Rapportage standardisé excision ganglionnaire et dissection cervicale pour tumeurs tête et cou

Conclusion

Thérapie néoadjuvante : Choisissez une option.

Stations ganglionnaires soumises[1] :

Gauche :

Droite :

Compartiment central :

Autre :

Localisation tumeur primaire : Choisissez une option.

Si connue, spécifiez :

Type histologique de la tumeur :

Carcinome épidermoïde : Choisissez une option.

Carcinome nasopharyngé : Choisissez une option.

Carcinome des glandes salivaires : Choisissez une option.

Si possible, spécifiez le type :

Autre : Choisissez une option.

Spécifiez le type de tumeur :

Degré de différenciation : Choisissez une option.

Si non évaluable, spécifiez :

[1] Veuillez utiliser la terminologie correcte pour décrire les stations ganglionnaires soumises : niveau IA (sub-mentale), IB (sub-mandibulaire), II (jugulaire supérieure), III (jugulaire moyenne), IV (jugulaire inférieure) et V (cervicale postérieure), VI (compartiment central : prétrachéale/paratrachéale) et VII (médiastinale).

Atteinte de la marge chirurgicale périnodale par du carcinome invasif : Choisissez une option.

Si non atteinte, spécifiez la localisation de la marge minimale (si possible) :

Si atteinte :

Spécifiez le côté : Choisissez une option.

Spécifiez le niveau/compartiment :

Si non évaluable, spécifiez :

Si autre, spécifiez :

** A compléter seulement si des ganglions lymphatiques du côté gauche ont été retirés :*

Niveau IA gauche (groupe ganglionnaire sub-mental) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau IB gauche (groupe ganglionnaire sub-mandibulaire) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau II gauche (groupe ganglionnaire jugulaire supérieur)[2] : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau III gauche (groupe ganglionnaire jugulaire moyen)[2] : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

[2] Pour les ganglions présentant seulement une métastase de niveau II ou III provenant d'un carcinome épidermoïde d'origine primitive inconnue, il est indispensable de réaliser une coloration p16, notamment si la tumeur n'est pas kératinisante. Si ces groupes ganglionnaires sont évalués, une coloration p16 doit être réalisée. Veuillez indiquer les résultats de cette coloration dans la variable « Analyses complémentaires ».

Niveau IV gauche (groupe ganglionnaire jugulaire inférieur) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau V gauche (groupe ganglionnaire cervical postérieur) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Taille maximale de la plus grande métastase ganglionnaire (en mm) :

Taille maximale du plus grand ganglion lymphatique atteint (en mm) :

Métastases dans les tissus mous : Choisissez une option.

Si métastases dans les tissus mous, spécifiez la localisation (niveau) :

Atteinte de structures non lymphatiques : Choisissez une option.

Atteinte d'un vaisseau sanguin : Choisissez une option.

Spécifiez le nom du vaisseau sanguin, si possible :

Atteinte d'un nerf : Choisissez une option.

Spécifiez le nom du nerf, si possible :

Atteinte d'un muscle squelettique : Choisissez une option.

Spécifiez le nom du muscle squelettique, si possible :

Atteinte d'autres structures : Choisissez une option.

Spécifiez :

** A compléter seulement si des ganglions lymphatiques du côté droit ont été retirés :*

Niveau IA droit (groupe ganglionnaire sub-mental) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau IB droit (groupe ganglionnaire sub-mandibulaire) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau II droit (groupe ganglionnaire jugulaire supérieur)[3] : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau III droit (groupe ganglionnaire jugulaire moyen)[3] : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Niveau IV droit (groupe ganglionnaire jugulaire inférieur) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

[3] Pour les ganglions présentant seulement une métastase de niveau II ou III provenant d'un carcinome épidermoïde d'origine primitive inconnue, il est indispensable de réaliser une coloration p16, notamment si la tumeur n'est pas kératinisante. Si ces groupes ganglionnaires sont évalués, une coloration p16 doit être réalisée. Veuillez indiquer les résultats de cette coloration dans la variable « Analyses complémentaires ».

Niveau V droit (groupe ganglionnaire cervical postérieur) : Choisissez une option.

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Taille maximale de la plus grande métastase ganglionnaire (en mm) :

Taille maximale du plus grand ganglion lymphatique atteint (en mm) :

Métastases dans les tissus mous : Choisissez une option.

Si métastases dans les tissus mous, spécifiez la localisation (niveau) :

Atteinte de structures non lymphatiques : Choisissez une option.

Atteinte d'un vaisseau sanguin : Choisissez une option.

Spécifiez le nom du vaisseau sanguin, si possible :

Atteinte d'un nerf : Choisissez une option.

Spécifiez le nom du nerf, si possible :

Atteinte d'un muscle squelettique : Choisissez une option.

Spécifiez le nom du muscle squelettique, si possible :

Atteinte d'autres structures : Choisissez une option.

Spécifiez :

** A compléter seulement si des ganglions lymphatiques du compartiment central ont été retirés :*

Nombre de ganglions examinés :

Nombre de ganglions positifs :

Extension extra ganglionnaire : Choisissez une option.

Taille maximale de la plus grande métastase ganglionnaire (en mm) :

Taille maximale du plus grand ganglion lymphatique atteint (en mm) :

Métastases dans les tissus mous : Choisissez une option.

Si métastases dans les tissus mous, spécifiez la localisation (niveau) :

Atteinte de structures non lymphatiques : Choisissez une option.

Atteinte d'un vaisseau sanguin : Choisissez une option.

Spécifiez le nom du vaisseau sanguin, si possible :

Atteinte d'un nerf : Choisissez une option.

Spécifiez le nom du nerf, si possible :

Atteinte d'un muscle squelettique : Choisissez une option.

Spécifiez le nom du muscle squelettique, si possible :

Atteinte d'autres structures : Choisissez une option.

Spécifiez :

Analyses complémentaires : Choisissez une option.

Si test HPV, spécifiez la méthode et les résultats :

Si test EBV, spécifiez la méthode et les résultats :

Classification pTNM (8ème édition du TNM de l'UICC, avec errata)[4] : pN

Choisissez la classification d'application :

Carcinomes primitifs de la lèvre et de la cavité buccale, des glandes salivaires principales, de la cavité nasale et des sinus paranasaux, de l'oropharynx p16 négatifs, de l'hypopharynx, du larynx, carcinomes cutanés tête et cou (exceptés les carcinomes à cellules de Merkel) et carcinomes épidermoïdes d'origine primitive inconnue p16 négatifs et EBV négatifs : Choisissez une option.

Carcinome oropharyngé p16 positif : Choisissez une option.

Carcinome du nasopharynx : Choisissez une option.

Mélanome muqueux : Choisissez une option.

Préfixes :

r (récidive) : Choisissez une option.

y (après thérapie néoadjuvante) : Choisissez une option.

[4] La stadification pathologique est basée sur la 'TNM Classification of Malignant Tumours' (8ème édition, UICC). Une description de chaque catégorie pN est disponible dans la 'Note 6 – Regional lymph node categorisation' plus bas dans ce document.

Champ d'application

Résections ganglionnaires et dissections cervicales chez des patients atteints de carcinomes primitifs et de mélanomes muqueux tête et cou. Sont compris dans les mélanomes ceux du tractus nasosinusien, du nasopharynx, de la cavité buccale, de l'oropharynx, de l'hypopharynx, du larynx et de la trachée, des glandes salivaires principales et accessoires, de l'oreille et de l'os temporal. Les résections ganglionnaires et les dissections cervicales pour les tumeurs neuroendocrines (grade 1, 2 et 3) et les carcinomes neuroendocriniens sont également incluses dans ce dataset, de même que les mélanomes et les carcinomes cutanés (exceptés les carcinomes à cellules de Merkel).

Remarques :

- Les résections ganglionnaires pour les lymphomes et les sarcomes ne sont pas incluses dans ce dataset.
- Ce dataset n'est pas prévu pour les biopsies ou aspirations à l'aiguille fine d'un ganglion.
- Pour des résections relatives à des récidives, le dataset peut être utilisé de manière pragmatique, même si certaines variables peuvent ne pas être applicables ou évaluables.
- Ce dataset doit être utilisé en combinaison avec d'autres datasets de l'ICCR sur les tumeurs tête et cou. Les résections ganglionnaires et dissections cervicales peuvent précéder, accompagner ou suivre la biopsie ou la résection d'une tumeur primaire. Il est préférable de rapporter simultanément les variables des datasets des ganglions et de la tumeur primaire, étant donné que cela fournit aux cliniciens les informations les plus complètes pour leur permettre de catégoriser le stade de la tumeur.
- Les pathologistes doivent tenir compte de l'influence des interventions antérieures (par exemple une biopsie ganglionnaire diagnostique antérieure chez un patient présentant une masse cervicale) pour la détermination de la catégorie pN, et se référer au prélèvement histopathologique chirurgical antérieur, s'il est disponible. De même, les dissections cervicales peuvent être réalisées en tant que procédure de 'sauvetage' après radiothérapie et/ou chimiothérapie. Des procédures adjuvantes et néoadjuvantes peuvent avoir une influence sur la catégorie pN en réduisant la taille de la tumeur, ou même en la supprimant complètement.

Dataset basé sur

Bullock M, Carlson DL, Fonseca I, Katabi N, Taylor SM, Thavaraj S, Williams MD, Helliwell T, Thompson LDR (2024). *Nodal Excisions and Neck Dissection Specimens for Head and Neck Tumours Histopathology Reporting Guide. 2nd edition*. International Collaboration on Cancer Reporting; Sydney, Australia. ISBN: 978-1-922324-49-8.

Informations complémentaires[5]

Note 1 – Histological tumour type

Primary tumour site is a core item as it is relevant to both treatment and prognosis. Identification of the histological tumour type is crucial for several reasons, including: 1) confirmation that a metastasis is of the same type as the resected primary tumour; 2) facilitating a clinical search in cases of unknown primary tumours; 3) determining the correct T and N categories; and 4) guiding treatment, which varies by tumour type and lymph node status.[18,19]

Histological type is typically determined from the histology at the primary site, but this is not possible for tumours of unknown origin. Tissue from a neck metastasis may be required for ancillary testing (e.g., p16 immunohistochemistry, in situ hybridisation for high risk human papillomavirus (HPV), in situ hybridisation for Epstein Barr virus (EBV) encoded RNA/EBER). For patients with occult primary SSC in level II or III, the cN or pN categories are influenced by EBV and HPV status.[24] EBV-associated and HPV-associated carcinomas are given the N category that applies to nasopharyngeal and HPV-associated oropharyngeal carcinomas, respectively.[18,19]

Verrucous carcinoma and carcinoma cuniculatum are not included in the above list of squamous cell carcinoma (SSC) subtypes, as they are not considered SCC subtypes in the WHO Classification and they have no capacity to metastasise to lymph nodes.

The classification system for Neuroendocrine neoplasms (subdivided into tumours and carcinomas) is included, as per the most recent edition of the WHO Classification of Head and Neck Tumours, 5th edition, 2024.[2]

Note 2 – Histological tumour grade

When possible, tumour grade should be determined from the primary tumour, not from a metastasis. Some tumours are high grade or undifferentiated by definition (e.g., non-keratinising nasopharyngeal carcinoma (NPC)), while others do not require grading because behaviour is defined by pathogenesis and is not apparently influenced by morphology (e.g., HPV-associated orpharyngeal carcinoma). For most malignancies, the WHO grading system is most practical and widely utilised. Still, several grading systems are available for many tumours (e.g., mucoepidermoid carcinoma), with differing merits, and as such, recording which system has been applied is more clinically meaningfully (use 'specify' to state the system used).

Note 3 – Margin status

Margin status of the neck dissection is typically only relevant when extranodal extension (ENE) is

[5] Informations complémentaires ('notes') tirées et adaptées de
Bullock M, Carlson DL, Fonseca I, Katabi N, Taylor SM, Thavaraj S, Williams MD, Helliwell T, Thompson LDR (2024). Nodal Excisions and Neck Dissection Specimens for Head and Neck Tumours Histopathology Reporting Guide. 2nd edition. International Collaboration on Cancer Reporting; Sydney, Australia. ISBN: 978-1-922324-49-8.

present, as nodes without ENE are presumed to be removed in toto. Clinical correlation and orientation by the surgeon is required if the neck dissection is received as multiple specimens, so as to avoid a misinterpretation of the location of the true surgical margin.

Margin positivity increases the risk of local recurrence and is an indication for additional radiotherapy to that site.[25-27] The site of margin positivity can be used by the radiation oncologist to direct treatment to the area of greatest risk.

Note 4 – Lymph node status

Lymph node status may be presented in tabular form for ease of interpretation, as illustrated in the reporting guide.

For cases in which an involved lymph node or tumour deposit straddles more than one lymph node level, it is recommended to include it in the level in which the bulk of the deposit is found, with an explanatory comment. In other cases, it may not be possible to precisely divide the neck dissection into individual levels and more than one level may need to be combined. If a neck dissection is received without any level designation, clarification from the surgeon is suggested. If this is not obtained, the data may be reported without further qualification, such as 'right neck dissection, not further specified'.

'Soft tissue metastasis' refers to a deposit of tumour in connective tissue, without a microscopically identifiable residual lymph node. It does not refer to intralymphatic tumour emboli in adipose tissue surrounding the lymph nodes. Soft tissue metastasis has been found to negatively impact survival in patients who are otherwise node-negative or in those with positive nodes lacking ENE.[28,29] In many cases, a soft tissue metastasis is the largest focus of tumour in the specimen. This is presumed to represent one or more completely replaced lymph nodes and should be recorded as such. Less commonly, small soft tissue metastases (e.g., <1 mm in greatest dimension) are identified that do not appear to be of nodal origin.

Special stains and deeper levels may help to identify a vascular origin for these deposits. The pathologist must use his/her discretion as to their designation as positive lymph nodes, with the use of a clarifying comment.

For tumour deposits in which there is residual lymph node tissue with widespread ENE, a combined gross and microscopic estimate of the number of involved lymph nodes is suggested. Correlation with pre-surgical imaging studies may be of benefit.

The largest metastatic focus may be an intranodal or a soft tissue metastasis. Often, the maximum dimension of the largest metastatic tumour deposit is determined at gross examination of the specimen. Determination of the greatest dimension of a metastasis may be difficult in cases where multiple

microscopic intranodal deposits are identified. Options including measuring the greatest dimension of the largest microscopic deposit, combining the sizes of the deposits to give an aggregate dimension, and measuring the greatest dimension 'end-to-end' from a single slide, including discontinuous tumour deposits. The latter is recommended by the authoring committee.

The maximum dimension of the largest involved lymph node may not be the same as the maximum

dimension of the largest metastatic deposit. For instance, this may be due to the presence of an enlarged reactive lymph node in the tumour basin with a microscopic tumour deposit. Both measurements are considered 'core' items in this dataset so as to avoid confusion, to facilitate correlation with imaging studies and to provide the maximum amount of data that may be relevant for clinical decision-making. The greatest dimension of the largest tumour deposit should be used to determine the pN category. In occasional cases, the largest lymph node in the specimen may not even contain tumour. The pathologist may elect to make a comment to this effect. However, it is not considered a necessary reporting element.

The prognostic significance of isolated tumour cells (ITC) (foci <0.2 mm diameter or <200 cells) and micrometastases (foci 2 mm or less in greatest dimension) is currently unknown for head and neck cancers, and their designation is not required as part of the TNM staging.[18,19,30,31] ITCs are uncommon in metastatic SCC, but may occur in some less common primary tumours (e.g., small cell carcinoma of salivary origin). As such, any sized tumour deposit is considered a positive lymph node for staging purposes.[18,19,32] Specific identification of tumour deposits as ITCs or micrometastases is not required as part of this dataset, but can be recorded as per local requirements for data collection, such as in sentinel node dissections. Mummified cells and keratin debris may be found; it should not be regarded as viable metastatic disease and should be considered pN0 for categorisation purposes.

Neck dissections may be performed as salvage surgery for a persistent neck mass following adjuvant radiation therapy. In this circumstance, only viable tumour – not necrotic keratinous debris or keratin granulomas – should be considered as a positive lymph node. Extra sampling of residual neck deposits may be required to evaluate these specimens. The prefix 'yp' should be added to the TNM category. The presence and number of necrotic lymph nodes should be added.

Non-lymphatic structures involved is a core item referring to the involvement of **named** tissues (such as the spinal accessory nerve, internal jugular vein or sternocleidomastoid muscle) that are identified either by virtue of the specimen designation or in consultation with the surgeon. Clinical or imaging involvement of some extranodal tissues may imply the need for more aggressive neck dissection, and pathological involvement should be documented in the final report.[33]

Emerging evidence suggests that lymph node ratio (the ratio of positive nodes over total number of nodes resected) may be an independent prognostic indicator of survival in metastatic SSCs of the head and neck.[34-36] As yet, insufficient evidence has been gathered to include this as a reporting guide component.

Extranodal extension

Extranodal extension (ENE) refers to extension of tumour outside the capsule of a lymph node and into the perinodal soft tissue. This is the preferred terminology to 'extracapsular extension/spread'. ENE is an adverse prognostic factor for locoregional relapse and survival in cervical node positive head and neck SSCs.[37] The significance of ENE in HPV-associated oropharyngeal carcinoma has been less certain,[19-21] however some evidence confirms the adverse effect on survival in these carcinomas as well.[38,39]

The presence of ENE is an important factor for oncologists when considering treatment with postoperative radiotherapy and the addition of chemotherapy.[38-41]

Extranodal extension (ENE) is subcategorised pathologically as microscopic (ENE_{mi}, less than or equal

to 2 mm in extent) or major (ENE_{ma}, more than 2 mm in extent). These subcategories are not required for pN categorisation but are core items as they can impact treatment decisions,[37] and are relevant for data collection and future analysis. The more precise measurement of greatest extent of ENE in millimetres is a non-core item, as the reproducibility of this measurement is questionable. Certainly, an attempt to be more precise than tenths of a millimetre is not advised.

Interobserver variation in the determination of ENE may be minimised if the following guidance is used:

1. Lymph nodes, especially smaller nodes and those in the parotid area, may not have a complete capsule. The node hilum may merge with adipose tissue, or there may be a rim of lymphoid tissue external to the capsule. Generally speaking, a conservative approach is recommended. For instance, tumour within fat near the hilum of a node should be considered intranodal if benign lymphoid tissue is identified nearby. Tumour within lymphatics near an involved lymph node should not be considered ENE. However, tumour extending beyond a clearly identifiable node capsule is extranodal, even if there is a surrounding lymphoid response. A stromal desmoplastic reaction is not necessarily required.

2. Grossly 'matted' lymph nodes. Grossly adherent lymph nodes may represent true macroscopic ENE or several closely aggregated lymph nodes with thickened nodal capsules without microscopic evidence of ENE. Additional levels and sections are recommended to exclude ENE. The presence of matted nodes, their site, size and an estimated of the number involved, should be included in the gross description and may be mentioned in a comment. One study has found that radiographically matted lymph nodes are a risk factor for distant metastases and decreased survival in oropharyngeal cancer.[42]

3. Lymphatic spread to lymph nodes versus direct extension from the primary tumour. Some tumours may extend directly into adjacent lymph nodes without intervening normal tissue. This is common in parotid tumours as there are multiple lymph nodes within the parotid parenchyma itself. This finding is not considered nodal metastatic disease for the purposes of staging, and the concept of 'ENE' will not apply. Rare instances of direct extension into a lymph node from a mucosal site – for example, from a large floor of mouth primary to a level I node – is more controversial and potentially more difficult to evaluate. The general rule of choosing the lower stage in equivocal circumstances should apply, but a clarifying comment and/or discussion with the treating physicians is suggested.

4. The lymph node capsule is often markedly thickened and altered by large metastases with obliteration of the subcapsular sinus. ENE is measured as the greatest extent of tumour spread perpendicular to the external aspect of the node capsule. The exact site of the latter is subjective but may be estimated by examination of the remaining intact capsule and contour of the node (Figures 1 and 2).

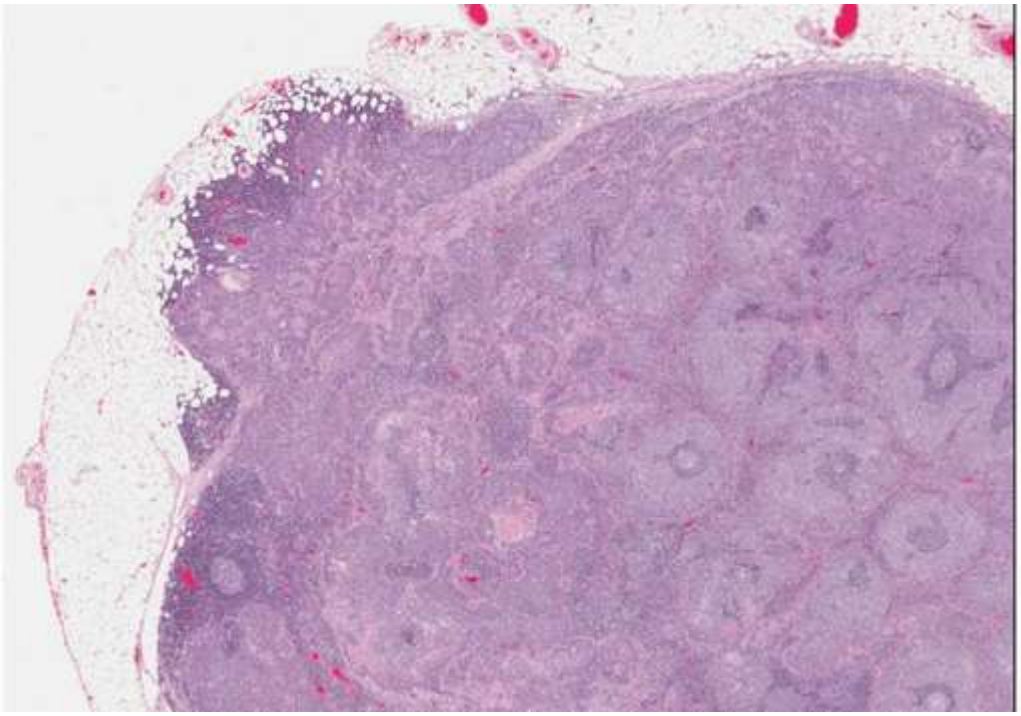

Figure 1: Low power image of a lymph node containing metastatic squamous cell carcinoma, with extranodal extension into perinodal adipose tissue (20x). Permission courtesy of Dr Martin Bullock.

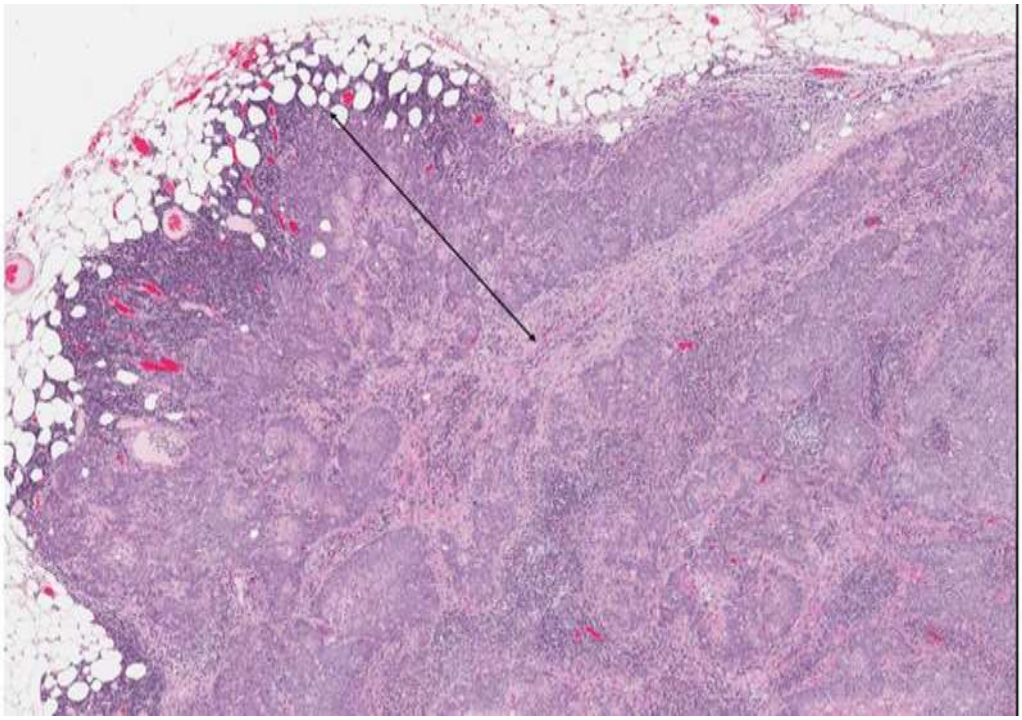

Figure 2: The extent of extranodal extension should be measured from external aspect of the capsule, or estimated site thereof, to the furthest point of tumour extension into the surrounding tissue. Permission courtesy of Dr Martin Bullock.

Note 5 – Ancillary studies

Ancillary testing for head and neck cancers most commonly refers to testing for high risk HPV status in tumours of the oropharynx and EBV status in tumours of the nasopharynx. Ancillary testing should be performed on the primary tumour if possible. Tumours presenting with a lymph node metastasis of squamous cell carcinoma and an unknown primary require testing on the lymph node specimen. When ancillary testing is performed, it is recommended to include the type of testing, the result and interpretive guidelines if applicable.[54]

Ancillary testing for HPV (either using p16 or an HPV-specific method) is a core item for metastases for SCC to level II or III lymph nodes, with an unknown primary. Neck tumours with a lymphoepithelial pattern should be tested for EBV (for example, using in situ hybridisation for EBV-encoded RNA).

Note 6 – Regional lymph node categorisation

Information on lymph node status is crucial for the staging and treatment of head and neck malignancies. The staging described below conforms to the 8th edition of the Union for International Cancer Control (UICC)/American Joint Committee on Cancer (AJCC) Staging Manuals.[18,19]

Regional lymph nodes (pN)

<u>(HPV-INDEPENDENT), HYPOPHARYNX, LARYNX, CUTANEOUS HEAD AND NECK CARCINOMAS (WITH THE EXCEPTION OF MERKEL CELL CARCINOMA) AND UNKNOWN PRIMARY SQUAMOUS CELL CARCINOMAS THAT ARE P16 AND EBV-NEGATIVE</u>

NX Regional lymph nodes cannot be assessed

N0 No regional lymph node metastasis

N1 Metastasis in a single ipsilateral lymph node, 3 cm or less in greatest dimension without ENE

N2 Metastasis described as:

- N2a Metastasis in a single ipsilateral lymph node, 3 cm or less in greatest dimension with ENE or more than 3 cm but not more than 6 cm in greatest dimension without ENE
- N2b Metastasis in multiple ipsilateral nodes, none more than 6 cm in greatest dimension, without ENE
- N2c Metastasis in bilateral or contralateral lymph nodes, none more than 6 cm in greatest dimension, without ENE

N3a Metastasis in a lymph node more than 6 cm in greatest dimension without ENE

N3b Metastasis in a lymph node more than 3 cm in greatest dimension with ENE, or multiple ipsilateral, or any contralateral or bilateral node(s) with ENE

<u>HPV-MEDIATED (p16 POSITIVE) OROPHARYNGEAL (HPV-ASSOCIATED)</u>

NX Regional lymph nodes cannot be assessed

N0 No regional lymph node metastasis

N1 Metastasis in 1 to 4 lymph node(s)

N2 Metastasis in 5 or more lymph node(s)

<u>NASOPHARYNGEAL CARCINOMA</u>

NX Regional lymph nodes cannot be assessed

N0 No regional lymph node metastasis

N1 Unilateral metastasis in cervical lymph node(s), and/or unilateral or bilateral metastasis in retropharyngeal lymph nodes, 6 cm or less in greatest dimension, above the caudal border of cricoid cartilage

N2 Bilateral metastasis in cervical lymph node(s), 6 cm or less in greatest dimension, above the caudal border of cricoid cartilage o N3 Metastasis in cervical lymph node(s) greater than 6 cm in dimension and/or extension below the caudal border of the cricoid cartilage

MUCOSAL MELANOMA

NX Regional lymph nodes cannot be assessed

N0 No regional lymph node metastasis

N1 Regional lymph node metastasis present

Note that (i) Midline nodes are considered ipsilateral nodes and (ii) ENE detected on histopathologic examination is designated as ENE_{mi} (microscopic ENE ≤2 mm) or ENE_{ma} (major ENE >2 mm). Both ENE_{mi} and ENE_{ma} qualify as ENE(+) for definition of pN.

Note that a designation of 'U' or 'L' may be used for any N category to indicate metastasis above the lower border of the cricoid (U) or below the lower border of the cricoid (L). Similarly, clinical and pathological ENE should be recorded as ENE(-) or ENE(+).

Assignment of a pN category is applicable for patients who are treated surgically with a cervical lymph node dissection, rather than single lymph node excisional biopsy, in which case the cN category is used.[18,19]

Nasopharyngeal carcinoma (NPC) commonly presents with bulky nodal neck disease, and a lymph node biopsy may occasionally precede biopsy of the primary site. However, NPC is not a surgically treated disease,[55] and therefore pathologists are rarely called upon to provide a pN category for NPC. A single positive lymph node biopsy would contribute to the cN categorisation.

The reference document TNM Supplement: A commentary on uniform use, 5th Edition (C Wittekind et al. editors) may be of assistance when staging.[56]

Notes on submission of neck dissection specimens

Correct submission of neck dissection specimens is required to obtain the most accurate and clinically useful information. The number of lymph nodes obtained in a neck dissection specimen can be used as a quality metric that is associated with loco-regional recurrence and overall survival in patients with head and neck cancer.[57]

Several points regarding submission of neck dissection specimens are emphasised as follows:

1. Inking of neck dissection specimens. Most neck dissections without lymph node involvement or with limited involvement (in which nodes are freely mobile and not matted or grossly involving non-lymphatic structures), will not need to be inked. However, as margin assessment is recommended,

specimens with large tumour deposits, in which ENE is considered likely, should be inked.

2. Grossly negative lymph nodes should be submitted in toto. Nodes 5 mm or more should be bisected or multisected to give tissue sections of 2-3 mm thickness. Grossly involved lymph node and soft tissue metastases need not be submitted in toto, but one section per centimetre (10 mm) in greatest dimension is a reasonable approach. Sections should focus on potential areas of ENE, involvement of non-lymphatic structures, and the margin.

3. Careful gross examination is required when attempting to estimate the number of lymph nodes involved by a soft tissue mass or matted group of lymph nodes. When submitting lymph nodes that cannot be removed from the surrounding tissue (e.g., parotidectomy specimens), care should be taken not to 'double count' nodes that may be bisected and present in two cassettes. An estimate of the number of nodes in each section, is recommended. In general, the gross estimate of the number of lymph nodes is most accurate, except when tissue originally designated as node is clearly another tissue (e.g., parathyroid gland).

Références

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