Letter to the Editor

Regarding Laryngeal Precursor Lesions: Interrater and Intrarater Reliability of Histopathological Assessment

Dear Editor:

The authors of the article “Laryngeal Precursor Lesions: Interrater and Intrarater Reliability of Histopathological Assessment”1 drew attention to an unfortunate error that occurred in the current World Health Organization (WHO) Classification of Head and Neck Tumours, chapter 3, Precursor Lesions.2 Their finding should be highlighted to prevent varying estimations of laryngeal precursor lesions (LPL). In chapter 3, on pages 91 and 92, Tables 3.02 and 3.03 are not entirely in agreement.2 Table 3.03 delineates low-grade dysplasia/low-grade squamous intraepithelial lesions (LGD/LGSIL) into the lower third instead of lower half of the epithelium, as defined in Table 3.02. The same error occurred in Table 3.03 for both Ljubljana classifications (LC).3–6 Consequently, Table 3.03 restricts high-grade dysplasia/high-grade squamous intraepithelial lesions (HGD/HGSIL) to the upper two-thirds instead of half of the epithelial thickness and upward, as is correctly shown in Table 3.02. We include the corrected Table 3.03 so that readers will be in no doubt about the morphological criteria of the current 2017 WHO classification.2 We deeply regret and apologize for this error.

In addition, the authors stated that the 2017 WHO grading system did not confirm the expected improvement in reliability. The morphological criteria of the amended LC, which were almost entirely transformed to the 2017 WHO classification, were verified by the largest published retrospective study. The prognostic value of the modified LC, presented by Kaplan-Meir survival curves, showed a significant difference ($P < 0.0001$) between patients with LGSILs and those with HGSILs. Patients with LGSILs progressed to malignancy in 1.6% of cases (19 of 1204) over a period of 2 to 15 years and patients with HGSILs in 12.5% of cases (30 of 240) over a period of 2 to 26 years. These data certainly confirm the prognostic value of the morphological criteria of the current 2017 WHO Classification.4

We do not agree with the authors that the 2017 WHO system has been created without consideration of any additional biomarkers of potential prognostic value.1 Several studies of biomarkers, cited in the article published in 2009,3 supported the concept of the LC, which provides together with the amended LC the foundation of the morphological criteria for the 2017 WHO classification. None of them, including very recent molecular studies,7,8 can replace morphological data as the leading guidance for clinicians in selecting appropriate treatment and evaluating the risk of progression.

Hopefully, further studies of laryngeal precursor lesions classified by the proposed 2017 WHO two-/three-

<table>
<thead>
<tr>
<th>Level of Abnormal Maturation</th>
<th>WHO 2005 Classification (146)</th>
<th>SIN Classification (850)</th>
<th>Ljubljana Classification (791)</th>
<th>Amended Ljubljana Classification (797)</th>
<th>WHO 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Squamous hyperplasia</td>
<td>Squamous hyperplasia</td>
<td>Squamous hyperplasia</td>
<td>Low-grade SIL</td>
<td>Low-grade dysplasia</td>
</tr>
<tr>
<td>Lower 1/3</td>
<td>Mild dysplasia</td>
<td>SIN 1</td>
<td>Basal/parabasal hyperplasia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/3 to 1/2</td>
<td>Moderate dysplasia</td>
<td>SIN 1 or SIN 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper 1/2–3/4</td>
<td>Moderate dysplasia</td>
<td>SIN 2</td>
<td>Atypical hyperplasia</td>
<td>High-grade SIL</td>
<td>High-grade dysplasia*</td>
</tr>
<tr>
<td>Full thickness</td>
<td>Severe dysplasia</td>
<td></td>
<td>CIS</td>
<td>CIS</td>
<td></td>
</tr>
</tbody>
</table>

*If a three-tiered system is used, carcinoma in situ is separated from high-grade dysplasia.
CIS = carcinoma in situ; SIL = squamous intraepithelial lesions; SIN = squamous intraepithelial neoplasia.

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A tiered system will prove morphologically well-founded and bring comparable results of treatment.

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