Commission on Cancer®

A QUALITY PROGRAM of the AMERICAN COLLEGE OF SURGEONS

Cancer Surgery Standards PROGRAM

AMERICAN COLLEGE OF SURGEONS

Surgeons,

The *Optimal Resources for Cancer Care (2020 Standards)* for Commission on Cancer (CoC) accreditation were updated in 2020 to include several new operative standards based on evidence from the *Operative Standards for Cancer Surgery* manuals. The attached document contains details of what is now required documentation to be included in the patient's chart.

There are four target areas that require documentation by the operative surgeon:

- **Sentinel node biopsy for breast cancer (Standard 5.3)**
- **Axillary lymph node dissection for breast cancer (Standard 5.4)**
- **Wide local excision for primary cutaneous melanoma (Standard 5.5)**
- **Colon resection (Standard 5.6)**

If you perform any of these procedures, your operative reports will need to include the elements in the attachment in synoptic format.

Two additional areas require specific documentation in the synoptic pathology report and necessitate coordinated communication between the operating surgeon and pathology:

- **Total mesorectal excision (Standard 5.7)**
- **Pulmonary resection (Standard 5.8)**

This pathology documentation is a requirement for continued accreditation.

In contrast to narrative reports, 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 synoptic reporting is to collect data in a manner where it can be easily collected, stored, and retrieved. Synoptic reporting has repeatedly been shown to improve both the completeness and the accuracy of clinical documentation.

Standards 5.3 through 5.8 apply to all operations conducted with curative intent. 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. Curative operations generally include complete resection of the primary tumor and nodal evaluation for therapeutic or staging purposes.* Any operation in which a surgeon deliberately deviates from these standards, as may occur in the setting of patient frailty or comorbidity, would not be considered curative. (*Lymphadenectomy is not performed for certain curative operations, such as resection of a thin melanoma.)

To facilitate the implementation of CoC Standards 5.3–5.8, the American College of Surgeons Cancer Surgery Standards Program (CSSP) has created an Operative Standards Toolkit with educational resources for surgeons, pathologists, and registrars at CoC-accredited cancer programs. We encourage you to take advantage of these educational webinars, short videos, visual abstracts, and podcasts to learn more about the operative standards and synoptic reporting requirements.

We greatly appreciate your support. If you have further questions, please reach out to cssp@facs.org.

CoC Operative Standards from *Optimal Resources for Cancer Care (2020 Standards)*

Standard 5.3: Sentinel Node Biopsy for Breast Cancer

Synoptic Operative Report Requirements
Operative reports for patients undergoing sentinel node biopsy for breast cancer must include the following elements in synoptic format:

Element	Response Options
Operation performed with curative intent.	Yes; No.
Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant) setting *(select all that apply).*	Dye; Radioactive tracer; Superparamagnetic iron oxide; Other *(with explanation)*; N/A.
Tracer(s) used to identify sentinel nodes in the neoadjuvant setting *(select all that apply).*	Dye; Radioactive tracer; Superparamagnetic iron oxide; Other *(with explanation)*; N/A.
All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed.	Yes; No *(with explanation)*; N/A.
All significantly radioactive nodes were removed.	Yes; No *(with explanation)*; N/A.
All palpably suspicious nodes were removed.	Yes; No *(with explanation)*; N/A.
Biopsy-proven positive nodes marked with clips prior to chemotherapy were identified and removed.	Yes; No *(with explanation)*; N/A.

Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

Synoptic Operative Report Requirements
Operative reports for patients undergoing axillary lymph node dissection must include the following elements in synoptic format:

Element	Response Options
Operation performed with curative intent.	Yes; No.
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.	Yes; No *(with explanation)*.
Nerves identified and preserved during dissection *(select all that apply)*	Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves; Other *(with explanation)*.
Level III nodes were removed.	Yes *(with explanation)*; No.

Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

Synoptic Operative Report Requirements
Operative reports for patients undergoing wide local excision of primary cutaneous melanomas must include the following elements in synoptic format:

Element	Response Options
Operation performed with curative intent.	Yes; No.
Original Breslow thickness of the lesion	Melanoma *in situ* (MIS); _._ mm *(to the tenth of a millimeter)*.
Clinical margin width *(measured from the edge of the lesion or the prior excision scar*	0.5 cm; 1 cm; 2 cm; Other: __ cm due to cosmetic/anatomic concerns; Other *(with explanation)*.
Depth of excision	Full-thickness skin/subcutaneous tissue down to fascia (melanoma); Only skin and superficial subcutaneous fat (melanoma in situ); Other *(with explanation)*.

Standard 5.6: Colon Resection

Synoptic Operative Report Requirements
Operative reports for patients undergoing resection for colon cancer must include the following minimum elements in synoptic format:

Element	Response Options
Operation performed with curative intent.	Yes; No.
Tumor location	Cecum; Ascending colon; Hepatic flexure; Transverse colon; Splenic flexure; Descending colon; Sigmoid colon; Rectosigmoid junction; Rectum, NOS; Colon, NOS.
Extent of colon and vascular resection	Right hemicolectomy – ileocolic, right colic (if present); Extended right hemicolectomy – ileocolic, right colic (if present), middle colic; Transverse colectomy – middle colic; Splenic flexure resection – middle and ascending left colic; Left hemicolectomy – inferior mesenteric; Sigmoid resection – inferior mesenteric; Total abdominal colectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric; Total abdominal colectomy, with proctectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal; Other *(with explanation)*.

Standard 5.7: Total Mesorectal Excision

Measure of Compliance
Each calendar year, the cancer program fulfills the compliance criteria:

1. Total mesorectal excision is performed for patients undergoing radical surgical resections of mid and low rectal cancers, resulting in complete or near-complete total mesorectal excision.
2. Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection (complete, near-complete, or incomplete) in synoptic format.

Standard 5.8: Pulmonary Resection

Measure of Compliance
Each calendar year, the cancer program fulfills the compliance criteria:

1. Pulmonary resections for primary lung malignancy include lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations.
2. Pathology reports for curative pulmonary resection document the nodal stations examined by the pathologist documented in synoptic format.