**** **Paediatric Renal Tumours 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**

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| 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 by the Dataset Authoring Committee (DAC).  Non-morphological testing e.g., molecular or immunohistochemical testing is a growing feature of cancer reporting. However, in many parts of the world this type of testing is limited by the available resources. In order to encourage the global adoption of ancillary tests for patient benefit, International Collaboration on Cancer Reporting (ICCR) includes the most relevant ancillary testing in ICCR Datasets as CORE elements, especially when they are necessary for the diagnosis. Where the technical capability does not yet exist, laboratories may consider temporarily using these data elements as NON-CORE items.  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 DAC. |
| Scope of this dataset | The dataset has been developed for the pathology reporting of resection specimens from paediatric patients with nephroblastoma also known as Wilms tumour (used here from now on), and all other renal tumours of childhood except renal cell carcinomas, for which the ICCR Invasive carcinoma of renal tubular origin dataset should be used.1 Rarely, other primitive tumours of childhood (including neuroblastoma, Ewing sarcoma/peripheral neuroectodermal tumour, desmoplastic small round cell tumour, among others) arise within the kidney but not within renal precursor cells; these should be staged and treated according to recommendations specific for their diagnosis. This dataset does not apply to these tumours, or to procedures involving only biopsy.  For bilateral tumours, complete a separate dataset for each kidney. For multifocal unilateral tumours, complete a single dataset.  **Reference**  1 International Collaboration on Cancer Reporting (2017). *Invasive Carcinoma of Renal Tubular Origin, Histopathology Reporting Guide. 1st edition*. Available from: https://www.iccr-cancer.org/datasets/published-datasets/urinary-male-genital/renal-tubular/ (Accessed 15th January 2023). |

| **Core/**  **Non-core** | **Element name** | **Values** | **Commentary** | **Implementation notes** |
| --- | --- | --- | --- | --- |
| Core | ***Protocol followed*** | * Children’s Oncology Group (COG) * International Society of Paediatric Oncology (SIOP) * Not known |  |  |
| Core and Non-core | PREVIOUS THERAPY | * Information not provided * No previous chemotherapy administered * Previous chemotherapy administered   Clinical information guiding previous therapy, *specify if*  *available* | The treatment of Wilms tumour may include the use of chemotherapy prior to resection or biopsy.1-3 The staging systems for these different approaches, although similar, have significant differences. Further, the histological appearance differs following chemotherapy, as does the assessment of risk stratification.4,5 Thus, it is critical that the status of preoperative therapy is known so that the relevant staging and classification systems can be applied. When completing this element, only chemotherapy used to treat the current renal tumour is considered as ‘prior treatment’.    **References**  1 Sonn G and Shortliffe LM (2008). Management of Wilms tumor: current standard of care. *Nat Clin Pract Urol* 5(10):551-560.  2 Vujanić GM, D'Hooghe E, Graf N, Vokuhl C, Al-Saadi R, Chowdhury T, Pritchard-Jones K and Furtwängler R (2021). Prognostic significance of histopathological response to preoperative chemotherapy in unilateral Wilms' tumor: An analysis of 899 patients treated on the SIOP WT 2001 protocol in the UK-CCLG and GPOH studies. *Int J Cancer* 149(6):1332-1340.  3 Dome JS, Perlman EJ and Graf N (2014). Risk stratification for wilms tumor: current approach and future directions. *Am Soc Clin Oncol Educ Book*:215-223.  4 Vujanić GM, D'Hooghe E, Popov SD, Sebire NJ and Kelsey A (2019). The effect of preoperative chemotherapy on histological subtyping and staging of Wilms tumors: The United Kingdom Children's Cancer Study Group (UKCCSG) Wilms tumor trial 3 (UKW3) experience. *Pediatr Blood Cancer* 66(3):e27549.  5 Perlman EJ (2005). Pediatric renal tumors: practical updates for the pathologist. *Pediatr Dev Pathol* 8(3):320-338. |  |
| Core | OPERATIVE PROCEDURE | * Not specified * Enucleation * Partial nephrectomy * Total or radical nephrectomy * Other, *specify* | There are three overall approaches to the initial diagnosis of Wilms tumour: i) upfront neoadjuvant chemotherapy (with no biopsy) for presumed Wilms tumour (within specified clinical parameters) followed by post-therapy resection; ii) initial biopsy followed by chemotherapy and then resection; and iii) primary resection prior to chemotherapy. The type and extent of the surgical procedure chosen depends on many factors, including the site, size and extent of the tumour. Total or radical nephrectomy includes resection of an intact kidney and any associated lymph nodes or tissue/organs adherent to the tumour. Partial nephrectomy seeks to completely excise a tumour with a margin of non-tumour tissue while sparing the remaining kidney. Enucleation seeks to remove the entire tumour, minimising the margin of non-tumoral tissue.  The choice of performing a biopsy has different implications depending upon which staging system is used. In the Children’s Oncology Group (COG) staging system, biopsy of any type, including percutaneous core or needle biopsy, upstages the tumour to at least a stage III.1,2 In the International Society of Paediatric Oncology (SIOP)/Renal Tumour Study Group (RTSG) staging system, only open biopsy upstages the tumour to at least stage III;3 needle or core biopsy using a posterior retroperitoneal approach does not upstage the tumour.4  It is important to note that in COG a biopsy performed at a previous procedure does not impact on the staging of subsequent procedures if interval therapy has been given. All procedures are newly staged based on features for the tumour at the time of the procedure in order to best guide the subsequent therapy. For example, a biopsy taken prior to therapy in a COG patient supports a local stage of III at the time of the initial biopsy, but is not itself a criterion for stage III in a subsequent post-therapy resection. In contrast, in SIOP open/wedge biopsy mandates a stage III designation even for subsequent procedures.  Other rare operative procedures merit annotation. Wilms tumour rarely originates outside the kidney. Extrarenal Wilms tumour may be associated with other congenital anomalies and the operative approach should be provided.5  **References**  1 Dome JS, Graf N, Geller JI, Fernandez CV, Mullen EA, Spreafico F, Van den Heuvel-Eibrink M and Pritchard-Jones K (2015). Advances in Wilms Tumor Treatment and Biology: Progress Through International Collaboration. *J Clin Oncol* 33(27):2999-3007.  2 College of American Pathologists (2023). *Protocol for the Examination of Resection Specimens From Patients With Wilms and Other Pediatric Renal Tumors*. Available from: https://documents.cap.org/protocols/Kidney.Wilms\_4.3.0.1.REL\_CAPCP.pdf (Accessed 25th September 2023).  3 Vujanić GM, D'Hooghe E, Popov SD, Sebire NJ and Kelsey A (2019). The effect of preoperative chemotherapy on histological subtyping and staging of Wilms tumors: The United Kingdom Children's Cancer Study Group (UKCCSG) Wilms tumor trial 3 (UKW3) experience. *Pediatr Blood Cancer* 66(3):e27549.  4 Jackson TJ, Brisse HJ, Pritchard-Jones K, Nakata K, Morosi C, Oue T, Irtan S, Vujanic G, van den Heuvel-Eibrink MM, Graf N and Chowdhury T (2022). How we approach paediatric renal tumour core needle biopsy in the setting of preoperative chemotherapy: A Review from the SIOP Renal Tumour Study Group. *Pediatr Blood Cancer* 69(9):e29702.  5 Liang H, He Y, Fu L, Tian J, Sun N, Yu T, Huang Y, Lin D and Wang G (2020). Extrarenal Wilms tumor in children: A retrospective observational case series. *J Pediatr Urol* 16(5):664.e661-664.e667. |  |
| Core | PREOPERATIVE RUPTURE OR INTRAOPERATIVE SPILLAGE | * Not identified * Identified * Cannot be determined, *specify* | Wilms tumours, particularly prior to therapy, may rupture spontaneously or following preoperative or operative trauma.[1](#_ENREF_12) In SIOP/RTSG and COG protocols, tumours that rupture either prior to surgery or at the time of surgery (the latter is an event more recently termed spillage by COG) are considered to have local stage III disease and to require additional therapy.2,3 The pathologic appearance of rupture/spillage changes with the passage of time. Spillage at the time of resection, and rupture near the time of resection both result in disruption of the Gerota’s fascia and the underlying tumour. However, at times the pathologic evidence of the spillage/rupture may be limited and may only be evident to the surgeon. Furthermore, the same gross appearance may be seen following trauma to the specimen after operative removal of the tumour, requiring correlation with intraoperative findings. Rupture prior to surgery results in the same disruptive process, but with increasing passage of time several changes occur to varying degrees, including tumour devitalization, resolving haemorrhage, fibrosis, and inflammation within the perirenal soft tissue. With even further passage of time, the site of rupture may heal and may become inapparent pathologically. The determination of whether rupture/spillage has occurred is therefore often difficult based on pathologic findings alone and may require multidisciplinary input, particularly by the surgeon. Pathologists should seek the opinion of the surgeon prior to establishing the presence of rupture or spillage and should be aware that the surgeon may independently establish the presence and extent of rupture/spillage for treatment purposes.  It is important to note that the following situations do not constitute rupture: 1) penetration of the renal capsule, or the peritumoral pseudocapsule, and extension of the tumour into the perirenal soft tissue; and 2) appearance of rupture/spillage confined to the renal capsule (not involving the Gerota’s fascia). Further, in these situations, if the tumour then extends to the surgical margin, this is defined as a positive margin (see **MARGIN STATUS**) and not rupture. This distinction may impact the type and amount of radiation therapy given.  Sufficient data are not currently available to utilise the presence of tumour cells detected within abdominal or pleural fluid in staging of Wilms tumour.  **References**  1 Zhang Y, Song HC, Yang YF, Sun N, Zhang WP and Huang CR (2021). Preoperative Wilms tumor rupture in children. *Int Urol Nephrol* 53(4):619-625.  2 Dome JS, Perlman EJ and Graf N (2014). Risk stratification for wilms tumor: current approach and future directions. *Am Soc Clin Oncol Educ Book*:215-223.  3 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701. |  |
| Core | ACCOMPANYING/  ATTACHED STRUCTURES | * None submitted * Adrenal gland * Other, *specify* | Depending upon the size and relationship of the tumour with the adrenal gland, the surgeon may choose to remove the adjacent adrenal gland with the goal of completely resecting the tumour. Whether or not the patient has one or two adrenal glands may be important in their care in the future. Similarly, to achieve total removal of the tumour, the surgeon may remove pieces of other organs adherent to the tumour (such as spleen, liver, bowel or diaphragm). This information may likewise be useful in the management of the patient in the future. When these accompanying structures are resected intact with the kidney, the presence of tumour within the accompanying structure does not support a local stage of III unless the surgical margin of the resection of the specimen is positive for tumour. |  |
| Core | SPECIMEN LATERALITY | * Not specified/Not applicable * Left * Right * Other (e.g., horseshoe kidney, single kidney), *specify* | The anatomic location of the tumour being evaluated is an elemental part of the accurate description of the tumour under consideration. |  |
| Core | SPECIMEN WEIGHT | * \_\_\_ g * Cannot be assessed | Nephrectomy specimens should be weighed prior to sectioning or processing.Nephrectomy weight may be an eligibility factor for some clinical trial protocols1 and may influence therapy decisions in certain circumstances.2  **Reference**  1 College of American Pathologists (2023). *Protocol for the Examination of Resection Specimens From Patients With Wilms and Other Pediatric Renal Tumors*. Available from: https://documents.cap.org/protocols/Kidney.Wilms\_4.3.0.1.REL\_CAPCP.pdf (Accessed 25th September 2023).  2 Wiener JS, Coppes MJ and Ritchey ML (1998). Current concepts in the biology and management of Wilms tumor. *J Urol* 159(4):1316-1325. |  |
| Core | TUMOUR FOCALITY | * Cannot be determined * Unifocal * Multifocal   Specify number of tumours \_\_\_ | Most Wilms tumours are solitary, but multifocal unilateral and/or bilateral disease may occur in over 10% of cases.[1](#_ENREF_14),2Multifocal tumours are associated with an increased risk of Wilms tumour developing in the contralateral kidney, usually in association with nephrogenic rests.3 The presence of multifocality often determines the treatment approach.4In case of multiple synchronous tumours in a specimen, a single dataset should be completed providing the number of tumours and their size. Within each kidney, each tumour should be individually staged and classified, and then the stage and classification should be determined for the entire kidney. For example, a kidney with a 40 millimetres (mm) (4 centimetres (cm)) tumour showing diffuse anaplasia, local stage I, and a 100 mm (10 cm) tumour with favourable histology, local stage III would receive a classification of diffuse anaplasia, local stage III. This example illustrates that there will be unusual combinations that need to be carefully discussed among a multidisciplinary team in order to determine the final treatment strategy. When bilateral tumours are sampled, a dataset should be recorded for each kidney.  **References**  1 Wiener JS, Coppes MJ and Ritchey ML (1998). Current concepts in the biology and management of Wilms tumor. *J Urol* 159(4):1316-1325.  2 Shearer P, Parham DM, Fontanesi J, Kumar M, Lobe TE, Fairclough D, Douglass EC and Wilimas J (1993). Bilateral Wilms tumor. Review of outcome, associated abnormalities, and late effects in 36 pediatric patients treated at a single institution. *Cancer* 72(4):1422-1426.  3 Coppes MJ, Arnold M, Beckwith JB, Ritchey ML, D'Angio GJ, Green DM and Breslow NE (1999). Factors affecting the risk of contralateral Wilms tumor development: a report from the National Wilms Tumor Study Group. *Cancer* 85(7):1616-1625.  4 Ehrlich PF, Chi YY, Chintagumpala MM, Hoffer FA, Perlman EJ, Kalapurakal JA, Tornwall B, Warwick A, Shamberger RC, Khanna G, Hamilton TE, Gow KW, Paulino AC, Gratias EJ, Mullen EA, Geller JI, Grundy PE, Fernandez CV and Dome JS (2020). Results of Treatment for Patients With Multicentric or Bilaterally Predisposed Unilateral Wilms Tumor (AREN0534): A report from the Children's Oncology Group. *Cancer* 126(15):3516-3525. |  |
| Core and  Non-core | TUMOUR DIMENSIONSa | **Nodule 1**  Greatest dimension \_\_\_ mm  Additional dimensions  \_\_\_ mm x \_\_\_ mm  **Nodule 2**  Greatest dimension \_\_\_ mm  Additional dimensions  \_\_\_ mm x \_\_\_ mm   * Cannot be assessed, *specify* | The macroscopic size of the tumour determines the pathological handling, whereby at least one microscopic section is taken per centimetre of maximal tumour diameter.1-3 For pre-treated cases, the SIOP recommends mapping out at least one longitudinal slice of tumour to evaluate percentages of different elements (chemotherapy-induced changes, blastema, stroma and epithelium) to establish the diagnosis.The pathologic and radiologic tumour dimensions may also be used to calculate the volume of the tumour, or the volume of the different histologic counterparts at the time of central review.4 These are currently important questions being addressed within SIOP studies. For kidneys with more than two tumours, the two tumours impacting on the stage and histology should be provided.  At least the greatest tumour dimension should be reported; preferably all three dimensions should be evaluated, particularly if tumour volume is desired.  **References**  1 College of American Pathologists (2023). *Protocol for the Examination of Resection Specimens From Patients With Wilms and Other Pediatric Renal Tumors*. Available from: https://documents.cap.org/protocols/Kidney.Wilms\_4.3.0.1.REL\_CAPCP.pdf (Accessed 25th September 2023).  2 Zuppan CW (1998). Handling and evaluation of pediatric renal tumors. *Am J Clin Pathol* 109(4 Suppl 1):S31-37.  3 Vujanić GM, Parsons LN, D'Hooghe E, Treece AL, Collini P and Perlman EJ (2022). Pathology of Wilms' tumour in International Society of Paediatric Oncology (SIOP) and Children's oncology group (COG) renal tumour studies: Similarities and differences. *Histopathology* 80(7):1026-1037.  4 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701. | a Specify for each nodule, or  for the two nodules that  determine the stage and/or  histologic classification. |
| 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 should the need for internal or external review arise. 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. It is useful to have a digital macroscopic picture of the specimen and a record of the origin of the tumour blocks.    Recording the origin/designation of tissue blocks also facilitates retrieval of blocks for further immunohistochemical or molecular analysis, research studies or clinical trials. |  |
| Core | RENAL SINUS INVOLVEMENT | * Cannot be determined * Not identified * Renal sinus vessel involvement by viable tumour with negative marginb * Invasion of the wall of the ureter or collecting system outside of the kidney by viable tumour (but completely resected with negative margin)b * More than minimal renal sinus soft tissue invasion present (but completely resected with negative margin)b * Minimal renal sinus soft tissue invasion by viable tumour   present (<5 mm in greatest dimension and >5 mm from a  margin)c | The renal sinus is composed predominantly of adipose tissue and harbors nerves and vessels supplying and draining the kidney, and the extrarenal collecting system. The renal sinus also extends deeply into the contours of the kidney. The most important renal sinus sections are those taken from regions adjacent to the tumour. SIOP/RTSG and COG protocols separately evaluate the invasion of renal sinus soft tissue and the involvement of renal sinus vessels to provide tumour staging which dictates subsequent treatment. For both SIOP/RTSG and COG, only **viable** tumour within the renal sinus results in upgrading to local stage II, providing the margins are negative for viable and non-viable tumour.1,2  **Sinus soft tissue:** Unlike the majority of the kidney, the renal sinus lacks a fibrous capsule separating the kidney from the adjacent adipose tissue. Therefore, tumour that is confined to the kidney may directly abut the renal sinus fat, without truly invading the renal sinus soft tissue. Similarly, nephrogenic rests located deep in the kidney may also involve the renal sinus soft tissue and mimic involvement by Wilms tumour. COG protocols include an additional refinement that identifies patients with only minimal renal sinus soft tissue invasion that is distant from the soft tissue margin. Unless there are other features upstaging these patients, they are treated as local stage I tumours. In practice, ‘minimal invasion’ includes tumours that show tumour extension into the sinus that is less than 5 millimetres (mm) in greatest dimension, and is located greater than 5 mm from a surgical margin.  **Sinus vessels:** Evaluating renal sinus vascular involvement may likewise be challenging. During processing, small fragments of tumour may be displaced into vascular structures and mimic true vascular involvement. Artifactually displaced tumour fragments are commonly highly irregular ragged and may contain ink that is displaced by the knife or blade. True vascular involvement has a smooth surface and is often (but not always) adherent to the vessel. Any degree or size of true sinus vascular involvement is a criterion for local stage II. This is distinct from staging based on invasion of sinus soft tissue, as above.  **References**  1 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701.  2 Zuppan CW (1998). Handling and evaluation of pediatric renal tumors. *Am J Clin Pathol* 109(4 Suppl 1):S31-37. | b Criteria for local stage II by both COG and SIOP.  c Allowed within local stage I by COG, considered stage II by SIOP. |
| Core | RENAL CAPSULE PENETRATION | * Cannot be assessed * No viable tumour outside the renal capsule * Viable tumour outside the renal capsule (including adrenal gland) that **is not** surrounded by a fibrous pseudocapsule, with negative marginsd * Viable tumour outside the renal capsule or within the adrenal gland that **is** surrounded by a fibrous pseudocapsule, with negative marginse | The SIOP/RTSG and COG protocols evaluate the invasion of tumour beyond the renal capsule in order to provide tumour staging which dictates subsequent treatment.1,2 The renal capsule is a layer of collagen covering the entire kidney, except for the renal sinus. The renal capsule may be quite thin, particularly if compressed by an expanding tumour. The fibrous pseudocapsule formed by the tumour itself may merge with the renal capsule, making the distinction between the tumour pseudocapsule and the renal capsule difficult. The presence of the tumour beyond the renal capsule is best seen by taking sections of the triangular region where the normal kidney and renal capsule meets the confluence of the tumour with its pseudocapsule.  Beyond the renal capsule is a layer of adipose tissue, often containing dilated vessels, which is covered by the Gerota’s fascia. Viable tumour that penetrates the renal capsule and invades or is otherwise present within this soft tissue or vessels without invasion beyond, or rupture of, the Gerota’s fascia meet the criteria for stage II. Non-viable tumour in this region, in the absence of other criteria, does not upstage to stage II. For institutions that treat patients according to SIOP/RTSG protocols, additional refinements have been made that identify a small number of patients with viable tumour within the perirenal fat or within the adrenal gland that is surrounded by a fibrous pseudocapasule, which is allowed within local stage I for SIOP/RTSG (but not for COG).  **References**  1 Dome JS, Perlman EJ and Graf N (2014). Risk stratification for wilms tumor: current approach and future directions. *Am Soc Clin Oncol Educ Book*:215-223.  2 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701. | d Supports local stage II by SIOP and COG.  e Supports local stage II for COG; allowed within local stage I for SIOP. |
| Core | PRIMARY TUMOUR EXCISED IN ONE PIECE | * Cannot be assessed * Tumour excised in one piece * Tumour excised in more than one piecef | In the COG and National Wilms Tumour Study Group protocols, removal of tumour in more than one piece is a criterion for local stage III.1 Some examples include: 1) primary tumour excised in more than one piece; 2) tumour identified in a separately excised adrenal gland; 3) a tumour thrombus within the renal vein that is removed separately from the nephrectomy specimen; and 4) tumour nodules within the perirenal fat (resembling lymph nodes) that are separately excised. The separately excised specimens may or may not represent contiguous tumour.  **Reference**  1 Dome JS, Perlman EJ and Graf N (2014). Risk stratification for wilms tumor: current approach and future directions. *Am Soc Clin Oncol Educ Book*:215-223. | f Applicable only for COG staging, for which excision in more than one piece supports local stage III. |
| Core | NEPHROGENIC RESTSg | * Cannot be assessed * Not identified * Present * Intralobar * Single * Multiple * Perilobar * Single * Multiple * Diffuse, hyperplastic * Unclassified | Nephrogenic rests are foci of persistent embryonic tissue, and may be single, multiple, or diffusely distributed. More than 30% of Wilms nephrectomy specimens contain nephrogenic rests. Rests often appear paler than surrounding non-neoplastic kidney parenchyma and these areas should be sampled. The two fundamental categories of nephrogenic rests are based on the topography and histology; perilobar nephrogenic restsare located at the periphery of the lobule, are usually subcapsular and comprised predominantly of blastema or epithelial differentiation. Intralobar nephrogenic rests are usually located deep within the lobule. They have indistinct margins and contain blastemal, tubular, and prominent stromal elements interspersed among normal glomerular and tubular elements.1,2 Diffuse hyperplastic perilobar nephroblastomatosis is a rare form of perilobar nephrogenic rests that forms a rind of nephroblastomatosis involving one or both kidneys, in whole or in part.3,4 Nephrogenic rests have important implications concerning the risk of contralateral Wilms tumour development and association with certain syndromes.5,6  **References**  1 Beckwith JB (1993). Precursor lesions of Wilms tumor: clinical and biological implications. *Med Pediatr Oncol* 21(3):158-168.  2 Beckwith JB, Kiviat NB and Bonadio JF (1990). Nephrogenic rests, nephroblastomatosis, and the pathogenesis of Wilms' tumor. *Pediatr Pathol* 10(1-2):1-36.  3 Ehrlich PF, Tornwall B, Chintagumpala MM, Chi YY, Hoffer FA, Perlman EJ, Kalapurakal JA, Warwick A, Shamberger RC, Khanna G, Hamilton TE, Gow KW, Paulino AC, Gratias EJ, Mullen EA, Geller JI, Fernandez CV and Dome JS (2022). Kidney Preservation and Wilms Tumor Development in Children with Diffuse Hyperplastic Perilobar Nephroblastomatosis: A Report from the Children's Oncology Group Study AREN0534. *Ann Surg Oncol* 29(5):3252-3261.  4 Perlman EJ, Faria P, Soares A, Hoffer F, Sredni S, Ritchey M, Shamberger RC, Green D and Beckwith JB (2006). Hyperplastic perilobar nephroblastomatosis: long-term survival of 52 patients. *Pediatr Blood Cancer* 46(2):203-221.  5 Coppes MJ, Arnold M, Beckwith JB, Ritchey ML, D'Angio GJ, Green DM and Breslow NE (1999). Factors affecting the risk of contralateral Wilms tumor development: a report from the National Wilms Tumor Study Group. *Cancer* 85(7):1616-1625.  6 Beckwith JB (1998). Nephrogenic rests and the pathogenesis of Wilms tumor: developmental and clinical considerations. *Am J Med Genet* 79(4):268-273. | g Nephrogenic rests are not included in staging criteria. |
| Core | HISTOLOGICAL TUMOUR TYPE | * Wilms tumour (nephroblastoma) * Favourable histology * Focal anaplasia * Diffuse anaplasia * Nephrogenic rest only (without Wilms tumour) * Intralobar * Perilobar * Mesoblastic nephroma * Cellular * Classic * Mixed * Paediatric cystic nephroma * Cystic partly differentiated nephroblastoma * Metanephric stromal tumour * Metanephric adenoma * Metanephric adenofibroma * Ossifiying renal tumour of infancy * Clear cell sarcoma of the kidney * Rhabdoid tumour of the kidney * Anaplastic sarcoma of the kidney (DICER-1 associated) * Other, *specify* | Histologic diagnosis is based on the 2022 World Health Organization (WHO) Classification of Paediatric Tumours, 5th edition (Table 1).1 Accurate histological diagnosis of paediatric renal tumours is critical in order to provide the optimal therapy and outcome. Because they are rare, they often present a diagnostic challenge. Over 85% of renal malignancies in children will be Wilms tumours (favourable and anaplastic subtypes). Anaplastic Wilms tumour is defined as the presence of enlarged, atypical mitotic figures, marked nuclear enlargement, and hyperchromasia.1 Other paediatric renal tumours can have a similar appearance to Wilms tumour, and the addition of immunohistochemical and molecular analyses will aid in differentiating the various tumour types. It is beyond the scope of this document to provide detailed descriptions of the subtypes of paediatric renal tumours (refer to WHO 5th edition).1  **Table 1 (See end of the document for Table)**  **References**  1 WHO Classification of Tumours Editorial Board (ed) (2022). *Pediatric Tumours, WHO Classification of Tumours, 5th edition, Volume 7*. IARC Publications, Lyon.  2 Fritz A, Percy C, Jack A,  Shanmugaratnam K, Sobin L, Parkin DM  and Whelan S (eds) (2020). *International Classification of Diseases for Oncology, Third edition, Second revision ICD-O-3.2*. Available from: ttp://www.iacr.com.fr/index.php?option=com\_content&view=category&layout=blog&id=100&Itemid=577 (Accessed 16th December 2022). | Value list based on the WHO  Classification of Paediatric Tumours (2023).  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 (IARC). |
| Core | POST-THERAPY HISTOLOGICAL CLASSIFICATION OF  WILMS TUMOUR | * Not applicableh   **Low risk tumours**   * Completely necrotic (100% necrosis although residual tubules from nephrogenic rests may be present)   **Intermediate risk tumours**   * Favourable histology, epithelial type (≤66% necrosis; >66% of viable component epithelial and <10% blastema) * Favourable histology stromal type (≤66% necrosis; >66% of viable component stromal and <10% blastemal) * Favourable histology mixed type (≤66% necrosis with viable component containing at least two components, none of which comprise more than two thirds of the viable tumour, or tumours that are 10-66% blastemal) * Favourable histology, regressive type (66-99% necrosis) * Focal anaplasia (except blastemal type)i   **High risk tumours**   * Blastemal type (≤66% necrosis with >66% viable blastemal component) * Diffuse anaplasiai | The histologic response to prior therapy is taken into consideration by both SIOP and COG in order to guide future therapy of patients with post-therapy Wilms tumour.1,2 Tumours are stratified into three risk groups based on the histology following preoperative chemotherapy and on the assessment of percentages of chemotherapy-induced changes and all viable components.  **Low risk**:Completely necrotic tumours showing no viable tumour are classified as low risk. Small foci of tubules, stroma and/or blastema representing residual nephrogenic rests may be present.  **Intermediate risk**: All favourable histology Wilms tumours falling outside of low and high risk as defined above are classified as intermediate risk. In addition, SIOP tumours with focal anaplasia are included in the intermediate risk category. COG tumours with focal and diffuse anaplasia are separately classified and treated. SIOP also separately classifies intermediate risk tumours by histology due to their potential prognostic implications.3,4  **High risk**: Tumours with diffuse anaplasia are classified as high risk by SIOP, and are separately classified and treated by COG. Favourable histology Wilms tumours that are ≥33% viable with >66% of the viable tumour composed of blastema are classified by both SIOP and COG as high risk.  **References**  1 Vujanić GM, Parsons LN, D'Hooghe E, Treece AL, Collini P and Perlman EJ (2022). Pathology of Wilms' tumour in International Society of Paediatric Oncology (SIOP) and Children's oncology group (COG) renal tumour studies: Similarities and differences. *Histopathology* 80(7):1026-1037.  2 Zuppan CW, Beckwith JB, Weeks DA, Luckey DW and Pringle KC (1991). The effect of preoperative therapy on the histologic features of Wilms' tumor. An analysis of cases from the Third National Wilms' Tumor Study. *Cancer* 68(2):385-394.  3 Verschuur AC, Vujanic GM, Van Tinteren H, Jones KP, de Kraker J and Sandstedt B (2010). Stromal and epithelial predominant Wilms tumours have an excellent outcome: the SIOP 93 01 experience. *Pediatr Blood Cancer* 55(2):233-238.  4 Weirich A, Leuschner I, Harms D, Vujanic GM, Tröger J, Abel U, Graf N, Schmidt D, Ludwig R and Voûte PA (2001). Clinical impact of histologic subtypes in localized non-anaplastic nephroblastoma treated according to the trial and study SIOP-9/GPOH. *Ann Oncol* 12(3):311-319. | h Not post-therapy or not Wilms tumour*.*  i Focal and diffuse anaplasia are included in the post-therapy risk stratification by SIOP, but are treated by separate clinical protocols by COG. |
| Core and Non-core | MARGIN STATUS | * Cannot be assessed * Not involved   Distance of viable tumour from  closest margin \_\_\_ mm  Specify closest margin(s), if  possible   * Involved by viable tumourj * Renal vein margin * Ureteral margin * Inked soft tissue or parenchymal margin * Other, *specify* * Involved by non-viable tumour * Renal vein marginj * Ureteral marginj * Inked soft tissue or parenchymal margink * Other, *specify* * Presence of viable or non-viable tumour in peritoneal or   abdominal or pelvic nodules or implantsj | Margin status is critical for the staging of Wilms tumours. Margins positive for **viable tumour** upstage the tumour to stage III in all staging systems. The evaluation of non-viable tumour at the margin differs depending upon margin location and on the staging system used. In SIOP, **non-viable** tumour at the ureteral or renal vein margin or within abdominal or peritoneal implants is considered local stage III, whereas **non-viable** tumour at the soft tissue margin is not considered local stage III. COG considers **non-viable tumour** at all margins to represent local stage III.  The status of the renal parenchymal margin for partial nephrectomy is important, as positive margins are associated with consideration of the need for radiotherapy. However, after radiotherapy, the local recurrence rate was not greater in such patients.1 The presence of nephrogenic rest at the parenchymal margin of partial nephrectomy specimen represents a challenge in interpretation, but is not considered to be positive.  The area with the closest margin and the distance of the closest margin from tumour, while not required, may aid in in planning post-operative therapy in non-treated tumours.1,2  Assessment of the renal vein margin may be challenging, particularly if there is bulging thrombus. If the thrombus is intact (by gross assessment and discussion with the surgeon), and if the renal vein wall is not attached to the thrombus at its most distal aspect, the margin can be assumed to be negative.[3](#_ENREF_32)  **References**  1 Kieran K, Williams MA, Dome JS, McGregor LM, Krasin MJ and Davidoff AM (2013). Margin status and tumor recurrence after nephron-sparing surgery for bilateral Wilms tumor. *J Pediatr Surg* 48(7):1481-1485.  2 Ritchey M, Daley S, Shamberger RC, Ehrlich P, Hamilton T, Haase G and Sawin R (2008). Ureteral extension in Wilms' tumor: a report from the National Wilms' Tumor Study Group (NWTSG). *J Pediatr Surg* 43(9):1625-1629.  3 WM Murphy, DJ Grignon and EJ Perlman (2004). *Tumors of the Kidney, Bladder, and Related Urinary Structures*. AFIP Atlas of Tumor Pathology, Series 4. American Registry of Pathology, Washington, D.C., USA. | j Supports local stage III by both COG and SIOP.  k Supports local stage III by COG, but not by SIOP. |
| Core and Non-core | LYMPH NODE STATUS | * Cannot be assessed * No nodes submitted or found   Number of lymph nodes examined \_\_\_\_\_   * Not involved * Involved (viable or non-viable tumour)j   Number of involved lymph  Nodes \_\_\_   * Number cannot be determined   Location of involved lymph  Nodes   * Regional * Non-regional (outside the abdomino-pelvic region) | Lymph node involvement is a critical factor in determining stage, and lymph node involvement by either viable or non-viable tumour requires a designation of stage III in both the National Wilms Tumour Study Group/ COG and SIOP/ RTSG staging systems.1,2 Positive lymph node status in any site is associated with a worse prognosis,3 particularly for those patients with anaplasia.2  The recognition of lymph node metastasis in certain circumstances can be challenging. Small aggregates of tumour cells in the subcapsular sinuses may be overlooked, and these sites should be examined carefully for metastatic disease. In post-treatment tumours, lymph nodes may contain totally necrotic tumour, which still upstages the tumour to local stage III.4,5 Such necrotic tumour foci should replace part of the nodal architecture; prominent sinus histiocytes should not be considered evidence for stage III tumour. Lastly, when tumour causes obstruction of the kidney, Tamm-Horsfall protein may accumulate within the kidney and displaced into the regional lymph node. This may be accompanied by displaced non-neoplastic renal tubular epithelial cells and such foci may mimic lymph node metastasis. Such foci are cytologically consistent with reactive epithelial cells and do not resemble Wilms tumour.6  Involvement of abdominal or pelvic lymph nodes is a criterion for local stage III, whereas lymph node involvement in the thorax or other extra-abdominal sites is a criterion for stage IV.  **References**  1 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701.  2 Kieran K, Anderson JR, Dome JS, Ehrlich PF, Ritchey ML, Shamberger RC, Perlman EJ, Green DM and Davidoff AM (2012). Lymph node involvement in Wilms tumor: results from National Wilms Tumor Studies 4 and 5. *J Pediatr Surg* 47(4):700-706.  3 Honeyman JN, Rich BS, McEvoy MP, Knowles MA, Heller G, Riachy E, Kobos R, Shukla N, Wolden SL, Steinherz PG and La Quaglia MP (2012). Factors associated with relapse and survival in Wilms tumor: a multivariate analysis. *J Pediatr Surg* 47(6):1228-1233.  4 Vujanić GM, Parsons LN, D'Hooghe E, Treece AL, Collini P and Perlman EJ (2022). Pathology of Wilms' tumour in International Society of Paediatric Oncology (SIOP) and Children's oncology group (COG) renal tumour studies: Similarities and differences. *Histopathology* 80(7):1026-1037.  5 Vujanić GM, Sandstedt B, Harms D, Kelsey A, Leuschner I and de Kraker J (2002). Revised International Society of Paediatric Oncology (SIOP) working classification of renal tumors of childhood. *Med Pediatr Oncol* 38(2):79-82.  6 WM Murphy, DJ Grignon and EJ Perlman (2004). *Tumors of the Kidney, Bladder, and Related Urinary Structures*. AFIP Atlas of Tumor Pathology, Series 4. American Registry of Pathology, Washington, D.C., USA. | j Supports local stage III by both COG and SIOP. |
| Non-core | COEXISTENT PATHOLOGY | * None identified * Present, *specify* | In some situations, inclusion of coexisting conditions such as glomerulopathy may support clinico-pathological correlation or patient management. |  |
| Core and Non-core | ANCILLARY STUDIES | * Not performed * Performed * Immunohistochemistry, *specify test(s) and result(s)* * Molecular genetic testing, *specify test(s) and result(s)* * Other, *record test(s), methodology and results*   **Representative blocks for ancillary studies**, *specify those blocks best representing tumour and/or normal tissue for further study* | **Wilms tumour**: Ancillary studies are usually not necessary for the diagnosis of Wilms tumour in resection specimens. However, immunohistochemical staining for WT1 and/or PAX8 may be useful for problematic cases when differentiating blastemal-predominant Wilms tumour from other embryonal soft tissue tumours presenting within the kidney (which are not covered by this dataset). Similarly, no single recurrent genetic abnormality has been found in Wilms tumour, although molecular genetic tests may be performed for diagnostically difficult cases. Several studies suggest that the common underlying marker of anaplasia is mutation of the p53 protein.1-3 Mutation of p53 often (but not always) results in abnormal p53 protein accumulation and strong nuclear positivity for p53 by immunohistochemistry. However, the diagnostic utility of immunohistochemistry for p53 protein is limited by difficulties in performing and interpreting the test. Furthermore, some p53 mutations do not cause abnormal protein accumulation. However, strong nuclear p53 protein accumulation identified in a tumour that is suspicious for anaplasia may contribute to the diagnosis.4  Molecular tests such as loss of heterozygosity (LOH) at chromosomes 1p and 16q, gain of 1q, and 11p15 loss have prognostic significance in certain patient populations. Augmentation of therapy has been shown to be effective for Wilms tumours with combined LOH at 1p and 16q, therefore analysis of these loci, most commonly by targeted or genome-wide microarray that includes evaluation of zygosity (SNP array), has become routine practice in North America.5,6 While 1q gain is associated with adverse prognosis, the benefit of increased therapy is an area of active investigation.7 LOH and imprinting abnormalities of 11p15 have been associated with increased risk of relapse in young patients with stage I favourable histology Wilms tumour treated with nephrectomy alone without adjuvant therapy.8,9 On occasion, ancillary germline genetic testing may be useful after the diagnosis has been made. For example, there is an association between perilobar nephrogenic rests, LOH for IGF2 and overgrowth syndromes; and between intralobar nephrogenic rests, mutations of the WT1 gene and the WAGR and Denys-Drash syndromes (reviewed in Beckwith 199810).  **Clear cell sarcoma of the kidney**: Clear cell sarcomas of the kidney often show expression of BCOR, cyclin D1, NGFR, and TLE1 by immunohistochemistry; however none of these are either fully sensitive nor specific.11-14 Clear cell sarcoma of the kidney frequently contain *BCOR*-ITD mutations or other BCOR alterations;15 a minority have *YWHAE-NUTM2B* fusion.16,17  **Rhabdoid tumour**: Rhabdoid tumours of the kidney are most often characterised by alterations in *SMARCB1* gene, causing loss of INI1 expression by immunohistochemistry.18  Paediatric cystic nephromas (but not cystic partially differentiated nephroblastomas) are often associated with germline or somatic mutations in *DICER1* gene and are associated with pleuropulmonary blastoma familial cancer syndrome.19-21 Rarely, sarcomas with varying degrees of anaplasia histologically similar to pleuropulmonary blastoma may also be identified within the kidney,22,23 at times arising within a cystic nephroma.24,25  Metanephric adenomas, adenofibromas, and stromal tumours often carry somatic *BRAF* mutations.26  Congenital mesoblastic nephromas containing a cellular component often demonstrate *ETV6-NTRK3* fusions (as well as other variant fusions); alterations of *EGFR*, *BRAF* and other genes have also been reported in ETV6-NTRK3 negative cases.26  **References**  1 Bardeesy N, Falkoff D, Petruzzi MJ, Nowak N, Zabel B, Adam M, Aguiar MC, Grundy P, Shows T and Pelletier J (1994). 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| Core | HISTOLOGICALLY CONFIRMED DISTANT METASTASES | * Not applicable * Not identified * Present, *specify site(s)* | Documentation of known metastatic disease correlates with outcome and is an important part of the pathology report.1 Such information, if available, should be recorded with as much detail as is available, including the site, specimen type, and histologic pattern. If distant sites are sampled and pathologically shown to be negative, metastatic disease is ‘not identified’, whereas if sampling is not performed, this section is ’not applicable’.  **Reference**  1 Berger M, Fernandez-Pineda I, Cabello R, Ramírez-Villar GL, Márquez-Vega C, Nustede R, Linderkamp C, Schmid I, Neth O, Graf N, de Agustin JC, von Schweinitz D, Lacher M and Hubertus J (2013). The relationship between the site of metastases and outcome in children with stage IV Wilms Tumor: data from 3 European Pediatric Cancer Institutions. *J Pediatr Hematol Oncol* 35(7):518-524. |  |
| Core | PATHOLOGICAL STAGING | **Pathologic staging system used**   * Children’s Oncology Group (COG) * International Society of Paediatric Oncology (SIOP)   **Local stage (based on the data elements for each stage)**   * Local stage I   All staging elements are consistent with local stage I, and none indicate local stages II or III   * Local stage II   Presence of any staging element supporting local stage II and no parameters for local stage III   * Local stage III   Presence of any staging element for local stage III   * Local stage not determined | Staging of Wilms tumour remains one of the most important factors in determining prognosis and in making therapeutic decisions. Two main systems are in use: the SIOP/RTSG staging system is predominantly used for pre-treated tumours; and the National Wilms Tumour Study Group/ COG staging system is used for tumours undergoing primary resection as well as following therapy.1,2 The evaluation of tumour viability is only taken into consideration following therapy.  When bilateral tumours are sampled, a separate dataset should be recorded for each kidney.  The local staging criteria for COG are provided below:  **COG Local stage I: Tumour (viable) is limited to the kidney with negative margins and lymph nodes. All criteria listed below are met:**   1. Renal capsule is not penetrated by viable tumour. 2. Tumour may protrude (botryoid) into the renal pelvis or ureter but does not infiltrate their walls. 3. The vessels of the renal sinus are not involved by viable tumour. 4. The soft tissue of the renal sinus is not more than minimally involved by viable tumour. 5. The tumour was not ruptured or biopsied prior to removal. 6. There is no evidence of tumour at or beyond the margin of resection. 7. Necrotic tumour may be present within the renal sinus or beyond the renal capsule and remain local stage I provided the margins are negative for viable and non-viable tumour. 8. Extrarenal primary tumours are not eligible for stage I.   **COG Local stage II: The tumour is resected in one piece; there is no evidence of tumour at or beyond the margins and the lymph nodes are negative for tumour (viable or non-viable); at least one of the following is present:**   1. Viable tumour is present in the perirenal fat or adrenal gland. 2. Viable tumour infiltrates the blood or lymphatic vessels outside the renal parenchyma, including the renal sinus. 3. Viable tumour more than minimally infiltrates the soft tissue of the renal sinus. 4. Viable tumour infiltrates the wall of the renal pelvis or the ureter. 5. Viable tumour may infiltrate the adrenal gland or be adherent to adjacent structures but remain stage II if surgical margins are negative for tumour.   **COG Local stage III****: Residual non-haematogenous tumour present after surgery and confined to the abdomen. At least one of the following is present:**   1. Tumour (viable or non-viable) involves abdominal/pelvic lymph nodes. 2. Tumour (viable or non-viable) is present at a surgical margin of resection (documented by microscopic examination). 3. Pre- or intraoperative tumour rupture/spillage has occurred (documented histologically or confirmed by the surgeon). 4. The tumour is resected in more than one piece (piecemeal). 5. The tumour is biopsied before surgery regardless of biopsy type: tru-cut, open, or fine needle aspiration. (Only applies to staging at time of biopsy, should not be used as a criterion for assigning the stage III in a post-therapy resection specimen). 6. Tumour (viable or non-viable) has penetrated through the peritoneal surface. 7. Tumour implants (viable or non-viable) are found anywhere in the abdomen.   The local staging criteria for SIOP are provided below:  **SIOP Local stage I:** **Viable tumour is limited to the kidney with negative margins and lymph nodes.**  **All criteria listed below are met:**   1. Renal capsule intact, not penetrated by viable tumour. 2. Tumour might protrude (botryoid) into the renal pelvis or ureter but does not infiltrate their walls. 3. The vessels of the renal sinus are not involved by viable tumour. 4. The soft tissue of the renal sinus is not involved by viable tumour. 5. Non-viable tumour may be present within the renal sinus or beyond the renal capsule and remain stage I. 6. Viable tumour may remain Stage I if present in the perirenal fat or within the adrenal gland but surrounded by a fibrous pseudocapsule.   **SIOP Local stage II: The margins are negative for viable tumour and the lymph nodes are negative for viable or non-viable tumour; at least one of the following is present:**   1. Viable tumour is present in the perirenal fat or adrenal gland and is not covered by a pseudocapsule. 2. Viable tumour infiltrates the blood or lymphatic vessels outside the renal parenchyma. 3. Viable tumour infiltrates the soft tissue of the renal sinus. 4. Tumour may be adherent to adjacent structures but remain stage II if the surgical margin is negative. 5. Viable tumour infiltrates the vena cava or adjacent organs (except the adrenal gland), but is completely resected. 6. Viable tumour infiltrates the wall of the renal pelvis or the ureter.   **SIOP Local stage III: Residual non-haematogenous tumour present after surgery and confined to abdomen. Any one of the following may occur:**   1. Tumour (viable or non-viable) involving abdominal-pelvic lymph nodes. 2. Tumour (viable only) present at a soft tissue surgical margin of resection. 3. Tumour (viable or non-viable) present at resection margins of ureter, renal vein or inferior vena cava. 4. Pre- or intraoperative tumour rupture/spillage, if confirmed by microscopic examination (positive margin in area of the rupture). 5. Tumour thrombus (viable or non-viable) attached to the inferior vena cava wall removed piecemeal. 6. Wedge/open tumour biopsy prior to preoperative chemotherapy or surgery. 7. Tumour implants (viable or non-viable) are found anywhere in the abdomen. 8. Tumour (viable or non-viable) has penetrated through the peritoneal surface.   Reporting of pathological staging categories is based on the evidence available to the pathologist at the time of reporting. The final stage grouping of a patient's tumour is based on a combination of pathological staging and other clinical and imaging information.  **References**  1 Vujanić GM, Gessler M, Ooms A, Collini P, Coulomb-l'Hermine A, D'Hooghe E, de Krijger RR, Perotti D, Pritchard-Jones K, Vokuhl C, van den Heuvel-Eibrink MM and Graf N (2018). The UMBRELLA SIOP-RTSG 2016 Wilms tumour pathology and molecular biology protocol. *Nat Rev Urol* 15(11):693-701.  2 Vujanić GM, Parsons LN, D'Hooghe E, Treece AL, Collini P and Perlman EJ (2022). Pathology of Wilms' tumour in International Society of Paediatric Oncology (SIOP) and Children's oncology group (COG) renal tumour studies: Similarities and differences. *Histopathology* 80(7):1026-1037. |  |

**Tables**

**Table 1: World Health Organization classification of paediatric renal tumours.1**

| **Descriptor** | **ICD-O codes**a |
| --- | --- |
| Wilms tumour (nephroblastoma) | 8360/3 |
| Nephrogenic rest |  |
| Congenital mesoblastic nephroma | 8960/1 |
| Paediatric cystic nephroma | 8959/0 |
| Cystic partially-differentiated nephroblastoma | 8959/1 |
| Metanephric stromal tumour | 8935/1 |
| Metanephric adenoma | 8325/0 |
| Metanephric adenofibroma | 8965/0 |
| Ossifying renal tumour of infancy | 8967/0 |
| Clear cell sarcoma of kidney | 8964/3 |
| Rhabdoid tumour | 8963/3 |
| Anaplastic sarcoma of kidney (DICER-1 associate) | 8800/3 |

a These morphology codes are from the International Classification of Diseases for Oncology, third Edition, second revision (ICD-O-3.2).[2](#_ENREF_26) 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.

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**References**

1 WHO Classification of Tumours Editorial Board (ed) (2022). *Pediatric Tumours, WHO Classification of Tumours, 5th edition, Volume 7*. IARC Publications, Lyon.

2 Fritz A, Percy C, Jack A,  Shanmugaratnam K, Sobin L, Parkin DM  and Whelan S (eds) (2020). *International Classification of Diseases for Oncology, Third edition, Second revision ICD-O-3.2*. Available from: ttp://www.iacr.com.fr/index.php?option=com\_content&view=category&layout=blog&id=100&Itemid=577 (Accessed 16th December 2022).