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Cytological differentiation between benign and malignant perianal gland proliferative lesions in dogs: a preliminary study

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1 CYTOLOGICAL DIFFERENTIATION BETWEEN BENIGN AND MALIGNANT PERIANAL GLAND

2 PROLIFERATIVE LESIONS IN DOGS: A PRELIMINARY STUDY

3 SUMMARY

4 **Objectives.** Castration and conservative surgical removal are the treatments of choice for perianal
5 gland adenomas, whereas carcinomas have no hormone dependency and must be treated with
6 wide margin surgical excision. Given the lack of specific guidelines, the present study aimed to
7 evaluate the diagnostic power of individual cytological criteria and their best combination to allow
8 the differentiation between benign and malignant perianal gland proliferative lesions in dogs.

9 **Methods.** A retrospective study was carried out on cytological samples of canine perianal gland
10 proliferative lesions with subsequent histopathological confirmation on surgical samples.

11 **Results.** Seventy-seven perianal gland nodules from 56 dogs were included in the study.
12 Histologically, lesions were diagnosed as hyperplasia (n = 2), adenoma (n = 53), epithelioma (n = 6)
13 and carcinoma (n = 16). Of the 28 cytological criteria assessed, 13 were statistically significant,
14 including lack of distinction between hepatoid and reserve cells, low proportion of mature
15 hepatoid cells, delocalization of reserve cells inside clusters and reserve cell morphological atypia
16 (coarse nuclear chromatin, anisocytosis, anisokaryosis). A diagnostic algorithm was proposed
17 accordingly, showing an 87% accuracy (sensitivity, 90.9%; specificity, 85.4%).

18 **Clinical Significance.** Cytology can provide useful information for the pre-surgical differentiation
19 between benign and malignant hepatoid gland proliferative lesions. Further studies are warranted to
20 validate the proposed algorithm and test its reproducibility on larger case series.

21 KEYWORDS

22 Dog; hepatoid glands; perianal glands; perianal gland tumours; cytology.

23 INTRODUCTION

24 Canine perianal gland tumours (PGT) are common neoplasms arising from hepatoid glands
25 (perianal glands, circumanal glands), which are modified sebaceous glands. These ductless glands
26 in dogs are located in the perianal region, on the dorsal and ventral aspect of the tail, in the
27 parapreputial area in males, in the abdominal mammary region in females, on the posterior aspect
28 of the hindlimbs, and on the midline of the back and thorax (Nielsen & Aftosmis 1964, Isitor &
29 Weinman 1979, Gross *et al.* 2005, Turek & Withrow 2013, Goldschmidt & Goldschmidt 2017).
30 Histologically, the lobules of perianal glands consist of mature cells (referred to as “hepatoid”
31 because morphologically resembling hepatocytes), peripherally surrounded by a single layer of
32 basal reserve cells (RC) (Isitor & Weinman 1979).

33 Proliferative lesions of hepatoid glands include hyperplasia, adenoma, epithelioma and carcinoma
34 (Gross *et al.* 2005).

35 Adenomas represent the majority (58-96%) of canine PGT and are the third most prevalent
36 tumour type in male dogs (Turek & Withrow 2013, Goldschmidt & Goldschmidt 2017). Their
37 development and progression appear to be sex hormone-dependent, with growth stimulated by
38 androgenic hormones and depressed by estrogenic hormones. The older, intact male is at higher
39 risk, while they are rarely observed in females (mostly in ovariohysterectomized
40 animals) or in castrated males (Hayes & Wilson 1977, Wilson & Hayes 1979, Pisani *et al.* 2006).

41 Perianal gland carcinomas are much less frequent than their benign counterpart, representing 3%
42 to 21% of all tumours in this region, and may occur in castrated or intact males, as well as in
43 females, implying no hormonal dependency (Turek & Withrow 2013, Goldschmidt & Goldschmidt
44 2017). Carcinomas tend to grow more rapidly, become ulcerated, adhere to underlying tissues,
45 recur following conservative surgery, and are generally larger than their benign counterpart.

46 Metastases are rare (15% of cases), and most likely to develop late in the course of disease, as the
47 primary tumour becomes bigger and locally invasive. The most frequent metastatic sites are

48 regional lymph nodes, but distant metastases may rarely affect lungs, liver, kidney, bone and
49 abdominal lymph nodes (Nielsen *et al.* 1964, Vail *et al.* 1990, Turek & Withrow 2013, McCourt *et*
50 *al.* 2018).

51 Histologically, PGT are composed by both RC and hepatoid cells (HC). In well-differentiated
52 adenomas, RC can be identified surrounding the lobules of HC, to mimic the normal glandular
53 architecture. Conversely, in the majority of malignant PGT, HC are irregularly intermingled with
54 and dissociated by RC (Berrocal *et al.* 1989, Goldschmidt *et al.* 1998, Gross *et al.* 2005,
55 Goldschmidt & Goldschmidt 2017). Epitheliomas are predominantly composed by RC, with fewer
56 HC, and are characterised by low-grade malignancy (Gross *et al.* 2005, Goldschmidt & Goldschmidt
57 2017).

58 The importance of distinguishing between benign and malignant perianal gland tumours is due to
59 the different influence of testosterone on the evolution of these neoplasms, and consequently on
60 the therapeutic strategies that can be applied. Castration and conservative surgical removal
61 remain the treatments of choice for hyperplasia and adenomas, whereas full staging and wide
62 margin surgical excision are recommended for carcinomas and epitheliomas (Wilson & Hayes
63 1979, Turek & Withrow 2013).

64 Fine-needle aspiration cytology (FNAC) offers several advantages over histology, including minimal
65 invasiveness, lower risk of complications, ease of sample collection and rapid results; however,
66 among the main diagnostic limits of cytology is the impossibility of assessing tissue architecture
67 and the infiltrative nature of the lesion (Klaassen 2002, Shelly 2003, Fisher 2014). Additionally,
68 specific cytological criteria to aid the differentiation between perianal gland adenomas and
69 carcinomas are currently lacking.

70 The aim of this retrospective study was to identify cytological criteria to differentiate benign and
71 malignant perianal gland proliferative lesions and develop a diagnostic algorithm to be applied in
72 clinical practice.

73 **MATERIALS AND METHODS**

74 A retrospective study was carried out on cytological samples of canine PGT with subsequent
75 histopathological confirmation on surgical samples. Cases were recruited at the Pathology Service
76 of the Department of Veterinary Medical Sciences, University of Bologna, Italy.

77 Histological samples were reviewed by two of the authors (SS and AR2) and cases with a diagnosis
78 of perianal gland hyperplasia, adenoma, epithelioma or carcinoma according to Gross *et al.* (2005)
79 were included.

80 For each case, the corresponding cytological sample was examined and the smears with
81 inadequate cellularity or with a high percentage of damaged cells were excluded from the analysis.
82 All cytological smears were obtained by fine-needle aspiration of the nodules, allowed to air-dry
83 and stained with May Grünwald-Giemsa.

84 Background information recorded in all cases included dogs' breed, age, sex and neutering status,
85 tumour location (perianal region or ectopic) and number of days between cytological and
86 histological examination. When available, information on tumour size and ulceration was also
87 retrieved from specimen submission forms.

88 Evaluated cytological criteria included cellularity, blood contamination, characteristics of cellular
89 clusters, characteristics of HC and RC, squamous and sebaceous differentiation, background
90 findings and inflammation. A full description of the evaluated criteria is provided as supplemental
91 material (Supplemental Table 1). These criteria were blindly assessed by three of the authors (SS,
92 AR1 and AR2) and diagnosis was by consensus.

93 Cases were divided in two groups (group 1: hyperplasia/adenoma; group 2:
94 epithelioma/carcinoma) based on the final histological diagnosis. Mann-Whitney U test and
95 Fisher's exact test/Chi-square test were used to identify the variables that were significantly
96 different between the two groups. Among the cytological criteria with statistically significant *P*
97 values, those judged more inclusive and easily assessable were combined into various algorithms.
98 These combinations were tested for their sensitivity, specificity and accuracy in the identification
99 of tumours from group 2 by two blinded observers (SS and AR1).
100 Descriptive statistics were used to present dogs and tumour characteristics. When appropriate,
101 data sets were tested for normality by use of the D'Agostino and Pearson omnibus normality test.
102 Values were expressed as mean \pm SD in case of normal distribution, or as median with an
103 interquartile range (IQR) in case of non-normal distribution.
104 Data were analysed by use of commercial software programs (SPSS Statistics v.19, IBM, Somers,
105 New York, and Prism v.5.0, GraphPad, San Diego, California). P-values < 0.05 were considered
106 significant.

107

108 **RESULTS**

109 *Background information*

110 Seventy-seven hepatoid gland nodules from 56 dogs fulfilled the inclusion criteria. Thirteen dogs
111 with multiple (2-4) nodules were included. Upon histological examination, 55 nodules (71%) were
112 judged as benign or hyperplastic (group 1; 2 hyperplasia and 53 adenomas), while 22 (29%) were
113 diagnosed as malignant (group 2; 6 epitheliomas and 16 carcinomas). In group 2, the malignant
114 areas occupied the majority of the nodule in 11 (50%) cases, while in the remaining 11, only a
115 small portion of the nodule was considered malignant.

116 The 55 tumours from Group 1 (benign proliferative lesions) belonged to 32 intact males (82%), 3
 117 castrated males (8%), 1 intact female (2%) and 3 spayed females (8%). Eighteen dogs were
 118 crossbred; the most represented breeds were Siberian husky, Yorkshire terrier and German
 119 shepherd (two cases each). The mean age was 11 ± 2.2 years.
 120 Forty-nine (89%) nodules were located around the anal ring, whereas 6 (11%) were ectopic (tail, n
 121 = 3; inguinal region, $n = 1$; abdomen, $n = 2$).
 122
 123 The 22 tumours from Group 2 (malignant proliferative lesions) belonged to 16 intact males (94%)
 124 and 1 spayed female (6%). Nine dogs were crossbred; the most represented breed was Siberian
 125 husky ($n = 3$). The mean age was 13 ± 2.4 years.
 126 Eighteen (82%) nodules were located around the anal ring, whereas 4 (18%) were ectopic (tail, $n =$
 127 3; trunk, $n = 1$).
 128 None of the above demographic features was significantly different between groups 1 and 2.
 129 Information on nodule diameter and ulceration was available in 60 (78%) and 57 (74%) cases,
 130 respectively. Median tumour diameter was significantly larger in group 2 (2 cm; IQR, 2-3 cm)
 131 compared with group 1 (1.3 cm; IQR, 0.7-2 cm; $P = 0.003$). The percentage of ulcerated nodules
 132 was 93% in group 2 and 65% in group 1 (difference not statistically significant; $P = 0.08$).
 133 *Cytological examination*
 134 The median time elapsed between cytological and histological examination was 21 days (IQR, 9-31
 135 days). The cytological criteria significantly associated with histological malignancy included larger
 136 cell clusters, irregular cluster margins, lack of distinction between HC and RC, low proportion of
 137 mature HC, nodular foci of RC inside clusters, dissociation of HC by RC, increased proportion of
 138 cells with N:C ratio > 1 , HC anisocytosis/anisokaryosis, RC anisocytosis/anisokaryosis and coarse

139 chromatin pattern and, high numbers of cells with cytoplasmic vacuoles, sebaceous differentiation
140 and lymphoplasmacytic inflammation (Table 1; Figure 1).

141 Based on these results, a diagnostic algorithm was developed to differentiate benign and
142 malignant proliferative lesions (Figure 2).

143 This algorithm allowed the identification of malignant tumours (group 2) with 90.9% sensitivity
144 (95% CI, 70.8-98.9%), 85.4% specificity (95% CI, 73.3-93.5%) and 87% accuracy (95% CI, 77.4-
145 93.6%). Overall, 2 (9%) malignant tumours were misdiagnosed as benign with this method, all of
146 which only had a minor portion of the nodule containing malignant cells.

147 **DISCUSSION**

148 While a generic cytological diagnosis of PGT is straightforward, the cytological distinction between
149 benign and malignant PGT can be more prone to error. Indeed, no specific guidelines for the
150 cytological identification of these neoplasms have been proposed and a recent report found no
151 evidence that the proportion of basal cells in canine PGT cytology is an indication of malignancy
152 (Evans et al. 2018). Even histologically, the differential diagnosis between adenoma and well-
153 differentiated carcinoma can be difficult and mostly relied on architectural elements, like evidence
154 of infiltrative growth and haphazardous cellular arrangement (Gross *et al.* 2005, Goldschmidt &
155 Goldschmidt 2017).

156 Herein, we present the results of a study aimed at evaluating the best combination of cytological
157 criteria to differentiate benign and malignant hepatoid gland proliferative lesions.

158 Despite the indications provided in the literature, demographic information and macroscopic
159 features were not always helpful in this distinction, as 13% of benign lesions were observed in
160 castrated males and in spayed/intact females, and the presence of ulceration was not an hallmark
161 of malignancy. This highlights even more the importance of a presurgical diagnosis for these
162 tumours.

163 Of the 28 cytological criteria assessed, as many as 13 were statistically significant, including
164 cellular morphological features, arrangement of cells inside clusters and numerical proportion
165 between cellular types.

166 By providing an indirect indication of tissue architecture, the arrangement of RC within clusters
167 represents a major diagnostic element for the cytological evaluation of PGT. In fine-needle
168 aspirates of perianal gland adenomas, the typical finding is that of three-dimensional clusters of
169 HC entirely surrounded by RC, impairing a clear identification of cellular components. However,
170 examination should focus on the areas of the smear where glandular adenomeres are broken into
171 bidimensional clusters and cell morphology becomes appreciable. Even if a complete peripheral
172 layer of RC surrounding clusters is hard to be found, seeing just a part of the rim in the absence of
173 RC inside clusters is highly suggestive of a benign form. These clusters are also generally
174 characterised by clean, smooth margins. In contrast, in the majority of malignant PGT, RC are
175 irregularly admixed with HC, with dissociation of the latter, or cluster of proliferation of RC alone
176 are observed. However, delocalization of RC may also occur in benign tumours and should not be,
177 in itself, sufficient to diagnose a perianal gland carcinoma. According to the proposed algorithm,
178 this criterion must be associated with evidence of RC anisocytosis/anisokaryosis or nuclear
179 activation. Poorly-differentiated carcinomas can be identified by the presence of an increased
180 number of cells with scant cytoplasm, resembling RC, but with larger nuclei and prominent
181 nucleoli (cells with intermediate differentiation). These cells are the results of dysregulations in
182 the maturation pattern from RC to HC. As malignancy increases, tumours may be entirely
183 composed by poorly-differentiated cells, with total disappearance of HC (Goldschmidt &
184 Goldschmidt 2017); in these cases, the differential diagnosis from anal sac carcinomas can be
185 difficult.

186 In the impossibility to directly assess tissue architecture or tumour invasiveness, cellular
187 morphology remains the most powerful criterion for the identification of malignant neoplasms in
188 cytological samples. In perianal glands, however, atypia must be judged with caution, because the
189 physiological presence of a dimorphic cell population can generate a false impression of
190 pleomorphism. In the examined cases, the true cellular pleomorphism was regularly associated
191 with nuclear activation (anisokaryosis, coarse chromatin) in cells other than HC.

192 An additional morphological element significantly associated with carcinomas was the presence of
193 cytoplasmic vacuoles: while not representing a true cytological criterion of malignancy, it might
194 reflect a state of cell degeneration and fragility more often found in malignant tumours, or an
195 initial stage of sebaceous metaplasia, which was frequently observed in hepatoid gland
196 carcinomas in this and other studies (Gross *et al.* 2005).

197 A further difficulty in the cytological assessment of PGT is that these tumours are frequently
198 surrounded by areas of perianal gland hyperplasia; so the presence of well-differentiated
199 adenomeres is a constant finding, even in carcinoma smears. Additionally, in half of the
200 carcinomas in this study, the malignant areas were limited to a small portion of the nodule, with
201 the remaining part being referable to adenoma. So these areas may not be sampled, or just a few
202 less differentiated cell clusters may be seen within an otherwise benign population. This has most
203 likely reduced the sensitivity of the proposed algorithm in this study.

204 Finally, the malignant transformation of a benign PGT during the time elapsed between cytological
205 and histological sampling cannot be completely excluded.

206 The main limitations of this study include the relatively small number of malignant PGT, which
207 reflects their lower frequency, and the fact that the algorithm has not been tested on *de novo*
208 neoplasms.

209 In conclusion, the present study proposes an algorithm to aid the pre-surgical differentiation
210 between benign and malignant perianal gland proliferative lesions by cytology. Further research
211 will be necessary to confirm these preliminary data, assess the accuracy of the algorithm and
212 evaluate its inter-observer reproducibility.

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257

258 **CONFLICTS OF INTEREST**

259 No conflicts of interest have been declared.

260

261 **REFERENCES**

262 **Figure 1.** A – Fine-needle aspirate of a well-differentiated perianal gland adenoma; three-
 263 dimensional cluster of cells with a smooth border, for the presence of a complete peripheral layer
 264 of small reserve cells (RC) with hyperchromatic nuclei (arrow) enclosing hepatoid cells (HC). May
 265 Grünwald-Giemsa (MGG) stain. B – Corresponding histological sample showing multiple
 266 adenomeres of mature HC surrounded by a rim of basaloid RC. Haematoxylin and eosin (HE) stain.
 267 C – HC irregularly admixed with RC. MGG. D – The same cellular arrangement can be observed in
 268 the corresponding histological sample. HE. E – HC dissociated by RC. Being RC nuclei small and
 269 hyperchromatic, this should not be considered a sign of malignancy. MGG. F – HC dissociated by
 270 enlarged RC with nuclear activation in a well-differentiated perianal gland carcinoma. Note the
 271 vacuolation of HC. MGG. G – Cluster predominantly composed by cells with intermediate
 272 differentiation, with disappearance of mature HC, suggestive of a poorly-differentiated perianal

273 gland carcinoma. MGG. H – The same elements can be observed in the corresponding histological
274 sample, where the dimorphism between HC and RC can no longer be appreciated. Note the
275 prominent mitotic activity of neoplastic cells. HE.

276 **Figure 2.** Algorithm to differentiate canine perianal gland hyperplasia/adenoma from their
277 malignant counterpart (epithelioma/carcinoma) in cytological smears obtained by fine-needle
278 aspiration cytology.