Q&A column, 12/17

Editor: Frederick L. Kiechle, MD, PhD

Submit your pathology-related question for reply by appropriate medical consultants. CAP TODAY will make every effort to answer all relevant questions. However, those questions that are not of general interest may not receive a reply. For your question to be considered, you must include your name and address; this information will be omitted if your question is published in CAP TODAY.

Submit a Question

Q. Is a tumor embolus in the capsule of the lymph nodes considered metastasis? Does the lung, like the lymph nodes of the breast, have the concept of isolated tumor cells? As the staging rule is "when in doubt, understage," would the case therefore be pT2, N0?

A. The American Joint Committee on Cancer staging manual does not specify whether tumor should be present within the parenchyma or within the capsule. My interpretation is that any tumor deposit within a lymph node >0.2 mm should be considered metastasis.

The eighth edition of the AJCC manual defines isolated tumor cells (ITC) for lung cancer as single tumor cells or small clusters of cells 0.2 mm in greatest dimension.1 Such cells are usually found in the subcapsular nodal sinuses, but they may be seen within the nodal parenchyma. Lymph nodes with only ITCs should be staged as N0. Before the lymph node metastasis is categorized as ITC, it is essential to cut deeper H&E levels to make sure the tumor focus is not larger than 0.2 mm. The concept regarding ITCs in lung cancer is evolving, and further studies are warranted.

The staging rule "when in doubt, understage" also applies to lung cancer.

1. Amin MB, Edge SB, Greene FL, et al., eds. *AJCC Cancer Staging Manual*, 8th ed. New York: Springer; 2017.

Sanja Dacic, MD, PhD, Professor of Pathology, University of Pittsburgh Medical Center, Member, CAP Cancer Committee

Q. I am an MLS(ASCP) and have just started a new job in a hospital. Here, there are only three reportable parameters on the vaginal wet prep: yeast cells, clue cells, and Trichomonas vaginalis—but not white blood cells. If we do not report WBCs, are we leaving out an important parameter for diagnosing vaginitis?

A. WBCs (specifically polymorphonuclears, or PMNs) can be recognized in the vaginal wet prep and can be important for interpretation of results. Yeast and *Trichomonas* infections are inflammatory conditions characterized by the presence of PMNs, while bacterial vaginosis is not inflammatory so PMNs will not be present. It is also important to understand that the presence of clue cells is very specific but not very sensitive for the diagnosis of bacterial vaginosis. When using microscopy to diagnose bacterial vaginosis, a Gram stain scored using Nugent criteria is recommended (Nugent RP, et al. *J Clin Microbiol.* 1991;29[2]:297–301).

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Q. When amending a surgical pathology report, is there a requirement to keep the original incorrect report with the new corrected report in one document?

A. The anatomic pathology checklist requirement ANP.12185 provides supportive information for amended reports.

The format of amended anatomic pathology reports is at the discretion of the laboratory. Surgical pathology reports often have extensive interpretive or textual data, which may make replicating the entire original and amended pathology report cumbersome and may render the report difficult to interpret. In such cases, a comment in the amended report summarizing the previous information and the reason for the amendment can be provided. Additionally, records of notifications to clinicians for amendments to reports that may significantly affect patient care must include the date and name of the person notified and preferably appear in the amended report.

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Clinical Laboratory Improvement Amendments of 1988; final rule. *Fed Regist.* 2003; 42 CFR §493.1291(k).

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