College of American Pathologists
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Advancing Excellence

January 6, 2009

Frederick L. Greene, MD, FACS, Chair
American College of Surgeons, Commission on Cancer
633 N. Saint Clair St.
Chicago, IL 60611

Dear Dr. Greene:

The College of American Pathologists (CAP) applauds and supports the Commission on Cancer's (COC) initiative to motivate cancer centers to incorporate a synopsis of cancer pathology staging, prognostic and predictive parameters (CAP protocol endorsed scientifically validated data elements – SVDE) into their reports by offering commendation status in COC Standard 4.6. The following definitions and examples attempt to create guidelines for writing, reading, and inspecting pathology reports. Standard 4.6 allows traditional narrative style reporting in addition to, but not instead of, synoptic style reporting in which the required SVDE defined in the published CAP Cancer Protocols are listed.

The CAP has developed this list of specific features that define *synoptic* reporting formatting:

1. Data is displayed as the required checklist item (SVDE) followed by its answer (response), e.g. "Tumor Size: 5.5 cm".
2. Each diagnostic parameter pair (checklist SVDE: response) is listed on a separate line.
3. The synopsis can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all SVDE and responses must be listed together in one location.
4. Additional items (not required for the CAP checklist) may be included in the synopsis but all required SVDE must be present.
5. Narrative style comments are permitted in addition to, but are not as a substitute for the synoptic reporting. It is not uncommon for narrative style comments to be used for clinical history, gross descriptions and microscopic descriptions.

The CAP has developed a few examples of synoptic reporting and I have included these for the use of the COC as training tools for COC inspectors. Sample reports 1 and 2 are examples of acceptable synoptic reporting; Sample reports 3 and 4 do not show acceptable synoptic style reporting. We would recommend that CoC surveyors focus their evaluation of synoptic reporting only on definitive resection specimens and not biopsies at this time.

To make this important transition more effective the College of American Pathologists Cancer Committee, along with the Diagnostic Intelligence and Health Information Technology Committee, offer to form an ad-hoc review panel for cancer centers who may want to submit up to 3 cases to ensure if they conform to the synoptic reporting format.

Sincerely,

Mahul B. Amin, MD
Cancer Committee Chair

cc: John F. Madden MD PhD, Monica de Baca MD, Thomas M. Wheeler MD,
Paul N. Valenstein MD

Pathology Report Sample 1
NAME: JIM DOE

DIAGNOSIS SECTION:

KIDNEY (LEFT): ADENOCARCINOMA

MACROSCOPIC
SPECIMEN TYPE: Radical Nephrectomy
LATERALITY: Left
TUMOR SITE: Upper pole
FOCALITY: Unifocal
TUMOR SIZE: Greatest dimension is 7.2 cm
MACROSCOPIC EXTENT OF TUMOR: Tumor extends into major veins

MICROSCOPIC
HISTOLOGIC TYPE: Clear cell (conventional) renal carcinoma
HISTOLOGIC GRADE: (Furhman Nuclear Grade): 2

PATHOLOGIC STAGING (pTN)
PRIMARY TUMOR (pT): pT3
REGIONAL LYMPH NODES (pN): Nx
Number of lymph nodes examined: 0
Number of lymph nodes involved: 0
MARGINS: Renal vein margin positive
ADRENAL GLAND: Univolved
VENOUS (LARGE VESSEL) INVASION (V)(excluding renal vein and inferior vena cava): Negative
LYMPHATIC (SMALL VESSEL) INVASION (L): present
ADDITIONAL PATHOLOGIC FINDINGS: Chronic glomerulonephritis present in non-involved renal parenchyma.

CLINICAL HISTORY: A 76 year old male with a left renal mass in the upper pole; hematuria

GROSS DESCRIPTION SECTION: Received in formalin, labeled “left kidney” is a 12.2 x 7.1 x 2.5 cm kidney with unremarkable perirenal fat present at the upper pole (suture oriented, per requisition). A 2.3 cm in length segment of ureter exits from the hilum. The renal vein appears occluded. The cut sections demonstrate a 7.2 x 1.5 x1.5 cm brown-orange circumscribed tumor with sharp borders present in the upper pole. Gerota’s fascia appears uninvolved. The tumor extends into the renal vein; the venous margin appears positive for tumor.

MICROSCOPIC SECTION: Microscopic examination performed.

ACCEPTABLE AS SYNOPTIC STYLE REPORTING

Pathology Report Sample 2
Name: John Doe

History: 79 year old male with dyspepsia and weight loss. A recent supraclavicular lymph node biopsy revealed signet ring cell adenocarcinoma

Gross Description: Received in formalin is a 10.0 x 6.5 x 3.2 cm segment of stomach, with a palpable firm 4.0 x 2.2 cm mass on the designated lesser curvature. The external surface of the specimen is unremarkable and inked black. The cut surfaces demonstrate the mass and adjacent firm areas of nodularity. The remainder of the gastric mucosa is unremarkable. Six lymph node candidates and representative sections of the stomach are submitted.

Microscopic description: Microscopic examination was performed. See synoptic report. The uninvolved stomach shows chronic inactive gastritis with intestinal metaplasia.

DIAGNOSIS: Stomach (proximal): Invasive adenocarcinoma

SPECIMEN TYPE: Stomach, partial gastrectomy, proximal
TUMOR SITE: Lesser curvature
TUMOR CONFIGURATION: Diffusely infiltrative
TUMOR SIZE: 4 cm in greatest dimension
HISTOLOGIC TYPE: Signet ring cell carcinoma
HISTOLOGIC GRADE: See comment below
MARGINS
- PROXIMAL: Negative
- DISTAL: Negative
- RADIAL: Negative
- DISTANCE OF INVASIVE CARCINOMA FROM NEAREST MARGIN: 3 mm, radial

LYMPHATIC INVASION: Present
LARGE VESSEL INVASION: Absent
PERINEURAL INVASION: Present

PATHOLOGIC STAGING (pTN):
PRIMARY TUMOR: pT2a (tumor invades muscularis propria)
REGIONAL LYMPH NODES: pN1
- Number examined: 6
- Number involved: 5

DISTANT METASTASIS: pM1
- See report S2343 (non-regional lymph node metastasis)

COMMENT: Signet-ring cell carcinomas are not typically graded but are high-grade and would correspond to grade 3.

ACCEPTABLE AS SYNOPTIC STYLE REPORTING

Pathology Report Sample 3
Name: Jane Doe

History: 76 y/o female with colonic mass

DIAGNOSIS:

Invasive adenocarcinoma, 3.4 x 3.0 cm involving muscularis propria
All margins negative
No lymphatic invasion
No metastatic tumor identified.

GROSS DESCRIPTION: Received fresh is a right colon 32 cm in length. Upon opening of the specimen, there is a 3.4 x 3.0 cm nodular mass. 36 lymph nodes were retrieved. Representative sections are submitted.

MICROSCOPIC DESCRIPTION: Microscopic examination performed.

NOT ACCEPTABLE AS SYNOPTIC STYLE REPORTING, NOT ALL ELEMENTS ARE PRESENT

Pathology Report Sample 4
NAME: JANIS DOE

DIAGNOSIS:

KIDNEY, LEFT (RADICAL NEPHRECTOMY):

Clear cell adenocarcinoma, Furhman nuclear grade 3, 8.3 cm, unifocal involving upper pole of kidney and extending into the renal vein with the renal vein margin positive.

No lymph nodes submitted, adrenal gland uninvolved, lymphatic invasion present, no venous large vessel invasion, pT3, Nx.

CLINICAL HISTORY: A 86 year old female with a left renal mass in the upper pole

GROSS DESCRIPTION SECTION: Received in formalin, labeled "left kidney" is a 14.5 x 7.1 x 2.5 cm kidney with unremarkable perirenal fat present at the upper pole (suture oriented, per requisition). A 5.3 cm in length segment of ureter exits from the hilum. The renal vein appears occluded. The cut sections of the specimen demonstrate a 8.3 x 2.5 x1.5 cm tan-orange partially circumscribed tumor with sharp borders and central hemorrhage present in the upper pole. Gerota's fascia appears uninvolved. The tumor extends into the renal vein; the venous margin appears positive for tumor. The remainder of the kidney is unremarkable.

MICROSCOPIC SECTION: Microscopic examination performed.

ALTHOUGH ALL ELEMENTS ARE PRESENT, NOT ACCEPTABLE AS SYNOPTIC STYLE REPORTING