Cervical Cancer in Excisional Biopsies of Cervix
– an audit of compliance with the RCPath dataset for histological reporting

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Introduction:

- NHSCSP publication no. 10 – Histopathology reporting in cervical screening – an integrated approach, September 2012
  – Recommends standardised histology reporting proformas or templates for reporting excisional biopsies and resections with cervical cancer
- Accurate and high quality histopathology reporting is critical for optimal patient management
- High quality histology reports are an important data source for cancer registries and help to evaluate the effectiveness of screening programmes

Background:

- The RCPath cervical cancer dataset is recommended
- Reports must include a macroscopic description
- All cervical cancers must be classified according to the WHO classification system
- All cervical cancers must be staged according to the FIGO system.
- The cancer type, differentiation, tumour dimensions, presence or absence of lymphovascular invasion, completeness of excision and relationship to excision planes must be reported
- All reports should be assigned SNOMED topography and morphology codes

Dataset for histological reporting of cervical neoplasia (3rd edition)

- **Appendix C1** **Reporting proforma for cervical cancer in excisional cervical biopsies**
- Surname: Forenames: Date of birth:
- Patient identifier (CHI/NHS no): Hospital: Hospital no:
- Date of receipt: Date of reporting: Report no:
- Pathologist: Surgeon:
- **Description of specimen and core macroscopic items**
- Wedge ☐ Cone ☐ Loop ☐ biopsy of cervix:……..mm x ……..mm and ……. mm thick/deep
- Number of fragments received, measurement of each and block designation: ……
- ……
- **Core microscopic items**
- Invasive malignancy:
- Type: Squamous carcinoma ☐ Adenosquamous carcinoma ☐ Adenocarcinoma ☐
- Neuroendocrine carcinoma ☐ Other ☐ (specify……)
- Differentiation/grade:
- Well/Grade 1 ☐ Moderate/Grade 2 ☐ Poor/Grade 3 ☐ Not assessable/GX ☐ N/A ☐
- Distribution of invasive component: Unifocal ☐ Multifocal ☐
- Tumour size: Maximum horizontal dimension……mm
- Maximum thickness/depth of invasion (delete as appropriate) ……..mm
- Are invasive foci present in three or more sequential slices of tissue*: Yes ☐ No ☐
- Excision status: Incomplete ☐ Complete ☐ Not assessable ☐
- If complete excision, distance to closest resection margin: .....mm.
- Specify margin: ectocervical/endocervical/deep radial
- **Other features**:
- CIN (cervical intra-epithelial neoplasia): Present ☐ Absent ☐
- Grade: CIN 1 ☐ CIN 2 ☐ CIN 3 ☐
- CGIN (cervical glandular intraepithelial neoplasia): Present ☐ Absent ☐
- Grade: Low ☐ High ☐
- SMILE (stratified mucin-producing intra-epithelial lesion): Present ☐ Absent ☐
- **Excision margins: (specify whether involved by CIN, CGIN or SMILE)**
- Ectocervical resection margin: Clear ☐ Involved by CIN ☐ CGIN☐ SMILE ☐ Not assessable ☐
- Endocervical resection margin: Clear ☐ Involved by CIN ☐ CGIN☐ SMILE ☐ Not assessable ☐
- Deep lateral/radial resection margin:Clear ☐ Involved by CIN ☐ CGIN☐ SMILE ☐ Not assessable ☐
- **Lymphovascular space invasion:** Present ☐ Absent ☐
- ***Note:** If invasive foci are seen in three or more sequential sections of tissue, the third dimension of the lesion (which is not routinely measured) may exceed 7 mm (i.e. more than Stage IA).
- **Provisional pathological FIGO stage……** **SNOMED codes: T…… M……**
- **Signature of pathologist: ……** **Date……**

Objective:

- To demonstrate the extent of compliance with RCPath April 2011 dataset for cervical cancer reporting in cervical excision specimens
- Standard set at 100%

Method:

- Departmental database of cases submitted for the national audit of cervical cancers and the departmental i-lab records were interrogated for the 12 month period 1st January to 31st December 2011
- All cervical excision samples performed at South Tees and with cervical cancer reported were identified.
- The pathology reports for each case were scrutinised for completeness of:
  – Demographics
  – Clinical details
  – Macroscopic core items
  – Microscopic core items
  – Staging
  – SNOMED

Results:

- A total of 23 cervical excision specimens with reported cervical cancer were performed at South Tees in the stated period
- 11 of these cases were primary reported by the gynae-oncology MDT lead/deputy, 12 by colleagues
- **Demographic details** – 100% compliance
  (except for NHS numbers which are available in web-ICE but not i-LAB)
- **Core macroscopic items** – 96% compliance
  (except for measurement in 3 dimensions as departmental protocol requires only 2) **One failure to measure dimension of each tissue piece and one failure in detailing block designation.**
- **Core microscopic items** – variable compliance
  – Tumour type, distribution and sequential slice involvement detailed in 100%
  Excision status not recorded in 1 case
  Horizontal size and tumour thickness not recorded in 2 cases
  Distance to margin and specifying which margin not recorded in 3 cases
  Grade/differentiation not recorded in 4 cases
  – Presence or absence of CIN, CGIN and SMILE
  - not recorded in 3, 5 and 23 (100%) of cases respectively
  – Excision margin status for CIN, CGIN and SMILE
  - not recorded in 12, 11 and 12 cases respectively
  – Presence or absence of LVI **- not recorded in 8 cases**
- **FIGO stage - not recorded in 7 cases at initial reporting and still not recorded (in i-lab at least) in 5 cases after MDT review**
- **SNOMED recording** – 100% compliance

Discussion:

- 100% compliance for demographic details, clinical details and SNOMED coding
- 96% compliance for core macroscopic items *(excluding measurement in 3 dimensions as determined by departmental protocol)*
- Compliance for various aspects of the core microscopic items was variable and there was failure to record some data items in a significant number of cases
- Most of the missing data items identified were in cases not primary reported by the gynae-oncology MDT lead/deputy
- Majority of missing data items were corrected at the time of MDT review and recorded in a supplementary report
- Some of the omissions might be explained by the fact the audited period over-lapped with the time the dataset was produced – a standard of 100% may have been excessive?
- The majority (if not all) of the noted omissions are regarded as of no significance to patient management and appear to largely reflect either:
  – difficulties in the microscopic assessment of particular cases (eg tumour grade in very small lesions) or
  – a failure to record irrelevant features in a particular case (eg margin status for CIN when invasive tumour is incompletely excised) or
  – a failure in all cases to document the presence or absence of SMILE or
  – FIGO staging in the absence of relevant clinical information

Conclusion:

- This audit has identified partial compliance with the RCPath dataset for cervical cancer reporting in cervical excision specimens
- It has highlighted the difficulties in comparing proforma/template dataset standards against free text reports
- Many of the omissions (although not significant) may have been avoided by reference to or use of a proforma/template reporting system

Action:

- Present findings at departmental audit meeting and high-light areas of failure to meet standards
- Encourage reference to dataset standards at the time of reporting
- Consider potential for introduction of template reporting or primary reporting of all cervical excision samples with invasive cervical cancer by the gynaecological subspecialist team and subsequently re-audit

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