available)

3.4 Lymphovascular space invasion (LVSI):

3.5 Any relevant positive findings: (cervix, parametrium, uterine serosa and adnexal involvement)

3.6 Provisional pathology staging

Rujukan:

1. Endometrial Cancer Histopathology Reporting Guide, International Collaboration on Cancer Reporting (ICCR), Version 5.0, August 2024.
2. Protocol for the examination of specimens from patients with carcinoma and carcinosarcoma of endometrium, Version 4, 2020