

Anus

**Protocol applies to all invasive carcinomas
of the anal canal.**

*Protocol revision date: January 2004
Based on AJCC/UICC TNM, 6th edition*

Procedures

- **Cytology** (No Accompanying Checklist)
- **Incisional Biopsy**
- **Excisional Biopsy**
- **Abdominoperineal Resection**

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Surgical Pathology Cancer Case Summary (Checklist)

Protocol revision date: January 2004
Applies to invasive carcinomas only
Based on AJCC/UICC TNM, 6th edition

ANUS: Polypectomy

Patient name:

Surgical pathology number:

Note: Check 1 response unless otherwise indicated.

MACROSCOPIC

*Tumor Site

* Specify, if known: _____

* ___ Not specified

Polyp Size

Greatest dimension: ___ cm

*Additional dimensions: ___x___ cm

___ Cannot be determined (see Comment)

*Polyp Configuration

* ___ Pedunculated, with stalk

*Stalk length: ___ mm

* ___ Pedunculated, no stalk, narrow-based

* ___ Sessile/broad-based

* ___ Cannot be determined

MICROSCOPIC

Histologic Type

___ Squamous cell carcinoma

___ Adenocarcinoma

___ Mucinous adenocarcinoma

___ Small cell carcinoma

___ Undifferentiated carcinoma

___ Other (specify): _____

___ Carcinoma, type cannot be determined

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* Data elements **with asterisks** are **not required** for accreditation purposes for the Commission on Cancer. These elements may be clinically important, but are not yet validated or regularly used in patient management. Alternatively, the necessary data may not be available to the pathologist at the time of pathologic assessment of this specimen.

Histologic Grade (if applicable to tumor type)

- Not applicable
 GX: Cannot be assessed
 G1: Well differentiated
 G2: Moderately differentiated
 G3: Poorly differentiated
 G4: Undifferentiated

Extent of Invasion

- Epithelium only (no invasion)
 Invasion (deepest):
 Cannot be determined
 Into lamina propria
 Into muscularis mucosae
 Into submucosa

Polyp Resection Margin (check all that apply)

- Cannot be assessed
 Uninvolved by invasive carcinoma
 Distance of invasive carcinoma from margin: ___ mm
 Carcinoma in situ absent at mucosal margin
 Carcinoma in situ present at mucosal margin
 Involved by invasive carcinoma
 Not applicable (specify reason): _____

Venous/Lymphatic (Large/Small Vessel) Invasion (V/L)

- Not applicable
 Absent
 Present
 Indeterminate

***Additional Pathologic Findings (check all that apply)**

- * None identified
 * Active colitis
 * Other (specify): _____

***Comment(s)**

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Surgical Pathology Cancer Case Summary (Checklist)

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ANUS: Local Excision (Transanal Disk Excision)

Patient name:

Surgical pathology number:

| |
|---|
| Note: Check 1 response unless otherwise indicated. |
|---|

MACROSCOPIC**Specimen Integrity** Intact Fragmented

*Number of pieces in fragmented specimens: ____

 Other (specify): _____***Tumor Site*** Unknown

* Specify, if known: _____

Tumor Size

Greatest dimension: ____ cm

*Additional dimensions: ____x____ cm

 Cannot be determined (see Comment)***Tumor Configuration*** Polypoid* Infiltrative* Ulcerating* Other (specify): _____

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MICROSCOPIC**Histologic Type**

- Squamous cell carcinoma
 Adenocarcinoma
 Mucinous adenocarcinoma
 Small cell carcinoma
 Undifferentiated carcinoma
 Paget disease
 Other (specify): _____
 Carcinoma, type cannot be determined

Histologic Grade

- Not applicable
 GX: Cannot be assessed
 G1: Well differentiated
 G2: Moderately differentiated
 G3: Poorly differentiated
 G4: Undifferentiated
 Other (specify): _____

Pathologic Staging (pTNM)Primary Tumor (pT)

- pTX: Cannot be assessed
 pT0: No evidence of primary tumor
 pTis: Carcinoma in situ
 pT1: Tumor 2 cm or less in greatest dimension
 pT2: Tumor more than 2 cm but not more than 5 cm in greatest dimension
 pT3: Tumor more than 5 cm in greatest dimension
 pT4: Tumor of any size with invasion of adjacent organ(s); eg, vagina, urethra, bladder (involvement of sphincter muscles alone is not classified as T4).

Margins (check all that apply)

- Cannot be assessed
 Margins uninvolved by invasive carcinoma
 Distance of invasive carcinoma from closest margin: ____ mm
 Specify margin (if possible): _____
 Carcinoma in situ absent at lateral mucosal margin
 Carcinoma in situ present at lateral mucosal margin
 Margin(s) involved by invasive carcinoma
 Not applicable (specify reason): _____

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***Venous/Lymphatic (Large/Small Vessel) Invasion (V/L)**

- * Absent
- * Present
- * Indeterminate

***Perineural Invasion**

- * Absent
- * Present

***Additional Pathologic Findings (check all that apply)**

- * None identified
- * Crohn disease
- * Condyloma accuminatum
- * Dysplasia
- * Associated rectal carcinoma (Paget disease)
- * Other (specify): _____

***Comment(s)**

* Data elements **with asterisks** are **not required** for accreditation purposes for the Commission on Cancer. These elements may be clinically important, but are not yet validated or regularly used in patient management. Alternatively, the necessary data may not be available to the pathologist at the time of pathologic assessment of this specimen.

Surgical Pathology Cancer Case Summary (Checklist)

Protocol revision date: January 2004
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ANUS: Resection

Patient name:

Surgical pathology number:

Note: Check 1 response unless otherwise indicated.

MACROSCOPIC

Specimen Type

Abdominoperineal resection

Other (specify): _____

Not specified

Tumor Site (check all that apply)

Anterior wall

Anal margin

Not specified

Tumor Size

Greatest dimension: ____ cm

*Additional dimensions: ____x____ cm

Cannot be determined (see Comment)

*Tumor Configuration:

* Polypoid

* Infiltrative

* Ulcerating

* Other (specify): _____

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MICROSCOPIC**Histologic Type**

- Squamous cell carcinoma
 Adenocarcinoma
 Mucinous adenocarcinoma
 Small cell carcinoma
 Undifferentiated carcinoma
 Paget disease
 Other (specify): _____
 Carcinoma, type cannot be determined

Histologic Grade

- Not applicable
 GX: Cannot be assessed
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 G2: Moderately differentiated
 G3: Poorly differentiated
 G4: Undifferentiated

Pathologic Staging (pTNM)Primary Tumor (pT)

- pTX: Cannot be assessed
 pT0: No evidence of primary tumor
 pTis: Carcinoma in situ
 pT1: Tumor 2 cm or less in greatest dimension
 pT2: Tumor more than 2 cm but not more than 5 cm in greatest dimension
 pT3: Tumor more than 5 cm in greatest dimension
 pT4: Tumor of any size with invasion of adjacent organ(s); eg, vagina, urethra, bladder (involvement of sphincter muscles alone is not classified as T4).

Regional Lymph Nodes (pN)

- pNX: Cannot be assessed
 pN0: No regional lymph node metastasis
 pN1: Metastasis in perirectal lymph nodes
 pN2: Metastasis in unilateral internal iliac and/or inguinal lymph node(s)
 pN3: Metastasis in perirectal and inguinal lymph nodes and/or bilateral internal iliac and/or inguinal lymph nodes

Specify: Number examined: ____
 Number involved: ____

Distant Metastasis (pM)

- pMX: Cannot be assessed
 pM1: Distant metastasis
 *Specify site(s), if known: _____

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Margins (check all that apply)Proximal Margin

- Cannot be assessed
 Uninvolved by invasive carcinoma
 Carcinoma in situ absent at mucosal margin
 Carcinoma in situ present at mucosal margin
 Involved by invasive carcinoma

Distal Margin

- Cannot be assessed
 Uninvolved by invasive carcinoma
 Carcinoma in situ absent at mucosal margin
 Carcinoma in situ present at mucosal margin
 Involved by invasive carcinoma

Circumferential (Radial) Margin

- Cannot be assessed
 Uninvolved by invasive carcinoma
 Involved by invasive carcinoma

Distance of invasive carcinoma from closest margin: ___ mm

Specify margin: _____

***Perineural Invasion**

- * Absent
 * Present

***Venous/Lymphatic (Large/Small Vessel) Invasion (V/L)**

- * Absent
 * Present
 * Indeterminate

***Additional Pathologic Findings (check all that apply)**

- * None identified
 * Crohn disease
 * Condyloma accuminatum
 * Dysplasia
 * Associated rectal carcinoma (Paget disease)
 * Other (specify): _____

***Comment(s)**

* Data elements **with asterisks** are **not required** for accreditation purposes for the Commission on Cancer. These elements may be clinically important, but are not yet validated or regularly used in patient management. Alternatively, the necessary data may not be available to the pathologist at the time of pathologic assessment of this specimen.

Background Documentation

Protocol revision date: January 2004

I. Cytologic Material

A. Clinical Information

1. Patient identification
 - a. Name
 - b. Identification number
 - c. Age (birth date)
 - d. Sex
2. Responsible physician(s)
3. Date of procedure
4. Other clinical information
 - a. Relevant history
 - (1) sexually transmitted diseases (human immunodeficiency virus [HIV], herpes simplex virus [HSV], human papilloma virus [HPV])
 - (2) genital neoplasms
 - (3) immunosuppression
 - (4) inflammatory bowel disease
 - b. Relevant findings (eg, direct inspection, endoscopic and/or imaging studies)
 - c. Clinical diagnosis
 - d. Procedure (brushing, washing, other)
 - e. Anatomic site(s) of specimen(s) (Note **A**)

B. Macroscopic Examination

1. Specimen
 - a. Unfixed/fixed (specify fixative)
 - b. Number of slides received, if applicable
 - c. Quantity and appearance of fluid specimen, if applicable
 - d. Other (eg, cytologic preparation from tissue)
 - e. Results of intraprocedural consultation
2. Material submitted for microscopic evaluation
3. Special studies, specify (eg, cytochemistry, immunocytochemistry, DNA analysis [specify type], morphometry, cytogenetic analysis)

C. Microscopic Evaluation

1. Adequacy of specimen (if unsatisfactory for evaluation, specify reason)
2. Tumor, if present
 - a. Histologic type, if possible (Note **B**)
 - b. Other characteristics of neoplasm (eg, nuclear grade, necrosis) (Note **C**)
3. Additional pathologic findings, if present (specify)
4. Results/status of special studies (specify)
5. Comments
 - a. Correlation with intraprocedural consultation, as appropriate
 - b. Correlation with other specimens, as appropriate
 - c. Correlation with clinical information, as appropriate

II. Biopsy (Incisional, Local Excision, or Other)

A. Clinical Information

1. Patient identification

- a. Name
 - b. Identification number
 - c. Age (birth date)
 - d. Sex
 2. Responsible physician(s)
 3. Date of procedure
 4. Other clinical information
 - a. Relevant history
 - (1) sexually transmitted diseases (human immunodeficiency virus [HIV], herpes simplex virus [HSV], human papilloma virus [HPV])
 - (2) genital neoplasms
 - (3) immunosuppression
 - (4) inflammatory bowel disease
 - b. Relevant findings (eg, direct inspection, endoscopic and/or imaging studies)
 - c. Clinical diagnosis
 - d. Procedure (eg, endoscopic biopsy, local excision)
 - e. Anatomic site(s) of specimen(s) (Note **A**)
- B. Macroscopic Examination**
1. Specimen
 - a. Unfixed/fixed (specify fixative)
 - b. Number of pieces
 - c. Largest dimension of each piece
 - d. Results of intraoperative consultation
 2. Tumor, if discernible
 - a. Largest dimension
 - b. Configuration
 3. Margins, relation to tumor in an excisional biopsy
 4. Additional pathologic findings, if present
 5. Tissue submitted for microscopic evaluation
 - a. Incisional biopsy: submit entirely
 - b. Excisional biopsy
 - (1) tumor
 - (2) margin(s) of excision, if identifiable
 - (3) other lesions, if applicable
 - c. Frozen section tissue fragment(s) (unless saved for special studies)
 6. Special studies (specify) (eg, histochemistry, immunohistochemistry, DNA analysis [specify type], morphometry, cytogenetic analysis)
- C. Microscopic Evaluation**
1. Tumor
 - a. Histologic type (Note **B**)
 - b. Histologic grade (Note **C**)
 - c. Extent of invasion, as appropriate
 - d. Relationship of tumor to anal transitional zone or glandular mucosa or perianal skin, if possible
 2. Margins (excisional biopsy)
 - a. Lateral (distance to closest margin in millimeters)
 - b. Deep (distance to closest approach of tumor in millimeters)
 3. Additional pathologic findings, if present
 - a. Condyloma

- b. Anal canal intraepithelial neoplasia
- c. Inflammatory processes
- d. Other(s)
- 4. Results/status of special studies (specify)
- 5. Comments
 - a. Correlation with intraoperative consultation, as appropriate
 - b. Correlation with other specimens, as appropriate
 - c. Correlation with clinical information, as appropriate

III. Abdominoperineal Resection

A. Clinical Information

- 1. Patient identification
 - a. Name
 - b. Identification number
 - c. Age (birth date)
 - d. Sex
- 2. Responsible physician(s)
- 3. Date of procedure
- 4. Other clinical information
 - a. Relevant history
 - (1) sexually transmitted diseases (human immunodeficiency virus [HIV], herpes simplex virus [HSV], human papilloma virus [HPV])
 - (2) genital neoplasms
 - (3) immunosuppression
 - (4) inflammatory bowel disease
 - b. Relevant findings (eg, endoscopic and/or imaging studies)
 - c. Clinical diagnosis
 - d. Procedure (eg, abdominoperineal resection)
 - e. Anatomic site(s) of specimen(s) (Note **A**)

B. Macroscopic Examination

- 1. Specimen
 - a. Organ(s)/tissue(s) received (specify)
 - b. Unfixed/fixed (specify fixative)
 - c. Number of pieces
 - d. Dimensions
 - e. Descriptive characteristics
 - f. Orientation of specimen
 - g. Results of intraoperative consultation
- 2. Tumor
 - a. Location (Note **A**)
 - b. Configuration (Note **D**)
 - c. Size
 - d. Descriptive characteristics (eg, color, consistency)
 - e. Sinus or anorectal fistula, if present
 - f. Distance from margins
 - (1) proximal
 - (2) distal
 - (3) circumferential (lateral/radial soft tissue margin closest to deepest tumor penetration)

7. Results of special studies (specify) (Note F)
8. Comments
 - a. Correlation with intraoperative consultation, as appropriate
 - b. Correlation with other specimens, as appropriate
 - c. Correlation with clinical information, as appropriate

Explanatory Notes

A. Location

Documentation of tumor location within the anal canal is important for purposes of stage assignment. Because the staging systems and the regional lymph nodes at risk of metastasis differ significantly for cancers of the anal canal, the rectum, and the perianal skin, it is essential to assure that the anatomic site of the tumor is the anal canal. For the pathologist, however, the documentation of location may be problematic. Currently, most anal canal carcinomas are managed successfully without surgery using combination chemotherapy and radiation therapy,¹ and resection specimens of anal tumors are seen only infrequently (primarily for small anal margin lesions or following failure of other treatment modalities). Although histological diagnosis is almost always performed on small biopsies, determination of the primary tumor location from biopsy specimens may be difficult or impossible. Therefore, documentation of anatomic site often requires clinical correlation.

A major problem complicating determination of anatomic site clinically or pathologically is the controversy over the anatomic definition of the anal canal itself. The surgical definition of the anal canal is the one most widely accepted for practical reasons and is the preferred definition of the American Joint Committee on Cancer (AJCC).² However, it is based on clinically identifiable landmarks that are difficult or impossible for the pathologist to locate. By this definition, the start of the anal canal is defined as the point where the rectum enters the puborectalis sling at the apex of the anal sphincter complex, a landmark that is palpable in vivo on digital exam as the anorectal ring. The termination of the anal canal is defined as the squamous mucocutaneous junction (ie, the junction of the distal squamous mucosa of the anal canal with the perianal hair-bearing skin).² Thus defined, the lining mucosa of the proximal anal canal includes a narrow zone (approximately 1 to 2 cm) of rectal-type glandular mucosa and transitional mucosa (if present) at the dentate line. In other words, this definition of the anal canal includes the anal transition zone (ATZ) and the dentate line, from which many of the most important and characteristic anal carcinomas develop. In the region of the dentate line, anal glands may be found subjacent to the mucosa extending across the internal sphincter.

B. Histologic Type

For consistency in reporting, the histologic classification proposed by the World Health Organization (WHO) is recommended.³ However, this protocol does not preclude the use of other systems of classification or histologic types.

The great majority of carcinomas of the anus are squamous cell carcinomas. The previous edition of the WHO classification included 3 subtypes of squamous cell carcinoma (SCC): large cell keratinizing, large cell nonkeratinizing, and basaloid. However, because most SCCs of the anal canal show more than 1 subtype, the diagnostic reproducibility of these subtypes has been low. Furthermore, no significant prognostic differences between subtypes have been established. Therefore, the WHO now recommends that the generic diagnostic term “squamous cell carcinoma” be used for all squamous tumors of the anal canal. However, additional descriptive comment regarding specific histologic features, such as predominant cell size, basaloid features, degree of keratinization, or adjacent intraepithelial neoplasia, is encouraged. Prominent

basaloid features and small tumor cell size are related to infection with “high-risk” human papilloma virus.³ SCC with a predominantly basaloid differentiation pattern was formerly known as cloacogenic carcinoma, but this term is now considered obsolete.

Two variants of SCC of the anal canal deserve note because they differ in prognosis from typical squamous tumors. One is verrucous carcinoma (also known as giant condyloma or Buschke-Lowenstein tumor), which resembles a condyloma macroscopically but is larger and fails to respond to conservative therapy. These lesions are regarded as biologic intermediates between condylomas and SCCs, with a better prognosis than SCC. However, nearly half of these lesions undergo malignant transformation. Another important variant is SCC with mucinous microcysts (well-formed cystic spaces containing Alcian blue- or PAS-stainable mucin). This entity has an unfavorable prognosis compared to SCC.

Finally, 2 rare types of anal canal carcinoma, anaplastic carcinoma and small cell carcinoma (high-grade neuroendocrine carcinoma), are tumors with aggressive biologic behavior and an unfavorable prognosis compared to typical SCC. Tumors of the more distal anal canal and especially anal margin (mucocutaneous junction) are generally purely squamous in type and show fewer basaloid or glandular features.

WHO Classification of Carcinoma of the Anal Canal³

Intraepithelial neoplasia

 Squamous or transitional epithelium

 Glandular

 Paget disease

Carcinoma

 Squamous cell carcinoma

 Adenocarcinoma

 Mucinous adenocarcinoma

 Small cell carcinoma[#]

 Undifferentiated carcinoma[#]

 Others

[#] By convention, these histologic types are assigned grade 4.

The term carcinoma, NOS (not otherwise specified) is not part of the WHO classification.

C. Histologic Grade

Histologic grades for anal canal squamous carcinoma are as follows.²

Grade X Grade cannot be assessed

Grade 1 Well differentiated

Grade 2 Moderately differentiated

Grade 3 Poorly differentiated

If there are variations in the differentiation within the tumor, the highest (least favorable) grade is recorded as the overall grade.

Histologic grades for adenocarcinoma of the anal canal based on the proportion of gland formation by the tumor are suggested as follows.

| | |
|---------|--|
| Grade X | Grade cannot be assessed |
| Grade 1 | Well differentiated (greater than 95% of tumor composed of glands) |
| Grade 2 | Moderately differentiated (50% to 95% of tumor composed of glands) |
| Grade 3 | Poorly differentiated (49% or less of tumor composed of glands) |

Small cell carcinomas and tumors with no differentiation or minimal differentiation that is discernible only in rare, tiny foci (undifferentiated carcinomas by WHO classification) are categorized as grade 4.

D. Configuration

Configurations include exophytic (fungating/polypoid), endophytic (ulcerative), and diffusely infiltrative, but overlap among these types is common. Complex configurations may be reported using more than 1 descriptor.

E. Regional Lymph Nodes

Regional lymph nodes (N) comprise the perirectal (anorectal, perirectal and lateral sacral), the internal iliac (hypogastric), and the inguinal (superficial and deep).² All other nodal groups represent sites of distant metastasis (M). The sites of regional node involvement correspond to the local lymphatic drainage, above to the rectal ampulla and below to the perineum. Tumors that arise in the anal canal usually spread initially to the anorectal and perirectal nodes, and those that arise at the anal margin spread to the superficial inguinal nodes.

F. Special Studies

Immunohistochemistry may be an especially helpful adjunct to the pathologic analysis of anal Paget disease. Immunohistochemical staining for cytokeratin (CK) 7 is a sensitive method for detection of Paget cells within involved anal and perianal epithelium. In addition, however, the specific immunophenotype of Paget cells has been shown to correlate with pathogenesis and may be important in patient management. Staining for CK20 has been shown to identify Paget disease that is likely to be associated with underlying rectal adenocarcinoma (presenting either synchronously or metachronously). In contrast, Paget cells that do not express CK20 but instead are positive for gross cystic disease fluid protein (GCDFP) are likely to represent primary cutaneous intraepithelial malignancy (with sweat gland differentiation).^{3,4}

G. TNM and Stage Groupings

The TNM staging system for anal carcinoma of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) is recommended by the protocol and shown below.^{2,5} The primary tumor is staged according to its size and local extension, as determined by clinical or pathologic examination. For most histologic types of anal canal cancer, the diameter of the tumor correlates with the depth of penetration. The staging system applies to all carcinomas arising in the anal canal, including carcinomas that arise within anorectal fistulas and anal glands, but excluding melanomas, carcinoid tumors, and sarcomas. Cancers that arise in the perianal skin are staged according to the classification for cancers of the skin (see Skin protocols).

By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination. pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions. Clinical classification (cTNM) is usually carried out by the referring physician before treatment during initial evaluation of the patient or when pathologic classification is not possible.

Pathologic staging is usually performed after surgical resection of the primary tumor. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed. If a biopsied tumor is not resected for any reason (eg, when technically unfeasible) and if the highest T and N categories or the M1 category of the tumor can be confirmed microscopically, the criteria for pathologic classification and staging have been satisfied without total removal of the primary cancer.

Primary Tumor (T)

| | |
|-----|--|
| TX | Primary tumor cannot be assessed |
| T0 | No evidence of primary tumor |
| Tis | Carcinoma in situ |
| T1 | Tumor 2 cm or less in greatest dimension |
| T2 | Tumor more than 2 cm but not more than 5 cm in greatest dimension |
| T3 | Tumor more than 5 cm in greatest dimension |
| T4 | Tumor of any size invades adjacent organ(s), eg, vagina, urethra, bladder [#] |

[#] Direct invasion of the rectal wall, perianal skin, subcutaneous tissue, or the sphincter muscle is not classified as T4.

Regional Lymph Nodes (N)

| | |
|----|---|
| NX | Regional lymph nodes cannot be assessed |
| N0 | No regional lymph node metastasis [#] |
| N1 | Metastasis in perirectal lymph node(s) |
| N2 | Metastasis in unilateral internal iliac and/or inguinal lymph node(s) |
| N3 | Metastasis in perirectal and inguinal lymph nodes and/or bilateral internal iliac and/or inguinal lymph nodes |

[#] Regional Lymph Nodes (pN0): Isolated Tumor Cells

Isolated tumor cells (ITCs) are single cells or small clusters of cells not more than 0.2 mm in greatest dimension. Lymph nodes or distant sites with ITCs found by either histologic examination, immunohistochemistry, or nonmorphologic techniques (eg, flow cytometry, DNA analysis, polymerase chain reaction [PCR] amplification of a specific tumor marker) should be classified as N0 or M0, respectively. Specific denotation of the assigned N category is suggested as follows for cases in which ITCs are the only evidence of possible metastatic disease.^{6,7}

| | |
|-----|--|
| pN0 | No regional lymph node metastasis histologically, no examination for isolated tumor cells (ITCs) |
|-----|--|

| | |
|-----------|--|
| pN0(i-) | No regional lymph node metastasis histologically, negative morphologic (any morphologic technique, including hematoxylin-eosin and immunohistochemistry) findings for ITCs |
| pN0(i+) | No regional lymph node metastasis histologically, positive morphologic (any morphologic technique, including hematoxylin-eosin and immunohistochemistry) findings for ITCs |
| pN0(mol-) | No regional lymph node metastasis histologically, negative nonmorphologic (molecular) findings for ITCs |
| pN0(mol+) | No regional lymph node metastasis histologically, positive nonmorphologic (molecular) findings for ITCs |

Distant Metastasis (M)

| | |
|----|---------------------------------------|
| MX | Distant metastasis cannot be assessed |
| M0 | No distant metastasis |
| M1 | Distant metastasis |

Stage Groupings

| | | | |
|------------|-------|-------|----|
| Stage 0 | Tis | N0 | M0 |
| Stage I | T1 | N0 | M0 |
| Stage II | T2 | N0 | M0 |
| | T3 | N0 | M0 |
| Stage IIIA | T1 | N1 | M0 |
| | T2 | N1 | M0 |
| | T3 | N1 | M0 |
| | T4 | N0 | M0 |
| Stage IIIB | T4 | N1 | M0 |
| | Any T | N2 | M0 |
| | Any T | N3 | M0 |
| Stage IV | Any T | Any N | M1 |

TNM Descriptors

For identification of special cases of TNM or pTNM classifications, the “m” suffix and “y,” “r,” and “a” prefixes are used. Although they do not affect the stage grouping, they indicate cases needing separate analysis.

The “m” suffix indicates the presence of multiple primary tumors in a single site and is recorded in parentheses: pT(m)NM.

The “y” prefix indicates those cases in which classification is performed during or following initial multimodality therapy (ie, neoadjuvant chemotherapy, radiation therapy, or both chemotherapy and radiation therapy). The cTNM or pTNM category is identified by a “y” prefix. The ycTNM or ypTNM categorizes the extent of tumor actually present at the time of that examination. The “y” categorization is not an estimate of tumor prior to multimodality therapy (ie, before initiation of neoadjuvant therapy).

The “r” prefix indicates a recurrent tumor when staged after a documented disease-free interval, and is identified by the “r” prefix: rTNM.

The “a” prefix designates the stage determined at autopsy: aTNM.

Additional DescriptorsResidual Tumor (R)

Tumor remaining in a patient after therapy with curative intent (eg, surgical resection for cure) is categorized by a system known as R classification, shown below.

| | |
|----|---|
| RX | Presence of residual tumor cannot be assessed |
| R0 | No residual tumor |
| R1 | Microscopic residual tumor |
| R2 | Macroscopic residual tumor |

For the surgeon, the R classification may be useful to indicate the known or assumed status of the completeness of a surgical excision. For the pathologist, the R classification is relevant to the status of the margins of a surgical resection specimen. That is, tumor involving the resection margin on pathologic examination may be assumed to correspond to residual tumor in the patient and may be classified as macroscopic or microscopic according to the findings at the specimen margin(s).

Vessel Invasion

By AJCC/UICC convention, vessel invasion (lymphatic or venous) does not affect the T category indicating local extent of tumor unless specifically included in the definition of a T category. In all other cases, lymphatic and venous invasion by tumor are coded separately as follows.

Lymphatic Vessel Invasion (L)

| | |
|----|--|
| LX | Lymphatic vessel invasion cannot be assessed |
| L0 | No lymphatic vessel invasion |
| L1 | Lymphatic vessel invasion |

Venous Invasion (V)

| | |
|----|------------------------------------|
| VX | Venous invasion cannot be assessed |
| V0 | No venous invasion |
| V1 | Microscopic venous invasion |
| V2 | Macroscopic venous invasion |

References

1. Ryan DP, Compton CC, Mayer RJ. Carcinoma of the anal canal. *N Engl J Med*. 2000;342:792-800.
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