Extent of invasion (Core and Non-core)

Myometrial or cervical stromal invasion

The depth of myometrial invasion is an essential parameter in the staging of adenosarcomas located in the uterine corpus or cervix (see **PROVISIONAL PATHOLOGICAL STAGING**). According to the current International Federation of Gynecology and Obstetrics (FIGO) Staging System,[1] Stage IA adenosarcoma is limited to the endometrium/endocervix; Stage IB invades ≤50% of the myometrium or cervical stroma; and Stage IC invades more than 50% of the myometrium or cervical stroma.[2,3] Myometrial infiltration is also an important prognostic factor in uterine adenosarcoma for overall survival and recurrence.[4-6]

Because the staging of low and high grade endometrial stromal sarcomas, leiomyosarcoma and undifferentiated uterine sarcoma (and other sarcomas) is not based currently on myometrial infiltration, the depth of myometrial infiltration is not relevant.

Uterine serosa involvement

Uterine serosal involvement should be documented as it is an adverse prognostic factor in uterine leiomyosarcoma.[7] Although evidence for clinical relevance for other uterine sarcomas is limited, the International Collaboration on Cancer Reporting (ICCR) Uterine Sarcoma Dataset Authoring Committee (DAC) considers it to represent a core element in reporting.

Tumour-free distance to uterine serosa refers to the distance between the deepest point of tumour within the myometrium and the nearest serosal surface and is considered a non-core element.

Parametrial involvement

Parametrium is defined as the fibro-adipose connective tissue located laterally in the supracervical portion of the uterus. Most hysterectomies for uterine sarcoma will be simple hysterectomies without parametrial resections. If parametrial tissue is removed, the presence or absence of parametrial involvement should be documented as best practice. Although evidence for clinical relevance of parametrial involvement in uterine sarcomas is limited, the DAC considers it to represent a core element in reporting.

Omentum

Omental involvement should be documented as it contributes to the staging assessment. FIGO Stage IIIA equates to one site of abdominal involvement and IIIB to more than one site.[1]

Vagina

A total hysterectomy can have a vaginal cuff which should be measured. The presence or absence of vaginal involvement in such cases should be documented on the report.

Fallopian tube

The presence or absence of adnexal (ovarian/fallopian tube) involvement should be documented. Adnexal involvement affects the tumour stage (FIGO Stage IIA) which remains the most powerful prognostic factor for uterine sarcomas,[3,5,8,9] and may occur as a result of direct extension or metastatic spread of tumour.

Ovary

The presence or absence of adnexal (ovarian/fallopian tube) involvement should be documented. Adnexal involvement affects the tumour stage (FIGO Stage IIA) which remains the most powerful prognostic factor for uterine sarcomas,[3,5,8,9] and may occur as a result of direct extension or metastatic spread of tumour.

Peritoneal biopsies

Peritoneal involvement should be documented as it contributes to the staging assessment. Pelvic peritoneal involvement equates to FIGO Stage IIB while abdominal peritoneal involvement equates to FIGO Stage IIIA or IIIB depending on the number of sites involved.[1]

Peritoneal washings/peritoneal fluid

The presence or absence of tumour cells in peritoneal fluid/washings should be documented if this specimen type is submitted. There is only limited data suggesting that positive peritoneal cytology may be an adverse prognostic factor in uterine sarcomas with one study suggesting that positive peritoneal cytology may be a prognostic factor for mortality in uterine sarcomas, particularly in leiomyosarcoma.[10] Accrual of this data prospectively will facilitate future study regarding the prognostic significance of positive peritoneal fluid.

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