

## WG3 Terminology for Minimally Invasive Cancers, Integrating Morphology, Biology, and Clinical Management - Public Comments February 6, 2012 – February 12, 2012

Practice Type		
Clinician	0	0%
Pathologist	3	100%
Other, please specify	0	0%

Years of Experience		
More than 20 years	2	67%
11-20 years	1	33%
10 years or less	0	0%
Currently a resident/student	0	0%

Practice Setting		
Academic	2	67%
Community/Private Practice	1	33%
Government	0	0%
Industry	0	0%
Insurance/Payers	0	0%
*Other, please specify	0	0%

### Clinician Public Comments

**Question 1: Were any published articles omitted from consideration (please refer to Work Group scope/key questions and inclusion/exclusion criteria links above)? How would these articles impact the Work Group's conclusions?**

No responses received

**Question 2: Do you think there are any significant misrepresentations or biases in the draft recommendations?**

No responses received

**Question 3: Do you have any disagreements with the main conclusions and/or evaluations of the literature?**

No responses received

**Question 4: What topics/gaps for future research/guidelines should be priorities?**

No responses received

**Question 5: Other comments (including, if applicable, support for the recommendations):**

No responses received

## **Pathologist Public Comments**

**Question 1: Were any published articles omitted from consideration (please refer to Work Group scope/key questions and inclusion/exclusion criteria links above)? How would these articles impact the Work Group's conclusions?**

no

No

**Question 2: Do you think there are any significant misrepresentations or biases in the draft recommendations?**

no

No

**Question 3: Do you have any disagreements with the main conclusions and/or evaluations of the literature?**

some

No

**Question 4: What topics/gaps for future research/guidelines should be priorities?**

Minimally invasive adenocarcinoma concept and definition should also be addressed

**Question 5: Other comments (including, if applicable, support for the recommendations):**

At the risk of conflicting some with my LAST colleagues, I offer a few cents: Unlike the evolution from dysplasia, to CIN to SIL which followed a better understanding of biology and limitations of morphologic interpretive reproducibility, the problem with the term microinvasive/ion is not the concept, but the application of criteria. The concept is clear and well embedded in the literature: The term should ONLY be used when all the empirically established criteria are met that allows a patient with an invasive cancer to be managed essentially as one without invasion. Those criteria for cervix are well established and indeed the LAST group as done a great job at establishing the parameters of what is and is not known for such a class of tumors at each lower genital tract site. Regarding the requirement to know whether a tumor is grossly visible to kick it out of IA, this only really applies in the situation of a biopsy which by definition does not allow one to assess all the criteria necessary to make a proper microinvasive/IA assessment. I would submit that a grossly visible tumor that meets the parameters on excision of a IA should still be treated as such. Ergo rather than having to totally re-educate the world on terminology, my bias is to stick with the term microinvasion which is so well linked to the literature, but EMPHASIZE the proper use of criteria and definition, which has to be done any way.

WG3 should be complimented for handling a broad and difficult topic

## Other

<b>Practice Type</b>
No responses received

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**Question 5: Other comments (including, if applicable, support for the recommendations):**

No responses received