Management of Gynaecological Cancers: Histopathology Guidelines (2019 v2) – Review due Nov 2021

Principle

The general principle is that all pathology discussed at the specialist gynaecological MDT should have been reviewed by a core MDT pathologist who is accredited in gynaecological pathology. **Accreditation is defined as: participating and maintaining adequate scores in the relevant quality assessment scheme (that is, the National Gynaecological Pathology EQA) and sustaining a workload sufficient to uphold adequate skill in this subspeciality.** It follows that, in general, MDT reviews should be carried out by the local core MDT pathologist(s) where they meet the above criteria. There may be a need for central pathology review where the reporting/reviewing pathologist or MDT feel this is warranted.

General recommendations

1. The National Cancer Peer Review have published: ***"NHS National Peer Review Programme: Manual for cancer services, Gynaecology measures (version 1.0, January 2014)"*** and the Royal College of Pathologists has a document (under review as of September 2019) entitled: "***The role of the lead pathologist and attending pathologists in the MDT (March 2014***)".

The manual recommends that the lead pathologist for the gynaecology MDT in each hospital should participate in a specialist EQA scheme. *To reiterate, the Network guidelines therefore advise that all core pathologists for Gynaecological cancer MDTs should participate in the National Gynaecological Pathology EQA scheme.*

2. A best practice scenario would involve slide review for all cases discussed at MDT by the core MDT pathologist. This is strongly encouraged; however, due to time constraints and limited resources it may not always be possible. **It is therefore advised that slide review (by an accredited local or central pathologist) should always occur in the following situations:**

a) Where review of the pathology report raises queries or where something in the report requires further clarification.

b) Where there has been a significant discrepancy between histological findings and clinical or imaging features. These cases will have been identified at the time of the MDT.

c) Where primary reporting has been done by a pathologist who is non-accredited. For these cases it is strongly advised that a slide review be performed by the MDT pathologist *in advance of* MDT pathology discussion, in the event that there are changes arising from the review.

d) In areas where published audits have indicated an area of acknowledged diagnostic difficulty leading to frequent revision of diagnosis.

e) For uncommon conditions seen within the spectrum of practice of the MDT, as a means of maintaining skills amongst the group of pathologists supporting the diagnostic area. These cases may well necessitate central pathology review, supported by implementation of the above guidelines and by the maintenance of good communication between local and central reviewing pathologists.

3. Occasional cases do represent cross referrals clinically where patients from the South are treated at MRI and vice versa. If a central review has been performed at one or other of the two centre Histopathology departments then double reviews should not take place, although some exceptions may occur.

Specific recommendations

Peritoneal Biopsies

Since peritoneal carcinomatosis usually arises from gynaecological or gastrointestinal malignancy, it is recommended that biopsy assessment includes the immunohistochemistry panel below:

CK7
PAX8
ER
WT1
p53
+/- GATA-3, CDX2, CK20, TTF-1 – depending on degree of suspicion for a non-gynaecological primary
+/- Ki-67, p16 – if there is uncertainty between low and high-grade serous carcinoma

Where the biopsy shows features in keeping with a neoplasm of gynaecological origin, this should be highlighted for MDT review by the reporting pathologist at the earliest opportunity in order to streamline the process.

Endometrial Tumours

Where there is any uncertainty regarding pathological assessment of an endometrial carcinoma following local review, early proactive central review is encouraged. p53, p16 and progesterone receptor are of value in the differential diagnosis of 'high nuclear grade' endometrioid carcinoma, since a proportion of these may in reality represent gland-forming serous carcinoma.

Cervical Tumours

Early invasive cervical carcinomas can be difficult to diagnose and stage on a loop biopsy. Where there is any uncertainty regarding the pathological assessment, early proactive central review is advised.

Suspected Gynaecological sarcomas

All potential sarcomas, including low-grade endometrial sarcomas, should be sent for central review at the earliest opportunity in order to streamline the process.

At the initial assessment of small biopsies where this diagnosis is suspected, 12 unstained sections should be cut to facilitate subsequent immunohistochemistry.

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