**Neoplasms of the Heart, Pericardium, and Great Vessels Histopathology Reporting Guide**

**Elements in black text are CORE Elements in grey text are NON-CORE o indicates single select values □ indicates multi-select values**

|  |  |
| --- | --- |
| Definition of Core elements | Core elements are those which are essential for the clinical management, staging or prognosis of the cancer. These elements will either have evidentiary support at Level III-2 or above (based on prognostic factors in the National Health and Medical Research Council (NHMRC) levels of evidence1). In rare circumstances, where level III-2 evidence is not available an element may be made a core element where there is unanimous agreement in the expert committee. An appropriate staging system, e.g., Pathological TNM staging, would normally be included as a core element. The summation of all core elements is considered to be the minimum reporting standard for a specific cancer.**Reference** 1 Merlin T, Weston A and Tooher R (2009). Extending an evidence hierarchy to include topics other than treatment: revising the Australian 'levels of evidence'. *BMC Med Res Methodol* 9:34. |
| Definition of Non-core elements | Non-core elements are those which are unanimously agreed should be included in the dataset but are not supported by level III-2 evidence. These elements may be clinically important and recommended as good practice but are not yet validated or regularly used in patient management.Key information other than that which is essential for clinical management, staging or prognosis of the cancer such as macroscopic observations and interpretation, which are fundamental to the histological diagnosis and conclusion e.g., macroscopic tumour details, may be included as either core or non-core elements by consensus of the Dataset Authoring Committee. |
| Scope of this dataset | The dataset has been developed for biopsy and resection specimens of neoplasms of the heart, pericardium, and great vessels. It includes both benign and malignant primary tumours of the heart, pericardium, and great vessels.Mesothelioma and haematolymphoid neoplasms (such as primary cardiaclymphoma) are not included in this dataset. For pericardial mesotheliomas refer to the International Collaboration on Cancer Reporting (ICCR) Mesothelioma in the pleura and peritoneum dataset.1 Haematolymphoid tumours will be covered in a future ICCR dataset. Metastatic lesions should not be recorded using this dataset. There is currently no agreed-upon staging system (such as TNM) for cardiac tumours, due to an insufficiency of evidence. The second edition includes changes to align the dataset with the World Health Organization (WHO) Classification of Thoracic Tumours, 5th edition, 2021.2**References**1 International Collaboration on Cancer Reporting (2021). *Mesothelioma in the Pleura and Peritoneum Histopathology Reporting Guide.* Available from: http://www.iccr-cancer.org/datasets/published-datasets/thorax/mesothelioma (Accessed 10th November 2021).2 WHO Classification of Tumours Editorial Board (2021). *Thoracic Tumours, 5th Edition, Volume 5*. IARC Press, Lyon.  |

| **Core/** **Non-core** | **Element name** | **Values** | **Commentary** | **Implementation notes** |
| --- | --- | --- | --- | --- |
| Core | OPERATIVE PROCEDURE | * Not specified
* Resection
* Endovascular biopsy
* Image guided percutaneous biopsy
* Explantation
* Other, *specify*
 | As there may be more than one approach or technique to removing or sampling a tumour at a given location within the heart, specifying the nature of the operative procedure to the extent possible is important and is therefore a core element.1,2**References**1 Burke AP, Tavora F, Maleszewski J and Frazier A (2015). *Tumors of the Heart and Great Vessels. AFIP Atlas of Tumor Pathology, Series 4*. ARP Press, Washington DC.2 Bakaeen FG, Jaroszewski DE, Rice DC, Walsh GL, Vaporciyan AA, Swisher SS, Benjamin R, Blackmon S and Reardon MJ (2009). Outcomes after surgical resection of cardiac sarcoma in the multimodality treatment era. *J Thorac Cardiovasc Surg* 137(6):1454-1460.  |  |
| Core  | TUMOUR SITE | * Not specified
* Atrium
* Left
* Right
* Laterallity not specified
* Ventricle
* Left
* Right
* Laterallity not specified
* Endocardial
* Myocardial
* Epicardial
* Septum
* Free wall
* Parietal pericardium
* Valve, *specify*
* Great vessel, *specify*
* Other, *specify*
 | The tumour site within the heart has implications in terms of obstruction of blood flow, valvular dysfunction, and potential embolisation and haematogenous spread to downstream vascular beds.1,2 All sites including the chamber and substructures that are involved by tumour should be listed.3 An accurate listing of sites of tumour involvement may require radiological and intra-operative correlation. **References**1 Burke AP, Tavora F, Maleszewski J and Frazier A (2015). *Tumors of the Heart and Great Vessels. AFIP Atlas of Tumor Pathology, Series 4*. ARP Press, Washington DC.2 Siontis BL, Leja M and Chugh R (2020). Current clinical management of primary cardiac sarcoma. *Expert Rev Anticancer Ther* 20(1):45-51.3 Scicchitano P, Sergi MC, Cameli M, Miglioranza MH, Ciccone MM, Gentile M, Porta C and Tucci M (2021). Primary Soft Tissue Sarcoma of the Heart: An Emerging Chapter in Cardio-Oncology. *Biomedicines* 9(7):774 doi: 710.3390/biomedicines9070774. |  |
| Core | MAXIMUM DIMENSION OF PRIMARY TUMOUR | \_\_\_\_ mm* Cannot be assessed
 | This element applies only to resection and explant specimens in which the entire tumour can be measured. Reporting the size in biopsy and other incomplete tumour samples may be misleading clinically. | Applicable for resection and explant specimens only. |
| Core | TUMOUR FOCALITY | * Indeterminate
* Unifocal
* Multifocal, *specify number of tumours in specimen and*

*their locations* | Multiple tumours may be present at the same site or at different sites. A single tumour may invade multiple structures and thereby also be present in multiple cardiac locations. The tumour focality element clarifies this issue and is therefore a core element. |  |
| Non-core | BLOCK IDENTIFICATION KEY | List overleaf or separately with an indication of the nature and origin of all tissue blocks | The origin/designation of all tissue blocks should be recorded. This information should be documented in the final pathology report and is particularly important should the need for internal or external review arise. The reviewer needs to be clear about the origin of each block in order to provide an informed specialist opinion. If this information is not included in the final pathology report, it should be available on the laboratory computer system and relayed to the reviewing pathologist.  Recording the origin/designation of tissue blocks also facilitates retrieval of blocks for further immunohistochemical or molecular analysis, research studies, or clinical trials.  |  |

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| --- | --- | --- | --- | --- |
| Core  | HISTOLOGICAL TUMOUR TYPE | **Heart**BENIGN* Papillary fibroelastoma
* Cardiac myxoma
* Cardiac fibroma
* Cardiac rhabdomyoma
* Adult cellular rhabdomyoma
* Cardiac lipoma
* Lipomatous hypertrophy of atrial septum
* Lipomatous hamartoma of atrioventricular valve
* Hamartoma of mature cardiac myocytes
* Mesenchymal cardiac hamartoma
* Cardiac haemangioma
* Capillary
* Arteriovenous
* Cavernous
* Venous
* Conduction system hamartoma
* Cystic tumour of atrioventricular node

MALIGNANT* Cardiac angiosarcoma
* Cardiac leiomyosarcoma
* Cardiac undifferentiated pleomorphic sarcoma
* Other sarcoma, *specify*

TUMOURS OF UNCERTAIN BEHAVIOUR* Inflammatory myofibroblastic tumour

**Paraganglioma*** Solitary fibrous tumour
* Mixed germ cell tumour
* Angiosarcoma
* Other, *specify*

**Great vessels*** Angiosarcoma
* Pulmonary artery intimal sarcoma
* Other, *specify*
 | Neoplastic entities occurring in the heart, pericardium, and great vessels should be classified according to the most recent edition of the WHO Classification of Thoracic Tumours, 5th edition, 2021 (Table 1).1 The neoplastic nature of some space-occupying lesions (lipomatous hypertrophy of the atrial septum, vascular malformations, hamartoma of mature cardiac myocytes, conduction system hamartoma, etc.) is not entirely clear.2,3 Whether or not this dataset should be used on these lesions is left to the discretion of the pathologist. **Table 1 (See end of the document for tables)****References**1 WHO Classification of Tumours Editorial Board (2021). *Thoracic Tumours, 5th Edition, Volume 5*. IARC Press, Lyon.2 Burke AP, Tavora F, Maleszewski J and Frazier A (2015). *Tumors of the Heart and Great Vessels. AFIP Atlas of Tumor Pathology, Series 4*. ARP Press, Washington DC.3 Chen TW, Loong HH, Srikanthan A, Zer A, Barua R, Butany J, Cusimano RJ, Liang YC, Chang CH, Iakobishvili Z, Razak ARA and Lewin J (2019). Primary cardiac sarcomas: A multi-national retrospective review. *Cancer Med* 8(1):104-110.4 Fritz A, Percy C, Jack A, Shanmurgaratnam K, Lobin L, Parkin DM and Whelan S (eds) (2020). *International Classification of Diseases for Oncology. Third edition, Second revision ICD-O-3.2.* Available from: http://www.iacr.com.fr/index.php?option=com\_content&view=category&layout=blog&id=100&Itemid=577 (Accessed 16th June 2021). | Value list based on theWHO Classification of Thoracic Tumours (2021).Note that permission to publish the WHO Classification of Tumours may be needed in your implementation. It is advisable to check with the International Agency for Research on Cancer. |
| Core and Non-core | HISTOLOGICAL TUMOUR GRADE | * Cannot be graded
* Grade 1
* Grade 2
* Grade 3
* Ungraded sarcoma

**Necrosis*** Cannot be assessed
* Not identified
* Present

 **Extent of necrosis** \_\_\_\_ %**Mitotic count** \_\_\_\_ /mm2(most proliferative area) | This element only applies to sarcomas of the heart, pericardium, and great vessels. This element captures information shown to be prognostically important in sarcomas at other body sites.1 Evidence that these have the same importance in sarcomas of the heart, pericardium, and great vessels is lacking.2,3There is no formal grading system for cardiac tumours. However, the French Federation of Cancer Centers Sarcoma Group (FNCLCC) system for the grading of sarcomas4 can be used as a guide. The FNCLCC system includes an assessment of mitotic activity, necrosis, nuclear grade and cellularity (refer to Table 2).**Necrosis**The extent of necrosis is estimated as a percentage of total tumour. **Mitotic count** Mitotic count is a non-core element. If recorded it should be expressed as ’#/mm2’ due to the fact that differing field diameters of high power (x40) objectives dramatically vary the size of a single high power field (HPF). **Table 2 (See end of the document for tables)**The scores for these variables are added to calculate the following values:* Grade 1 - Total score of 2 or 3
* Grade 2 - Total score of 4 or 5
* Grade 3 - Total score of 6 or higher.

**References**1 International Collaboration on Cancer Reporting (2021). *Soft Tissue Sarcoma Histopathology Reporting Guide - Resection Specimens, 1st edition.* Available from: http://www.iccr-cancer.org/datasets/published-datasets/soft-tissue-bone/soft-tissue-sarcoma-resection-specimens (Accessed 10th November 2021).2 Trojani M, Contesso G, Coindre JM, Rouesse J, Bui NB, de Mascarel A, Goussot JF, David M, Bonichon F and Lagarde C (1984). Soft-tissue sarcomas of adults; study of pathological prognostic variables and definition of a histopathological grading system. *Int J Cancer* 33:37-42.3 Burke AP, Tavora F, Maleszewski J and Frazier A (2015). *Tumors of the Heart and Great Vessels. AFIP Atlas of Tumor Pathology, Series 4*. ARP Press, Washington DC.4 Guillou L, Coindre JM, Bonichon F, Nguyen BB, Terrier P, Collin F, Vilain MO, Mandard AM, Le D V, Leroux A, Jacquemier J, Duplay H, Sastre-Garau X and Costa J (1997). Comparative study of the National Cancer Institute and French Federation of Cancer Centers Sarcoma Group grading systems in a population of 410 adult patients with soft tissue sarcoma. *J Clin Oncol* 15:350-362.5 Amin MB, Edge SB, Greene FL, Byrd DR, Brookland RK, Washington MK, Gershenwald JE, Compton CC, Hess KR, Sullivan DC, Jessup JM, Brierley JD, Gaspar LE, Schilsky RL, Balch CM, Winchester DP, Asare EA, Madera M, Gress DM and Meyer LR (eds) (2017). *AJCC Cancer Staging Manual. 8th ed.*, Springer, New York.  | Applicable to sarcomas only. |

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| --- | --- | --- | --- | --- |
| Core | EXTENT OF INVASION | * Cannot be assessed
* Intracardiac invasion
* Extracardiac invasion (i.e., into the great vessels or beyond the parietal pericardium), *specify structures*
* Intraluminal/intracavitary extension, *specify*
 | For the purposes of this data element, the parietal pericardium represents the anatomic boundary between the heart tissues and adjacent organs. Tumours that extend into the great vessels or beyond the parietal pericardium (such as into the pleura, oesophagus, diaphragm, or chest wall) should be considered‘extracardiac invasion’. Tumours crossing tissue boundaries in the heart (e.g., one chamber to another, across a valve, or into the pericardium) should be considered ‘intracardiac invasion’.1,2For cases with tumour thrombus/embolus or intraluminal/intracavitary tumour extension, this should be indicated as well as the vessel(s) or chambers involved. **References**1 WHO Classification of Tumours Editorial Board (2021). *Thoracic Tumours, 5th Edition, Volume 5*. IARC Press, Lyon.2 Burke AP, Tavora F, Maleszewski J and Frazier A (2015). *Tumors of the Heart and Great Vessels. AFIP Atlas of Tumor Pathology, Series 4*. ARP Press, Washington DC.  |  |
| Core  | MARGIN STATUS | * Cannot be assessed
* Not involved
* Involved, *specify margin(s)*
 |  | Applicable for resection and explant specimens only. |
| Non-core | LYMPHOVASCULAR INVASION | * Indeterminate
* Not identified
* Present

**Method of evaluation*** Routine staining (H&E)
* Immunohistochemistry for lymphovascular endothelium, *specify*
 | This element is commonly reported for malignancies; however, since the majority of tumours in the heart and great vessels exist within the vasculature and have immediate access to haematogenous dissemination, this element should only be reported for pericardial tumours, such as germ cell tumours and solitary fibrous tumour, that do not arise within the vascular system. | Applicable to solitary fibrous and germ cell tumours of thePericardium. |
| Non-core | ANCILLARY STUDIES | * Not performed
* Performed
* Immunohistochemistry, *specify test(s) and result(s)*
* Molecular pathology, *specify test(s) and result(s)*
* Cytogenetics, *specify test(s) and result(s)*
* Other, *specify test(s) and result(s)*

**Representative blocks for ancillary studies**, *specify those blocks best representing tumour and/or normal tissue for further study* | While ancillary studies are not essential for the diagnosis of entities in this dataset, immunohistochemistry and molecular studies are often useful in classifying many of the tumours listed herein, particularly the differentiated mesenchymal neoplasms and germ cell tumours.1 If any additional studies are undertaken, they should be recorded. **Reference**1 Urbini M, Astolfi A, Indio V, Nannini M, Pizzi C, Paolisso P, Tarantino G, Pantaleo MA and Saponara M (2020). Genetic aberrations and molecular biology of cardiac sarcoma. *Ther Adv Med Oncol* 12:1758835920918492. |  |

**Tables**

**Table 1:** **World Health Organization classification of thoracic tumours.1**

| **Descriptor** | **ICD-O codes**d |
| --- | --- |
| **Heart** |  |
| **Benign tumours** |  |
| Papillary fibroelastoma  | 8820/0† |
| Cardiac myxoma  | 8840/0 |
| Cardiac fibroma  | 8810/0 |
| Cardiac rhabdomyoma  | 8900/0 |
| Adult cellular rhabdomyoma  | 8904/0 |
| Cardiac lipoma  | 8850/0 |
| Lipomatous hypertrophy of atrial septum |  |
| Lipomatous hamartoma of atrioventricular valve  |  |
| Hamartoma of mature cardiac myocytes  |  |
| Mesenchymal cardiac hamartoma  |  |
| Cardiac haemangioma  | 9120/0 |
| Venous haemangioma  | 9122/0 |
| Capillary haemangioma  | 9131/0 |
| Arteriovenous haemangioma  | 9123/0 |
| Cavernous haemangioma  | 9121/0 |
| Conduction system hamartomaa |  |
| Cystic tumour of atrioventricular node | 8454/0 |
| **Malignant tumours** |  |
| Cardiac angiosarcoma  | 9120/3 |
| Cardiac leiomyosarcoma  | 8890/3 |
| Cardiac undifferentiated pleomorphic sarcoma | 8802/3 |

|  |  |
| --- | --- |
| **Descriptor** | **ICD-O codes**d |
| **Tumours of uncertain behaviour** |  |
| Inflammatory myofibroblastic tumour | 8825/1 |
| Paragangliomab | 8693/3 |
|  |  |
| **Pericardium** |  |
| Solitary fibrous tumour | 8815/1 |
| Mixed germ cell tumour | 9085/3 |
| Angiosarcoma | 9120/3 |
|  |  |
| **Great vessels**  |  |
| Angiosarcoma | 9120/3 |
| Pulmonary artery intimal sarcomac | 9137/3 |

a Previously histiocytoid cardiomyopathy.

b Previously extra-adrenal paraganglioma.

c Previously intimal sarcoma.

d These morphology codes are from the International Classification of Diseases for Oncology, third edition, second revision (ICD-O-3.2).4 Behaviour is coded /0 for benign tumours; /1 for unspecified, borderline, or uncertain behaviour; /2 for carcinoma in situ and grade III intraepithelial neoplasia; /3 for malignant tumours, primary site; and /6 for malignant tumours, metastatic site. Behaviour code /6 is not generally used by cancer registries. Subtype labels are indented.

† Labels marked with a dagger constitute a change in terminology of a previous code.

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**References**

1 WHO Classification of Tumours Editorial Board (2021). *Thoracic Tumours, 5th Edition, Volume 5*. IARC Press, Lyon.

4 Fritz A, Percy C, Jack A, Shanmurgaratnam K, Lobin L, Parkin DM and Whelan S (eds) (2020). *International Classification of Diseases for Oncology. Third edition, Second revision ICD-O-3.2.* Available from: http://www.iacr.com.fr/index.php?option=com\_content&view=category&layout=blog&id=100&Itemid=577 (Accessed 16th June 2021).

**Table 2: Histologic grading for soft tissue sarcoma.5**

|  |  |  |
| --- | --- | --- |
| **Tumour differentiation** | **Mitotic count** | **Tumour necrosis** |
| Sarcoma closely resembling normal adult mesenchymal tissue (e.g., low grade leiomyosarcoma) (1 point) | 0-9 mitoses per 2mm2 (1 point) | No necrosis (0 points) |
| Sarcomas for which histologic typing is certain (e.g., myxoid/round cell liposarcoma) (2 points) | 10-19 mitoses per 2mm2 (2 points) | < 50% tumour necrosis (1 point) |
| Undifferentiated sarcomas, sarcomas of doubtful type, synovial sarcomas, osteosarcoma (3 points) | ≥20 mitoses per 2mm2 (3 points) | ≥50% tumour necrosis (2 points) |

2mm2 = 10 high power fields (HPF) if the field diameter is 0.55mm (each pathologist should ensure calibration of their own microscope).

**Reference**

5 Amin MB, Edge SB, Greene FL, Byrd DR, Brookland RK, Washington MK, Gershenwald JE, Compton CC, Hess KR, Sullivan DC, Jessup JM, Brierley JD, Gaspar LE, Schilsky RL, Balch CM, Winchester DP, Asare EA, Madera M, Gress DM and Meyer LR (eds) (2017). *AJCC Cancer Staging Manual. 8th ed.*, Springer, New York.