

Background

- In 2020, the CoC introduced accreditation standards for sentinel node biopsy (Standard 5.3) and axillary dissection (Standard 5.4) for breast cancer, which include requirements for synoptic operative reports
- Adherence to evidence-based oncologic standards (negative resection margins, use of adjuvant therapy, number of lymph nodes examined) is associated with [improved survival for patients with breast cancer](#)

Rationale and Requirements for CoC Standard 5.3: Sentinel Node Biopsy for Breast Cancer

- Sentinel lymph node biopsy improves staging and oncologic outcomes, offers a decreased risk of lymphedema and operative morbidity in appropriate clinically node-negative patients, and is a standard approach to care
 - Nodes which are dye-stained, radioactive, at the end of a dye-filled lymphatic channel, or palpably suspicious, as well as biopsy-proven positive nodes marked with clips prior to chemotherapy, should be removed
- Both of the following must be met for a case to be compliant with Standard 5.3:
 - All sentinel nodes for breast cancer must be diligently searched for using tracers or palpation, removed, and subjected to pathologic analysis.
 - Operative reports for sentinel node biopsies for breast cancer document the required elements in synoptic format, as listed in [Optimal Resources for Cancer Care \(2020 Standards\)](#)
- Programs can perform a self-audit for compliance by following the [Case Identification Guidelines for Standard 5.3](#)

Rationale and Requirements for CoC Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

- High-quality axillary lymph node dissection (ALND) improves staging and oncologic outcomes in appropriate patients and is accepted as standard approach to care
- ALND for breast cancer constitutes removal of level I and II lymph nodes within an anatomic triangle defined by the axillary vein, chest wall, and latissimus dorsi, with preservation of key neurovascular structures.
 - The long thoracic nerve and the thoracodorsal nerve should be preserved unless visibly involved with cancer. The intercostobrachial nerves should be spared when possible.
 - Level III typically has low lymph node yields and should not routinely be removed for breast cancer procedures.
- Both of the following must be met for a case to be compliant with Standard 5.4:
 - Axillary lymph node dissections for breast cancer include removal of level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall (serratus anterior), and latissimus dorsi, with preservation of the main nerves in the axilla
 - Operative reports for axillary lymph node dissections for breast cancer document the required elements in synoptic format, as listed in [Optimal Resources for Cancer Care \(2020 Standards\)](#)
- Programs can perform a self-audit for compliance by following the [Case Identification Guidelines for Standard 5.4](#)

Best Practices to Optimize Compliance

- While not required for these standards, it is recommended that CoC-accredited programs perform internal audits to identify gaps in compliance.
- An internal review was performed at a for-profit, community-based hospital system of a single quarter (34 axillary cases) and found a compliance rate of 0% for Standards 5.3 and 5.4

- When excluding identification of curative intent, compliance rates increased to 50% for Standard 5.3 and 25% for Standard 5.4
- Sharing information and data during key meetings with stakeholders (e.g., cancer committee meeting, tumor boards, breast panels) can improve engagement for implementing these standards
 - Interventions can include tailored education for teams, working within the EMR to create solutions, and developing an internal timeline for monitoring and increasing compliance

Synoptic Operative Reporting for Standards 5.3 & 5.4

- In comparison to narrative reporting, synoptic reporting has been found to improve the accuracy of documentation, efficiency of data entry and abstraction, and reduce costs.
 - Synoptic reports can also reinforce education (by emphasizing the critical elements of oncologic operations) and reduce variability in care, leading overall to improved quality of cancer care
- [Standards 5.3 and 5.4 will take full effect on January 1, 2023](#). Site visits in 2024 will evaluate charts from 2023 to determine whether 70% of operative reports within the scope of the standards meet the requirements for compliance. The compliance rate will increase to 80% starting with site visits in 2025.
- Current options for synoptic operative reporting to meet the requirements of Standards 5.3 & 5.4:
 - Create institutional synoptic reporting templates with required elements/responses
 - Work with a [third-party vendor](#) to integrate their synoptic operative reporting tool
 - Use fillable PDF forms downloaded from the Standards Resource Library in QPort

Frequently Asked Questions

Question	Answer
We are a large institution and many community surgeons may do surgery at our organization. Do you have any recommendations for how to educate surgeons especially those who may only do 1 case per year with our institution? How have others been successful educating surgeons? Has there been pushback from surgeons and how might we address pushback?	One approach may be to use meetings to present the supporting evidence behind these accreditation standards (references can be found in the bibliography of each standard). Another recommendation is to focus first on increasing awareness of the standards. A number of resources (such as videos, podcasts, and visual abstract-style infographics) are available online in the Operative Standards Toolkit and can be shared with surgeons and staff at CoC-accredited programs.
If a positive node is found on frozen section during the sentinel node procedure and an axillary dissection is performed, are both synoptic operative reports for sentinel node biopsy and axillary dissection required?	Yes, if both procedures fall within the scope of the standards, the synoptic reporting requirements for both Standard 5.3 and 5.4 would apply.
If the procedure was not curative, then does the surgeon need to complete the required synoptic elements/responses for these standards?	Standards 5.3 and 5.4 only apply to cases performed with curative intent. We recommend communicating with the surgeons at your facility to ensure they understand the scope of these standards and when the required synoptic elements/responses are needed.
Are these standards for invasive breast cancer only or do they include DCIS?	These standards include procedures done for DCIS.
Is there a specific format that is required for the synoptic operative standards? For instance should it look the same as the pathology synoptic reporting structure?	To meet synoptic formatting requirements, the completed synoptic operative report must list each required data element followed by its response (answer) in a “diagnostic parameter pair” format, similar to the synoptic pathology reporting of CAP. Please note that

	providing the required data elements and responses in prose format does not meet these requirements.
Can the SOR be anywhere in the EMR or is there a specific place it should be located?	The required elements/responses must be a part of the operative report of record and cannot be in the brief op note. The only exception is if a CoC program is utilizing the fillable PDF forms developed by the CSSP, which is intended as a stop-gap measure for programs unable to otherwise incorporate synoptic reporting into their EMR.
Some of our surgeons are still utilizing narrative reporting (i.e. dictation). If they still want to use dictation is that acceptable as long as the required CoC elements are in an additional synoptic report?	Yes. Only the required elements/responses from the CoC accreditation standards must be in synoptic format. These can be present in a separate synoptic section of the operative report, in addition to a narrative section.
Where exactly can we locate the "Fillable PDF Forms"? What is it labeled as?	The fillable PDF forms for Standards 5.3, 5.4, 5.5, and 5.6 are located in the Standards Resource Library, which is now accessed through QPort . Please log in to QPort using the same credentials you use for CoC Datalinks. Once logged in, navigate to "Resources" and from there click on the "Standards Resource Library", and then each form is listed under its specific standard number in Chapter 5.
What if the surgery is performed at a different facility? Are those surgeons required to meet the standards? If a provider is not part of our cancer committee or employed by our hospital but perform their surgeries in our OR do they also still need to use the synoptic report that we develop?	If a surgeon from your CoC-accredited program performs an operation at a different hospital, that operation is not required to meet the CoC Operative Standards. However, if a provider from another facility performs an operation in your CoC-accredited program's OR, that operation is included in the CoC Operative Standards.