

**<INSERT CANCER NAME>  
STRUCTURED REPORTING  
PROTOCOL**

**(*<Insert whether 1<sup>st</sup>, 2<sup>nd</sup> etc>  
Edition> <Insert year  
published here e.g. 2009>*)**

**Core Document versions:**

- AJCC Cancer Staging Manual *x<sup>th</sup>* edition. *State whether this is a reprint or includes any errata.*
- WHO Classification of Neoplasms of *xxxx*. *Year of publication*

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  - Commentary from the Protocol may be added or hyperlinked to the relevant checklist item.

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# Contents

Instructions for 'Contents'	Done
Right click within the table of contents and select 'Update Field'. Choose the option 'Update entire table'.	
Delete this box and its contents	

<b>Scope .....</b>	<b>v</b>
<b>Abbreviations .....</b>	<b>vi</b>
<b>Definitions.....</b>	<b>vii</b>
<b>Introduction .....</b>	<b>1</b>
<b>Authority and development .....</b>	<b>3</b>
<b>1 Clinical information and surgical handling .....</b>	<b>5</b>
<b>2 Specimen handling and macroscopic findings .....</b>	<b>8</b>
<b>3 Microscopic findings.....</b>	<b>10</b>
<b>4 Ancillary studies findings .....</b>	<b>11</b>
<b>5 Synthesis and overview .....</b>	<b>13</b>
<b>6 Structured checklist .....</b>	<b>15</b>
<b>7 Formatting of pathology reports .....</b>	<b>18</b>
<b>Appendix 1 Pathology request form for &lt;insert cancer name&gt;.....</b>	<b>19</b>
<b>Appendix 2 Guidelines for formatting of a pathology report .....</b>	<b>20</b>
<b>Appendix 3 Example of a pathology report .....</b>	<b>21</b>
<b>References .....</b>	<b>22</b>

# Scope

Instructions for 'Scope'	Done
Insert a concise summary (~150 words) that explains the purpose and application of the document, the techniques used and the intended audience.	
Name the precise types of cancer and sample covered by the protocol	
Specify any specimen types, anatomical sites etc that are excluded from the protocol.	
Insert the following if appropriate: "In cases of multiple, or synchronous primary tumours, a separate protocol should be recorded for each tumour."	
Delete this box and its contents	

This protocol contains standards and guidelines for the preparation of structured reports for <<specimen type>> for <Insert cancer type>.

Structured reporting aims to improve the completeness and usability of pathology reports for clinicians, and improve decision support for cancer treatment. The protocol provides the framework for the reporting of any <Insert cancer type> cancer, whether as a minimum data set or fully comprehensive report.

<Insert text, as necessary>

# Abbreviations

Instructions for 'Abbreviations'	Done
Add abbreviations to the table below, as necessary (the table contains some blank rows; add more rows or delete, as required).	
List abbreviations in alphabetical order in the table.	
Give all abbreviations in full at first use in the text followed by the abbreviated form, in brackets; thereafter, use the abbreviation throughout the document.	
Delete this box and its contents	

AJCC	American Joint Committee on Cancer
IHC	Immunohistochemistry
IHI	Individual health identifier
LIS	Laboratory Information System
MRN	Medical Record Number
NHI	National Health Identifier (NZ)
PBS	Pharmaceutical Benefits Scheme
RCPA	Royal College of Pathologists of Australasia
TNM	tumour-node-metastasis
UHI	Unique Health Identifier
UICC	International Union Against Cancer
WHO	World Health Organization

# Definitions

Instructions for 'Definitions'	Done
Add definitions to the table below, as necessary (add rows as required).	
Define any general or technical terms used in the protocol that may require more explanation.	
List items in alphabetical order.	
The definitions for standard, guideline and commentary given in the table below should remain because they explain the structure used to categorise the reporting items identified by the expert group that developed the protocol.	
Delete this box and its contents	

The table below provides definitions for general or technical terms used in this protocol. Readers should take particular note of the definitions for 'standard', 'guideline' and 'commentary', because these form the basis of the protocol.

Ancillary study	An ancillary study is any pathology investigation that may form part of a cancer pathology report but is not part of routine histological assessment.
Clinical information	Patient information required to inform pathological assessment, usually provided with the specimen request form, also referred to as "pre-test information".
Commentary	<p>Commentary is text, diagrams or photographs that clarify the standards (see below) and guidelines (see below), provide examples and help with interpretation, where necessary (not every standard or guideline has commentary).</p> <p>Commentary is used to:</p> <ul style="list-style-type: none"> <li>define the way an item should be reported, to foster reproducibility</li> <li>explain why an item is included (e.g. how does the item assist with clinical management or prognosis of the specific cancer).</li> <li>cite published evidence in support of the standard or guideline</li> <li>state any exceptions to a standard or guideline.</li> </ul> <p>In this document, commentary is prefixed with 'CS' (for commentary on a standard) or 'CG' (for commentary on a guideline), numbered to be consistent with the relevant standard or guideline, and with sequential alphabetic lettering within each set of commentaries (eg CS1.01a, CG2.05b).</p>

General commentary	<p>General commentary is text that is not associated with a specific standard or guideline. It is used:</p> <ul style="list-style-type: none"> <li>• to provide a brief introduction to a chapter, if necessary</li> <li>• for items that are not standards or guidelines but are included in the protocol as items of potential importance, for which there is currently insufficient evidence to recommend their inclusion. (Note: in future reviews of protocols, such items may be reclassified as either standards or guidelines, in line with diagnostic and prognostic advances, following evidentiary review).</li> </ul>
Guideline	<p>Guidelines are recommendations; they are not mandatory, as indicated by the use of the word 'should'. Guidelines cover items that are not essential for clinical management, staging or prognosis of a cancer, but are recommended.</p> <p>Guidelines include key observational and interpretative findings that are fundamental to the diagnosis and conclusion. Such findings are essential from a clinical governance perspective, because they provide a clear, evidentiary decision-making trail.</p> <p>Guidelines are not used for research items.</p> <p>In this document, guidelines are prefixed with 'G' and numbered consecutively within each chapter (eg G1.10).</p>
Macroscopic findings	Measurements, or assessment of a biopsy specimen made by the unaided eye.
Microscopic findings	In this document, the term 'microscopic findings' refers to morphological assessment using a microscope or equivalent.
Predictive factor	A <i>predictive factor</i> is a measurement that is associated with response or lack of response to a particular therapy.
Prognostic factor	A <i>prognostic factor</i> is a measurement that is associated with clinical outcome in the absence of therapy or with the application of a standard therapy. It can be thought of as a measure of the natural history of the disease.
Standard	<p>Standards are mandatory, as indicated by the use of the term 'must'. Their use is reserved for core items essential for the clinical management, staging or prognosis of the cancer.</p> <p>The summation of all standards represents the minimum dataset for the cancer.</p> <p>In this document, standards are prefixed with 'S' and numbered consecutively within each chapter (eg <b>S1.02</b>).</p>
Structured report	A report format which utilises standard headings, definitions and nomenclature with required information.
Synoptic report	A structured report in condensed form (as a synopsis or precis).

## Synthesis

Synthesis is the process in which two or more pre-existing elements are combined, resulting in the formation of something new. In the context of structured pathology reporting, synthesis represents the integration and interpretation of information from two or more modalities to derive new information

# Introduction

Instructions for 'Introduction'	Done
Write an introduction that includes the following information:	
<ul style="list-style-type: none"><li>• a brief summary of the cancer type</li></ul>	
<ul style="list-style-type: none"><li>• the importance of histopathological reporting for clinical management and prognosis in general, and specific to the cancer type (e.g. examples of different pathological findings leading to different treatment or management decisions)</li></ul>	
<ul style="list-style-type: none"><li>• a summary of the benefits of structured reporting, including secondary issues such as research and the benefits to patient care in the long term</li></ul>	
<ul style="list-style-type: none"><li>• acknowledgment of key documentation used in the development process (e.g. existing guidelines, World Health Organization (WHO) reports)</li></ul>	
<ul style="list-style-type: none"><li>• acknowledgement of any areas of uncertainty and method of dealing with them</li></ul>	
<ul style="list-style-type: none"><li>• a brief summary of changes since the last edition (e.g. a scientific breakthrough that has necessitated the inclusion of new data items).</li></ul>	
Delete this box and its contents	

## <NAME> cancer

< Insert text about specific,cancer >

## Importance of histopathological reporting

< Insert text, as necessary>

## Benefits of structured reporting

Structured pathology reports with standardised definitions for each component have been shown to significantly enhance the completeness and quality of data provided to clinicians, and have been recommended both in North America and the United Kingdom<sup>1-4</sup>.

The College of American Pathologists and the Royal College of Pathologists (UK) have recently published useful protocols for the reporting of cancer<sup>5-6</sup>. A protocol endorsed by the Royal College of Pathologists of Australasia and other Australasian organisations involved in the management of <CANCER> is timely.

< Insert text, as necessary>

## Design of this protocol

This structured reporting protocol provides a complete framework for the assessment and documentation of all the pathological features of << cancer >>.

Mandatory elements (standards) are differentiated from those that are not mandatory but are recommended (guidelines). Consistency and speed of reporting is improved by the use of discrete data elements recorded from the checklist. However, the pathologist is encouraged to include free text or narrative to document any other relevant issues, to give reasons for coming to a particular opinion and to explain any points of uncertainty.

The structure provided by the following chapters, headings and subheadings describes the elements of information and their groupings, but does not necessarily represent the format of either a pathology report (Chapter 7) or checklist (Chapter 6). These, and the structured pathology request form (Appendix 1) are templates that represent information from this protocol, organised and formatted differently to suit different purposes.

## **Key documentation**

*< Insert text, as necessary >*

- *Guidelines for Authors of Structured Cancer Pathology Reporting Protocol<sup>7</sup>s*
- *The Pathology Request-Test-Report Cycle — Guidelines for Requesters and Pathology Provider<sup>8</sup>*
- *AJCC Cancer Staging Manual, 7th edition<sup>9</sup>*

## **Changes since the last edition**

*< Insert text, as necessary >*

# Authority and development

Instructions for 'Authority and development'	Done
Amend the introductory text in each section, if necessary.	
Under 'Expert committee', list the members of the committee, giving the title, academic credentials, profession for each person, and adding 'Chair' and 'Author' in brackets after the appropriate name.	
Under "International liaison", list any representation from international bodies, such as CAP or RCPATH, who are assisting the expert committee.	
Under 'Stakeholders', list any stakeholders who gave feedback or endorsed the protocol.	
Under 'Secretariat', list the secretariat members for the protocol.	
Under 'Medical editor', give the name of the medical editor for the protocol, if appropriate.	
Under 'Development process', give details of the process used to develop the protocol, highlighting any deviations from the process outlined in <i>Guidelines for authors of structured cancer pathology reporting protocols</i> , and amend the text on evidence, if necessary.	
Delete this box and its contents	

This section provides details of the committee involved in developing this protocol and the process by which it was developed.

## Protocol developers

This protocol was developed by an expert committee, with assistance from relevant stakeholders.

### Expert committee

< Insert text, as necessary >

### International Liaison

< Insert text, as necessary >

### Acknowledgements

The < Insert text about specific cancer > expert committee wish to thank all the pathologists and clinicians who contributed to the discussion around this document. In particular, we acknowledge the contributions of .....

### Stakeholders

< Insert text, as necessary >

### Secretariat

< Insert text, as necessary >

## **Medical editor**

*< Insert text, as necessary >*

## **Development process**

*< Insert text, as necessary >*

This protocol has been developed following the nine-step process set out in *Guidelines for Authors of Structured Cancer Pathology Reporting Protocols* <sup>7</sup>

Where no reference is provided, the authority is the consensus of the expert group.

# 1 Clinical information and surgical handling

Instructions for 'Clinical information and surgical handling'	Done
Amend the introductory text, if necessary.	
Amend the standards, guidelines and commentary given below as required (e.g. change text, delete, change a standard to a guideline, etc), and adjust numbering as necessary.	
Provide additional standards, guidelines and commentary, as necessary, for any specific features expected to be relevant for the specific cancer type.	
Give a separate <b>standard</b> for any item that <b>must</b> be included	
Give a separate <b>guideline</b> for any item that <b>should</b> or <b>may</b> be included	
Add <b>commentary</b> to standards and guidelines as appropriate, and adjust numbering as necessary.	
Complete Appendix 1 in this template, ensuring that it is consistent with the standards and guidelines given in this section. Further instructions are given in Appendix 1	
Delete this box and its contents	

This chapter relates to information that should be collected before the pathology test, and procedures that are required before handover of specimens to the laboratory.

The standards and guidelines below specify the particular information and specimens required for <insert cancer name>. Some of this information can be collected on generic pathology request forms; any additional information required specifically for the reporting of <insert cancer name> may be recorded on a separate data sheet. Appendix 1 provides a standardised data sheet that may be useful in obtaining all relevant information.

## S1.01 Adequate demographic and request information must be provided with the specimen by the requesting clinician.

CS1.01a The Royal College of Pathologists of Australasia (RCPA) *The Pathology Request-Test-Report Cycle — Guidelines for Requesters and Pathology Providers* must be adhered to.<sup>8</sup> This document specifies the minimum information to be provided by the requesting clinician for any pathology test. Items relevant to cancer reporting protocols include:

- patient name
- date of birth
- sex
- identification and contact details of requesting doctor
- date of request

Additional information specified in the RCPA *The Pathology Request-Test-Report Cycle — Guidelines for Requesters and Pathology Providers* such as the specimen type and

clinical information relevant to the investigation is catered for in the following standards and guidelines.

CS1.01b The patient's ethnicity must be recorded, if known.

G1.01 The patient's health identifiers should be recorded where provided.

CG1.01a The patient's health identifiers may include the patient's Medical Record Number as well as a national health number such as a NHI or the Individual Healthcare Identifier (IHI).

**S1.02 The pathology accession number of the specimen should be recorded.**

**S1.03 The principal clinician involved in the patient's care and responsible for investigating the patient must be identified.**

CS1.03a The requesting clinician (identified under S1.01) may be the doctor who performs the surgery or biopsy, and may not be the person with overall responsibility for investigating and managing the patient. Identification of the principal clinician is essential, to ensure that clinical information is communicated effectively.

**S1.0X The anatomical site of the biopsy or resection must be recorded.**

CS1.0Xa Site is an important identifier when multiple biopsies are performed.

CS1.0Xb Sufficient information is required to localise the lesion for subsequent therapy. A diagram or photograph can facilitate this.

CS1.0Xc Prognostic significance <Insert text or delete commentary>

**S1.0X The laterality of the lesion must be recorded.**

CS1.0Xa Laterality information is needed for identification purposes.

G1.0X The clinical diagnosis or differential diagnosis should be recorded.

CG1.0X Providing the provisional clinical diagnosis or differential diagnosis improves clinicopathological correlation and improves diagnostic accuracy.

**S1.0X The <insert specific item> must be recorded.**

CS1.0Xa <Insert commentary here as necessary, or delete>.

G1.0X The <insert specific item> should be recorded.

CS1.0Xa <Insert commentary here as necessary, or delete>.

## Surgical handling

G1.0X The specimen should be capable of orientation if the status of specific surgical margins is critical in determining the need for, or extent of, further surgery.

CG1.0Xa Where there are no anatomical landmarks, specimen orientation may be indicated with marking sutures or other techniques. If a specimen is orientated, the orientation should be indicated on the specimen request form (this may be facilitated by the use of a diagram).

G1.0X Identification of research sections should preferably be done in consultation with the pathologist in order to avoid compromising the diagnosis.

**S1.0X < *Insert specific measures* > must be taken when collecting specimens.**

CS1.0Xa <Insert commentary here as necessary, or delete>.

G1.0X < *Insert specific measures* > should be taken when collecting specimens.

CS1.0Xa <Insert commentary here as necessary, or delete>.

## 2 Specimen handling and macroscopic findings

Instructions for 'Specimen handling and macroscopic findings'	Done
Amend the introductory text, if necessary.	
Amend the standards, guidelines and commentary given below as required (e.g. change text, delete, change a standard to a guideline, etc), and adjust numbering as necessary.	
Provide additional standards, guidelines and commentary, as necessary, for any specific features expected to be relevant for the specific cancer type.	
Give a separate <b>standard</b> for any item that <b>must</b> be included	
Give a separate <b>guideline</b> for any item that <b>should</b> or <b>may</b> be included	
Add <b>commentary</b> to standards and guidelines as appropriate, and adjust numbering as necessary.	
Delete this box and its contents	

This chapter relates to the procedures required after the information has been handed over from the requesting clinician and the specimen has been received in the laboratory.

### Specimen handling

G2.01 Pathologists may be asked to provide tissue samples from fresh specimens for tissue banking or research purposes. The decision to provide tissue should only be made when the pathologist is sure that the diagnostic process including the measurement of maximum depth of invasion and other important parameters that influence patient prognosis and management will not be compromised. As a safeguard, research use of the specimen may be put on hold until the diagnostic process is complete so that the specimen can be retrieved.

**S2.0X <Insert specific measure> must be done immediately on receipt of the specimen.**

CS2.0Xa <Insert commentary here as necessary, or delete>.

G2.0X <Insert specific measures> should be done immediately on receipt of the specimen.

CS2.0Xa <Insert commentary here as necessary, or delete>.

**S2.0X <Insert procedure> must be used in examination and block selection.**

CS2.0Xa <Insert commentary here as necessary, or delete>.

G2.0X <Insert specific measures> should be used in examination and block selection.

CS2.0Xa <Insert commentary here as necessary, or delete>.

## Macroscopic findings

### **S2.0X All measurements are in SI units, unless explicitly stated.**

CS2.0X If any measurements are not in SI units, this must be explicitly stated.

### **S2.0X <Insert item to be described> must be described.**

CS2.0Xa <Insert commentary here as necessary, or delete>.

G2.0X <Insert specific measures> should be described.

CS2.0Xa <Insert commentary here as necessary, or delete>.

### **S2.0X <Insert item to be measured> must be measured.**

CS2.0Xa <Insert commentary here as necessary, or delete>.

G2.0X <Insert specific measures> should be measured.

CS2.0Xa <Insert commentary here as necessary, or delete>.

G2.0X A descriptive or narrative field should be provided to record any macroscopic information that is not recorded in the above standards and guidelines, and that would normally form part of the macroscopic description.

CG2.0Xa The traditional macroscopic narrative recorded at the time of specimen dissection is often reported separately from the cancer dataset. Although this remains an option, it is recommended that macroscopic information be recorded within the overall structure of this protocol.

CG2.0Xb Much of the information recorded in a traditional macroscopic narrative is covered in the standards and guidelines above and in many cases, no further description is required.

### 3 Microscopic findings

Instructions for 'Microscopic findings'	Done
Amend the introductory text, if necessary.	
Amend the standards, guidelines and commentary given below as required (e.g. change text, delete, change a standard to a guideline, etc), and adjust numbering as necessary.	
Provide additional standards, guidelines and commentary, as necessary, for any specific features expected to be relevant for the specific cancer type.	
Give a separate <b>standard</b> for any item that <b>must</b> be included	
Give a separate <b>guideline</b> for any item that <b>should</b> or <b>may</b> be included	
Add <b>commentary</b> to standards and guidelines as appropriate (e.g. to provide referenced explanatory notes on the use of the parameters specified), and adjust numbering as necessary.	
Delete this box and its contents	

Microscopic findings relates to purely histological (morphological) assessment. Information derived from multiple investigational modalities, or from two or more chapters, are described in Chapter 5.

**S3.0X** < *Insert specific finding* > **must be recorded.**

CS3.0Xa < Insert commentary here as necessary, or delete >.

**G3.0X** < *Insert specific measures* > should be recorded.

CS3.0Xa < Insert commentary here as necessary, or delete >.

**G3.0X** A descriptive or narrative field should be provided to record any microscopic information that is not recorded in the above standards and guidelines.

## 4 Ancillary studies findings

Instructions for 'Ancillary studies findings'	Done
Amend the introductory text, if necessary. For example, if this chapter is not relevant to the specific cancer, add the following to the introductory text: 'Ancillary studies are currently not required for the diagnosis, staging or management of <insert cancer type here>.'	
Decide which ancillary tests should be performed for this cancer.	
Insert a subheadings for each class of ancillary test (e.g. 'Immunohistochemistry', 'Cytogenetics' or 'Flow cytometry').	
Amend the text, standards, guidelines and commentary given below as required (e.g. change text, delete, change a standard to a guideline, etc), and adjust numbering as necessary.	
Provide additional standards, guidelines and commentary, as necessary, for any specific features expected to be relevant for the specific cancer type.	
Give a separate <b>standard</b> for any item that <b>must</b> be included	
Give a separate <b>guideline</b> for any item that <b>should</b> or <b>may</b> be included	
Add <b>commentary</b> to standards and guidelines as appropriate (e.g. to provide referenced explanatory notes on the use of the parameters specified), and adjust numbering as necessary.	
Delete this box and its contents	

Ancillary studies may be used to determine lineage, clonality or disease classification or subclassification; as prognostic biomarkers; or to indicate the likelihood of patient response to specific biologic therapies.

Some studies, such as Her-2 testing, are required under the Pharmaceutical Benefits Scheme, to enable certain specific therapies to be prescribed.

### <Insert class of ancillary test here>

G4.0X <Insert ancillary test> should be performed and the results incorporated into the pathology report.

CG4.0Xa Ancillary tests performed externally may contain information needed for compliance with NPAAC and RCPA requirements, but that are not relevant to cancer reporting protocols. The specific elements of an ancillary study report needed for cancer reporting include the following:

- laboratory performing the test
- substrate (e.g. cytology smears, fluid in special media, paraffin block, fresh tissue, etc)
- method (where relevant)

- results
- conclusion (usually a text field)
- person responsible for reporting the ancillary test.

CG4.0Xb Documentation of all relevant ancillary study findings is essential for overarching commentary (see *Synthesis and Overview*, Chapter 5), in which the significance of each finding is interpreted in the overall context of the case.

CG4.0Xc <Insert commentary here as necessary, or delete>

**S4.0X** <*Insert specific finding*> **must be recorded.**

CS4.0Xa <Insert commentary here as necessary, or delete>.

G4.0X <*Insert specific measures*> should be recorded.

CS4.0Xa <Insert commentary here as necessary, or delete>.

## 5 Synthesis and overview

Instructions for 'Synthesis'	Done
Amend the introductory text, if necessary.	
Amend the standards, guidelines and commentary given below as required (e.g. change text, delete, change a standard to a guideline, etc), and adjust numbering as necessary.	
Provide additional standards, guidelines and commentary, as necessary, for any specific features expected to be relevant for the specific cancer type. Include any data elements that are synthesized from more than one chapter.	
Give a separate <b>standard</b> for any item that <b>must</b> be included	
Give a separate <b>guideline</b> for any item that <b>should</b> or <b>may</b> be included	
Add <b>commentary</b> to standards and guidelines as appropriate, and adjust numbering as necessary.	
Delete this box and its contents	

Information that is synthesised from multiple modalities and therefore cannot reside solely in any one of the preceding chapters is described here.

For example. tumour stage is synthesised from multiple classes of information – clinical, macroscopic and microscopic.

By definition, synthetic elements are inferential rather than observational, often representing high-level information that is likely to form part of the report 'Summary' or 'Diagnosis' section in the final formatted report.

Overarching case comment is synthesis in narrative format. Although it may not necessarily be required in any given report, the provision of the facility for overarching commentary in a cancer report is essential.

**S5.01 The tumour stage must be recorded according to the <insert text here> system <insert version here>**

CS5.01a <Insert commentary here as necessary, or delete>

**S5.02 The year of publication and edition of the cancer staging system used in S5.01 must be included in the report.**

G5.02 The "Diagnostic summary" section of the final formatted report should include:

- a. Specimen type (GXX)
- b. Tumour site and laterality (GXX)
- c. Tumour type (SXX)

- d. Tumour grade (GXX)
- e. Tumour stage (SXX)
- f. Completeness of excision (SXX)

**S5.0X <Insert specific finding> must be recorded.**

CS5.0Xa <Insert commentary here as necessary, or delete>.

G5.0X <Insert specific finding> should be recorded.

CG5.0Xa <Insert commentary here as necessary, or delete>.

**S5.0X The reporting system must provide a field for free text or narrative in which the reporting pathologist can give overarching case comment.**

CS5.0Xa This field may be used, for example, to:

- list any relevant ancillary tests
- document any noteworthy adverse gross and/or histological features
- express any diagnostic subtlety or nuance that is beyond synoptic capture
- document further consultation or results still pending.

CS5.0Xa Use of this field is at the discretion of the reporting pathologist.

## 6 Structured checklist

Instructions for 'Structured checklist'	Done
Amend the introductory text, if necessary.	
Provide a structured reporting checklist that a pathologist can use as a guide to the reporting process.	
Include in the checklist all standards and guidelines detailed in the protocol	
Indicate whether defined values or free text is required.	
Use black text to depict standards and grey to depict guidelines.	
Delete this box and its contents	

The following checklist includes the standards and guidelines for this protocol which must be considered when reporting, in the simplest possible form. The summation of all "Standards" is equivalent to the "Minimum Data Set" for <cancer>. For emphasis, standards (mandatory elements) are formatted in bold font.

**S6.01 The structured checklist provided below may be modified as required but with the following restrictions:**

- a. All standards and their respective naming conventions, definitions and value lists must be adhered to.**
- b. Guidelines are not mandatory but are recommendations and where used, must follow the naming conventions, definitions and value lists given in the protocol.**

G6.01 The order of information and design of the checklist may be varied according to the laboratory information system (LIS) capabilities.

CG6.01a Where the LIS allows dissociation between data entry and report format, the structured checklist is usually best formatted to follow pathologist workflow. In this situation, the elements of synthesis or conclusions are necessarily at the end. The report format is then optimised independently by the LIS.

CG6.01b Where the LIS does not allow dissociation between data entry and report format, (for example where only a single text field is provided for the report), pathologists may elect to create a checklist in the format of the final report. In this situation, communication with the clinician takes precedence and the checklist design is according to principles given in Chapter 7.

G6.02 Where the checklist is used as a report template (see G6.01), the principles in Chapter 7 and Appendix 2 apply

CG6.02a All extraneous information, tick boxes and unused values should be deleted

G6.03 Additional comment may be added to an individual response where necessary to describe any uncertainty or nuance in the selection of a prescribed response in the checklist. Additional comment is not required where the prescribed response is adequate.

Format to be used for the checklist:

## Clinical information and surgical handling

**S1.01 Patient name**

---

**Date of birth**

---

**Sex**

---

**Identification and  
contact details of  
requesting doctor**

---

**Date of request**

---

**Ethnicity:**

**Aboriginal or  
Torres Strait  
Islander**

---

**Other ethnicity**

---

**Unknown**

---

**G1.01 Patient identifiers  
(eg MRN, IHI, NHI)**

---

---

**G1.02 Pathology accession  
number**

---

## 7 Formatting of pathology reports

Instructions for 'Formatting of pathology reports'	Done
Amend the introductory text, if necessary.	
Provide a de-identified example report for the specific cancer type	
Delete this box and its contents	

Good formatting of the pathology report is essential for optimising communication with the clinician, and will be an important contributor to the success of cancer reporting protocols. The report should be formatted to provide information clearly and unambiguously to the treating doctors, and should be organised with their use of the report in mind. In this sense, the report differs from the structured checklist, which is organised with the pathologists' workflow as a priority.

Uniformity in the format as well as in the data items of cancer reports between laboratories makes it easier for treating doctors to understand the reports; it is therefore seen as an important element of the systematic reporting of cancer. For guidance on formatting pathology reports, please refer to Appendix 2.

# Appendix 1 Pathology request form for <insert cancer name>

Format to be used for the request form:

**S1.01 Patient name** \_\_\_\_\_

**Date of birth** \_\_\_\_\_

**Sex** \_\_\_\_\_

**Identification and contact details of requesting doctor** \_\_\_\_\_

**Date of request** \_\_\_\_\_

**Ethnicity:**

**Aboriginal or Torres Strait Islander** \_\_\_\_\_

**Other ethnicity** \_\_\_\_\_

**Unknown** \_\_\_\_\_

**G1.01 Patient identifiers** \_\_\_\_\_

(eg MRN, IHI, NHI) \_\_\_\_\_

**S1.03 Principal clinician involved in the patient's care** \_\_\_\_\_

# Appendix 2 Guidelines for formatting of a pathology report

## Layout

Headings and spaces should be used to indicate subsections of the report, and heading hierarchies should be used where the Laboratory Information System (LIS) allows it. Heading hierarchies may be defined by a combination of case, font size, style and, if necessary, indentation.

- Grouping like data elements under headings and using 'white space' assists in rapid transfer of information.<sup>10</sup>

Descriptive titles and headings should be consistent across the protocol, checklist and report.

When reporting on different tumour types, similar layout of headings and blocks of data should be used, and this layout should be maintained over time.

- Consistent positioning speeds data transfer and, over time, may reduce the need for field descriptions or headings, thus reducing unnecessary information or 'clutter'.

Within any given subsection, information density should be optimised to assist in data assimilation and recall.

- Configuring reports in such a way that they 'chunk' data elements into a single unit will help to improve recall for the clinician.<sup>10</sup>
- 'Clutter' should be reduced to a minimum.<sup>10</sup> Thus, information that is not part of the protocol (e.g. billing information, Snomed codes, etc) should not appear on the reports or should be minimized.
- Injudicious use of formatting elements (e.g. too much bold, underlining or use of footnotes) constitutes clutter and may distract the reader from the key information.

Where a structured report checklist is used as a template for the actual report, any values provided in the checklist but not applying to the case in question must be deleted from the formatted report.

Reports should be formatted with an understanding of the potential for the information to mutate or be degraded as the report is transferred from the LIS to other health information systems.

As a report is transferred between systems:

- text characteristics such as font type, size, bold, italics and colour are often lost
- tables are likely to be corrupted as vertical alignment of text is lost when fixed font widths of the LIS are rendered as proportional fonts on screen or in print
- spaces, tabs and blank lines may be stripped from the report, disrupting the formatting
- supplementary reports may merge into the initial report.

## **Appendix 3 report**

## **Example of a pathology**

# References

Instructions for 'References'	Done
If EndNote or other reference management software is used, enter the required references into the database, output the references and citations in Vancouver (numbered) style and provide a copy of the database to the medical editors.	
If reference management software is not used, cite the appropriate references in Harvard (author date) style; the medical editors will convert the Harvard citations to Vancouver style.	
List journal articles in the format: Name AB, Name BC and Name CD (2005). Title of paper: subtitle. <i>Name of Journal</i> 23(7):123-145.	
List books in the format: Name A (ed) (2005). <i>Title of Book: Subtitle of Book</i> , vol 3, 2nd edition, XYZ Publishing, Sydney, 123-145.	
Delete this box and its contents	

1 Cross S, Feeley K and Angel C (1998). The effect of four interventions on the informational content of histopathology reports of resected colorectal carcinomas. *J Clin Pathol* 51: 481-482.

2 Mathers M, Shrimankar J, Scott D, Charlton F, Griffith C and Angus B (2001). The use of a standard proforma in breast cancer reporting. *Journal of Clinical Pathology* 54(10): 809-811.

3 Srigley JR, McGowan T, MacLean A, Raby M, Ross J, Kramer S and Sawka C (2009). Standardized synoptic cancer pathology reporting: A population-based approach. *Journal of Surgical Oncology* 99(8): 517-524.

4 Gill A, Johns A, Eckstein R, Samra J, Kaufman A, Chang D, Merrett N, Cosman P, Smith R, Biankin A and Kench J (2009). Synoptic reporting improves histopathological assessment of pancreatic resection specimens. *Pathology* 41(2): 161 - 167

5 CAP (College of American Pathologists) (2009). *Cancer protocols and checklists* Available from: <[http://www.cap.org/apps/cap.portal?\\_nfpb=true&cntvwrPtl\\_t\\_actionOverride=%2Fportlets%2FcontentViewer%2Fshow&\\_windowLabel=cntvwrPtl\\_t&cntvwrPtl\\_t%7BactionForm.contentReference%7D=committees%2Fcancer%2Fcancer\\_protocols%2Fprotocols\\_index.html&\\_state=maximized&\\_pageLabel=cntvwr](http://www.cap.org/apps/cap.portal?_nfpb=true&cntvwrPtl_t_actionOverride=%2Fportlets%2FcontentViewer%2Fshow&_windowLabel=cntvwrPtl_t&cntvwrPtl_t%7BactionForm.contentReference%7D=committees%2Fcancer%2Fcancer_protocols%2Fprotocols_index.html&_state=maximized&_pageLabel=cntvwr)> (Accessed 13 October 2009).

6 RCP (Royal College of Pathologists) (2009). *Datasets and tissue pathways* RCP Available from: <<http://www.rcpath.org/index.asp?PageID=254>> (Accessed 13th Oct 09).

7 RCPA (Royal College of Pathologists of Australasia) (2009). *Guidelines for Authors of Structured Cancer Pathology Reporting Protocols*. RCPA, Surry Hills, NSW.

- 8 RCPA (Royal College of Pathologists of Australasia) (2004). *The Pathology Request-Test-Report Cycle — Guidelines for Requesters and Pathology Providers*, RCPA, Surry Hills, NSW.
- 9 Edge S, Byrd D, Compton C, Fritz A, Greene F and Trotti A (2009). *AJCC Cancer Staging Manual 7th edition*. Springer-Verlag, New York.
- 10 Valenstein PN (2008). Formatting pathology reports: applying four design principles to improve communication and patient safety. *Archives of Pathology and Laboratory Medicine* 132(1):84–94.