Welcome to the Commission on Cancer
Plenary

New Standards – An Open Forum

Session Moderators
James Harris, MD – Renown Regional Medical Center, Reno, NV
Heidi Nelson, MD – American College of Surgeons Cancer Programs, Chicago, IL
Today’s Program

- Welcome Remarks
- New CoC Surgical Standards – Can You Meet the 2020 Standards?
- Closing the Quality Gap in Cancer Care

Break

- CoC Elections, Recognition and Awards
- CoC Paper Competition Winner Presentation
- Working Together to Achieve Equity in Cancer Care
- Member Organization Updates
- National Cancer Database Data Clearance and Moving Sale
- 2020 CoC Standards – What you need to know now
- American College of Surgeons Foundation Update

Adjourn – head to Reception
This will be an interactive session using your cell phone or tablet.

Please connect to the Wi-Fi:
- Network: Hilton-Events
- Password: ACS2019

Then type in the website using any browser:
- Website: Vevox.app (don’t use www)
- Enter code: 164-136-679

Tap the center tab to ask questions of the panels.
Poll

What is Alcatraz named for?

• Devious inmates
• Sea birds
• Rocky formations
• Frigid waters
Poll

What is your generation (age)?

• Mature or Silent Generation (≥74)
• Baby Boomers (55-73)
• Generation X (43-54)
• Millennials or Generation Y (24-42)
• Generation Z, Centennials or Boomlets (≤ 23)
Can You Meet the 2020 CoC Surgical Standards?

Poll

Describe your community.

• Mature or Silent Generation (≥74)
• Large metropolitan area (>50,000 people)
• Suburban area near a large metropolitan area
• Micropolitan area (10,000 – 50,000 people)
• Rural town (<10,000 people)
Why are we discussing the new standards?

- Potential compliance GAP with new Operative standards
- Rates of compliance with the *operative* standards are estimated at 50-60%
- New CoC standards are being introduced in 2020
- Unclear if gap is for *technical* or *documentation* component
Can You Meet the 2020 CoC Surgical Standards?

Why are the Operative Standards important?

Adherence to surgical and oncologic standards improves survival in breast cancer patients

Standards:

- Resection margin status → R0 = meet standards
- Number of lymph nodes examined
  - ≥2 LNs for cT1 and cT2/3,
  - >10 LNs for pN2/3
- Adjuvant therapy (chemotherapy, hormonal, and radiation) → any = meet standards

<table>
<thead>
<tr>
<th>Minimal Standards</th>
<th>Number of cT1 Patients (%)</th>
<th># of cT2/3 Patients (%)</th>
<th># of pN2/3 Patients (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥2 LNs Examined</td>
<td>360316 (74.0%)</td>
<td>189208 (78.0%)</td>
<td>-</td>
</tr>
<tr>
<td>&gt;10 LNs Examined</td>
<td>-</td>
<td>-</td>
<td>91310 (78.3%)</td>
</tr>
</tbody>
</table>

Zhao et al JSO 2019: 120:148-159
Adherence to surgical and oncologic standards improves survival in breast cancer patients

<table>
<thead>
<tr>
<th>+ Standards</th>
<th>-- Standards</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year Overall Survival</td>
<td>0.872</td>
<td>0.745</td>
</tr>
<tr>
<td>10-Year Overall Survival</td>
<td>0.718</td>
<td>0.548</td>
</tr>
</tbody>
</table>

Zhao et al JSO 2019: 120:148-159
Can You Meet the 2020 CoC Surgical Standards?

Understanding the Gap

• Lack of clarity?
  • Purpose
  • Value
  • Supporting evidence

• Need more education about the standards?
  • Technical aspects
  • Documentation details
Breast Sentinel Lymph Node Biopsy

• Critical Elements
  • Identification of All Sentinel Nodes
  • Technique for Injecting Localizing Tracer or Dye
  • Preincision Evaluation of Drainage Pattern
  • Node Removal Technique to Limit Seroma Formation
Standard 5.3 - Breast Sentinel Node Biopsy

• **All** sentinel nodes for breast cancer must be **identified, removed, and subjected to pathologic analysis** to ensure that sentinel lymph node mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging.
Standard 5.3 - Breast Sentinel Node Biopsy

• Sentinel nodes are defined as nodes having uptake of a localization substrate (radioactive tracer and/or colored dye) that has been previously injected into the affected breast, a node to which an afferent colored lymphatic travels, or dominant lymph nodes that are suspicious, as identified by the operating surgeon.
Standard 5.3 - Breast Sentinel Node Biopsy

Operative reports must indicate that all colored, radioactive, and/or suspicious nodes were removed, in addition to any non-colored nodes at the end of a colored lymphatic.

Special situation:
Neoadjuvant chemotherapy
Poll

Is this how breast sentinel node biopsies are performed in your practice?

• Yes
• Variable
• No
• Not Applicable
Standard 5.3 - Breast Sentinel Node Biopsy
Operative Reporting Requirements

<table>
<thead>
<tr>
<th>Element</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substrate(s) used for sentinel node biopsy in the non-neoadjuvant setting</td>
<td>Dye; Radiotracer; Clips; Dye and Radiotracer; Dye and Clips; Radiotracer and Clips; Dye, Radiotracer, and Clips; None; N/A.</td>
</tr>
</tbody>
</table>

Poll
Which substrate do you use for sentinel nodes in the neoadjuvant setting?

- Dye
- Radiotracer
- Clips
- Dye and Radiotracer
- Dye and Clips
- Radiotracer and Clips
- Dye, Radiotracer, and Clips
- None
- N/A
Can You Meet the 2020 CoC Surgical Standards?

Poll

Do you routinely record these 6 elements in your operative report?

- Yes
- Variable
- No
- Not Applicable
Standard 5.5 - Primary Cutaneous Melanoma

• Critical Elements
  • Margin Width
  • Depth of Excision
  • Anatomic Orientation of the Excision
Standard 5.5 - Primary Cutaneous Melanoma

- Clinical margin width for wide local excision
  - Invasive melanomas <1 mm thick: 1cm
  - Invasive melanomas 1 - 2 mm thick: 1 - 2 cm
  - Invasive melanomas > 2 mm thick: 2 cm
  - Melanoma in situ: At least 5mm

- Margin width for melanoma wide local excision
  - Based on the Breslow thickness of the primary tumor
  - Margin is measured circumferentially with a ruler by the surgeon at the level of the skin from either residual gross tumor and/or the previous biopsy scar
  - Margin width refers to margin measured in situ clinically by the surgeon (not the pathologic margin width reported)

- Depth of excision
  - Invasive melanoma: Include the skin and all underlying subcutaneous tissue to the level of the underlying fascial plane
  - Melanoma in situ: Include the skin and the superficial subcutaneous fat
Poll

Is this how primary cutaneous melanoma procedures are performed in your practice?

- Yes
- Variable
- No
- Not Applicable
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.5 - Primary Cutaneous Melanoma Operative Report Requirements

<table>
<thead>
<tr>
<th>Element</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Breslow thickness of the lesion</td>
<td>Melanoma in situ (MIS); Invasive (to the tenth of a millimeter).</td>
</tr>
<tr>
<td>Clinical margin from the edge of the lesion or the prior excision scar</td>
<td>0.5 cm; 1 cm; 2 cm; Other; ___ cm due to cosmetic/anatomic concerns; Mohs micrographic surgery with ___ cm initial margin</td>
</tr>
<tr>
<td>Depth down to the fascia; if not down to the fascia, then document why</td>
<td>Yes; No; If no, why.</td>
</tr>
</tbody>
</table>
Panel – Breast and Melanoma
Synoptic Operative Reports
Can You Meet the 2020 CoC Surgical Standards?

- Improve accuracy of documentation
- Improve efficiency of entry
- Improve efficiency of data abstraction/measurement of compliance
- Education: emphasize the “critical elements” of oncologic operation
- Reduce variability in care
- Improve quality of cancer care
### Comparison of data elements recorded between free text and synoptic reports

<table>
<thead>
<tr>
<th>Data Element Recorded</th>
<th>Free Text (n=50)</th>
<th>Synoptic Report (n=50)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to the anterior peritoneal reflection</td>
<td>45 (90%)</td>
<td>50 (100%)</td>
<td>0.0218</td>
</tr>
<tr>
<td>Intactness of mesorectum</td>
<td>38 (76%)</td>
<td>50 (100%)</td>
<td>0.0002</td>
</tr>
<tr>
<td>Distance of tumor to the non-peritonealized CRM</td>
<td>38 (76%)</td>
<td>50 (100%)</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

**ANATOMICAL PATHOLOGY**

Structured pathology reporting improves the macroscopic assessment of rectal tumour resection specimens

**Simon King¹, Margaret Dimech² and Susan Johnstone¹**

¹Department of Anatomical Pathology, Pathology North, John Hunter Hospital, Newcastle, and ²Senior Project Manager, Royal College of Pathologists of Australasia, Surry Hills, Sydney, NSW, Australia

King et al. Pathology 2016
Can You Meet the 2020 CoC Surgical Standards?

Margins evaluated prior to enrollment in ACOSOG Z5031

<table>
<thead>
<tr>
<th>Result</th>
<th>Panc</th>
<th>CBD</th>
<th>SMA</th>
<th>AJCC/CAP*†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluated, n (%)</td>
<td>79 (100)</td>
<td>74 (94)</td>
<td>37 (47)</td>
<td>36 (46)</td>
</tr>
<tr>
<td>Positive, n (%)</td>
<td>12 (15)</td>
<td>2 (3)</td>
<td>14 (38)</td>
<td>16 (44)</td>
</tr>
</tbody>
</table>

Although only 25% of patients enrolled in Z5031 were reported to have undergone R1 resection, at least one margin was positive in 44% of the 36 patients in whom evaluation of all three AJCC/CAP margins was documented.
5.1 College of American Pathologists Synoptic Reporting

**Definition and Requirements**

Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologists (CAP) cancer protocols, including containing all core data elements within the synoptic format.

*The synoptic format is defined as a structured format that includes all of the following:*  
- All core elements must be reported (whether applicable or not)  
- All core elements must be reported in a "diagnostic parameter pair" format, in other words, data element followed by its response (answer)  
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation (refer to CAP Cancer Protocols for exceptions to this rule)  
- All core elements must be listed together in synoptic format in one location in the pathology report

*Note: Please refer to the CAP Cancer Protocols for specific guidance and examples.*

**Documentation**

**Reviewed On-Site**

- The site visit reviewer reviews the standardized synoptic pathology reports for eligible patients.

*Note: Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.*

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state-to-state.

**Measure of Compliance**

During the accreditation cycle, the cancer program fulfills the compliance criteria:

1. Ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologist (CAP) cancer protocols, including containing all core data elements within the synoptic format.
<table>
<thead>
<tr>
<th>Outcome or Subgroup</th>
<th># Studies</th>
<th>N</th>
<th>Statistical Method</th>
<th>Effect Estimate – Synoptic v. Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-rater Reliability</td>
<td>4</td>
<td>943</td>
<td>Mean Difference (95% CI)</td>
<td>0.35 [0.09, 0.62]</td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to complete (min)</td>
<td>6</td>
<td>891</td>
<td>Mean Difference (95% CI)</td>
<td>−0.86 min [-1.17, −0.55]</td>
</tr>
<tr>
<td>Time to verified report in chart/EPR (hours)</td>
<td>1</td>
<td>336</td>
<td>Mean Difference</td>
<td>−373.53 h</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accuracy</td>
<td>1</td>
<td>208</td>
<td>Mean Difference (95% CI)</td>
<td>40.60% [38.54, 42.66]</td>
</tr>
<tr>
<td>Critical Error (% of op notes)</td>
<td>1</td>
<td>110</td>
<td>Mean Difference</td>
<td>32.13%</td>
</tr>
<tr>
<td>Error Rate (% of op notes)</td>
<td>1</td>
<td>110</td>
<td>Mean Difference</td>
<td>75.26%</td>
</tr>
<tr>
<td>Validity</td>
<td>1</td>
<td>208</td>
<td>Mean Difference (95% CI)</td>
<td>3.40% [2.02, 4.78]</td>
</tr>
<tr>
<td>Cost ($/note)</td>
<td>2</td>
<td>72</td>
<td>Mean Difference</td>
<td>−$8.27</td>
</tr>
<tr>
<td>Standard</td>
<td>Disease Site</td>
<td>Procedure</td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Breast</td>
<td>Sentinel node biopsy</td>
<td>Operative report</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Breast</td>
<td>Axillary dissection</td>
<td>Operative report</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Melanoma</td>
<td>Wide local excision</td>
<td>Operative report</td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td>Colon</td>
<td>Colectomy (any)</td>
<td>Operative report</td>
<td></td>
</tr>
<tr>
<td>5.7</td>
<td>Rectum</td>
<td>Mid/low resection (TME)</td>
<td>Pathology report (CAP)</td>
<td></td>
</tr>
<tr>
<td>5.8</td>
<td>Lung</td>
<td>Lung resection (any)</td>
<td>Pathology report (CAP)</td>
<td></td>
</tr>
</tbody>
</table>
## Data elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Breslow thickness of the lesion</td>
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</tr>
<tr>
<td>Depth down to the fascia; if not down to the fascia, then document why</td>
<td>Yes; No; If no, why.</td>
</tr>
</tbody>
</table>
5.3 Breast: SLNB

Name: Mary Jones    MRN: 1234567

Preop Dx: Breast cancer
Postop dx: Same
Procedure: Sentinel lymph node biopsy
Anesthesia: GETA
EBL: minimal

Oncologic Synopsis
Substrates used for SLNB in non-neoadjuvant setting: N/A
Substrates used for SLNB in neoadjuvant setting: Dye
All colored nodes or non-colored nodes present at end of a dye filled channel removed: Yes
All radioactive nodes removed: N/A
All palpably suspicious nodes removed, if present: Yes
If clips were placed in pathologically-involved nodes, nodes removed: N/A

Narrative Report:
Informed consent was obtained. Preoperative antibiotics were administered. Ms. Jones...
5.4 Breast: Axillary dissection

Name: Mary Jones    MRN: 1234567

Preop Dx: Breast cancer
Postop dx: Same
Procedure: Axillary dissection
Anesthesia: GETA
EBL: minimal

Oncologic Synopsis
Resection performed within boundaries of axillary vein, serratus anterior and lat dorsi: Yes
Long thoracic and thoracodorsal nerves were spared: Yes
Attempts were made to spare the intercostobrachial nerves if possible: Yes
If one or more level III nodes are removed, then document why: palpable

Narrative Report:
Informed consent was obtained. Preoperative antibiotics were administered. Ms. Jones...
5.5 Melanoma: Wide local excision

Name: Mary Jones      MRN: 1234567
Preop Dx: Malignant melanoma of the thigh
Postop dx: Same
Procedure: Wide local excision
Anesthesia: Local/MAC
EBL: minimal

Oncologic Synopsis
Original Breslow thickness of lesion: 0.9mm
Clinical margin from the edge of the lesion or the prior excision scar: 1cm
Depth down to the fascia: Yes

Narrative Report:
Informed consent was obtained. Preoperative antibiotics were administered. Ms. Jones...
5.6 Colon: Colectomy

Name: Mary Jones     MRN: 1234567

Preop Dx: Colon cancer (right colon)
Postop dx: Same
Procedure: Ileocolectomy
Anesthesia: GETA
EBL: minimal

Oncologic Synopsis
Tumor location: right colon
Extent of Lymphovascular resection: high ligation of ileocolic artery and vein
If anatomic guidance other than listed above, document why: N/A
If patient excluded, document why: N/A

Narrative Report:
Informed consent was obtained. Preoperative antibiotics were administered. Ms. Jones...
Can You Meet the 2020 CoC Surgical Standards?

NAPRC Accreditation
NAPRC Pre-implementation study of 37 surgeons from 19 institutions

“I always put those metrics in my operative notes, anyway, so. So this is not helpful for me, personally.”

“And virtually everything that's in that synoptic report, you know, if you will, it's my custom to dictate ... I'm not perfect. Sometimes there are things that one should include and I think reminding you to include those elements is a good idea.”

“I worry about all forms of templated clinical notes, um, because there might be a temptation to say things that aren't-- are not true or that are unknown.”

“I think it could affect what happens in surgery because after, you know, a dozen times of knowing that you're about to be asked to fill in a certain item, it might improve your willing-- you know, it might improve the accuracy of actually measuring that item. Um, so I think it does have the-- it does have some purpose to that.”

“it's a report that ensures inclusion of certain criteria related to surgery of rectal cancer. So it's a quality assurance metric.”
How hard will it be to transition to a synoptic template in your practice?

- Very difficult
- Somewhat difficult
- Not very difficult
- Not at all difficult
- Already use a synoptic template
Can You Meet the 2020 CoC Surgical Standards?

Synoptic Reporting - Open microphone and panel discussion
Standard 5.7 - Total Mesorectal Excision

- Total mesorectal excision (TME) is performed for all patients undergoing radical surgical resection of mid and low rectal cancers. Limited, tumor-specific mesorectal excision with a distal mesorectal margin of 4 to 5 cm of mesorectum may be performed for proximal rectal cancers.
What is Total Mesorectal Excision (TME)?

• A specific surgical technique for removing the rectum that maintains an anatomical boundary (mesorectal fascia) around tumor and mesorectal lymph nodes.
Total Mesorectal Excision (TME): Key Steps

• Proximal vascular ligation (IMA)
Total Mesorectal Excision (TME): Key Steps

• Rectal dissection in the mesorectal plane

Plane of dissection preserves mesorectal fascia as envelope around the surgically resected rectum
Total Mesorectal Excision (TME): Key Steps

- Mesorectal division a minimum of 4-5 cm below distal edge of primary tumor
- Rectal wall division a minimum of 1 cm below distal edge of primary tumor

Why is TME Important?

- Maximizes odds of achieving a “clear margin” or “R0” resection
- Improves outcomes
  - Decreases local recurrence rates
  - Increases survival rates

Can You Meet the 2020 CoC Surgical Standards?
Poll

Is this how total mesorectal excision procedures are performed in your practice?

• Yes
• Variable
• No
• Not Applicable
Standard 5.7 - Total Mesorectal Excision

• Documentation/Measure of compliance
  • Total mesorectal excision is performed for all patients undergoing radical surgical resection of mid and low rectal cancers and results in a complete or near complete mesorectal excision
  • The site reviewer will review the standardized synoptic pathology reports for rectal cancer patients with middle and lower rectal cancers
Lung Cancer
(Pulmonary Resection)

Matthew A Facktor MD FACS
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

• Critical Elements
  • Confirmation of Imaging Findings
  • Mediastinal Staging for Central Tumors
  • Mediastinal Staging Prior to Treatment
  • Mediastinal Staging at the Time of Lung Resection
Standard 5.8 - Pulmonary Resection

• The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.

• The hilum and mediastinum should be thoroughly staged at the time of the lung resection, even in patients who are undergoing nonanatomic parenchyma-sparing resections such as...[a] wedge resection.

• Single digit stations are mediastinal (1-9) and double digit stations are hilar (10 or higher).
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

Any curative intent lung resection

- non-small cell
- small cell
- carcinoid
Can You Meet the 2020 CoC Surgical Standards?

**Standard 5.8 - Pulmonary Resection**

“1 + 3” rule

- 1 hilar lymph node
- 3 mediastinal lymph nodes

(three different mediastinal stations)
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

Exposing mediastinal nodal stations 8 (paraesophageal) and 9 (inferior pulmonary ligament)
Mediastinal nodal stations 8 and 9

Mediastinal nodal station 7 (subcarinal)
Clearing out mediastinal nodal station 7 from the right chest.
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

Harvesting mediastinal nodal stations 2R (upper paratracheal) and 4R (lower paratracheal)
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

Cleared out paratracheal node basin

Exposed mediastinal nodal station 5 (aortopulmonary window)
Can You Meet the 2020 CoC Surgical Standards?

Standard 5.8 - Pulmonary Resection

Where do we look for this?

- Surgical pathology report
- CAP already requires reporting
Standard 5.8 - Pulmonary Resection

Synoptic operative report

- NOT YET REQUIRED
- But now is a good time to start
# Can You Meet the 2020 CoC Surgical Standards?

## Lung Cancer Critical Elements of Synoptic

### Preresection Staging

<table>
<thead>
<tr>
<th>None</th>
<th>EBUS</th>
<th>EUS</th>
<th>Cervical mediastinoscopy</th>
<th>VATS/thoracotomy</th>
<th>Chamberlain</th>
</tr>
</thead>
</table>

### Preresection Nodal Staging (with Diagnostic Lymphoid Tissue)

<table>
<thead>
<tr>
<th>N/A</th>
<th>Right nodal stations</th>
<th>Left nodal stations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Other N1</td>
<td>9</td>
<td>Other N1</td>
</tr>
</tbody>
</table>

### Nodal Stations Examined at Time of Resection

<table>
<thead>
<tr>
<th>N/A</th>
<th>Right nodal stations</th>
<th>Left nodal stations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Other N1</td>
<td>9</td>
<td>Other N1</td>
</tr>
</tbody>
</table>

### Method of Lung Resection

- VATS
- Thoracotomy
- Robot assisted

### Extent of Lung Resection

<table>
<thead>
<tr>
<th>Segmentectomy</th>
<th>Lobectomy</th>
<th>Pneumonectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component of non-anatomic resection as part of anatomic resection</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

| Wedge resection | | | |
|-----------------|---|---|

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Poll

Do you routinely obtain “1+3” nodes during curative intent lung cancer surgery?

• Yes
• Variable
• No
• Not Applicable