STS Webinar – Understanding and Implementing the New CoC Lung Cancer Standards

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Q&A

Q1 - The curative intent standard is confusing. Many operative reports do not explicitly state these two words. Who is doing a lobectomy for anything but curative intent? Why track the presence of intent in the operative report? It states that if there is a deviation from standard of care due to comorbidity or other factors, then the operation is not curative intent. Wedges are almost always performed as a deviation from standard due to comorbidity or lung function. Therefore, by definition, they are no longer by curative intent, but in reality, wedges can be a cure to many patients who are not fit. In this era of patients having access to their medical records on their phones, we cannot state that the wedge was not for curative intent in the op report, then why did we do it in the first place? Can you clarify?
A1 – The Commission on Cancer encourages all surgeons to state the intent of surgery in every operative report (ie curative intent for oncologic resections). This is a component of the forthcoming Synoptic Operative reports, including for lung (currently there is NO requirement for synoptic operative reports for lung or esophageal cancer, but we should all start preparing for the inevitability). Pulmonary wedge resections are absolutely curative intent operations, especially when appropriately performed with negative parenchymal margins and adequate lymph node sampling (ie 1 + 3 at minimum). We recognize that wedge resection remains the least favored oncologic approach when compared to segmentectomy or lobectomy (or larger), and we also eagerly await the final outcomes from the CALGB 140503 randomized controlled trial to further help answer these questions.

Q2 - How about patients who had previous lung resection and MLND, developed a new primary and needs a resection. There may not be any nodes left. Another subset of pat
A2 - Clearly there are clinical scenarios in which compliance is not possible, which is the reason 20% of cases are not expected to comply.

Q3 - Another subset of patients are GGO lesions. Evidence has shown that nodal mets are quite rare. Why is there a need to do MLNS?
A3 – Excellent point, and ultimately may be proven true. Current standard of care (www.nccn.org) remains R0 pulmonary resection combined with adequate lymph node sampling (1 + 3). Clearly, this may be another scenario where you choose not to be 100% compliant. Thorough documentation regarding taking this exception is highly encouraged, albeit not specifically considered by the Site Reviewer when assessing Standard 5.8 (would pose too much of a burden upon them at this time).

Q4 –Is it permissable to complete an addendum to correct any missing data in previous path reports?
A4 - Yes, prior to the time of site visit it's perfectly reasonable to make corrections. All of us should be watching our path reports for errors, omissions, etc to help make the patient's oncologic record as accurate as possible (it's permanent for them, after all).

Q5 –How do you handle lymph node dissection and no node is found when actually doing the dissection in level 2,4,7,8,10,11 and sometimes no level 9 or 8 after extensive dissection? What about intraparenchymal level 12,13,14 which may not be counted by the pathologists? I am constantly requesting that the pathologists count the nodes within the lobectomy specimen, and sometimes it is done and sometimes not. How do you handle this?
A5 – The Commission on Cancer strongly recommends collaborative communication between surgeons and

pathologists, especially if you perceive a significant quality gap such as inadequate post-operative pathologic assessment of specimens. This could be a Quality Improvement project for your institution, which satisfies one of the annual Commission on Cancer quality standards. Lymph nodes will be found at surgery in the vast majority of cases, but we all have the occasional exception and thus Standard 5.8 has an 80% compliance expectation, not 100%.

Q6 –It has specificity about lymphadenectomy in carcinoid tumors? What is the standard? Simpling or classic stations?
A6 – Standard 5.8 applies to all curative intent pulmonary resections (non-small cell, small cell, and carcinoid tumors).

Q7 – How many surgeons are dissecting N1 nodes during a wedge resection? The operation is called wedge resection and mediastinal lymph node dissection. N2's are obviously sampled, but dissecting in the hilum when you don't need to be there carries non-necessary risk.
A7 – Hilar and mediastinal lymph node sampling has always been an oncologic standard of care for curative intent pulmonary resection. The CALGB 140503 randomized controlled trial is an excellent example, given intraoperative frozen sections were required on both hilar and mediastinal nodes prior to randomization. Level 10 and 11 hilar lymph nodes are excellent examples of nodes that can be harvested with relatively minimal parenchymal dissection in many (but not all) cases. We encourage you to view the upcoming lymph node anatomy videos associated with Standard 5.8 (will be available online through the Commission on Cancer, likely by the end of Summer 2022).