Protocol for the Examination of Specimens From Patients With Uveal Melanoma

Protocol applies to malignant melanoma of the uvea.

Based on AJCC/UICC TNM, 7th edition

Protocol web posting date: January 2016

Procedures
- Resection (Local Resection, Enucleation, Limited or Complete Exenteration)

Authors
Hans E. Grossniklaus MD, MBA, FCAP*
Departments of Ophthalmology and Pathology, Emory University School of Medicine, Atlanta, Georgia
Paul T. Finger MD
Department of Ophthalmology, The New York Eye Cancer Center, New York, New York
J. William Harbour MD
Department of Ophthalmology, Washington University School of Medicine, St. Louis, Missouri
Tero Kivela MD
Departments of Ophthalmology and Pathology, University of Helsinki, Finland

For the Members of the Cancer Committee, College of American Pathologists

* Denotes primary author. All other contributing authors are listed alphabetically.

Previous lead contributors: David L. Page, Harry H. Brown, MD
© 2016 College of American Pathologists (CAP). All rights reserved.

The College does not permit reproduction of any substantial portion of these protocols without its written authorization. The College hereby authorizes use of these protocols by physicians and other health care providers in reporting on surgical specimens, in teaching, and in carrying out medical research for nonprofit purposes. This authorization does not extend to reproduction or other use of any substantial portion of these protocols for commercial purposes without the written consent of the College.

The CAP also authorizes physicians and other health care practitioners to make modified versions of the Protocols solely for their individual use in reporting on surgical specimens for individual patients, teaching, and carrying out medical research for non-profit purposes.

The CAP further authorizes the following uses by physicians and other health care practitioners, in reporting on surgical specimens for individual patients, in teaching, and in carrying out medical research for non-profit purposes: (1) **Dictation** from the original or modified protocols for the purposes of creating a text-based patient record on paper, or in a word processing document; (2) **Copying** from the original or modified protocols into a text-based patient record on paper, or in a word processing document; (3) The use of a **computerized system** for items (1) and (2), provided that the protocol data is stored intact as a single text-based document, and is not stored as multiple discrete data fields.

Other than uses (1), (2), and (3) above, the CAP does not authorize any use of the Protocols in electronic medical records systems, pathology informatics systems, cancer registry computer systems, computerized databases, mappings between coding works, or any computerized system without a written license from the CAP.

Any public dissemination of the original or modified protocols is prohibited without a written license from the CAP.

The College of American Pathologists offers these protocols to assist pathologists in providing clinically useful and relevant information when reporting results of surgical specimen examinations of surgical specimens. The College regards the reporting elements in the “Surgical Pathology Cancer Case Summary” portion of the protocols as essential elements of the pathology report. However, the manner in which these elements are reported is at the discretion of each specific pathologist, taking into account clinician preferences, institutional policies, and individual practice.

The College developed these protocols as an educational tool to assist pathologists in the useful reporting of relevant information. It did not issue the protocols for use in litigation, reimbursement, or other contexts. Nevertheless, the College recognizes that the protocols might be used by hospitals, attorneys, payers, and others. Indeed, effective January 1, 2004, the Commission on Cancer of the American College of Surgeons mandated the use of the required data elements of the protocols as part of its Cancer Program Standards for Approved Cancer Programs. Therefore, it becomes even more important for pathologists to familiarize themselves with these documents. At the same time, the College cautions that use of the protocols other than for their intended educational purpose may involve additional considerations that are beyond the scope of this document.

The inclusion of a product name or service in a CAP publication should not be construed as an endorsement of such product or service, nor is failure to include the name of a product or service to be construed as disapproval.
CAP Uveal Melanoma Protocol Revision History

Version Code
The definition of the version code can be found at www.cap.org/cancerprotocols.

Version: UvealMelanoma 3.3.0.0

Summary of Changes
The following changes have been made since the October 2013 release.

The following data elements were modified:
- Procedure
- Tumor Site
- Tumor Size After Sectioning
- Tumor Site After Sectioning
- Growth Pattern
- Histologic Type
- Distant Metastasis (pM)

The following data elements were deleted:
- Specimen Size
- Tumor Basal Size on Transillumination
- Histologic Grade
Surgical Pathology Cancer Case Summary

Protocol web posting date: January 2016

UVEAL MELANOMA: Resection (Local Resection, Enucleation, Limited or Complete Exenteration) (Note A)

Select a single response unless otherwise indicated.

Procedure
___ Local resection
___ Enucleation
___ Limited exenteration
___ Complete exenteration
___ Other (specify): ____________________________
___ Not specified

Specimen Laterality
___ Right
___ Left
___ Unspecified

Tumor Site (macroscopic examination/transillumination) (select all that apply) (Note B)
___ Cannot be determined
___ Superotemporal quadrant of globe
___ Superonasal quadrant of globe
___ Inferotemporal quadrant of globe
___ Inferonasal quadrant of globe
___ Between ____ and ____ o’clock
___ Other (specify): ____________________________

Tumor Size After Sectioning (Note C)
___ Cannot be determined
Greatest basal diameter: ____ mm
+ Base at cut edge: _____ mm
Greatest height: ____ mm
+ Height at cut edge: ____ mm

Tumor Site After Sectioning (Note D)
___ Cannot be determined
___ Superonasal
___ Inferonasal
___ Superotemporal
___ Inferotemporal
+ Distance from anterior edge of tumor to limbus at cut edge: ____ mm
+ Distance of posterior margin of tumor base from edge of optic disc: ____ mm

Tumor Involvement of Other Ocular Structures (select all that apply)
___ Cannot be determined
___ Sclera
___ Vortex vein(s)
___ Optic disc
___ Vitreous
___ Choroid
___ Ciliary body

+ Data elements preceded by this symbol are not required. However, these elements may be clinically important but are not yet validated or regularly used in patient management.
___ Iris
___ Lens
___ Anterior chamber
___ Extrascleral extension (anterior)
___ Extrascleral extension (posterior)
___ Angle/Schlemm’s canal
___ Optic nerve
___ Retina
+ ___ Cornea

**Growth Pattern**
___ Cannot be determined
___ Solid mass
___ Dome shape
___ Mushroom shape
___ Diffuse (ciliary body ring)
___ Diffuse (flat)

**Histologic Type (Note E)**
___ Spindle cell melanoma (>90% spindle cells)
___ Mixed cell melanoma (>10% epithelioid cells and <90% spindle cells)
___ Epithelioid cell melanoma (>90% epithelioid cells)

**Microscopic Tumor Extension**

+ Tumor Location
  + ___ Anterior margin between equator and iris
  + ___ Anterior margin between disc and equator
  + ___ Posterior margin between equator and iris
  + ___ Posterior margin between disc and equator
  + ___ Cannot be determined
  + ___ None of above

**Scleral Involvement**
___ Cannot be determined
___ None
___ Extrascleral
___ Intrascleral

**Margins**
___ Cannot be assessed
___ No melanoma at margins
___ Extrascleral extension (for enucleation specimens)
___ Other margin(s) involved (specify): ____________________________

**Pathologic Staging (pTNM) (Note F)**

**TNM Descriptors (required only if applicable) (select all that apply)**
___ m (multiple primary tumors)
___ r (recurrent)
___ y (posttreatment)
Primary Tumor (pT)

Iris
___ pTX: Primary tumor cannot be assessed
___ pT0: No evidence of primary tumor
pT1: Tumor limited to the iris
   ___ pT1a: Tumor limited to the iris not more than 3 clock hours in size
   ___ pT1b: Tumor limited to the iris more than 3 clock hours in size
   ___ pT1c: Tumor limited to the iris with secondary glaucoma
   ___ pT2: Tumor confluent with or extending into the ciliary body, choroid, or both
   ___ pT2a: Tumor confluent with or extending into the ciliary body, choroid, or both, with secondary glaucoma
   ___ pT3: Tumor confluent with or extending into the ciliary body, choroid, or both, with scleral extension
   ___ pT3a: Tumor confluent with or extending into the ciliary body, choroid, or both, with scleral extension and secondary glaucoma
pT4: Tumor with extrascleral extension
   ___ pT4a: Tumor with extrascleral extension less than or equal to 5 mm in diameter
   ___ pT4b: Tumor with extrascleral extension more than 5 mm in diameter

Ciliary Body and Choroid
___ pTX: Primary tumor cannot be assessed
___ pT0: No evidence of primary tumor
pT1: Tumor size category 1
   ___ pT1a: Tumor size category 1 without ciliary body involvement and extraocular extension
   ___ pT1b: Tumor size category 1 with ciliary body involvement
   ___ pT1c: Tumor size category 1 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter
   ___ pT1d: Tumor size category 1 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter
pT2: Tumor size category 2
   ___ pT2a: Tumor size category 2 without ciliary body involvement and extraocular extension
   ___ pT2b: Tumor size category 2 with ciliary body involvement
   ___ pT2c: Tumor size category 2 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter
   ___ pT2d: Tumor size category 2 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter
pT3: Tumor size category 3
   ___ pT3a: Tumor size category 3 without ciliary body involvement and extraocular extension
   ___ pT3b: Tumor size category 3 with ciliary body involvement
   ___ pT3c: Tumor size category 3 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter
   ___ pT3d: Tumor size category 3 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter
pT4: Tumor size category 4
   ___ pT4a: Tumor size category 4 without ciliary body involvement and extraocular extension
   ___ pT4b: Tumor size category 4 with ciliary body involvement
   ___ pT4c: Tumor size category 4 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter
   ___ pT4d: Tumor size category 4 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter
   ___ pT4e: Any tumor size category with extraocular extension more than 5 mm in diameter

Regional Lymph Nodes (pN)
___ pNX: Regional lymph nodes cannot be assessed
___ pN0: No regional lymph node metastasis
___ pN1: Regional lymph node metastasis

+ Data elements preceded by this symbol are not required. However, these elements may be clinically important but are not yet validated or regularly used in patient management.
**Distant Metastasis (pM)** (required only if confirmed pathologically in this case)

___ pM: Distant metastasis

___ pM1a: Largest diameter of the largest metastasis 3 cm or less

___ pM1b: Largest diameter of the largest metastasis 3.1-8.0 cm

___ pM1c: Largest diameter of the largest metastasis 8.1 cm or more

Specify sites(s), if known: ______________________________

+ Additional Pathologic Findings (select all that apply) (Note G)

+ ___ None identified

+ ___ Mitotic rate (number of mitoses per 40X objective with a field area of 0.152 mm$^2$)
  (specify): __________

+ ___ Extravascular matrix pattern

+ ___ Vascular invasion (tumor vessels or other vessels)

+ ___ Degree of pigmentation

+ ___ Inflammatory cells/tumor infiltrating lymphocytes

+ ___ Drusen

+ ___ Retinal detachment

+ ___ Invasion of Bruch’s membrane

+ ___ Nevus

+ ___ Hemorrhage

+ ___ Neovascularization

+ ___ Other (specify): ______________________________

+ Comment(s)
Explanatory Notes

A. Fixative
The minimum recommended fixation time for whole globes with intraocular tumors is 48 hours. The globe should be fixed in an adequate volume of fixative with a 10:1 ratio of fixative volume to specimen volume recommended. Incisions or windows in the globe are not necessary for adequate penetration of fixative and are not recommended. Injection of fixative into the globe is also not recommended.

B. Orientation
The orientation of a globe may be determined by identification of extraocular muscle insertions, the optic nerve, and other landmarks, as illustrated in Figure 1. The terms temporal and nasal are generally used in place of lateral and medial with reference to ocular anatomy.

Figure 1. Anatomic landmarks of the posterior aspect of the globe (right eye). The position of the inferior oblique muscle relative to the optic nerve is most helpful in orienting the globe. The inferior oblique muscle insertion is located temporal (lateral) to the optic nerve on the sclera, and its fibers travel inferonasally from its insertion. The long posterior ciliary artery is often seen as a blue-gray line in the sclera on either side of the optic nerve and marks the horizontal meridian of the globe. Reprinted with permission from WB Saunders Company.

C. Tumor Size
Tumor size has prognostic significance. Many studies of choroidal and ciliary body melanoma have defined small tumors as being less than 10 mm in greatest diameter. More recently, an ongoing study started in 1986, the Collaborative Ocular Melanoma Study, defined the following size classification based on clinical measurements.

Small tumors: Smaller than medium or large tumors defined below
Medium tumors: Greater than or equal to 2.5 mm, less than or equal to 10 mm in height, and less than or equal to 16 mm in basal diameter
Large tumors: Greater than 10 mm in height or
Greater than 2 mm in height and greater than 16 mm in basal diameter or
Greater than 8 mm in height with optic nerve involvement

Small tumors have a more favorable prognosis.
D. Sectioning the Globe
The globe is generally sectioned in the horizontal or vertical plane, with care to include the pupil and optic nerve in the section to be submitted for microscopic examination. If the mass cannot be included with horizontal or vertical sectioning, the globe is sectioned obliquely to include the tumor, pupil, and optic nerve, as illustrated in Figure 2. Alternative methods of sectioning have been described.\(^6\)

![Diagram of eye sectioning](image)

Figure 2. The most common methods of sectioning a globe. After transillumination, the tumor base is marked, if possible, and included in the pupil-optic (p-o) nerve section and submitted for processing. If tumor is found in either of the calottes, these may also be submitted for sectioning. The meridian in which the globe was sectioned should be included in the gross description of the pathology report. It is not uncommon to induce an artifactitious retinal detachment while sectioning the globe. This can be minimized by gentle handling and by avoiding a sawing motion with the blade. Reprinted with permission from WB Saunders Company.

E. Histologic Type
The modified Callender classification shown below is used for determining cell type, but has prognostic significance only for tumors of the choroid and ciliary body, not those of the iris, which generally have a benign course.\(^1,7-9\) The American Joint Committee on Cancer (AJCC) defined the histopathologic types as follows\(^10,11\):

- Spindle cell melanoma (greater than 90% spindle cells)
- Mixed cell melanoma (>10% epithelioid cells and <90% spindle cells)
- Epithelioid cell melanoma (greater than 90% epithelioid cells)

\(^a\) Spindle cell melanomas have the most favorable prognosis, and epithelioid cell melanomas the least favorable in terms of survival.
F. TNM Stage Groupings
The American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC) TNM staging systems for uveal melanoma of the iris, ciliary body, and choroid are shown below.\(^{10}\)

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**

### All Uveal Melanomas

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Primary tumor cannot be assessed</td>
</tr>
<tr>
<td>T0</td>
<td>No evidence of primary tumor</td>
</tr>
<tr>
<td>T1</td>
<td>Tumor limited to the iris</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumor limited to the iris not more than 3 clock hours in size</td>
</tr>
<tr>
<td>T1b</td>
<td>Tumor limited to the iris more than 3 clock hours in size</td>
</tr>
<tr>
<td>T1c</td>
<td>Tumor limited to the iris with secondary glaucoma</td>
</tr>
<tr>
<td>T2</td>
<td>Tumor confluent with or extending into the ciliary body, choroid, or both</td>
</tr>
<tr>
<td>T2a</td>
<td>Tumor confluent with or extending into the ciliary body, choroid, or both, with secondary glaucoma</td>
</tr>
<tr>
<td>T3</td>
<td>Tumor confluent with or extending into the ciliary body, choroid or both, with scleral extension</td>
</tr>
<tr>
<td>T3a</td>
<td>Tumor confluent with or extending into the ciliary body, choroid or both, with scleral extension and secondary glaucoma</td>
</tr>
<tr>
<td>T4</td>
<td>Tumor with extrascleral extension</td>
</tr>
<tr>
<td>T4a</td>
<td>Tumor with extrascleral extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T4b</td>
<td>Tumor with extrascleral extension more than 5 mm in diameter</td>
</tr>
</tbody>
</table>

* Iris melanomas originate from, and are predominantly located in, this region of the uvea. If less than half of the tumor volume is located within the iris, the tumor may have originated in the ciliary body, and consideration should be given to classifying it accordingly.
Ciliary Body and Choroid
Primary ciliary body and choroidal melanomas are classified according to the 4 tumor size categories below:

<table>
<thead>
<tr>
<th>Tumor Size Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>Tumor size category 1</td>
</tr>
<tr>
<td>T1a</td>
<td>Tumor size category 1 without ciliary body involvement and extraocular extension</td>
</tr>
<tr>
<td>T1b</td>
<td>Tumor size category 1 with ciliary body involvement</td>
</tr>
<tr>
<td>T1c</td>
<td>Tumor size category 1 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T1d</td>
<td>Tumor size category 1 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T2</td>
<td>Tumor size category 2</td>
</tr>
<tr>
<td>T2a</td>
<td>Tumor size category 2 without ciliary body involvement and extraocular extension</td>
</tr>
<tr>
<td>T2b</td>
<td>Tumor size category 2 with ciliary body involvement</td>
</tr>
<tr>
<td>T2c</td>
<td>Tumor size category 2 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T2d</td>
<td>Tumor size category 2 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T3</td>
<td>Tumor size category 3</td>
</tr>
<tr>
<td>T3a</td>
<td>Tumor size category 3 without ciliary body involvement and extraocular extension</td>
</tr>
<tr>
<td>T3b</td>
<td>Tumor size category 3 with ciliary body involvement</td>
</tr>
<tr>
<td>T3c</td>
<td>Tumor size category 3 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T3d</td>
<td>Tumor size category 3 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T4</td>
<td>Tumor size category 4</td>
</tr>
<tr>
<td>T4a</td>
<td>Tumor size category 4 without ciliary body involvement and extraocular extension</td>
</tr>
<tr>
<td>T4b</td>
<td>Tumor size category 4 with ciliary body involvement</td>
</tr>
<tr>
<td>T4c</td>
<td>Tumor size category 4 without ciliary body involvement but with extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T4d</td>
<td>Tumor size category 4 with ciliary body involvement and extraocular extension less than or equal to 5 mm in diameter</td>
</tr>
<tr>
<td>T4e</td>
<td>Any tumor size category with extraocular extension more than 5 mm in diameter</td>
</tr>
</tbody>
</table>

Note: In clinical practice, the largest tumor basal diameter may be estimated in optic disc diameters (dd, average: 1 dd = 1.5 mm). Tumor thickness may be estimated in diopters (average: 2.5 diopters = 1 mm). However, techniques such as ultrasonography and fundus photography are used to provide more accurate measurements. Ciliary body involvement can be evaluated by the slit-lamp, ophthalmoscopy, gonioscopy, and transillumination. However, high-frequency ultrasonography (ultrasound biomicroscopy) is used for more accurate assessment. Extension through the sclera is evaluated visually before and during surgery, and with ultrasonography, computed tomography, or magnetic resonance imaging.
When histopathologic measurements are recorded after fixation, tumor diameter and thickness may be underestimated because of tissue shrinkage.

Regional Lymph Nodes (N)
NX Regional lymph nodes cannot be assessed
N0 No regional lymph node metastasis
N1 Regional lymph node metastasis

Distant Metastasis (M)
M0 No distant metastasis
M1 Distant metastasis
M1a Largest diameter of the largest metastasis 3 cm or less
M1b Largest diameter of the largest metastasis 3.1-8.0 cm
M1c Largest diameter of the largest metastasis 8.1 cm or more

Stage Grouping

<table>
<thead>
<tr>
<th>Stage</th>
<th>T1a</th>
<th>N0</th>
<th>M0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage IIA</td>
<td>T1b-d</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T2a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIB</td>
<td>T2b</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIA</td>
<td>T2c-d</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T3b-c</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T4a</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIB</td>
<td>T3d</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>T4b-c</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IIIC</td>
<td>T4d-e</td>
<td>N0</td>
<td>M0</td>
</tr>
<tr>
<td>Stage IV</td>
<td>Any T</td>
<td>N1</td>
<td>M0</td>
</tr>
<tr>
<td></td>
<td>Any T</td>
<td>Any N</td>
<td>M1a-c</td>
</tr>
</tbody>
</table>

It should be noted that regional lymph node involvement is rare in uveal melanoma, but metastasis to the liver and direct extension into the orbit are more common.

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 Descriptors

Residual 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).

Lymph-Vascular Invasion (LVI)
LVI indicates whether microscopic lymph-vascular invasion is identified in the pathology report. LVI includes lymphatic invasion, vascular invasion, or lymph-vascular invasion. By AJCC/UICC convention, LVI does not affect the T category indicating local extent of tumor unless specifically included in the definition of a T category.

G. Other Pathologic Features of Prognostic Significance
Other histologic features with prognostic significance in choroidal and ciliary body melanoma include the number of mitoses in 40 high-powered fields, pigmentation, degree of inflammation, growth pattern (diffuse choroidal melanomas and ring melanomas of the ciliary body have a much less favorable prognosis), location of anterior margin of tumor, degree and patterns of vascularity, blood vessel invasion (both tumor vessels and normal vessels), tumor necrosis, extraocular extension, and optic nerve involvement.1,11-20

References


