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American Joint Committee on Cancer

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# AJCC Future Directions and TNM Staging System Updates

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- J. Gershenwald - advisory board/consultant – Merck (unrelated to the content of this talk)
- D. Gress – nothing to disclose



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# Acknowledgement



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# Cancer Staging – Background



- AJCC → standard setter for cancer staging
- Principle communication tool – **common language** facilitates worldwide consistency
  - Cancer care – patient & clinician – clinician
  - Surveillance/Registry reporting: state/province, national, international, etc.
- Risk stratification defines patient groups → staging/prognosis
- Treatment recommendations → often stage-based
- Informs clinical trial eligibility, stratification, analysis
- Informs translational/correlative science

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# AJCC Cancer Staging Manuals

Source of Cancer Staging  
for Decades → 8 Editions

1<sup>st</sup> - 1977

2<sup>nd</sup> - 1983

3<sup>rd</sup> - 1988

4<sup>th</sup> - 1992

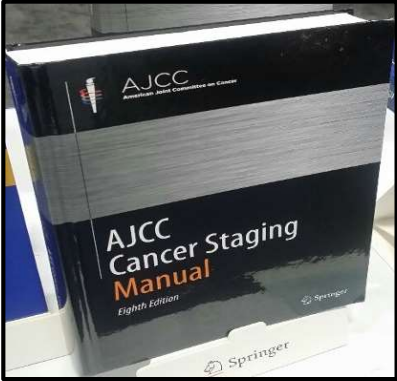
5<sup>th</sup> - 1997

6<sup>th</sup> - 2002


7<sup>th</sup> - 2010

8<sup>th</sup> - 2017

8<sup>th</sup> Edition



1<sup>st</sup> – 7<sup>th</sup> Editions



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## Eighth Edition Dedication

*The AJCC Cancer Staging Manual, 8<sup>th</sup> Edition is dedicated to all  
CANCER REGISTRARS in recognition of their:*

- education and unique commitment to the recording and maintenance of cancer data for clinical research and patient care;*
- professional expertise and leadership in the field of cancer staging;*
- dedication to the cataloging of information crucial to cancer research;*
- leadership, support, and promulgation of the principles of cancer staging;*
- AND THEIR POSITIVE IMPACT ON CANCER PATIENT OUTCOMES.*

THANK YOU!

AJCC Cancer Staging Manual. 8th Ed. New York: Springer; 2017

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## Evolution of Cancer Staging - I



- Cancer Staging Manual → rebranded as Cancer Staging System
- Goal → Continue to ensure cancer staging is current, evidence-based, and meets needs of clinical care and surveillance communities

8 <sup>th</sup> Edition	Version 9
Hardcopy book	Digital product leverages API*-based infrastructure
Chapters	Protocols (1 <sup>st</sup> protocol released October 2020)
Published every 5-7 years	Published on rolling basis
Entire manual (all chapters) published simultaneously	Protocols published disease site by disease site based on needs of clinical care & surveillance communities (and planned coordination with WHO Blue Book cycle update)
Print manual → “static”	Electronic platform facilitates rapid integration of updated staging information into EHRs and cancer registry databases & use of information; facilitates development of additional tools and applications

\*API – application programming interface



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## Evolution of Cancer Staging - II





- AJCC Version 9 disease site protocol releases will replace relevant existing Eighth edition chapters over next several years
- Eighth edition Cancer Staging Manual content will continue to be used for staging and cancer surveillance until new Version 9 disease site protocol available
- “Principles of Cancer Staging” chapter in eighth edition remains an important resource → select sections included in Version 9 content
- Communication efforts for this effort ongoing and to be expanded to ensure a seamless transition for end users



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# Version 9

# Protocol for Cancer Staging



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## Version 9 – Protocol Structure

- **Version control** to clearly indicate Version 9, and allow for minor corrections (typos and other errata)
- Clear indication of **effective date for implementation**
- **Standardized format** with required and optional sections
- Clear indications of **cancers covered** in Protocol and those not staged
- Outline of Staging Report Format to orientate reader

### Protocol for Cancer Staging Documentation: (Disease Site)

ACS.AJCC.Protocol.DiseaseSite.2021.v09.00.00  
Required Use Date: January 1, 2021

**Cancers Staged Using This Staging System**  
Cancers Staged Using This Staging System disease site text.

**Cancers Not Staged Using This Staging System**

These histopathologic types of cancer...	Are staged according to the classification for...
Cancers Not Staged Using This Staging System disease site text	

**Introductory Comments:**  
The following protocol is intended to standardize communication of critical components of cancer staging. It includes corresponding explanatory notes that provide the level of evidence for each critical element. While the focus of this protocol with synoptic report format is on cancer staging for clinical care and registry support, information on additional and emerging prognostic factors is included. Additional information on staging may be found in the AJCC 8<sup>th</sup> Edition Chapter 1: Principles of Staging on the AJCC website cancerstaging.org.

**Staging Report Format:**

- Instructions
- Summary of Changes
- Diagnostic Phase
  - Identification of Primary Site (anatomy)
  - Histopathologic Type
  - Histologic Grade
  - Consensus Molecular Subtype (optional)
  - Modalities Used for Diagnosis and Staging
    - Clinical examination
    - Imaging
    - Diagnostic Procedures/Surgical Procedures
    - Other (as needed)
- Staging Phase (Classification)
  - Clinical Staging and Workup
  - Pathological Staging and Workup
  - Staging Rules
  - Rules for Classification
  - Assignment of AJCC TNM (Tables)
  - AJCC Prognostic Stage Groups (Tables)

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## Protocol Format – 3 Key Components



- Synoptic staging report format
  - Provides key information registrars need
  - Includes new items
    - Modalities used for staging
    - Clinical staging and workup
    - Pathological staging and workup
    - Staging rules
- Explanatory notes
  - Provide the **same details** found in previous AJCC chapters
  - Includes **images** for primary site, nodal map, and T N M categories
- Supplemental information includes general staging rules

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## V9 Cervix Uteri Protocol Example - Synoptic Element & Explanatory Note



### Note I: Imaging

Magnetic resonance imaging (MRI) is currently the preferred modality for local assessment of cervical cancer.<sup>13</sup> Contrast-enhanced CT does not have the soft-tissue resolution necessary to evaluate the local extent of the tumor and may not be helpful in assessing early disease, specifically in patients who want to undergo fertility-preserving surgery.

### Imaging (Note I)

- \_\_\_\_\_ Ultrasound
- \_\_\_\_\_ CT scan
- \_\_\_\_\_ MRI
- \_\_\_\_\_ PET/CT
- \_\_\_\_\_ Other

Determine if the tumor is >1 cm in size, with abnormal being the setting of choice. MRI has excellent soft-tissue contrast resolution. Intravaginal gel is recommended in patients who have local disease. PET/CT is limited in evaluating primary tumor size as well as parametrial invasion. Ultrasound is a widely available, noninvasive imaging modality and is useful for evaluating for parametrial invasion.

### Contribution of Imaging to TNM Staging

Category T1a disease is not seen on imaging. Although invasion of the parametrium cannot be assessed with a level of certainty appropriate for this purpose is discouraged. In T1b disease, the tumor is visible by measuring the greatest diameter of the tumor in any plane, or if the disease involves the upper two-thirds of the vagina, which is visible on imaging. MRI is preferred for parametrial involvement, which can determine the size, with abnormal being the setting of choice. MRI has excellent soft-tissue contrast resolution. Intravaginal gel is recommended in patients who have local disease. PET/CT is limited in evaluating primary tumor size as well as parametrial invasion. Ultrasound is a widely available, noninvasive imaging modality and is useful for evaluating for parametrial invasion.

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## Version 9 - Clinical Staging and Workup



- Simplified algorithm of workup for clinical TNM stage
  - Type of diagnostic workup such as exam, imaging, and labs
  - Description of information provided
  - Specific contribution to TNM categories and stage groups
- Provides clarity and guidance to physicians
- Helps registrars understand
  - Why certain exams, procedures, imaging is ordered
  - How it contributes to staging and which TNM category is affected

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## Clinical Staging Workup—V9 Cervix Uteri



DIAGNOSTIC WORKUP	DESCRIPTION	SPECIFIC CONTRIBUTION TO TNM CATEGORY
<b>Clinical exam</b>		
Colposcopy	Size, local spread	T1a-T1b
Biopsy	Microscopic confirmation	T1a-T4
Endocervical curettage	Microscopic confirmation	T1a-T1b
Conization, cone biopsy Loop electrosurgical excision procedure (LEEP)	Microscopic confirmation	T1a1 - may be treatment
Inspection and palpation	Visible and palpable lesions	T1b-T4
Exam under anesthesia (EUA) Cystoscopy Proctoscopy	Size, spread to vagina, parametrium, or pelvic wall Bladder or rectum mucosa involvement	T1b-T4
<b>Imaging</b>		
CT	Chest/abdomen/pelvis for T1b-T4	T1b-T4, N0-2; T1a not seen on imaging
PET/CT (whole body)	Base of neck to mid-thigh	T1b-T4, N0-2, M0-1
MRI	Pelvis – define extent of local disease	T1b-T3b, N0-1; T1a not seen on imaging
US	Pelvis – define extent of local disease	T1b-T3b, N0-1; T1a not seen on imaging
Intravenous urography (IVP)	Hydronephrosis	T3b
X-ray lungs, skeleton	Pulmonary metastasis	M1 distant metastasis
<b>Labs</b>		
p16	Immunohistochemistry (IHC), microscopy	Histopathological classification

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## Version 9 – Pathological Staging and Workup



- Simplified algorithm of workup for pathological stage
  - Starts with specific TNM category
  - Lists specimen
  - Describes how **pathologist** uses information to assign category
  - Describes how **managing physician** uses info to assign category
  - Provides some key staging rules
- Provides guidance to pathologists and managing physicians
- **Helps registrars understand**
  - How it contributes to staging and which TNM category is affected
  - Provides some key rules

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## Pathological Staging Workup—V9 Cervix Uteri



CATEGORY	SPECIMEN	PATHOLOGIST	MANAGING PHYSICIAN (Stage Documented by Cancer Registry)
General Information		<ul style="list-style-type: none"><li>• Assignment of pTNM categories are based on surgical resection <b>specimen</b>, as well as intraoperative findings, biopsy procedures and clinical evaluation up to the point of definitive surgical treatment, if available</li><li>• All other surgical procedure specimens use cTNM. For example, biopsy of a positive regional lymph node without surgical resection of the primary carcinoma is classified as cN1</li></ul>	<ul style="list-style-type: none"><li>• Assignment of pTNM categories for the <b>patient</b> requires use of information from all biopsy procedures performed during the clinical evaluation up to and including definitive surgical treatment</li><li>• Requires information from clinical assessment or imaging studies or intraoperative findings to assign pTNM categories (may not change pTNM, but must be considered)</li></ul>
pTX		Not for use by pathologist; assigned only by managing physician	May assign if unable to determine pT category after surgical resection
pT0		No tumor found in specimen and never identified on diagnostic biopsies	No tumor found in specimen and never identified on diagnostic biopsies
pT1	Conization specimen, trachelectomy, simple or radical hysterectomy	Pathologic information from surgical specimen(s) only	Pathology Report(s)
pT1a			
pT1a1			
pT1a2			
pT1b		If unable to determine greatest dimension	Pathology Reports +/- appropriate imaging

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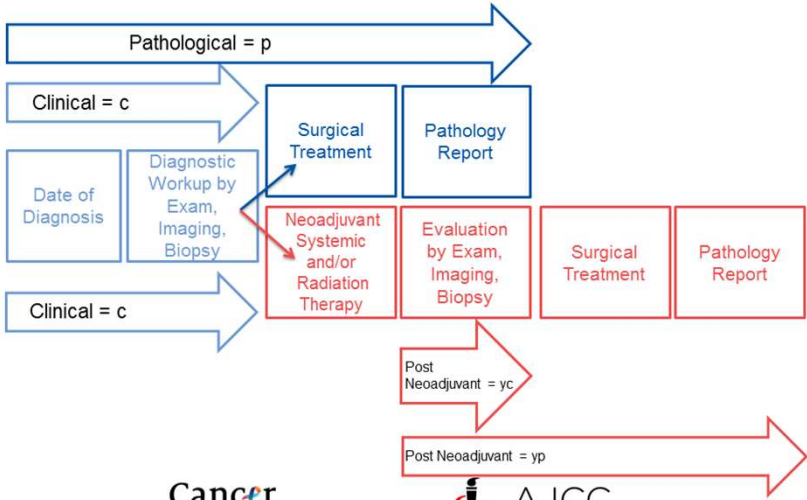


# Timing Is Everything



## AJCC Stage Classifications

Defining Time Frame and Criteria



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## Version 9 – Protocol Features



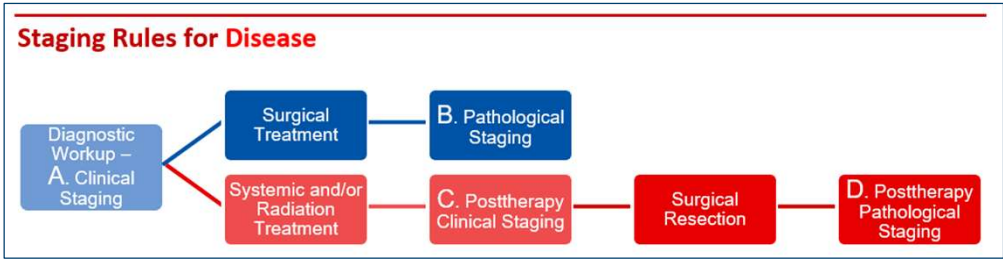
- Diagram of AJCC stage classification time frame & criteria
  - Specific to disease site
  - Based on common treatment
- Common staging scenarios
  - Provide staging guidelines for most common treatment scenarios
  - Reminds physicians of staging rules
  - Guidance for assigning clinical, pathological, or posttherapy stage



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# Version 9 Staging Rules for Disease



**Common staging scenarios:**

- 1) (scenario)**  
The most common scenario is .....physician assigns the **clinical staging (A)** of cT for the primary lesion, cN for any nodal involvement, and cM for distant metastasis found on exam or imaging and pM for microscopic proof of distant metastasis. The treatment plan based on the clinical stage.....
- 2) (scenario)**  
Less commonly, the patient may have neoadjuvant therapy .....after clinical staging it may be determined ..... **Clinical staging (A)**, cT, cN, and cM/pM are assigned based on physical exam and imaging findings.

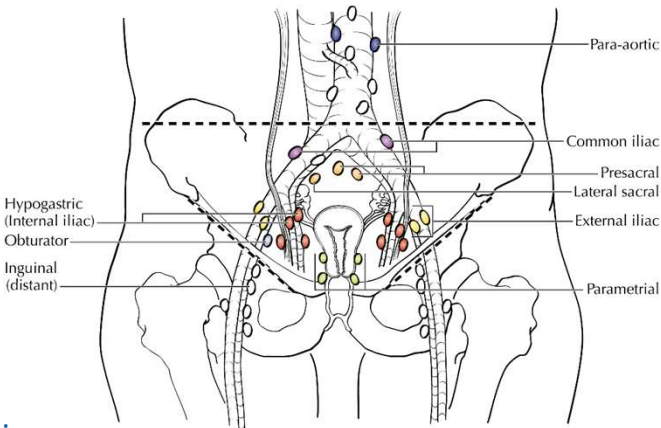
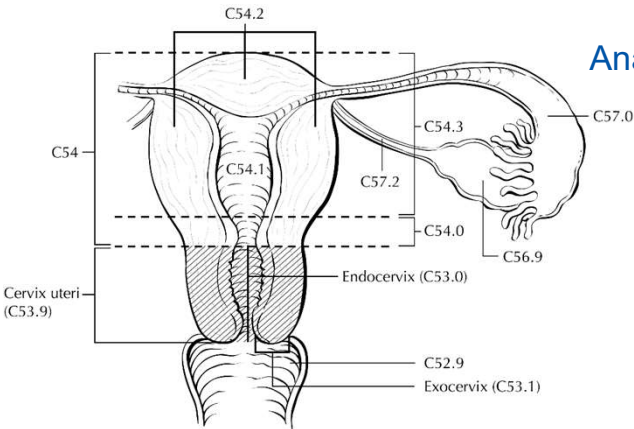
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# Version 9 – Updated Illustrations




## Anatomy and Nodal Map




**Additional illustrations for T and N categories**

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## Version 9 Implementation Plan



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## Next Disease Sites – Version 9



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- Timeline for Version 9 releases
  - Provided to surveillance partners in May
  - Included in Cancer Surveillance DLL for registry software by July
  - Release Disease Site Protocol in fall, digital and print
  - Effective for registrars the following January
- Timeline provides registrars with >8 months notice
- Upcoming Version 9 protocols - 2023
  - Anus
  - Appendix



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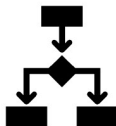
# Synoptic Operative Reports

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## What Are Synoptic Reports?



Standardized data elements organized as a structured checklist or template



Each data element’s value is “filled in” using a pre-specified format to ensure interoperability of information

- The information being sought is standardized
- The options for each variable are constrained to a pre-defined set of responses



Synoptic reports allow information to be easily collected, stored, and retrieved

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# Synoptic Operative Reports



- New Cancer Programs initiative
- Stay tuned...Saturday sessions will discuss
  - CoC Cancer Programs Concurrent Tracks**  
National Harbor 2-3
    - 9:00am-9:45am [New Directions in Cancer Care](#)
    - 9:50am-10:35am [Registrars Role in Measuring Compliance with CoC Synoptic Operative Reports](#)

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# Education and Resources



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## Education - AJCC Version 9



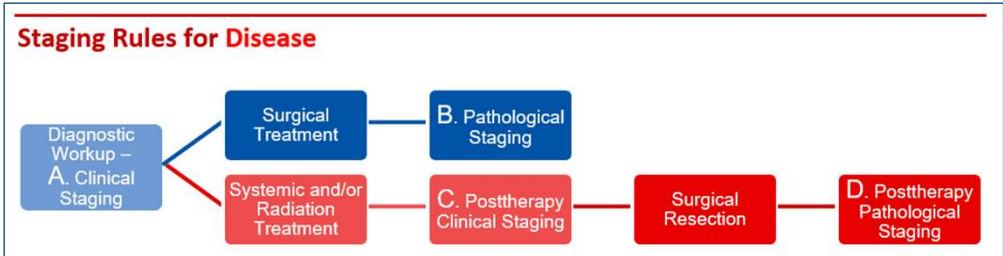
- Physician education
  - Expert panels - articles for medical journals
  - Physician to Physician short webinars
  - Information to AJCC member organizations to inform physicians of new protocols and education available
- Registrars
  - Webinars to highlight key changes in staging system
  - Disease sites will be added to CAnswer Forum - AJCC Version 9
- Expanded educational initiatives in development

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## Version 9 Staging Rules for *Disease*



### Common staging scenarios:

#### 1) (scenario)

The most common scenario is .....physician assigns the **clinical staging (A)** of cT for the primary lesion, cN for any nodal involvement, and cM for distant metastasis found on exam or imaging and pM for microscopic proof of distant metastasis. The treatment plan based on the clinical stage.....

#### 2) (scenario)

Less commonly, the patient may have neoadjuvant therapy .....after clinical staging it may be determined ..... **Clinical staging (A)**, cT, cN, and cM/pM are assigned based on physical exam and imaging findings.

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# AJCC Content Available in...

## EHR Software



## Registry Software



## Library Services



## Member Organizations



## Print and eBook



## Print 8th Edition



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# Accessing AJCC Content through Library Services

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Author

Subject

SUGGESTED RESOURCES

AJCC Cancer Staging Manual - Version 9 updates included

Read eBook

AJCC - Cervix Uteri Version 9 Protocol

Read eBook

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ARTICLE

AJCC 8th Edition oral cavity squamous cell carcinoma staging - Is it an improvement on the AJCC 7th Edition?

Polleas, Katherine ; Hinton-Bayre, Anton ; Friedland, Peter L ; Farah, Camille S

Oral oncology, 2018-07, Vol.62, p.23-28

PEER REVIEWED

Download PDFAvailable OnlineView Issue Contents

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BOOK

AJCC Cancer Staging Atlas A Companion to the Seventh Editions of the AJCC Cancer Staging Manual and Handbook

American Joint Committee on Cancer; Compton, Carolyn C. editor; Byrd, David R. editor; Garcia-Aguilar, Julio, editor; Kurtzman, Scott H. editor; Olawaiye, Alexander. editor; Washington, Mary Kay, editor.

2012; 2nd ed. 2012.

Available Online

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ARTICLE

AJCC 8th Edition: Colorectal Cancer

Weiser, Martin R

Annals of surgical oncology, 2018-04-03, Vol.25 (6), p.1454-1455

PEER REVIEWEDOPEN ACCESS

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AJCC Content Available through UpToDate



AJCC 8th edition melanoma TNM definitions

Regional lymph nodes (N)		
N2a	Two or three clinically occult (ie, detected by SLN biopsy)	No
N2b	Two or three, at least one of which was clinically detected	No
N2c	One clinically occult or clinically detected	Yes
N3	Four or more tumor-involved nodes or in-transit, satellite, and/or microsatellite metastases with two or more tumor-involved nodes, or any number of matted nodes without or with in-transit, satellite, and/or microsatellite metastases	
N3a	Four or more clinically occult (ie, detected by SLN biopsy)	No
N3b	Four or more, at least one of which was clinically detected, or presence of any number of matted nodes	No
N3c	Two or more clinically occult or clinically detected and/or presence of any number of matted nodes	Yes
Distant metastasis (M)		
M category	Anatomic site	M criteria
M0	No evidence of distant metastasis	LDH level
M1	Evidence of distant metastasis	Not applicable
M1a	Distant metastasis to skin, soft tissue including muscle, and/or nonregional lymph node	See below
M1a(0)		Not recorded or unspecified
M1a(1)		Not elevated
M1b	Distant metastasis to lung with or without M1a sites of disease	Elevated
M1b(0)		Not recorded or unspecified
M1b(1)		Not elevated
M1c	Distant metastasis to non-CNS visceral sites with or without M1a or M1b sites of disease	Elevated
M1c(0)		Not recorded or unspecified
M1c(1)		Not elevated
M1d	Distant metastasis to CNS with or without M1a, M1b, or M1c sites of disease	Elevated
M1d(0)		Not recorded or unspecified
M1d(1)		Normal
		Elevated

Suffixes for M category: (0) LDH not elevated, (1) LDH elevated. No suffix is used if LDH is not recorded or is unspecified.

AJCC: American Joint Committee on Cancer; TNM: tumor, node, metastasis; SLN: sentinel lymph node; LDH: lactate dehydrogenase; CNS: central nervous system.

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Commission on Cancer (CoC)  
100<sup>th</sup> Anniversary



## JANUARY 2022 | VOLUME 107 NUMBER 1

# Bulletin

**ACS** AMERICAN COLLEGE  
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- 100 years

Commission on Cancer | 1922–2022

<https://www.facsbulletin.com/acsbulletin/january2022/MobilePagedReplica.action?pm=2&folio=Cover#pg1>

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## Cancer registrars: Essential contributors



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## HIGHLIGHTS

- Describes the evolution of early cancer registries
- Summarizes how computerization and coding standards led to a transformation of the registrar's role
- Explains the need for enhanced focus on surveillance and staging in cancer care

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## Cancer registrars: Essential contributors



- 1982 – AJCC breast cancer staging became requirement
- AJCC staging relies on
  - Understanding anatomy and practice of medicine
  - Synthesize diagnostic workup info into clinical stage
  - Incorporate clinical stage, operative findings, and path report for pathological staging
- New threshold of knowledge for AJCC staging by registrars
- Article brings attention to registrars knowledge & role

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## Information and Questions on AJCC Staging

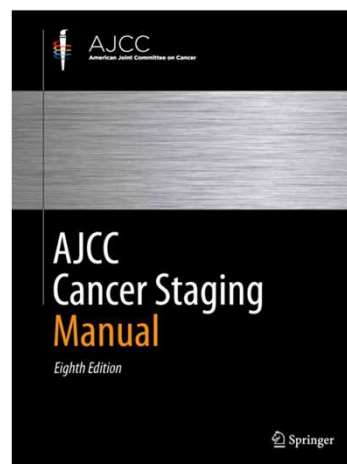


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## AJCC Web site



- <https://cancerstaging.org>
- <https://www.facs.org/quality-programs/cancer/ajcc>
- General information
  - Education
  - Articles
  - Updates
- For Registrars
  - Webinars with free CE hrs
  - Critical Clarifications
  - Staging Moments



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## CAnswer Forum




- Submit questions to AJCC Forum
  - Version 9 Forum
  - 8<sup>th</sup> Edition Forum
  - Located within CAnswer Forum
  - Provides information for all
  - Allows tracking for educational purposes
- <http://cancerbulletin.facs.org/forums/>




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## Summary

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- Illustrated key features of Version 9 protocol format
  - Examples of new areas
  - Revealed synergy between synoptic format and explanatory notes
  - Showcased staging rules diagram and scenarios
- Plans for protocol implementation - advance notice to stakeholders including registrars
- Introduced plans to educate stakeholders and provide resources

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