# AJCC Staging: A New Look at an Old System

**Lisa LaGue, CTR**
**Education and Training Coordinator**
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## Objectives

- Describe the importance of cancer staging
- Enhance knowledge of staging classifications
- Explain staging changes effective 1/1/2016
- Understand important guidelines/instructions/general rules
- Recognize need for special rules
- Update training resources
- Re-evaluate stage data considering new categories
- Highlight confusing staging concepts

## References

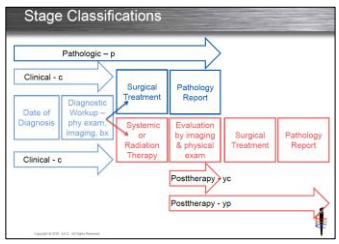
- AJCC Cancer Staging Manual, 7th Edition
- AJCC website: cancerstaging.org
- AJCC Forum within CAnswer Forum
- Registry coding manuals
  - FORDS, Revised for 2016
  - ISDH Policy and Procedure Manual for Reporting Facilities, May 2016
  - SEER Program Coding and Staging Manual 2016: Section V, Stage of Disease at Diagnosis

## Why Stage Cancer?

- The extent or *stage* of cancer at the time of diagnosis is a key factor that defines prognosis and is a critical element in determining appropriate treatment based on the experience and outcomes of groups of prior patients with similar stage.
- In addition, accurate staging is necessary to evaluate the results of treatments and clinical trials, to facilitate the exchange and comparison of information among treatment centers, and to serve as a basis for clinical and translational cancer research.

Source: *The AJCC Cancer Staging Manual,* Seventh Edition © 2010, American Joint Committee on Cancer, page 3

## Timing is Everything




Source:
*https://cancerstaging.org/CSE/Registrar/Documents/Stage%20Classifications%20c%20p%20yc%20yp.pdf*

## The Truth Behind the Change in AJCC Stage

- AJCC 7th edition has been in place since 2010
- AJCC rules didn't change 1/1/2016
- The way stage is recorded in abstracts changed 1/1/2016
- Assigning stage is the same
- Coding stage is different

## Staging vs Coding

- Assigning stage
- AJCC definition (the real picture)
  - Clinical stage _T_ _N_ _M_ Group_
  - Pathologic stage _T_ _N_ _M_ Group_
- Coding stage
- Entering stage into registry abstract (prior to v16)
  - Clinical stage cT_ cN_ cM_ Group_
  - Pathologic stage pT_ pN_ pM_ Group_

## Registry Software

- Two separate and mutually exclusive clinical and pathologic strings of T, N, M, and stage categories, with an implied "c" in the clinical TNM string, and an implied "p" in the pathologic TNM string
- Clinical stage cT_ cN_ cM_ Group
- Pathologic stage pT_ pN_ pM_ Group

## Pure Staging Concept

- Pure clinical stage group
- Pure pathologic stage group
- Follows AJCC rules for classification
- Prefixes do not have to match classification
  - Pure Clinical stage doesn't mean cT_ cN_ cM_ Group_
  - Pure Pathologic stage doesn't mean pT_ pN_ pM_ Group_

## New AJCC Categories - The Prefixes

- T, N and M categories describe the cancer
- "Prefixes" added to valid T, N and M categories 1/1/2016
- Prefixes do NOT determine classification
- Think of prefix as "assessment method"

## AJCC Prefixes and Other Terms

- New additions to existing categories
  - "c" prefix/indicator/designator
  - "p" prefix/indicator/designator
- Stage group descriptors
  - Prefix used for posttherapy classification ("y" stage)
  - Suffix used to further describe extent ("m", "E", "S")
  - Subscript used for lymphomas
    - Number of regions involved (ex. Stage $II_3$)
    - Really big mass or lesion (subscript letter X)

## Registry Software

- Prior to V16
  - Clinical stage cT_ cN_ cM_ Group_
  - Pathologic stage pT_ pN_ pM_ Group_
- V16
  - Clinical stage _T_ _N_ _M_ Group_
  - Pathologic stage _T_ _N_ _M_ Group_

## Chapter 1 - General Rules

- Cases with any X category generally cannot be assigned a stage group
- Extensive imaging is not necessary to assign clinical classifications
- Unless there is clinical or pathologic evidence of distant metastases, the case is classified as cM0
- pM not required to assign pathologic stage group
  - pT pN cM0
  - pT pN cM1

## Registry Software - General Rules

- Prior to V16
  - Clinical stage cTX cN0 cM0 Group 99
  - Pathologic stage pT3 pN1a pM_ Group IIIB
- V16
  - Clinical stage cTX cN0 cM0 Group 99
  - Pathologic stage pT3 pN1a cM0 Group IIIB

## Chapter 1 - Additional M1 Rules

- Assign appropriate M category for clinical classification
- Assign appropriate M category for pathologic classification
- Clinical stage M category based on assessment method
- Pathologic stage M category based on assessment method
- Only one M category for each stage classification

## Registry Software - cM1 Rule

- Prior to V16
  - Clinical stage cTX cNX cM1 Group IV
  - Pathologic stage pT3 pN1 pM_ Group IV
- V16
  - Clinical stage cTX cNX cM1 Group IV
  - Pathologic stage pT3 pN1 cM1 Group IV

## Registry Software - pM1 Rule

- Prior to V16
  - Clinical stage cTX cNX cM_ Group IV
  - Pathologic stage pT_ pN_ pM1 Group IV
- V16
  - Clinical stage cTX cNX pM1 Group IV
  - Pathologic stage pT_ pN_ pM1 Group IV

## Registry Software - Special M1 Case

- Prior to V16
  - Clinical stage cTX cN2 cM1a Group IVA
  - Pathologic stage pT3 pN2b pM1b Group IVB
- V16
  - Clinical stage cTX cN2 cM1a Group IVA
  - Pathologic stage pT3 pN2b pM1b Group IVB

## Warning for cM

- cM can be used to assign pathologic stage
  - cM0
  - cM1
- cM1 does not automatically make case pathologic stage IV
- Must still meet pT and pN requirements to assign pathologic stage

## Chapter 1 - In Situ Rule

- Carcinoma in situ, stage pTis cN0 cM0 as both clinical and pathologic stage 0
- In situ diagnosis cannot be made on imaging alone
- Must still meet pT requirement to assign pathologic stage

## Registry Software - In Situ Rule

- Prior to V16
  - Clinical stage cT_ cN0 cM0 Group 0
  - Pathologic stage pTis pN_ pM_ Group 0
- V16
  - Clinical stage pTis cN0 cM0 Group 0
  - Pathologic stage pTis cN0 cM0 Group 0

## In Situ Special Cases

- In situ disease diagnosed by biopsy (diagnostic work-up)
- Based on in situ diagnosis, treatment plan is resection of primary tumor only with no microscopic lymph node examination
- Invasive disease diagnosed by surgical resection

## Registry Software - In Situ Special Cases

- Prior to V16
  - Clinical stage cT_ cN0 cM0 Group 0
  - Pathologic stage pT1mi pNX pM_ Group 99
- V16
  - Clinical stage pTis cN0 cM0 Group 0
  - Pathologic stage pT1mi pNX cM0 Group 99

## Exceptions to Chapter 1 Rules

- Chapter 1 rules apply to all chapters
- Exceptions in site chapters over-ride general rules
  - Resection of primary tumor vs primary site required for pT
  - Number of lymph nodes for pN

## Bladder In Situ Case

- Carcinoma in situ diagnosed by TURBT (diagnostic workup)
- Based on in situ diagnosis, plan is for surveillance cystoscopies

## Registry Software - Bladder In Situ Case

- Prior to V16
  - Clinical stage cT_ cN0 cM0 Group 0is
  - Pathologic stage pTis pNX pM_ Group 99
- V16
  - Clinical stage pTis cN0 cM0 Group 0
  - Pathologic stage pT_ pN_ cM_ Group 99

TURBT does not qualify for pathologic stage classification; bladder chapter requires radical or partial cystectomy specimen

## Registrar Question

- Partial nephrectomy
  - pT1a kidney tumor (2cm mass unifocal/limited to kidney with negative margins)
  - No lymph nodes removed
- Physical exam and work-up negative for adenopathy and distant mets
- What is N for pathologic stage classification?
  - pT1a pNX pM_ Group 99
  - pT1a cN0 cM0 Group I

## Table 1.8 Anatomic Stage/Prognostic Grouping Rules

- pT pN cM0 or cM1 staged as pathologic stage group
- cT cN pM1 staged as clinical and pathologic stage group
- Use of cN0 for pathologic N is **limited to in situ tumors only in 2016**

## Site Specific Chapter Rules

- Melanoma
  - Pathologic staging includes microstaging of the primary melanoma and pathologic information about the regional lymph nodes after partial or complete lymphadenectomy
  - Pathologic stage 0 or IA patients are the exception; they do not require pathologic evaluation of their lymph nodes

## Registry Software - Early Stage Melanoma

- Prior to V16
  - Clinical stage cT1a cN0 cM0 Group IA
  - Pathologic stage pT1a pNX pM_ Group IA
- V16
  - Clinical stage cT1a cN0 cM0 Group IA
  - Pathologic stage pT1a pN_ cM0 Group IA

## How to Enter Stage in Abstract

- Clinical T, N, M categories
  - cTX → cX
  - pTis → pIS
  - cT1mic → c1MI
  - cN0b → c0B
  - cN3c → c3C
  - pM1b → p1B
- Clinical stage groups
  - 0is → 0IS
  - IB1 → 1B1
- Pathologic T, N, M categories
  - pT0 → p0
  - pTis → pIS
  - pT4e → p4E
  - pN0i+ → p0I+
  - pN1mi → p1MI
  - cM0 → c0
- Pathologic stage groups
  - Occult → OC
  - IIB → 2B

## How to Enter Stage in Abstract

- T, N and M categories
  - Cannot be assessed → X
  - Not recorded → (blank)
  - Unknown → (blank)
  - Not applicable → 88
- Stage groups
  - Cannot be assessed → 99
  - Not recorded → 99
  - Unknown → 99
  - Not applicable → 88

## X vs Blank

- X
  - Cannot be assessed
  - Diagnostic workup did not provide enough information
  - Surgical resection done but specimen not processed
- Blank
  - Not defined in AJCC manual
  - No diagnostic workup done
  - No surgical resection done
  - Registrar does not have information

## Ambiguous Terminology

- Lists still included in registry coding manuals
- Not used in AJCC
- Physicians still use
- Must still interpret

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April 22, 2016

**Ambiguous Terminology Lists: References of Last Resort**

The purpose of this communication is to clarify the use of Ambiguous Terminology for case reportability and staging in Commission on Cancer (CoC)-accredited programs. Registrars are to use the Ambiguous Terminology lists found in *FORDS: Revised for 2018* when abstracting. However, they need to be used correctly.

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to reportability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available), they should not refer to the Ambiguous Terminology lists. Registrars should not rely on these lists when abstracting all tumors, rather, only as a guideline when the situation is not clear and the case cannot be discussed with the appropriate physician/pathologist.

The CoC recognizes that not every registrar has access to the physician who diagnosed and/or staged the tumor; as a result, the Ambiguous Terminology lists continue to be used in CoC-accredited programs and maintained by CoC as "references of last resort".

## Questions?

lisa.lague@comcast.net