CoC Operative Standards (Standards 5.3–5.8)
Frequently Asked Questions

### Compliance & Implementation

What are the requirements for compliance with the operative standards? What year will compliance be enforced?
The ratings and compliance information for Standards 5.3 through 5.8 can be found on the Operative Standards Timeline and Compliance Information webpage along with the implementation timelines.

How will site reviewers be evaluating compliance with the operative standards?
Site reviewers will review 7 charts for each operative standard (42 total) to determine whether reports meet the requirements outlined in Standards 5.3–5.8. Please refer to the “Measure of Compliance" section of each standard for details.

How many cases will be reviewed for a network? Is this determined by the number of facilities?
These details are still under consideration. We are evaluating networks and different types of integrated systems and will share additional details in the coming weeks.

If our facility rarely performs/does not ever perform a certain operation that is included in the operative standards, does that standard still apply to our facility?
If a program has less than 7 patients that meet the patient criteria for a specific standard, then all patient charts meeting the criteria will be reviewed by the site reviewer. If a program does not perform the procedure covered by one of the operative standards, then that standard does not apply for your facility.

What is the penalty for not meeting compliance with the operative standards?
Programs that are assigned a "Noncompliant" rating for an operative standard must follow the same guidelines for deficiency resolution as other CoC standards. More details on specific documentation that must be submitted to resolve the deficiency will be provided at a later date.

If my facility’s next site review is in 2023, what are we required to show for that site review?
When do we need to start synoptic operative documentation?
In 2022, programs must document their final plan for implementing Standards 5.3–5.6 at their institution. Those plans will be reviewed at site visits in 2023. Sites should start synoptic operative documentation by January 1, 2023. Assessment of operative reports will begin with site visits in 2024, which will review operative reports from 2023 for 70% compliance. For additional details on ratings and compliance, please visit the Timeline and Compliance Information webpage.
What is a synoptic report?
A synoptic report is a document that has standardized data elements organized as a structured checklist or template. The value for each data element is “filled in” using a pre-specified format. The purpose of the synoptic report is to format information in a manner where information can be easily collected, stored, and retrieved.

Why is synoptic reporting important?
Synoptic reporting has repeatedly been shown to improve both the completeness and the accuracy of clinical documentation. Reporting accuracy and completeness is of particular importance in cancer care where multiple providers are involved in the care of a single patient and any omissions or inaccuracies in surgery or pathology reporting may adversely impact downstream decisions. It has also been shown to improve the ability for downstream functions such as registry extraction and compliance. While more long-term experience and critical assessment is available for synoptic pathology reports, there are also abundant reports showing the benefits of synoptic operative reports.

Is the use of routine phrases the same as a synoptic report?
In contrast to narrative reporting, synoptic reporting uses a checklist format—though synoptic reports may have data elements that allow for free form text to be entered. Routine narrative phrases are most commonly used to reduce the burden of reporting in narrative format when an activity or description is the same from one surgery to the next, and typically consist of sentences copied into a narrative operative report. Such phrases may include information about routine placement of incisions or ports, or they may be used to repeat information that is also documented by anesthesia or nurse providers. Although synoptic reports can be constructed using “smart text” phrases, routine phrases used within a narrative report generally do not serve the same function, nor do they typically ensure that information unique to the patient is captured in a standardized format.

Is the synoptic operative report different from the synoptic report on the pathology report?
The synoptic operative report documents details of a surgical procedure and is different from the synoptic pathology report, which collects pathologic information on specimens. Standards 5.3, 5.4, 5.5, and 5.6 require an operative synoptic report. Standards 5.7 and 5.8 will require pathology synoptic reports.

Do the synoptic reports need to be a separate note or can these elements be baked into a standard descriptive operative report as a separate section as long as it meets the language and specifications?
The required elements and responses need to be in the operative note in a distinct section. It can be part of your standard operative note or embedded into your narrative operative report, but it has to be separate and have all the required elements/responses together in synoptic format. A uniform synoptic reporting format should be used by all surgeons at the facility.
Can the required synoptic information be in the immediate post-op note/brief op note and still be compliant?
No. To demonstrate compliance with CoC standards, the elements/responses required for CoC accreditation must be included in synoptic format in the operative report of record.

Are we only required to put the elements/responses (that are listed in each standard in the updated 2020 Standards Manual) into the synoptic report? Or is there more information required to be in the synoptic report?
To be compliant with CoC Standards 5.3–5.6, in addition to fulfilling the surgical/technical measure of compliance, the required elements and responses listed in the 2020 Standards must be included in the operative note in synoptic format. No additional information is required to be in the operative note in synoptic format.

Do you anticipate that the synoptic report will replace the narrative report or be added to the narrative report?
A basic synoptic report that includes only the required CoC elements cannot replace the narrative report. However, more generally speaking, synoptic reporting can be made fully comprehensive in a manner that can replace narrative reports. A more comprehensive report, such as that now offered by third party vendors or as will be pushed via the ACS API, is designed to replace the narrative report if a surgeon so chooses. The templates developed by the ACS CSSP are designed to capture the most important aspects of surgical care and meet many surgical reporting requirements. These templates have the functionality to add narrative text for purposes of capturing findings or other details the surgeon feels important to include.

When programs have their site reviews, will the site reviewer request these synoptic operative reports from our EMR or will these reports be uploaded to the CoC for the site reviewer to pull?
Programs will need to provide the synoptic operative report for the selected patients. Whether this is done through live review of the EMR or through a printed copy of the report has yet to be determined.

Is it expected that the synoptic format be built in such a way that data reports can be built/pulled to assess the compliance? It sounds like the review will be more manual by the CoC site reviewer.
Yes, the review process will be more manual to assess the elements and responses. Ideally, for the future, the responses will be digitalized so you can mine that data/information to assess quality metrics and for other purposes. However, for the purposes of assessing compliance with Standards 5.3–5.6, starting with site reviews in 2024 (looking at operative reports from 2023) as long as you have the element and response to that element, it will fulfill that measure of compliance. Please refer to the 2020 Standards for all compliance criteria.
Are any of these options for CoC programs to meet the synoptic reporting requirements of Standards 5.3–5.6 free?
Creating your own templates, by only including the required elements and responses from the CoC Standards Manual, does not involve any cost to programs.

Is there an estimated date when the ACS template will be available?
The templates are now available for facility-designated contacts at CoC-accredited cancer programs to view at no cost via the ACS Learning Content Management site. Please refer to this announcement in the Cancer Programs News for details.

Will there be a fee for the ACS API templates?
We expect there will be a nominal fee for the ACS API, which includes coding and formatting for those programs who want to use the ACS templates to build a synoptic reporting tool for their facility.

Will STORE surgery codes be directly mapped in the templates??
The templates that are currently available for CoC programs do not include STORE surgery code mappings.

What EMR vendors will have the templates?
The third-party vendors have relationships with most of the major EMR vendors. Please check with them if their tools will work with your EMR system. In terms of integrating the templates directly into your existing EMR, we suggest that you reach out directly to your EMR contact to make this request. ACS is also in discussions with some major EMRs to get this content incorporated into their systems.

Are you still publishing PDFs like the CAP protocols?
We expect to publish PDFs of the full protocols, which include the evidence behind the standards and data elements, in mid to late 2021.

Do you have any sense of timelines around when the major EMR vendors might have content available?
We would encourage you to reach out to your EMR representative for timelines on availability of this content within their systems.

Has any program estimated the cost of the complete implementation?
To date, we do not have an estimate of the cost of complete implementation.

Given the plans for future standards, how are you preparing EMR vendors to be agile for your future plans?
The ACS has been in discussions with the EMR vendors about the requirements for these standards and the future of operative standards and synoptic reporting since early 2020.
Are there plans for more than 2 pathology-based surgical standards, or additional pathology reported data elements? Or are plans to stick with the operative notes only in the future? While there are currently only two CoC accreditation standards that assess pathology reports (Standards 5.7 and 5.8), additional standards may be built in the future which are best evaluated by data in the pathology report. The CSSP is focusing on building out synoptic operative reporting templates, as synoptic pathology reporting templates are already developed by CAP.

Are there articles published in surgical journals about these standards and the use of templates? Yes, we are publishing a series of articles in the *Annals of Surgical Oncology* on synoptic reporting and operative standards. We have also developed additional manuscripts on specific individual standards from the *Operative Standards for Cancer Surgery* manuals. In addition to these efforts, there already exists robust literature about the benefits of synoptic reporting in general. These resources will be added to the CSSP Resources webpage in the near future.

**Cancer Surgery Standards Program (CSSP)**

**What is the Cancer Surgery Standards Program (CSSP)?**
The Cancer Surgery Standards Program (CSSP) is one of the seven ACS Cancer Programs. The CSSP aims to improve care by setting evidence-based standards for the technical conduct of oncologic surgery and educating surgeons to help them meet those standards. To support implementation and adherence, the CSSP builds and disseminates tools, including synoptic operative report templates and the associated electronic infrastructure. You can read more about the CSSP at [facs.org/cssp](http://facs.org/cssp).

**How is the CSSP related to the Commission on Cancer? Is it an accreditation program?**
The CSSP is developing synoptic operative reporting templates and educational resources, which will be shared with CoC-accredited facilities to help implement the operative standards. The CSSP is not an accreditation program and will not require programs to enroll.

**Other**

**What other cancer operations will be added to the operative standards in the future?**
It has not yet been decided which operative standards/disease sites will be implemented in the CoC in the future. The focus will be on Standards 5.3–5.8 first and ensuring that CoC sites have the resources they need to be compliant with the existing standards.

**Are there plans for synoptic radiology reports in the future?**
There are no plans for incorporation of synoptic radiology reports into the CoC Standards at this time.
Do Standards 5.3 and 5.4 include all histologies for breast cancer (e.g. infiltrating ductal, lobular, inflammatory etc.)?
CoC Standards 5.3 and 5.4 applies to all cases with breast cancer where a sentinel lymph node surgery or axillary lymph node dissection is performed. If a sentinel node is not removed due to an older age, then that case would not apply.

Are the synoptic operative reports required only for breast cases with SLNB or axillary LND? (For example, if no LNs are removed, does this mean that no synoptic operative reports are required?)
Synoptic operative reports are required for both Standard 5.3 and 5.4. If axillary nodal surgery (SLN or ALND) is not performed and if nodes are not removed, CoC Standards 5.3 or 5.4 do not apply.

Will both blue and radioactive SLN be required for compliance with Standard 5.3?
Dual tracer is not necessary to follow Standard 5.3 to remove all sentinel nodes. However, the most accurate method employs a dual tracer technique.

Does Standard 5.3 require that patients who have undergone neoadjuvant chemotherapy and clip placement, have the clipped node removed?
Standard 5.3 does not require the clipped node to be removed. To achieve compliance, the documentation will need to include whether the clipped node was removed or was not removed.

Does Standard 5.3 apply to DCIS cases that may have SLN? What about cases that have a mastectomy for DCIS and have a SLN - does this apply?
Yes, CoC Standard 5.3 applies if the sentinel lymph node surgery is performed in patients with DCIS.

What is the standard for nodes outside of the axilla? Do these need to be removed for Standard 5.4?
CoC Standard 5.4 does not cover nodes outside of the axilla. These do not need to be removed to meet the standard.

If a surgeon takes a margin wider than recommended in Standard 5.5, is this a problem or issue with compliance? For example, a tumor with a 0.6mm Breslow thickness having a 2cm inked/excised margin when the standard only recommends 1cm margin.
As indicated in the Measure of Compliance for Standard 5.5, clinical margin width for wide local excision should be 1 cm for invasive melanomas less than or equal to 1 mm in thickness. A 2 cm margin would therefore not fulfill this requirement. Overtreatment should be avoided and, in the rare situation when deviation from the standard is judged to be the best option for care, we encourage the
surgeon to document why a wider margin was chosen, e.g. presence of satellite lesions. However, margins wider than those set by Standard 5.5 are not compliant. The threshold compliance rate is less than 100% to account for these exceptions.

Regarding melanoma in-situ cases, the NCCN guidelines have a range for the recommended clinical margins from 5 to 10 mm whereas the CoC standards simply say "at least 5 mm". Can margins be of any size and still fulfill the requirements of Standard 5.5?
There is no deficiency for having too large of a margin for melanoma in-situ. However, evidence-based recommendations would not recommend a gross margin at the time of resection over 1cm.

What do we do when a dermatologist has done a shave biopsy on melanoma?
The definitive surgical resection margin is the goal of Standard 5.5 and is based upon the Breslow depth of the biopsy, even if it is a shave biopsy.

What if the depth of melanoma was deeper on the final pathology than on the initial biopsy diagnosing the melanoma regarding the wide local excision margin?
Standard 5.5 sets margins for wide local excision based on the Breslow thickness of the primary tumor as indicated on the initial biopsy pathology report. The CoC revised the language of Standard 5.5 in early 2021 to clarify this definition.

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**Standard 5.6 – Colon Resection**

How are colectomies performed on an emergent basis measured and tracked? How does this standard apply to truly emergent operations for obstruction?
Standard 5.6 applies to "all resections performed with curative intent for patients with colon cancer and applies to all approaches." An indication for emergent surgery, (e.g. obstruction) does not necessarily preclude the performance of proximal vascular ligation and en bloc lymphadenectomy. If the high ligation cannot be performed due to an "emergency situation", then it should be documented in the operative note (or in a narrative portion of the synoptic report).

Do two colon primaries require two synoptic reports (if the surgery is at the same time)?
If the surgeon performs one resection with two primary tumors, one synoptic report would be required. If two resections are performed with two primary tumors, two synoptic reports would be required.

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**Standard 5.7 – Total Mesorectal Excision**

Will the synoptic report format for Standard 5.7 be shared with CoC facilities for pathology to use?
The rectal synoptic pathology report can be accessed for free via the College of American Pathologists (CAP) website.
How will mid and low rectal cancer cases be selected for compliance with Standard 5.7? Will all rectal cancer cases need to be provided?

Programs will provide an accession list of all eligible rectal cancer patients that underwent surgery during the period being reviewed. The site reviewer will preselect 7 patients for review. If any of the patients selected have cancer in the high rectum, the program will notify the site reviewer to select additional cases so that only mid and low cancers are reviewed.

How can a registrar tell if the rectal tumor location is low to mid since rectum only has one primary code site? Does the CAP pathology report have a field for tumor location?

The CAP pathology report specifies rectum but does not distinguish between “high, mid, or low.” This determination can be made based on MRI, clinical, or endoscopic evaluation.

What surgery code ranges should be used to identify cases that need to be compliant with Standard 5.7?

Standard 5.7 applies to surgical procedures assigned a Code 30 or higher. Please be sure that you are referencing the most current, recently updated versions of the CoC Standards and STORE manuals and refer to the Scope of the Standard section to help identify cases and evaluate compliance with Standard 5.7.

Should surgeons or pathologists take pictures for the rectal resection?

Pictures are not required to comply with CoC Standard 5.7. Only CAP pathology reports will be assessed.

If we follow the CAP protocol for all our cases, should our program be at 100% compliance with Standard 5.7?

CoC-accredited programs must meet ALL of the measures of compliance under Standard 5.7 for 70% of cases starting January 2021 in order to be compliant with the standard. If for every mid and low rectal cancer case the CAP report is accurately documented, most of the standard is met. The standard does mandate that the specimen be “complete” or “near-complete”, so there is a technical component based on the surgeon’s quality of dissection.

Will there be certain fields that the surgeons have to complete as well, or is only the pathology report assessed for this standard?

Surgeons will not have fields to complete on the CAP report. The quality of their submitted specimen, as graded by the pathologist on the CAP report, is the main contribution of the surgeon. We also encourage communication amongst surgeons, pathologists, and registrars to optimize documentation for appropriate cases. Intent should be assigned postoperatively by the operating surgeon on the basis of preoperative evaluation and intraoperative management and should be clearly documented in the operative report for any operation covered by these standards.
When there is no residual tumor in a neoadjuvant specimen and synoptic reporting is not required by CAP, how should this situation be handled?
The CoC revised Standard 5.7 in early 2021 to align with the CAP cancer protocol template for rectal cancer resections. The revisions show that Standard 5.7 does not apply to primary resection specimens with no residual cancer (e.g., following neoadjuvant therapy).

Do emergent cases due to obstruction count toward Standard 5.7?
Although it is rare that an emergent rectal cancer operation (for bleeding, obstruction, or perforation) would be conducted for curative intent, if the operating surgeon states that the surgery is being conducted with curative intent then the standard will apply. It should be emphasized that the accreditation standard may not be met in 100% of cases. Thus, the compliance threshold is set at 70% for 2022 site visits and 80% for 2023 site visits.

Standard 5.8 – Pulmonary Resection

If a mediastinoscopy/EBUS is performed prior to the curative resection, can these procedures qualify for Standard 5.8, and do they have to be included within the curative resection pathology report or can they remain in a separate report to qualify?
As endobronchial ultrasound (EBUS) does not remove nodes, those nodes do not count toward the requirements of Standard 5.8. Nodes biopsied during EBUS should be removed at surgery as additional confirmation of benign versus malignant pathology.
Nodes from mediastinoscopy must be included on the same pathology report as the lung resection to count toward the requirements of Standard 5.8. If nodes are sampled at the time of mediastinoscopy performed at a separate operation on a separate day prior to surgery, then those nodes would satisfy the requirement only if documented within the pathology report from the curative intent operation.
In general, the surgeon should always strive to obtain lymph nodes from at least one hilar station and at least three distinct mediastinal stations. However, we recognize that there may be infrequent clinical situations in which the standard is not able to be achieved, which is why the threshold compliance rate is less than 100%.

Do hilar nodes evaluated in the lobe with hilar nodes count as N1?
Yes (which encourages pathology to do due diligence in their specimen dissection). Surgeons should not rely solely upon hilar nodes being found by their pathology colleagues and should conduct interlobar hilar nodal dissection as well (levels 10 and 11).

Is needle biopsy with EBUS equivalent to removal or sampling of the nodes?
Rarely, if ever, would EBUS (endobronchial ultrasound) be performed at the same setting as curative intent pulmonary resection because one cannot accurately rely upon needle specimen assessment with ROSE (rapid on-site evaluation) to change management in the minutes prior to moving on to major surgery. Furthermore, a negative EBUS assessment of a lymph node does not satisfy the requirement for surgical lymph node harvesting at the time of surgery (EBUS and mediastinoscopy always carry a risk of false negative sampling). This is, in fact, a specific intent of Standard 5.8; surgical lymph node
harvesting minimizes the risk of false negatives by confirming nodes are truly benign or are in fact malignant despite preoperative clinical staging efforts. If an ipsilateral mediastinal lymph node is sampled at the time of mediastinoscopy performed at a separate operation on a separate day prior to surgery, then this lymph node would satisfy the standard only if it is documented within the pathology report from the curative intent operation. In this situation, communication between the surgeon and pathologist is required to ensure accurate documentation in the synoptic portion of the CAP pathology report. We are aware that some institutions are capable of combining pathology reports from separate procedures for this specific purpose.

If the 2R and 4R packet is sent together, does this count as one N2 or two N2?
The packet should be separated and labeled appropriately if the surgeon believes the nodes have been harvested from two separate lymph node stations (i.e., separate the 2R portion from the 4R portion if at all possible, and label accordingly). If the surgeon ultimately obtains mediastinal lymph nodes from at least 2 other stations (7, 8R, or 9R) then the point is moot given the goal of harvesting at least 3 different mediastinal nodal stations has been accomplished. The surgeon must take responsibility for appropriately and specifically labeling lymph nodes.

If you send a fat pad from a station and label it but no nodes are found, does this count or not count as an N2 node?
This will not satisfy the requirement for harvesting an N2 lymph node but is a realistic occurrence during these operations (one cannot always know for sure if a lymph node exists within a particular fat pad). Occasionally, lymph nodes will not be present or safely accessible during the conduct of an operation. The threshold compliance rate is less than 100% to take this infrequent occurrence into consideration. Surgeons should ideally document where they looked to harvest nodes, even if none were found in a particular station, to provide clarity to the extent of thoroughness during the surgery (e.g., “no lymph nodes were visible within the level 9L inferior pulmonary ligament station despite thorough dissection”).

A pathologist-dissected intrapulmonary node is really quite different than a surgeon-dissected hilar node from a surgical quality metric. Can you confirm whether the pathologist-dissected intrapulmonary node satisfies the requirement?
Yes, nodes dissected out from the primary lung specimen by the pathologist count as hilar lymph nodes for Standard 5.8. Ideally, however, the surgeon would obtain additional nodes from levels 10 and 11.

When the 4R/2R packet is sent to pathology, surely it has to have a marker to determine the highest node and orientate?
It is the surgeon’s responsibility to ensure harvested lymph nodes are labeled appropriately to allow for accurate pathologic assessment and documentation.

If the criteria are not met, and the nodes sampled are negative, is it reported as N0 or indeterminate?
The final pathologic stage will be based upon the lymph nodes that have been assessed. If lymph nodes have been harvested and are negative for metastatic disease, N0 will be documented. Nx should
be reserved for cases in which lymph nodes were not resected. Meeting the criteria does not change the pathologic staging process. The standard is a quality metric that insures the most accurate and clinically meaningful staging is achieved but it does not change the conduct of pathologic staging.

We have found some situations where it was not appropriate to remove nodes (such as a small peripheral lesion wedged out in a patient with significant comorbidities, or when nodes are densely adherent to a major vessel). Do you plan to publish some exceptions for these types of scenarios?

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. Surgeons should always document when/why they could not obtain more lymph nodes (it happens to all of us on occasion, just as is implied in this particular question).

Will a fully completed CAP Pathology Checklist serve as compliance for 5.8? Are all the critical data elements in the CAP report?

Programs must meet ALL measures of compliance under Standard 5.8 to satisfy the standard. This includes the surgical removal of the lymph nodes from the specific nodal stations listed in the standard.

Does Standard 5.8 replace the 10RLN quality measure or will this still need to be monitored as well?

The lung 10 node measure is not tracked in RCRS and will be retired. The Quality Integration Committee is undergoing their review of this and all existing measures.