Macroscopic appearance of tumour(s) (Non-core)

Documentation of the macroscopic appearance of cervical tumours allows correlation with the clinical and radiological assessment of the tumour. According to International Federation of Gynaecology and Obstetrics 2018, clinically visible cervical cancers are Stage IB.^{1,2} However, it now allows for pathologic or radiologic measurements to assign final stage if available. Therefore, even if a tumour is clinically visible, if on histological examination the lesion has the dimensions of a Stage IA neoplasm, it is recommended that it should be categorised as Stage IA (for example, associated erosion with minimal tumour present).^{1,2} This should also be discussed at the gynaecological oncology multidisciplinary tumour board.

Exophytic/polypoid carcinomas may have a growth pattern that results in very little or even no invasion of the underlying stroma and ulcerated tumours may entirely or predominantly supplant the surface epithelium. In both these circumstances, it may be necessary to measure tumour 'Thickness' rather than 'Depth of invasion' and it is helpful to document the macroscopic appearance to provide context and explanation for the use of the alternative measurements. In large circumferential tumours, there is a risk of overestimating the maximum horizontal extent of the tumour (see **TUMOUR DIMENSIONS**). The type of growth pattern in bulky (>40 millimetres (mm)) tumours may be prognostic. In one study, barrel-shaped cervical tumours >40 mm had a significantly worse overall and disease-free survival compared to exophytic tumours >40 mm.³

The macroscopic appearance of the tumour influences tumour sampling. For cases where there is no macroscopically visible tumour either because there has been a prior surgical procedure or prior therapy the entire cervix should be blocked. For cases with a large visible tumour, it is not necessary to block the whole tumour, but instead careful block selection ensuring representative sampling of the tumour, accurate assessment of margins and tumour extent is required. The blocks should be taken to include the nearest margin(s) and show the maximum depth of stromal invasion. In departments where the facility for processing oversize blocks is available, a good overview of the tumour and resection margins can be obtained. In departments where this facility is not available, large blocks may need to be subdivided; in such cases, the relationship of the blocks to one another should be clearly documented.

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