WHO'S WHO IN THE NEW WHO CLASSIFICATION OF UROLOGIC CANCER?

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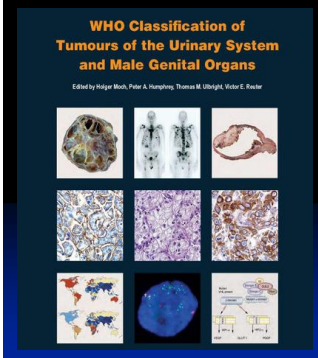
WHO (2015) BLUE BOOK COMMITTEE



- 21 Chapters - Mahul B Amin
- *Including Introduction/ Classification chapters :*
  - Prostate
  - Kidney
  - Bladder
  - Testis
  - Penis

2014: 12 major/new Concepts in the Blue book

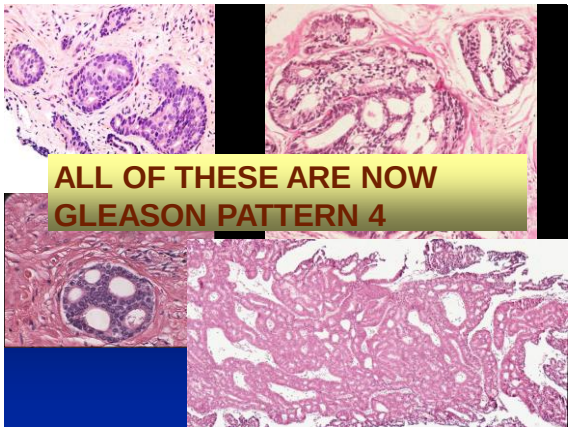
PROSTATE CANCER

What is new in the WHO 2016:

- **Topic 1:**
  Grading of prostate tumors

WHO/ISUP 2014 MAJOR RECOMMENDATION

- Report percent pattern 4 Gleason score 7 in both needle biopsies and radical prostatectomies.



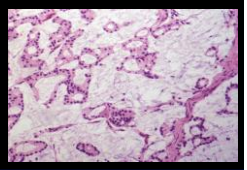
GLEASON GRADING OF VARIANTS OF PROSTATE CANCER

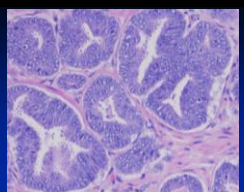
- **Ductal Ca.** - Gleason 4 or 5 (if necrosis)
- **Signet ring cell Ca.** - Gleason 4 or 5
- **Small cell Ca.** - do not grade
- **Sarcomatoid Ca.** - do not grade

GLEASON GRADING OF VARIANTS OF PROSTATE CANCER

NEW

- **Mucinous carcinoma behaves more indolently than previously believed – recommendation: subtract the mucin and grade the tumor – not all mucinous carcinomas are Gleason pattern 4**
- **PIN-like carcinoma is a Gleason pattern 3**





ORIGINAL ARTICLE

The 2014 International Society of Urological Pathology (ISUP) Consensus Conference on Gleason Grading of Prostatic Carcinoma

Definition of Grading Patterns and Proposal for a New Grading System

Jonathan I. Epstein, MD, Lars Egevad, MD, PhD,† Mahul B. Amin, MD,‡ Brett Delahunt, MD,§ John R. Srigley, MD,‖ Peter A. Humphrey, MD,*

Am J Surg Pathol 2016

Contemporary Gleason Grading of Prostatic Carcinoma

An Update With Discussion on Practical Issues to Implement the 2014 International Society of Urological Pathology (ISUP) Consensus Conference on Gleason Grading of Prostatic Carcinoma

Jonathan I. Epstein, MD,* Mahul B. Amin, MD,† Victor E. Reuter, MD,‡ and Peter A. Humphrey, MD, PhD§

Issues pertaining to implementation in clinical practice

- reporting of cancer per specimen/cores etc.
- reporting of different foci in RP

Am J Surg Pathol 2017, E Pub ahead of print.

Reporting of Gleason score Prognostic Grade Groups

Gleason score ≤ 6:	Grade Group I
Gleason score 3 + 4 = 7	Grade Group II
Gleason score 4 + 3 = 7	Grade Group III
Gleason score 8	Grade Group IV
Gleason score 9-10	Grade Group V

Gleason scores can be grouped and range from Grade Group I (most favorable) to Grade Group V (least favorable).

INCORPORTATION OF PROGNOSTIC GROUPS ENDORSED BY THE ISUP (2015) & WHO (2016)

Implications of Reporting of Gleason score Prognostic Grade Groups

Group 1: lowest grade, possible candidates for active surveillance; 20% cases may have higher unsampled grade; makes distinction between Gleason 2+2, 2+3, 3+3 irrelevant

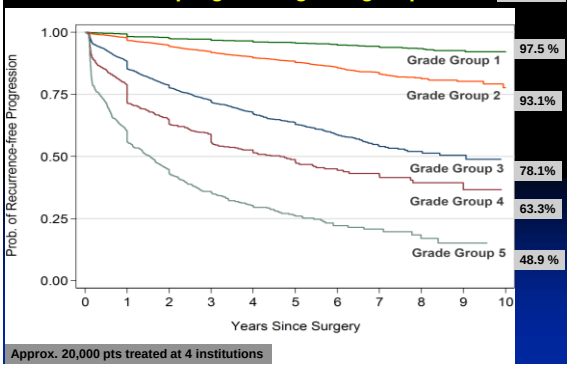
Group 2: Good prognosis, rare metastasis

Group 3: Worst prognosis than Group 2

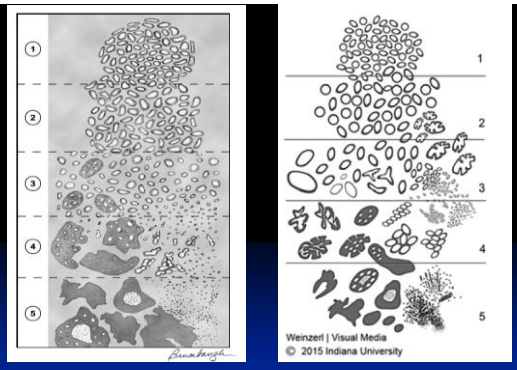
Group 4: Not nearly considered high-grade, has significantly better prognosis than Group 5

Group 5: Worst prognosis, obviates need to distinguish 4+5, 5+4, 5+5

Probability of recurrence- free progression for different prognostic grade groups



Approx. 20,000 pts treated at 4 institutions

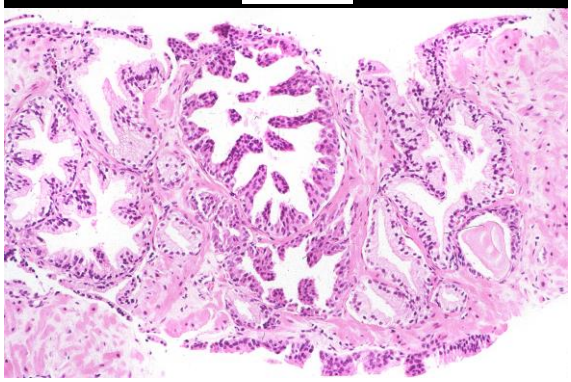


2005 **2014**

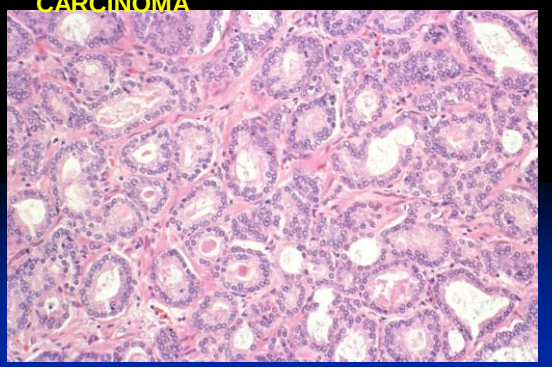
What is new in the WHO 2016:

- **Topic 2: Intraductal cancer**

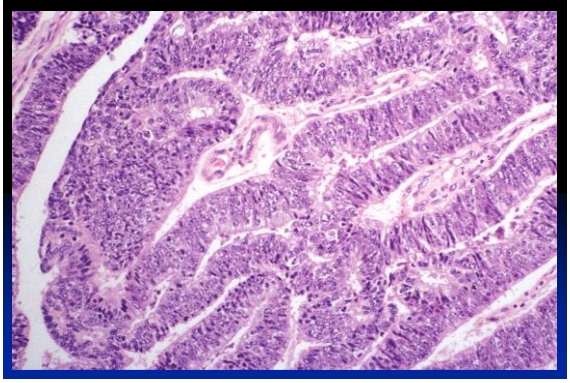
HG-PIN

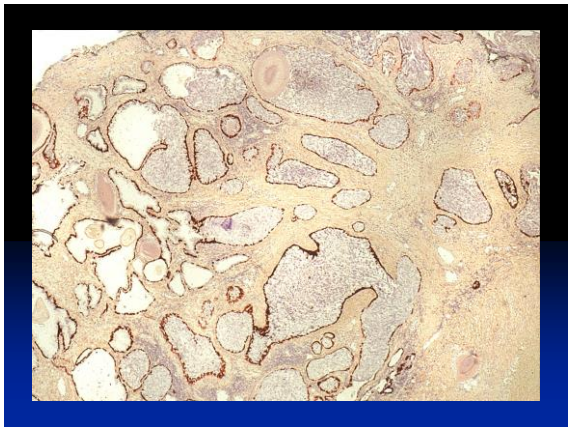


CONVENTIONAL (MICROACINAR) CARCINOMA



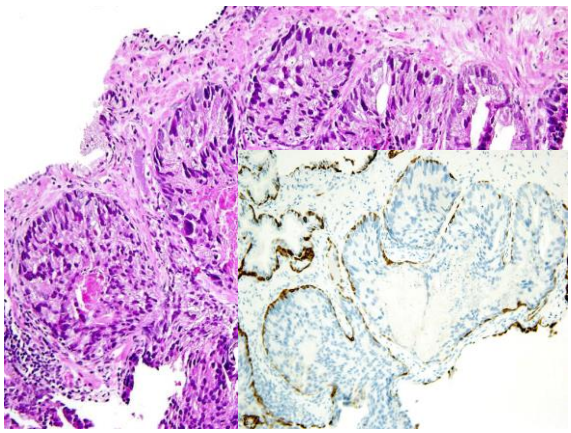
PROSTATIC DUCTAL CARCINOMA





Intraductal Carcinoma of the Prostate

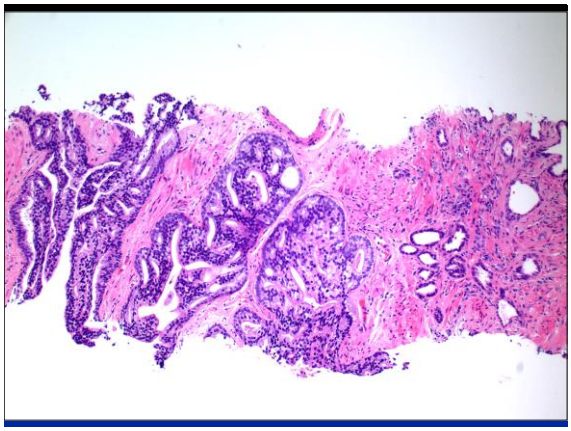
- Late event in P Ca evolution, with intraductal spread of aggressive P Ca and cancerization of preexisting ducts and acini by high-grade P Ca.
- In a minority of cases, may be precursor lesion because in approximately 10% of RP cases following a NBx dx of IDC, IDC in the whole prostate gland is found in pure form, without associated invasive carcinoma

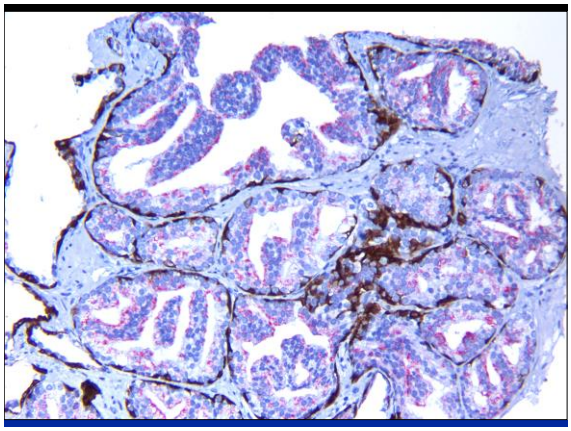


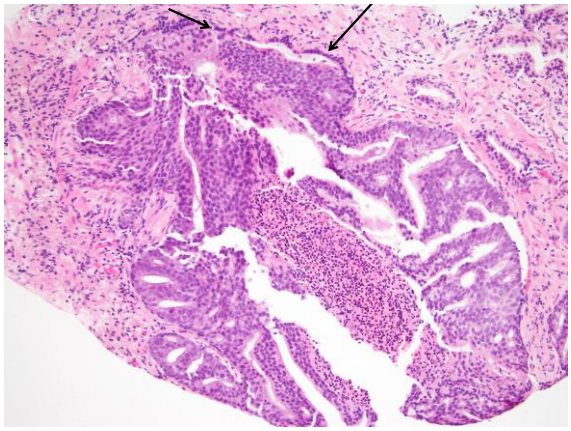
Intraductal Carcinoma of the Prostate

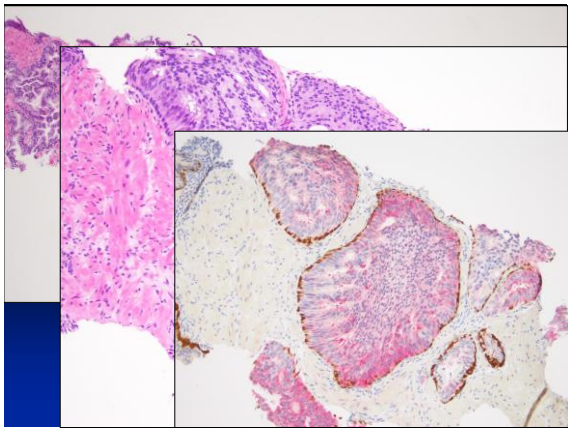
Criteria

- Marked expansile growth of atypical cells
  - Large cribriform/solid architecture
  - occasionally spans the width of the core
- Lesion within native prostate glands
  - Basal cell layer at least partially preserved
  - Complete or partial involvement of involved glands
- Prominent cytologic atypia, mitoses, comedonecrosis may be present

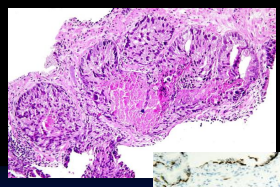


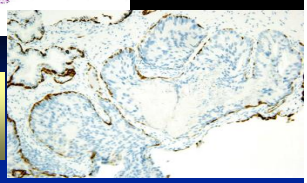






Grading of Intraductal Prostate cancer



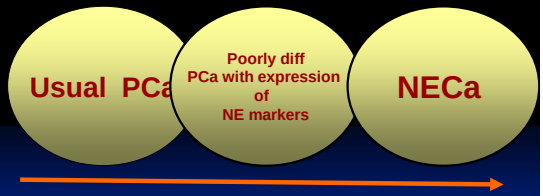


Pure Intraductal Carcinoma Should not be Graded

What is new in the WHO 2016:

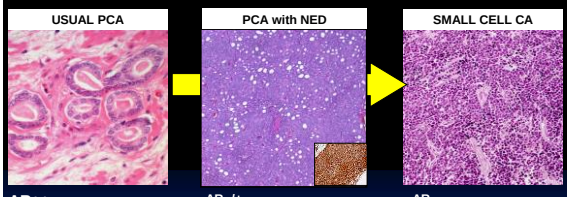
- **Topic 3:** Classification of neuroendocrine differentiation in prostate

PCa with neuroendocrine differentiation



- How do we characterize lesions along this spectrum
- At what point in this continuum is the NE marker expression clinically significant ?

EMERGENCE OF NE PHENOTYPE WITH MOLECULAR CORRELATES



USUAL PCA	PCA with NED	SMALL CELL CA
AR++ PSA++ REST++ MYC Amplif -/+ TMPRSS2- ERG -/+ PTEN Loss -/+	AR -/+ PSA-/+ REST low MYC Amplif -/+ TMPRSS2- ERG -/+ PTEN Loss -/+ ↑anti-apoptotic factors & neuronal genes	AR - PSA - REST - MYC Amplif -/+ AURKA Amplif -/+ Rb Loss -/+ ↑neuronal genes

CLASSIFICATION OF TUMORS ALONG

Proposed Morphologic Classification of Prostate Cancer with Neuroendocrine Differentiation

Epstein*, Amin*, Beltran, Lotan Mosquera, Reuter, Robinson, Troncoso, Rubin

** co-first authors*

Am J Surg Pathol (2014)

PROSTATE CANCER FOUNDATION

Accelerating the world's most promising research

Proposed Morphologic Classification of Prostate Cancer with Neuroendocrine Differentiation

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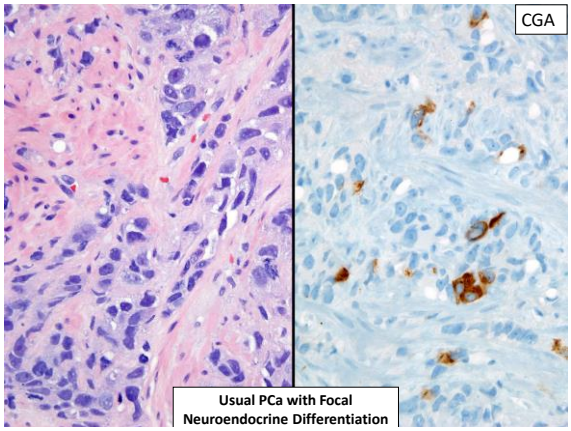
Am J Surg Pathol (2014)

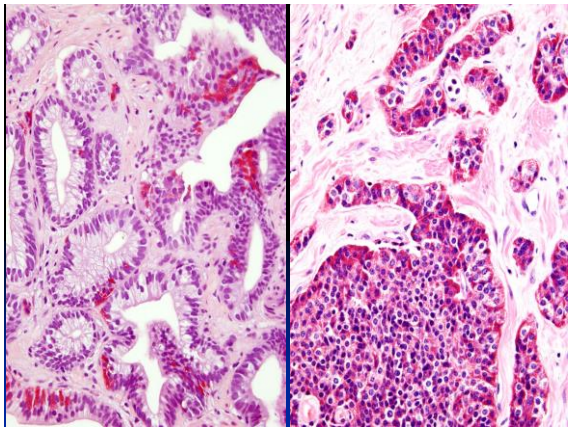
PCF 2013 Classification for PCa with Neuroendocrine Differentiation

- Usual PCa with Neuroendocrine (NE) Differentiation
- PCa with Paneth Cell NE Differentiation
- Carcinoid Tumor
- Small Cell NE Carcinoma
- Large Cell NE Carcinoma (LCNEC)
- Mixed (Small or Large Cell) NE Carcinoma - Acinar Adenocarcinoma
- *PCa with overlap features of small cell and acinar adenocarcinoma – Provisional Category*
- *Castration resistant PCa with small cell carcinoma-like clinical features – Clinical Category*

Usual PCa with NE Differentiation

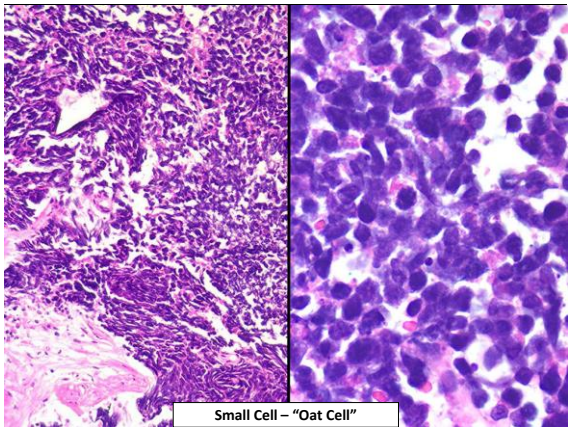
- **Definition:** Morphologically typical, usual acinar or ductal adenocarcinoma of the prostate in which NE differentiation is demonstrated by immunohistochemistry alone



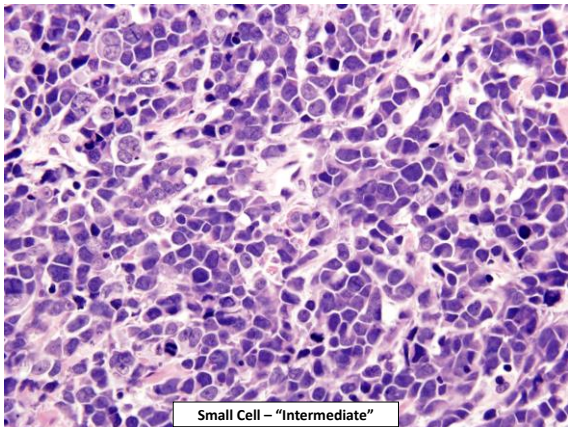


Carcinoid Tumor - WDNET

- Definition: A well differentiated NE tumor occurring primarily in the prostate gland, showing the classic morphology of carcinoid tumor at other sites such as the lung, but which is not closely associated with usual prostate carcinoma or which does not arise from the urethra or extend from the bladder
- In younger patients, screening for stigmata of MEN may be considered



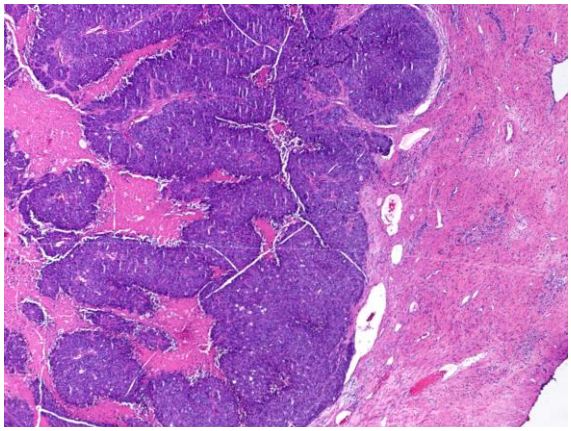
Small Cell – "Oat Cell"

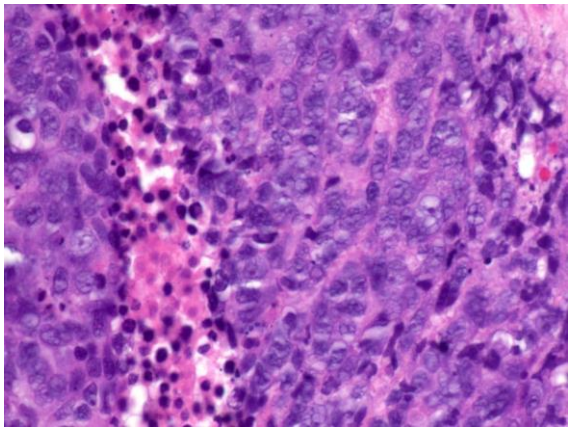


Small Cell – "Intermediate"

Large Cell NE Carcinoma

- **Definition:** High grade tumor with
  - NE architecture (organoid nests, palisading, rosettes, trabeculae, sheets)
  - Non-small cell NE carcinoma cytology (prominent nucleoli, vesicular clumpy chromatin and/or large cell size and abundant cytoplasm)
  - Expression of at least one neuroendocrine marker (excluding neuron specific enolase)





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KIDNEY CANCER

What is new in the WHO 2016:

- **Topic 4:**
  Classification of renal tumors

Will be covered tomorrow

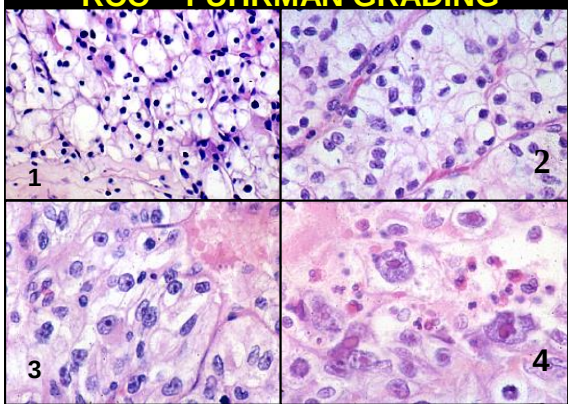
What is new in the WHO 2016:

- **Topic 5:**
  Grading of renal tumors

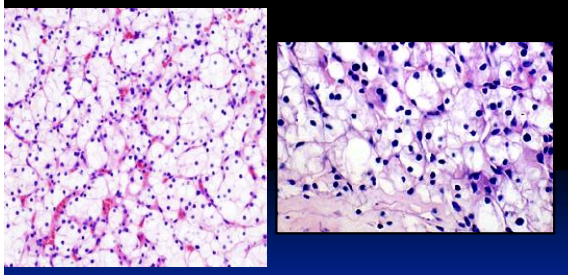
GRADING OF RCC (2016)

- **WHO/ISUP SYSTEM – modified from Fuhrman system**
- **To factor in necrosis for clear cell RCC**
- **Recommended to be used in all types of RCC though not validated beyond clear cell RCC**

RCC - FUHRMAN GRADING

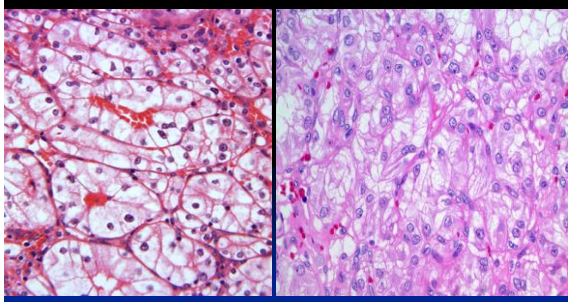


WHO/ISUP grade 1



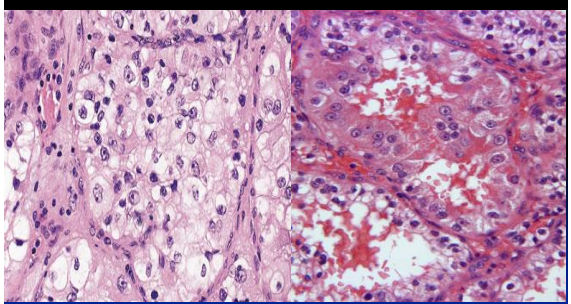
Nucleoli are inconspicuous or absent at low and high power

WHO/ISUP grade 2



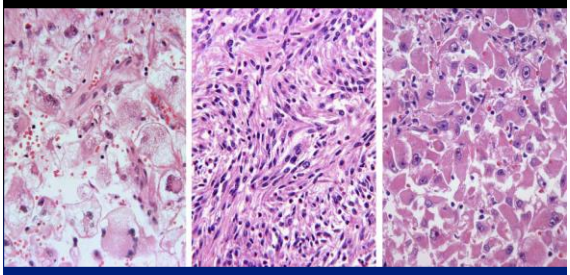
Grade 2: nucleoli are clearly visible at high-power magnification but are not prominent.

WHO/ISUP grade 3



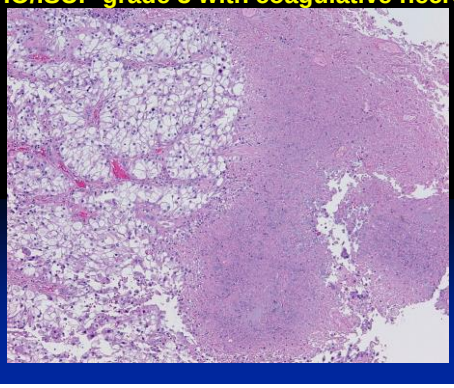
Grade 3: nucleoli are prominent and are easily visualized at low-power magnification

WHO/ISUP grade 4

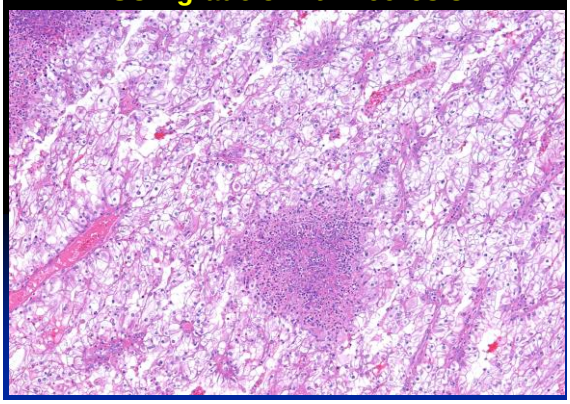


Grade 4: presence of tumor giant cells and/or marked nuclear pleomorphism; sarcomatoid carcinoma; carcinoma showing rhabdoid differentiation

WHO/ISUP grade 3 with coagulative necrosis



ISUP grade 3 with necrosis



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NEW IN BLADDER: WHO 2016

VI. Flat lesions –

- Atypia urothelial proliferation of unknown signficance

VII. Classification of variants – large nested, signet ring/plasmacytoid, chordoid

VIII. Urachal carcinoma including low grade cystic tumors

IX. Emerging Molecular subtypes

CLASSIFICATION OF BLADDER EPITHELIAL TUMORS

FLAT LESIONS

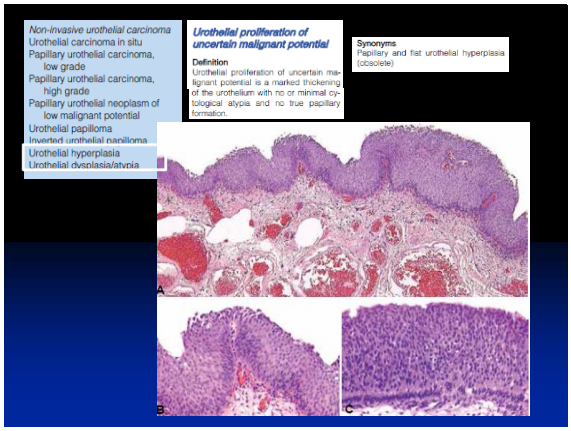
PAPILLARY LESIONS

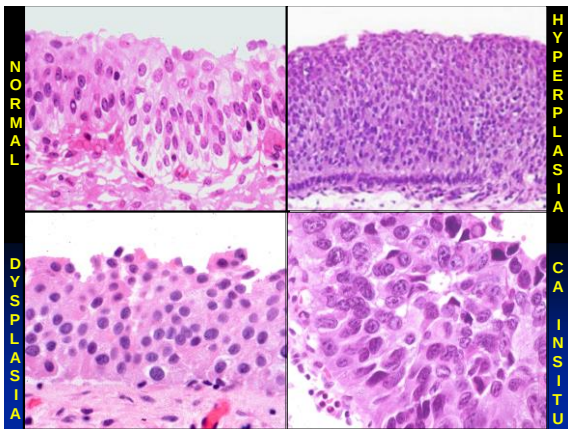
INVERTED LESIONS

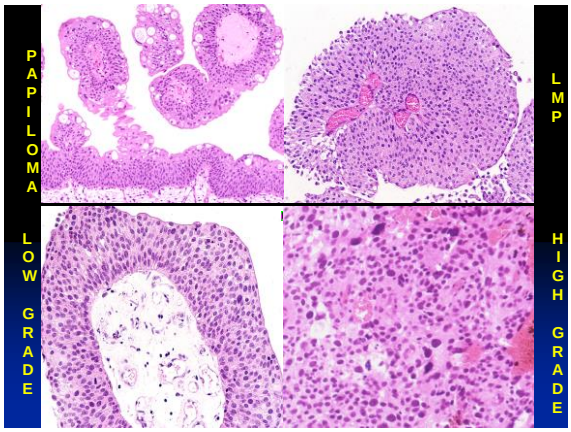
INVASIVE LESIONS

THE WHO (2016) / ISUP CLASSIFICATION OF UROTHELIAL (TRANSITIONAL CELL) NEOPLASMS OF THE URINARY BLADDER

- Normal
- Urothelial proliferation of uncertain malignant potential
- Flat lesions with atypia
  - Dysplasia
  - CIS (high-grade intraurothelial neoplasia)







Update for the practicing pathologist: The International Consultation On Urologic Disease-European association of urology consultation on bladder cancer

Mahul B Amin[1,27], Steven C Smith[1,27,28], Victor E Reuter[2], Jonathan I Epstein[3], David J Grignon[4], Donna E Hansel[5], Oscar Lin[2], Jesse K McKenney[6], Rodolfo Montironi[7], Gladell P Paner[8], Hikmat A Al-Ahmadie[2], Ferran Algaba[9], Syed Ali[3], Isabel Alvarado-Cabrero[10], Lukas Bubendorf[11], Liang Cheng[3], John C Cheville[12], Glen Kristiansen[13], Richard J Cote[14], Brett Delahunt[15], John N Eble[4], Elizabeth M Genega[16], Christian Gulmann[17], Arndt Hartmann[18], Cord Langner[19], Antonio Lopez-Beltran[20], Cristina Magi-Galluzzi[6], Jorda Merce[14], George J Netto[3], Esther Oliva[21], Priya Rao[22], Jae Y Ro[23], John R Srigley[24], Satish K Tickoo[2], Toyonori Tsuzuki[25], Saleem A Umar[14], Theo Van der Kwast[26], Robert H Young[21] and Mark S Soloway[14]

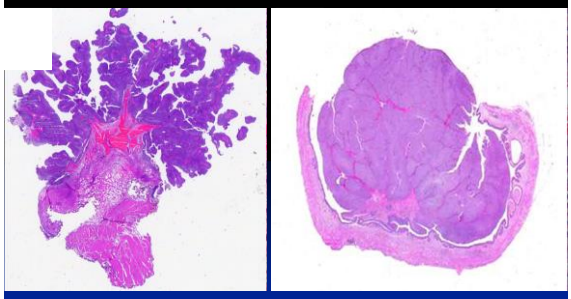
Modern Pathology:2014

Grading of Non-Invasive Urothelial Neoplasms of the Bladder

Flat Lesions	Papillary Tumors	Inverted Tumors
Normal	Urothelial Papilloma	Inverted Papilloma
Urothelial Hyperplasia	PUNLMP	Inverted PUNLMP
Urothelial Dysplasia	Papillary UCa, Low Grade	Inverted Papillary UCa, Low grade
Urothelial CIS	Papillary UCa, High Grade	Inverted Papillary UCa, High Grade

- PUNLMP, papillary urothelial neoplasm of low malignant potential

Courtesy R. Montironi, Italy

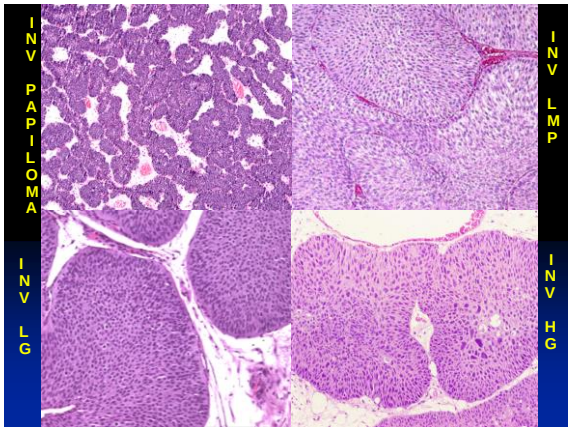


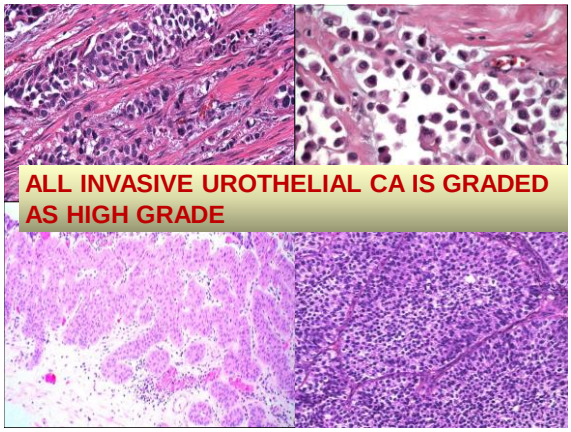
Exophytic tumor

Inverted tumor

CLASSIFICATION OF BLADDER LESIONS WITH INVERTED GROWTH PATTERN

- Inverted papilloma
- Inverted urothelial neoplasm of LMP
- Inverted urothelial carcinoma, low grade, non-invasive
- Inverted urothelial carcinoma, high grade, non-invasive
- Inverted urothelial carcinoma, high grade, invasive





ALL INVASIVE UROTHELIAL CA IS GRADED AS HIGH GRADE

CLASSIFICATION OF INVASIVE BLADDER CA

- **Urothelial carcinoma**
- **Squamous cell Ca**
  - *conventional*
  - *verrucous*
  - *basaloid*
- **Adenocarcinoma**
  - *mucosal based*
  - *urachal*

Neuroendocrine carcinoma
- Small cell
- Large cell
- Well differentiated tumor
- Paraganglioma

- **Variants of urothelial Ca**
  - *nested (incl. large nested)*
  - *microcystic*
  - *micropapillary*
  - *lymphoepithelioma-like*
  - *sarcomatoid*
  - *diffuse/plasmacytoid signet ring cell*
  - *giant cell*
  - *lipid rich*
  - *clear cell*
  - *undifferentiated*

CLASSIFICATION OF INVASIVE BLADDER CA

Will be covered tomorrow

PRIMARY ADENOCARCINOMA OF THE BLADDER

Anatomic:

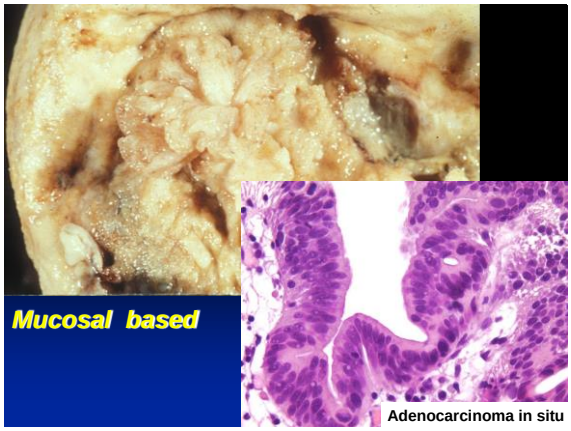
- Urachal
- Bladder mucosa

Histology:

- Adenocarcinoma NOS
- Enteric
- Mucinous
- Signet ring
- Clear cell
- Hepatoid
- Combined (from above)

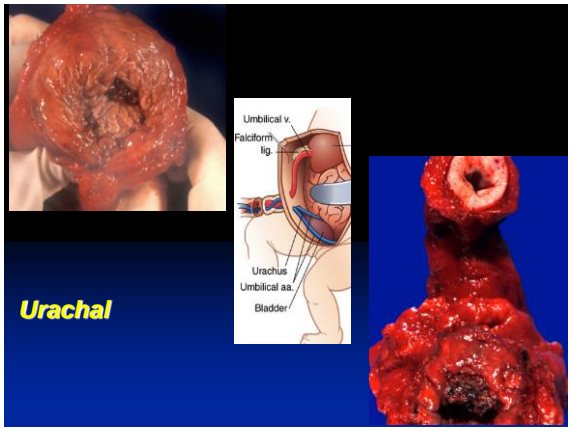
Rule out:

- Urothelial Ca with glandular features
- Metastasis

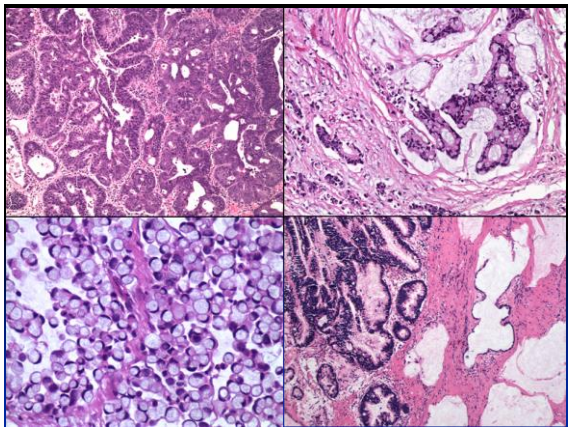


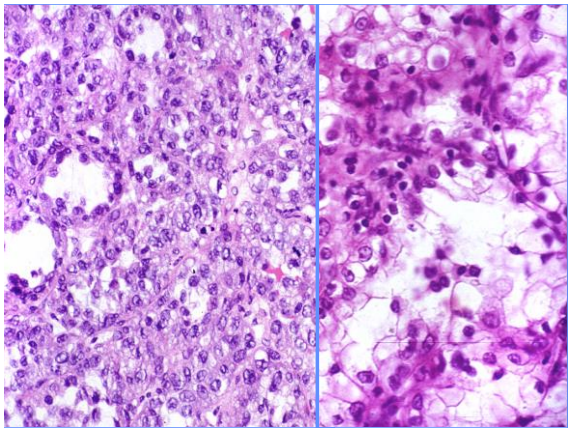
Mucosal based

Adenocarcinoma in situ



Urachal

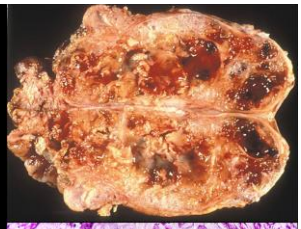


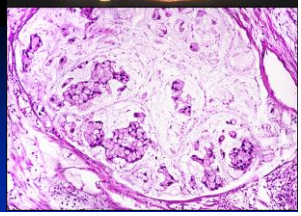


URACHAL CARCINOMA

Clinicopathologic diagnosis

- *Criteria:*
  - *Dome or anterior location*
  - *Absence of cystitis glandularis or intestinal metaplasia*
  - *Absence of primary elsewhere*
  - *Epicenter of mass in bladder wall*

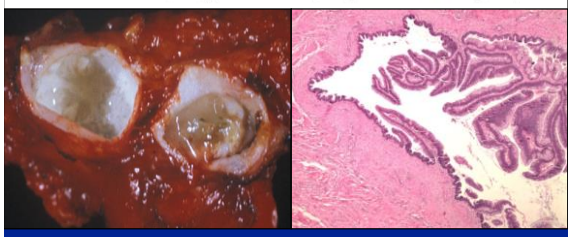




Glandular Neoplasms of the Urachus

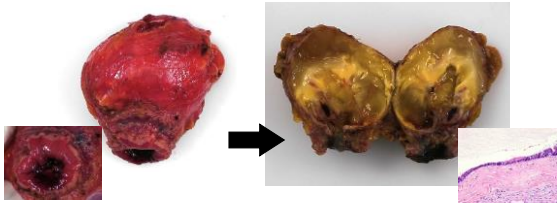
A Report of 55 Cases Emphasizing Mucinous Cystic Tumors With Proposed Classification

Mahul B. Amin, MD, Steven C. Smith, MD, PhD,* John N. Eble, MD,† Priya Rao, MD,* William W. L. Choi, MD,‡§ Pheroze Tamboli, MD,‖ and Robert H. Young, MD¶*



Am J Surg Pathol: 2014

Non-invasive and low grade mucinous cystic tumors of urachus



Cystic urachal tumor

Urachal mucinous cystadenoma

Glandular Neoplasms of the Urachus

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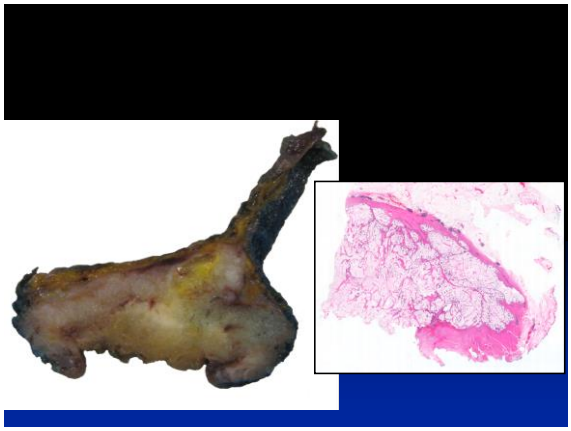
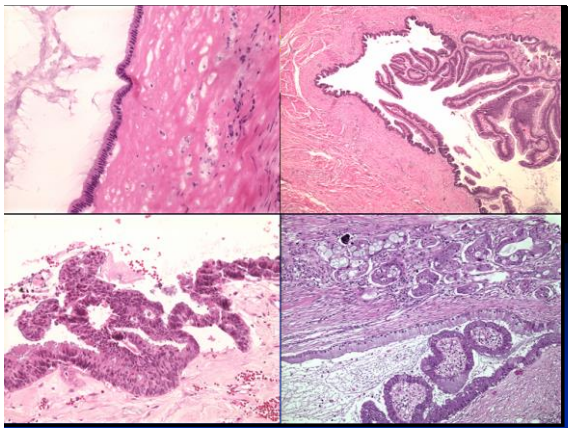
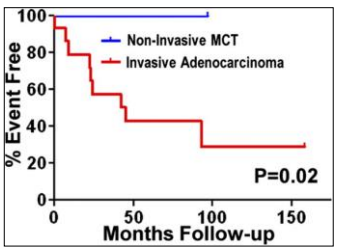
- 31 Mucinous cystic tumors (from 4 institutions & consult cases)
  - 4 cystadenoma
  - 22 low malignant potential (LMP)
    - 2 intraepithelial carcinoma
  - 8 invasive cystadenocarcinoma
    - 4 microinvasive carcinoma
    - 1 frankly invasive carcinoma
- 24 Invasive noncystic adenocarcinomas
  - 8 mucinous (colloid)
  - 6 enteric, 6 mucinous/enteric, 2 NOS

- Am J Surg Pathol 2014;38:1033

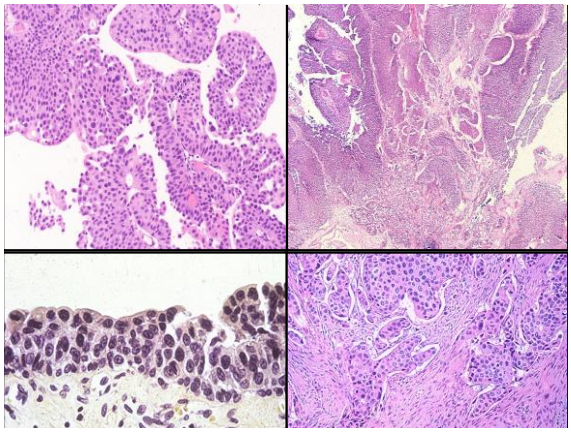


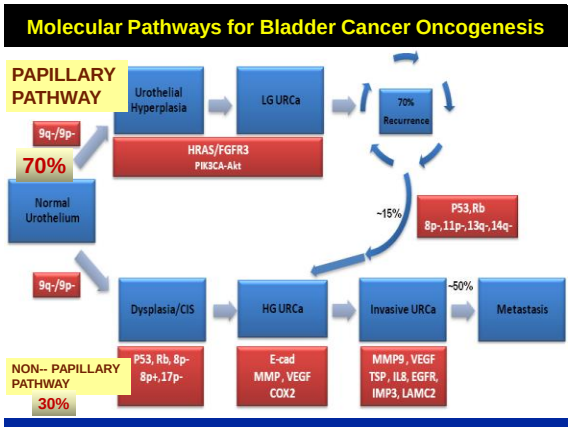


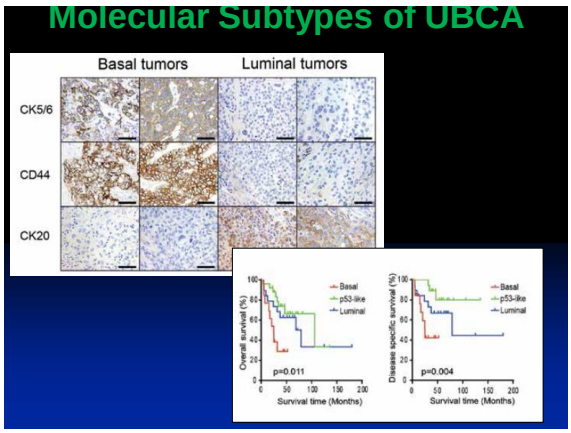
Survival of noninvasive mucinous cystic tumors of urachus



- Amin et al, Am J Surg Pathol 2014




Molecular Pathways for Bladder Cancer Oncogenesis
PAPILLARY PATHWAY
Urothelial Hyperplasia
LG URCa
70% Recurrence
9q-/9p-
HRAS/FGFR3
PIK3CA-Akt
70%
Normal Urothelium
~15%
P53,Rb
8p-,11p-,13q-,14q-
9q-/9p-
Dysplasia/CIS
HG URCa
Invasive URCa
~50%
Metastasis
P53, Rb, 8p-
8p+,17p-
E-cad
MMP, VEGF
COX2
MMP9, VEGF
TSP, IL8, EGFR,
IMP3, LAMC2
NON-- PAPILLARY PATHWAY
30%


Molecular Subtypes of UBCA
Basal tumors
Luminal tumors
CK5/6
CD44
CK20
Basal
p53-like
Luminal
Overall survival (%)
p=0.011
Survival time (Months)
Disease specific survival (%)
p=0.004
Survival time (Months)

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TESTIS CANCER

What is new in the WHO 2016:

- **Topic 10: Precursor lesion nomenclature for germ cell tumor of the testis**
- **Topic 11: Revised Classification for germ cell tumors**

GERM CELL TUMORS

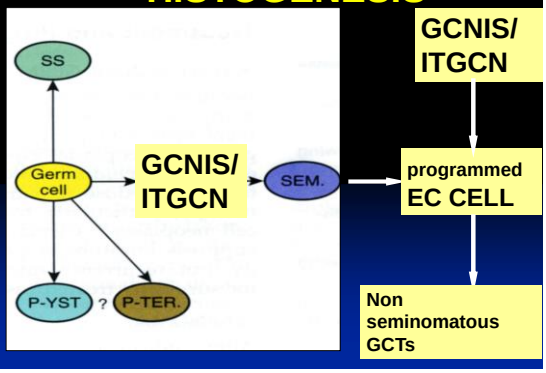
ITGCN = GCNIS (Germ Cell Neoplasia in Situ)

•ASSOCIATED WITH GCNIS

•NOT ASSOCIATED WITH GCNIS

- ASSOCIATED WITH GCNIS
  - Similar epidemiologic associations
  - Arise from maturation delayed germ cells arising in a damaged testicular milieu: *impaired spermatogenesis, tubular shrinkage, peritubular sclerosis, immature Sertoli cells, interstitial widening, hyalinized tubules, and microlithiasis*
  - *Isochromosome 12 p*

HISTOGENESIS



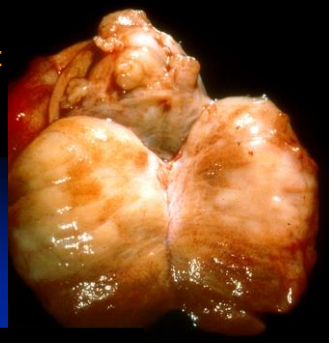
WHO 2015 CLASSIFICATION OF GERM CELL TUMORS OF TESTIS

•ASSOCIATED WITH GCNIS

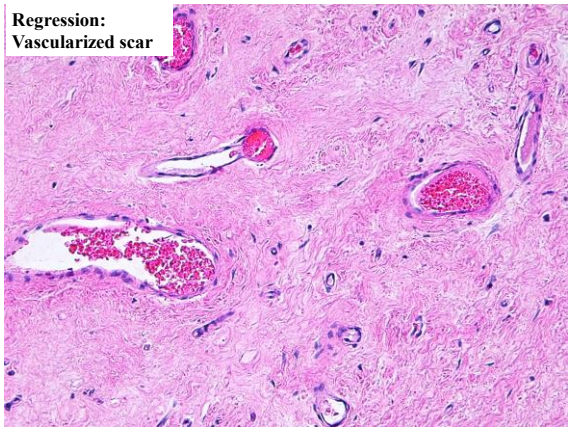
- Classic seminoma
- Pure or Mixed (non-seminomatous) tumor
  - *Embryonal carcinoma*
  - *Yolk sac tumor*
  - *Choriocarcinoma & other trophoblastic tumors*
  - *Teratoma, post-pubertal type*
  - *Mixed – combinations of above incl. Seminoma*

REGRESSED GERM CELL TUMOR
(Germ cell tumor of unknown type)

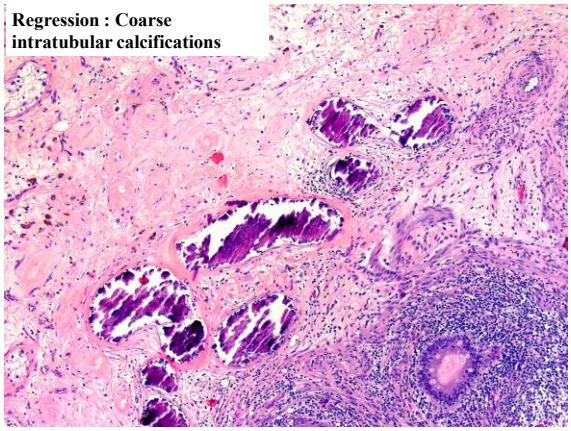
- **Spontaneous regression first presents with metastasis**
- ***Scar – band like or stellate***
- ***Cysts***
- ***Calcification***



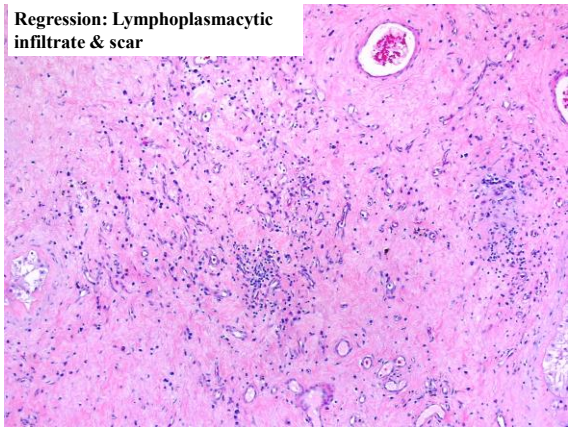
Regression: Vascularized scar

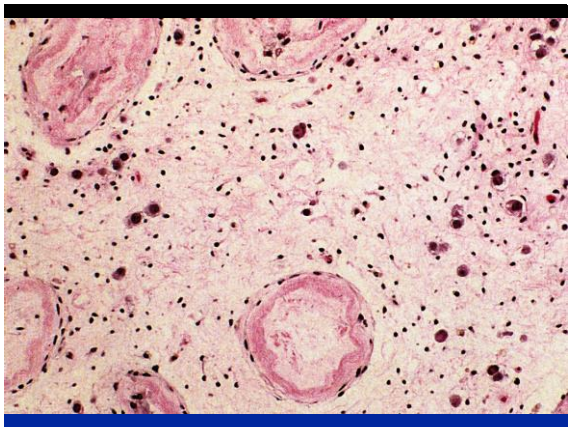


Regression : Coarse intratubular calcifications

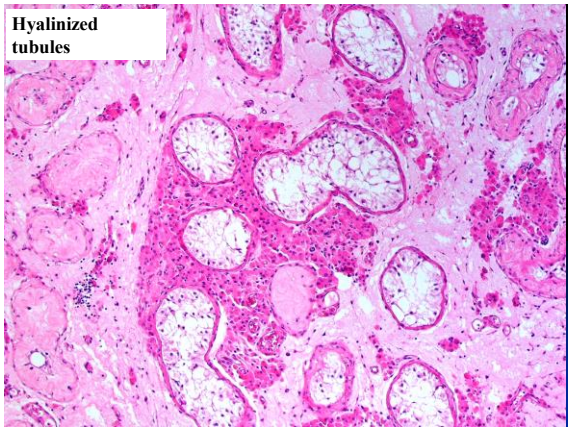


Regression: Lymphoplasmacytic infiltrate & scar

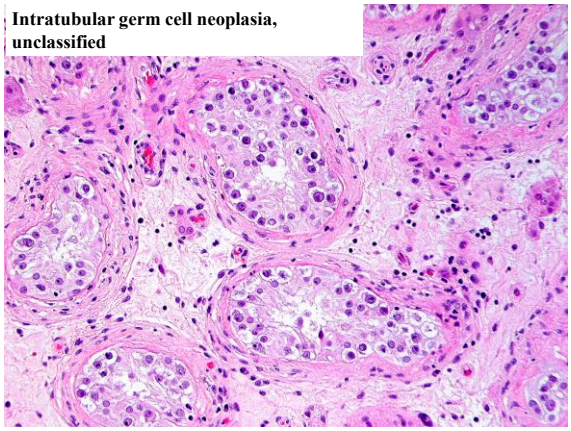




Hyalinized tubules



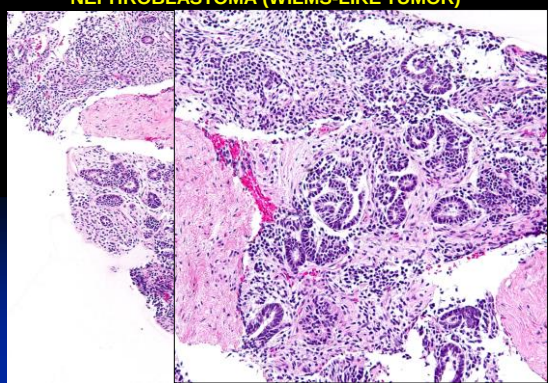
Intratubular germ cell neoplasia, unclassified



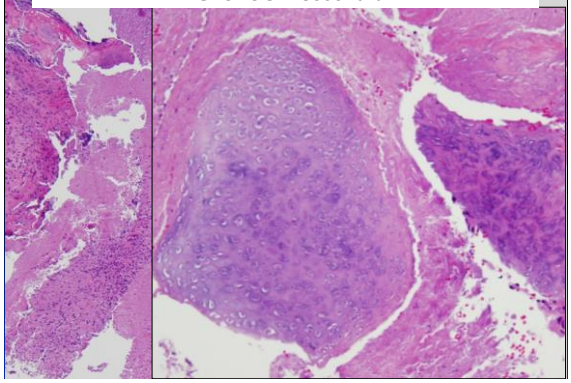
LESSONS FROM REGRESSION : when to look for signs of regression

- Patient presents with widespread metastatic choriocarcioma
- Patient presents with retroperitoneal GCT
- Patient with unusual tumor in retroperitoneum – Wilms', PNET
- Orchiectomy in a young patient for pain or non specific symptoms and scar in first few sections
- Patient with germ cell tumor in spermatic cord but none in testis
- Histology of the primary and mets does not match

METASTATIC GERM CELL TUMOR WITH NEPHROBLASTOMA (WILMS-LIKE TUMOR)



METASTATIC GERM CELL TUMOR WITH (WILMS-LIKE HISTOLOGY: second bx



TROPHOBLASTIC TUMORS OF TESTIS

- Choriocarcinoma (including monophasic CC)
- *Placental site trophoblastic tumor (HPL+. p63 -)*
- *Epithelioid trophoblastic tumor (HPL -. p63 +)**
- *Cystic trophoblastic tumor**

* *Frequently at metastatic sites*

WHO 2016 CLASSIFICATION OF GERM CELL TUMORS OF TESTIS

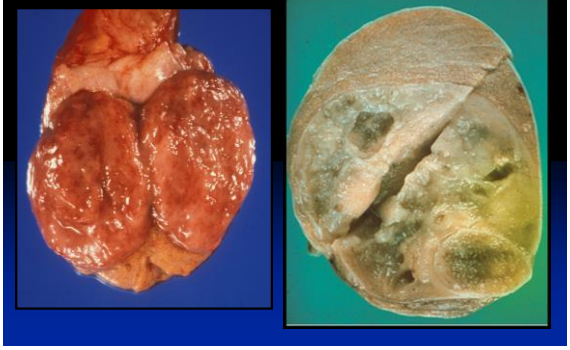
- **NOT ASSOCIATED WITH GCNIS**
  - *-Spermatocytic tumor*
  - *- Yolk sac tumor, prepubertal type*
  - *- Teratoma, prepubertal type (all age groups)*
    - *- Epidermoid and Dermoid cyst*
    - *- Well differentiated neuroendocrine tumor (monodermal teratoma)*
  - *- Mixed teratoma and Yolk sac tumor, prepubertal type*

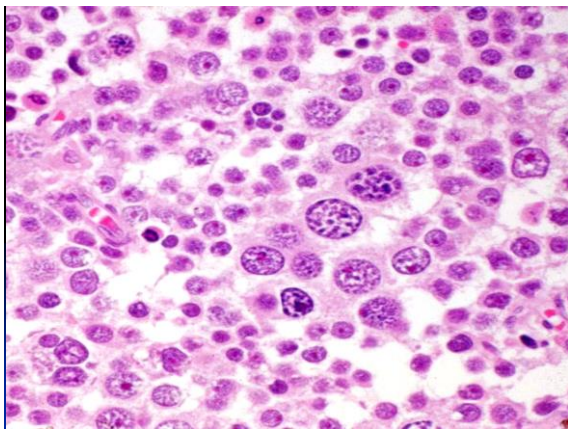
SPERMATOCYTIC TUMOR (2016 WHO NOMENCLATURE)

Unique

- Older age group (average age 52 yrs; 19-92 range)
- Not associated with GCNIS/ITGCN
- Not associated with cryptorchidism
- Not associated with 12p abnormalities – gains of Chr 9 and1:*FGFR3* & *HRAS* mutations or gene amplifications
- Not associated with other germ cell components
- No ovarian counterpart or extragonadal location
- Clinically benign, rare metastasis. Death if associated with sarcomatous transformation

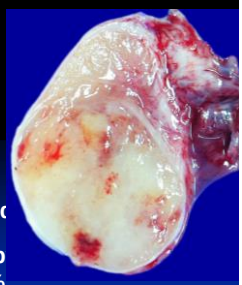
SPERMATOCYTIC TUMOR





PEDIATRIC YST

- **Unlike Adult YST**
  - *No racial or geographic predilection*
  - *Stable incidence*
  - *not associated with GCNIS/ITGCN*
  - *Always pure*
  - *16-20 months age*
  - Low incidence of advance and metastasis
  - Responds to chemotherap
  - Survival approaches 100%



TERATOMA

"Prepubertal"

- *Teratoma in prepubertal age*
  Teratoma without ITGCN/GCNIS
- Teratoma in postpubertal age
  Teratoma without ITGCN/GCNIS

"Postpubertal"

- Teratoma in postpubertal age
  with ITGCN/GCNIS

PEDIATRIC TERATOMA

- No association with GCINIS, dysgenetic gonadal changes, scarring or i12p
- Tumors with this histology occur in post-pubertal age – "benign prepubertal teratoma"- designation encompasses all ages

Distinct differences from adult teratoma:

Calcification, hair follicles frequest; may have other endodermal, mesenchymal or ectodermal components

Smooth muscle tends to envelop epithelium

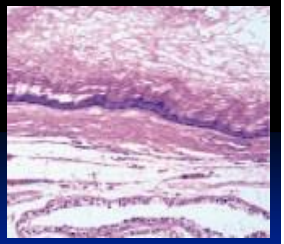
Salivary gland, pancreas etc

In postpubertal setting: Lack scar, tubular atrophy, necrosis, microlithiasis – consider 12p study

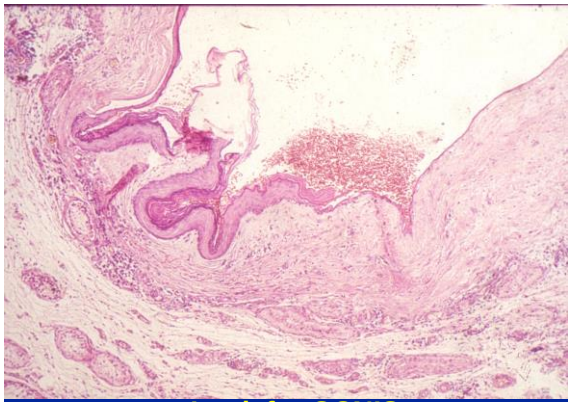
TERATOMA –POST PUBERTAL TYPE

- Young adults
- 3-7% pure
- Almost 50% of mixed GCT contain teratoma
- Immaturity in epithelial or mesenchymal elements no impact on prognosis – *atypia is not graded*
- Cytologic atypia with architectural overgrowth – X4 –low power field - *" malignant transformation in teratoma"*

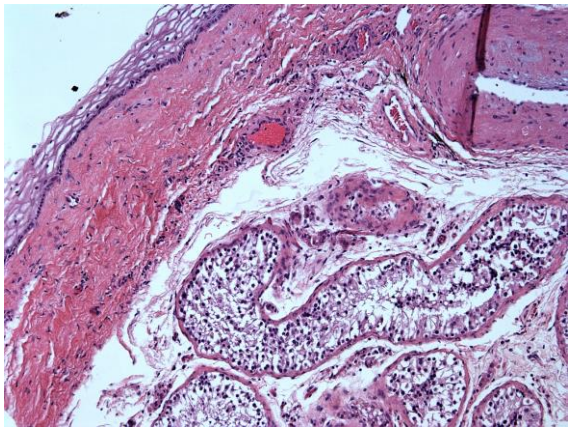
TERATOMA, "prepubertal type" - EPIDERMOID CYST - BENIGN



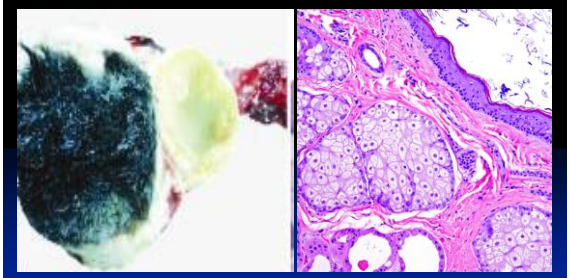
Lacks ITGCN



Look for GCNIS



TERATOMA "prepubertal type", - DERMOID CYST



Lacks GCNIS

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PENILE CANCER

What is new in the WHO 2016:

- Topic 11: Classification of Intraepithelial lesions

CLASSIFICATION OF PENILE SCC

Non HPV-related	HPV-related
INTRAEPITHELIAL LESIONS	INTRAEPITHELIAL LESIONS
INVASIVE LESIONS	INVASIVE LESIONS

Penile intraepithelial neoplasia (PeIN)
Historical nomenclature

- Erythroplasia of Queyrat (glans)
- Bowen's disease (shaft)
- Bowenoid papulosis
- Dysplasia (Mild, moderate, and severe)
- Carcinoma in situ
- Squamous intraepithelial lesion (SIL); low and high grade
- Penile intraepithelial neoplasia (PeIN 1, 2, 3)

Penile intraepithelial neoplasia (PeIN)

HPV-UNRELATED

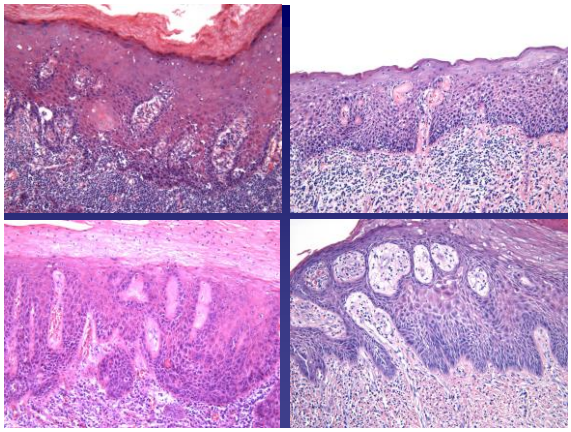
DIFFERENTIATED (Simplex) PeIN

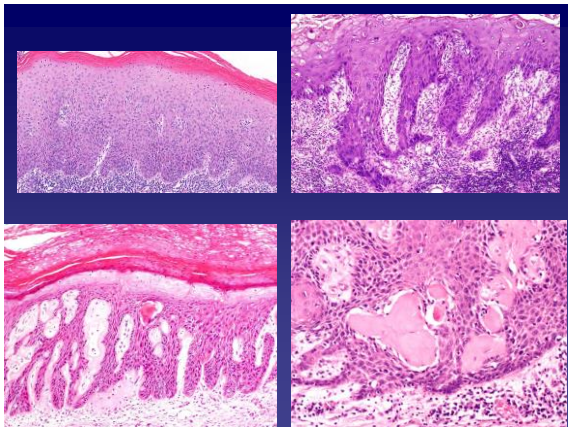
HPV-RELATED

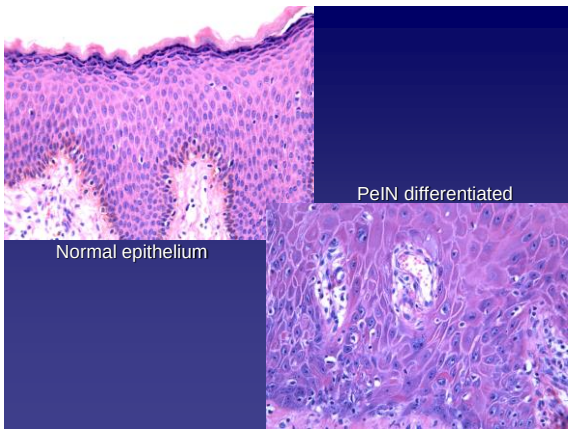
UNDIFFERENTIATED PeIN

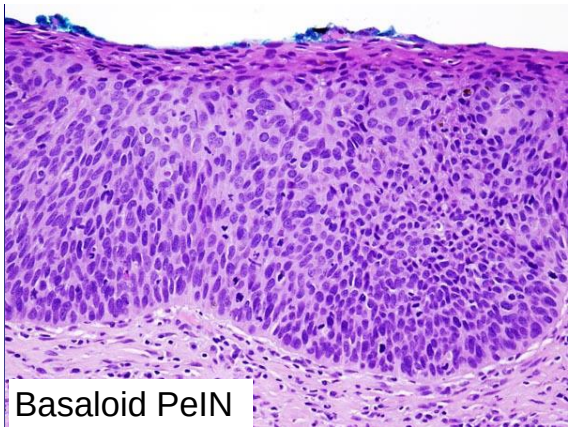
- Basaloid
- Warty
- Warty/basaloid

	Differentiated PeIN	Undifferentiated PeIN
Age (years)	>60	40-50
Location	Foreskin	Glans
Color	White/gray	Red
Multifocal	Sometimes	Often
HPV-related	No	Yes
p16	Negative	Positive
LS	Yes	No
Associated SCC	Usual Verrucous Sarcomatoid	Warty Basaloid Warty-Basaloid



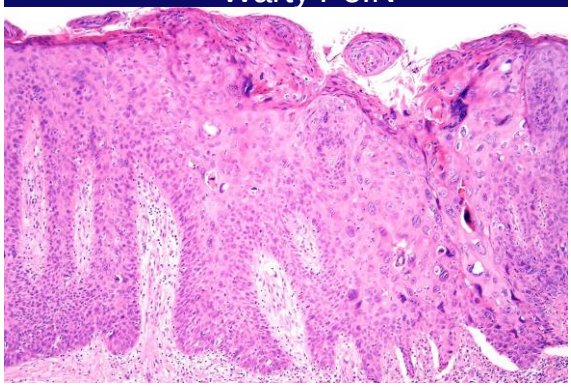


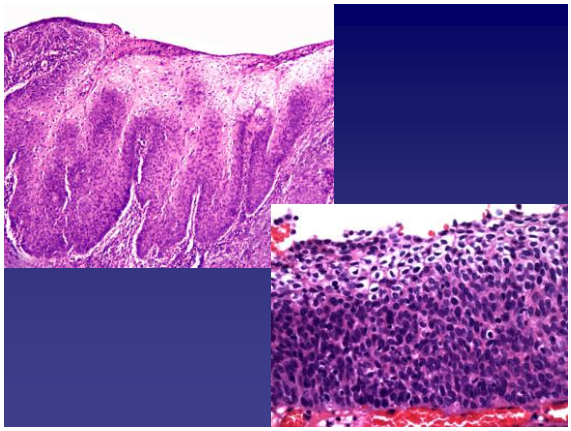

PeIN differentiated
Normal epithelium



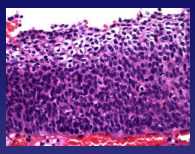
Basaloid PeIN

Warty PeIN





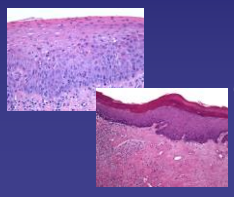
Penile SCC
Bimodal pathway of ca progression



HPV-related

40% →

Warty Ca (100%)
Basaloid Ca (>80%)



HPV-unrelated

60% →

Keratinizing SCC (>65%)
Verrucous Ca (>65%)
Pseudohyperplastic Ca (100%)

What is new in the WHO 2016:

- **Topic 12: Classification & Grading of Squamous cell carcinoma**

WHO CLASSIFICATION OF PENILE SQUAMOUS CELL CA

Non HPV related:

SCC:
- -usual
- -pseudoglandular
- -Psudohyperplastic

Verrucous:
- - pure
- - cuniculatum

Papillary NOS
Adenosquamous
Sarcomatoid
Mixed

HPV related

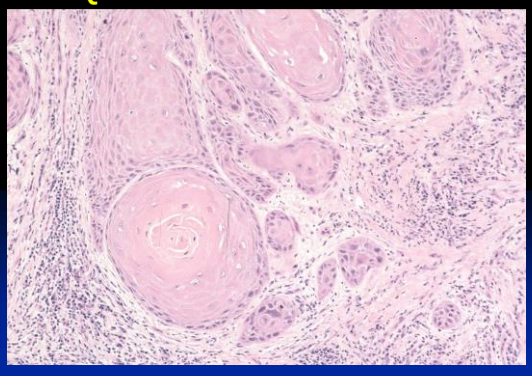
Basaloid
- -classical
- -papillary variant

Warty
- - classical
- - warty-basaloid
- - clear cell

Lymphoepithelioma like

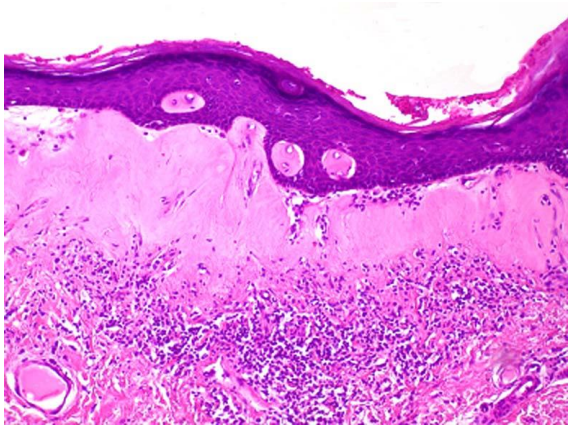
Other rare

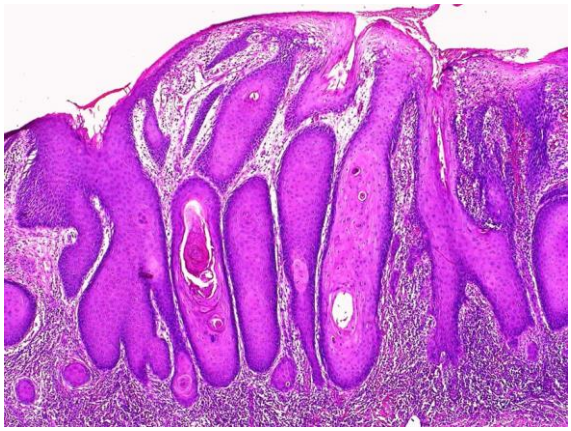
SQUAMOUS CELL CARCINOMA

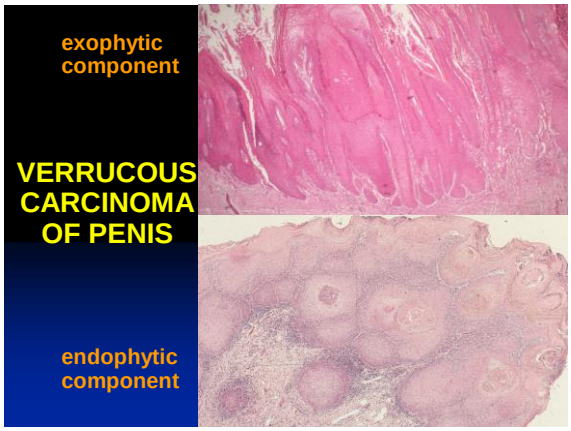


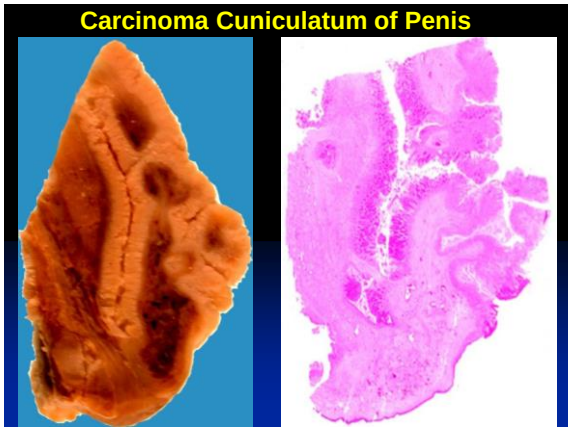
PSEUDOHYPERPLASTIC SQUAMOUS CELL CARCINOMA ASSOCIATED WITH BXO

- Foreskin mucosal lesions, frequently multicentric
- Background of balanitis xerotica obliterans
- Very well-differentiated squamous cell carcinoma with features resembling pseudoepitheliomatous hyperplasia
- Carcinoma – pushing invasion beyond lamina propria into dartos or corpus spongiosum
  - *Marked asymmetry of pushing edges of neoplasm*
  - *Nests may show keratinization at base*
  - *Destructive invasion lacking*

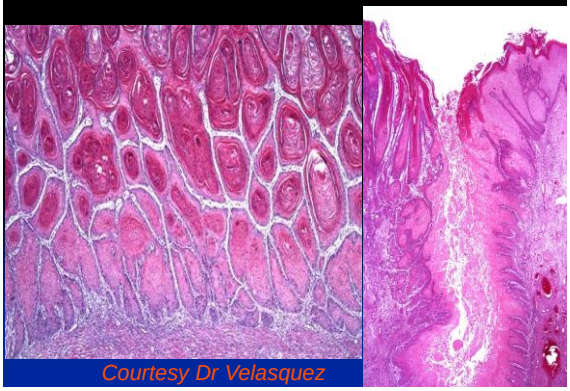





exophytic component
VERRUCOUS CARCINOMA OF PENIS
endophytic component


Carcinoma Cuniculatum of Penis

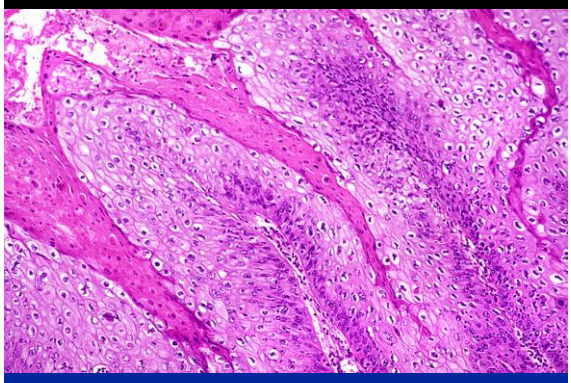
Carcinoma Cuniculatum of Penis

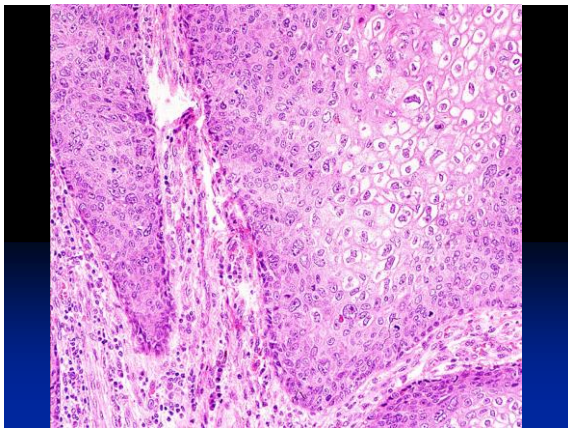


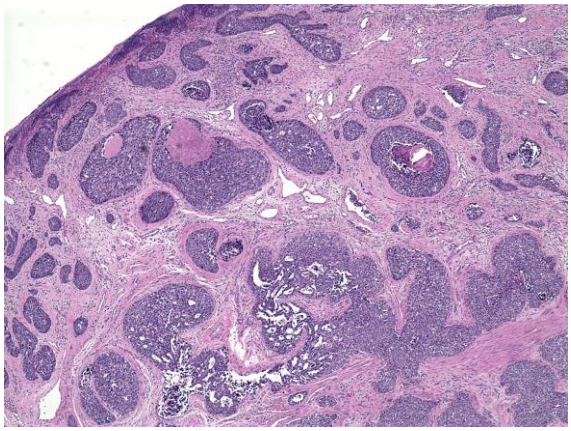
Courtesy Dr Velasquez

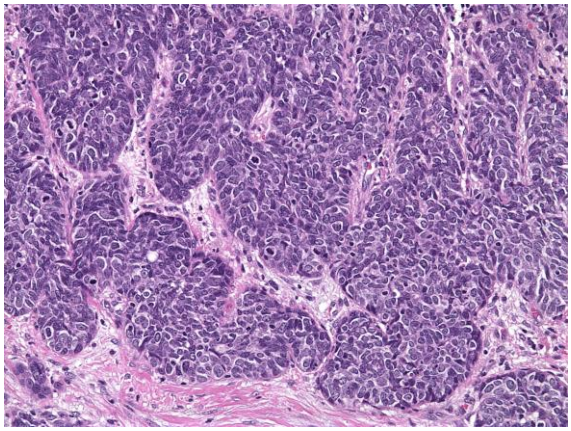
WARTY (CONDYLOMATOUS) CARCINOMA

- Complex undulating appearance
- Long papillae - fibrovascular cores
- Deeper - burrowing into lamina propria and corpus spongiosum
- Hyperkeratosis, parakeratosis, HPV changes
- Obvious cytologic atypia (well to moderately differentiated)









WHO/ISUP Grading in penile SCC.

- Gr I, well differentiated
- Gr II, moderately differentiated
- Gr III, poorly differentiated