Cancer Surgery Standards PROGRAM
AMERICAN COLLEGE OF SURGEONS

Cancer Surgery Standards Program (CSSP)
Best Practices for Compliance with CoC Standards 5.7 & 5.8
Webinar held on June 3, 2021

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CoC Standard 5.7: Total Mesorectal Excision

- Requirements: Complete or near-complete total mesorectal excision (TME) is performed for curative-intent radical surgical resection of mid and low rectal cancers *and* the quality of TME is documented in the pathology report in synoptic format
  - TME quality is scored by the pathologist based on the worst area of the specimen
  - Compliance with Standard 5.7 began on January 1, 2021: Site visits in 2022 will review synoptic pathology reports from 2021 for 70% compliance, increasing to 80% starting with site visits in 2023
- Strategies to optimize compliance
  - Surgeons should clearly document curative intent and indication (low/mid rectal tumor) in operative notes
  - Ensure your institution is utilizing standardized CAP reports for all rectal cancer procedures
  - Encourage communication amongst surgeons, pathologists, & registrars

CoC Standard 5.8: Pulmonary Resection

- Requirements: Curative-intent pulmonary resections for primary lung malignancy include lymph nodes from at least 1 (named and/or numbered) hilar station & at least 3 distinct (named and/or numbered) mediastinal stations *and* those stations are documented in the pathology report in synoptic format
  - Single digit stations are mediastinal (2-9) and double-digit stations are hilar (10 or higher)
  - Compliance with Standard 5.8 began on January 1, 2021: Site visits in 2022 will review synoptic pathology reports from 2021 for 70% compliance, increasing to 80% starting with site visits in 2023
- Strategies to optimize compliance:
  - Surgeons should document curative intent and label nodal stations clearly and separately
  - Ensure institution is utilizing standardized CAP reports for all lung cancer procedures
  - Encourage communication amongst surgeons, pathologists, & registrars

Adherence to CoC Standards 5.7 & 5.8 - Case Study

- An internal review to assess adherence with Standards 5.7 & 5.8 was performed at Brooke Army Medical Center with the objective of identifying deficits and developing a site-specific plan to address them
- All cases from 2018–2020 for which Standards 5.7 & 5.8 would apply were identified and assessed for appropriate surgical technique and synoptic pathology documentation, as required by these standards
  - Results showed 50% compliance with Standard 5.7 and 35% compliance with Standard 5.8
- Specific opportunities for improvement were identified by reviewing operative and pathology reports
  - Interventions used to address deficits included educating the Cancer Committee and meeting with department leadership to help clarify the requirements of the standards
- Outcomes: 100% compliance so far in 2021 (4 rectal cases + 3 lung cases)

Standard 5.7: Total Mesorectal Excision – Pathological Examination

- The plane of surgery correlates with the integrity of the mesorectum
  - Muscularis propria must be exposed to be considered an incomplete resection
- The current version of the CAP protocol for colon and rectum resection (v4.1.0.0) requires documentation of *Macroscopic Evaluation of Mesorectum*
- While the surgeon is encouraged to document the integrity of the mesorectum in their operative report, the pathologist must grade the mesorectum independently from the surgeon. Multidisciplinary team discussions can provide an opportunity for the pathologist to give feedback to the surgeon

Standard 5.8: Pulmonary Resection – Pathological Examination

- Surgeons must clearly label (with number or name) mediastinal/N2 nodal stations and hilar/N1 nodal stations in separate specimen containers for pathological examination
    - Nodes dissected out by the pathology team count toward the requirements of Standard 5.8
    - Fat pads with no identified nodes and nodes sampled by EBUS do *not* count toward the requirements of Standard 5.8
    - Nodes from mediastinoscopy can count toward the requirements of Standard 5.8 if they are documented in the same pathology report as the curative resection
- The current version of the CAP protocol for lung resection (v4.1.0.1) requires pathologists to report the number of lymph nodes involved/examined *and* specify the nodal stations involved/examined
- Pathological nodal staging can still be performed as long as nodes are present in the specimen even if Standard 5.8 is not met; however, Standard 5.8 is a quality metric intended to ensure the most accurate staging of lymph nodes for patients

Frequently asked questions

Question	**Answer**
Are lymph nodes needed for curative intent intrapulmonary wedge resections that are small (2-2.5 cm width)? Many of these cases get EBUS preoperatively.	Yes, Standard 5.8 applies to all curative intent pulmonary resections, including all wedge resections. Historically, curative-intent wedge resections have the lowest lymph node yield when compared to lobectomy and segmentectomy. More thorough lymph node sampling increases the accuracy of lung cancer staging, which leads directly to more accurate and effective treatment and ultimately overall improved survival. Nodes biopsied during EBUS are certainly important in formulating accurate clinical staging, but do not specifically count toward the requirements of CoC Standard 5.8 (pathologic staging). Nodes biopsied during EBUS, along with as many other nodes as possible, should ideally be removed at surgery for additional confirmation of benign versus malignant pathology.
If the surgeon documents in the operative note that is not safe to perform extensive mediastinal sampling, will these cases count against us?	We have set the threshold of compliance at 70% in the first year, and 80% in subsequent years to account for the inevitable and infrequent clinical situations in which the standard is not able to be achieved. Although these cases would not meet the requirements of the standard, we always recommend that surgeons document when/why they could not obtain more lymph nodes. If for any reason the surgeon declares that the operation is no longer curative intent, then the standard would not apply.
Should the surgeon be documenting curative intent to help the pathologist identify when to use the synoptic report?	Yes, intent should be assigned postoperatively by the operating surgeon on the basis of preoperative evaluation and intraoperative management and is to be clearly documented in the operative report for any operation covered by these standards.
If the surgeon documents curative intent in their preop notes but not in the operative report, would that still be acceptable?	We recommend that curative intent is clearly documented in the operative report. This documentation is needed for CoC programs to identify eligible cases when preparing for site visits. However, each program should encourage communication amongst their surgeons, pathologists, and registrars to optimize compliance for these standards.
How does reviewing of 5.7 and 5.8 reflect on the surgeons (are there any repercussions for physicians--not facilities--for falling below 70% and 80%)?	The goal of these standards is to "raise the bar" of quality for all surgeons, and to identify opportunities for improvement. They are not meant to be punitive.

Is AJCC staging required for CoC Standards 5.7 and 5.8, or simply for CAP and other standards?	Documentation of AJCC stage is not specifically mandated as part of the CoC Operative Standards. However, AJCC staging is encouraged, and is an integral component of the CAP pathology report.
CAP and ACS CoC have campaigns for education, preparation, etc. Are there any similar initiatives with registrar organizations? Or is there anybody to point registrars/cancer registries to learn more about their own roles/responsibilities/changes, to help manage their expectations for CSSP?	Yes, we believe education on these standards specifically for registrars is critically important. The CSSP committees include representation from NCRA and the registrar community, and CSSP representatives presented at the NCRA 2021 Virtual Education Conference about the registrar's role in these standards. We are developing resources for registrars for these standards, including guidelines documents to help registrars determine which cases meet eligibility for the CoC Operative Standards. Guidelines for Standards 5.7 and 5.8 are available on the Operative Standards Toolkit webpage, with additional guidelines for Standards 5.3–5.6 coming soon.
Are 4R and 4L two separate nodal stations? If you had nodes from 4R, 4L, 9, and 11 would that be compliant?	Yes, 4R and 4L count as two different mediastinal stations as long as they are specifically distinguished as "right" (R) and "left" (L). The example provided would be compliant with the standard as long as the pathology report documents these stations in synoptic format.
Would stations 4, 4, 7, and 10 on the synoptic pathology report meet the requirements of Standard 5.8?	Standard 5.8 requires nodes from at least 1 hilar station and at least 3 distinct mediastinal stations. The example provided would not be compliant as written, since nodes from only 2 mediastinal stations ("4" and "7") were sampled.
What does the 70% compliance rate specifically refer to? The percent of complete total mesorectal excisions, or the percent of pathology reports documenting the completeness?	Standards 5.7 and 5.8 require that the technical standard has been met and appropriate documentation. In case of Standard 5.7, a compliant case would show a complete or near-complete total mesorectal excision and would be reported in the synoptic pathology report appropriately. 70% of reviewed pathology reports must meet the requirements of Standards 5.7 and 5.8 to achieve compliance with these standards. Additional information can be found on the Ratings and Compliance Information for CoC Operative Standards webpage.
Can the nodes from mediastinoscopy count if those nodes are included on the synoptic surgery pathology report?	Nodes from mediastinoscopy can be utilized to meet requirements of Standard 5.8 only if they are documented in the same pathology report as the curative resection.