


# Registrar's Guide to Chapter 1, AJCC Seventh Edition

Registrar's Guide to  
Chapter 1, AJCC Seventh Edition

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American Joint Committee on Cancer  
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## Overview

- Provide guidance to cancer registrars on key topics
  - Introduction and overview of AJCC staging
  - General rules for AJCC TNM staging
    - Introduction to T, N, and M
    - Required nonanatomic prognostic factors
    - Use of unknown X designation
  - Stage classifications and T, N, M categories
    - Clinical classification
    - Pathologic classification
    - Postneoadjuvant therapy classification
    - Retreatment classification
    - Autopsy classification
  - Stage groupings
  - Additional guidelines
  - Cancer staging data form
  - Recording cancer stage in medical record
  - Information and questions on AJCC staging



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## Learning Objectives

- Describe intent and purpose of AJCC staging
- Utilize general rules for AJCC staging
- Employ stage classification and T, N, M category principles
- Demonstrate stage grouping principles
- Recognize additional guidelines available
- Evaluate best use of cancer staging data form
- Relate options for stage documentation in medical record
- Identify resources for AJCC staging



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Introduction and Overview of  
AJCC Staging



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Introduction and Overview

- AJCC TNM – the common language of cancer
- International method to clearly convey without ambiguity
  - Clinical experience
  - Patient care
- Accurate staging is necessary to
  - Evaluate results of treatments and clinical trials
  - Facilitate exchange and comparison of information among treatment centers
  - Serve as basis for clinical and translational cancer research
- Stage or extent of cancer at time of diagnosis
  - Defines prognosis
  - Determines appropriate treatment
  - Based on experience and outcomes of prior patients



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Introduction and Overview

- Stage is determined based on
  - T is primary site tumor
  - N is regional lymph nodes
  - M is distant metastasis
  - Grouping cases with similar prognosis
- Criteria for defining anatomic extent of disease
  - Specific for tumors at different anatomic sites
    - Anatomic structure differences: tissue layers or homogeneous
    - Key factors in prognosis such as size, depth of invasion, number of nodes, location of nodes, distant metastasis
  - Specific for different histologic types
- AJCC staging rules
  - General rules in Chapter 1
  - Specifics for each disease in their respective chapter



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General Rules  
for AJCC TNM Staging



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Introduction to T

- T category
  - Defined by size, and/or
  - Contiguous extension of primary tumor
- T specifically designed for each primary site
  - Roles of size and contiguous spread depend on site characteristics

Primary Tumor (T) valid values	
T0	No evidence of primary tumor
Tis	Carcinoma in situ
T1, T2, T3, T4	Increasing size and/or local extension of primary tumor
TX	Primary tumor cannot be assessed (minimize use of TX)

Note: Subcategories are allowed, such as T1mi, T1a



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Introduction to N

- N category
  - Defined by absence or presence of cancer in regional draining lymph nodes
- N involvement categorized specifically for each site by
  - Number of positive nodes and/or
  - Involvement of specific regional nodal groups

Regional Lymph Nodes (N) valid values	
N0	No regional lymph node metastases
N1, N2, N3	Increasing number or extent of regional lymph node involvement
NX	Regional lymph nodes cannot be assessed (minimize use of NX)

Note: Subcategories are allowed, such as N0(+), N1mi, N2a



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### Introduction to M

- M category
  - Defined by absence or presence of distant spread or metastases
  - Generally in locations to which cancer is spread by
    - Vascular channels or
    - Lymphatics beyond nodes defined as regional
- M specifically designed for some sites
  - Subcategories for detailed areas of involvement

Distant Metastasis (M) valid values	
M0	No distant metastases
M1	Distant metastases present

Note: The MX designation has been eliminated from the AJCC TNM system. Subcategories are allowed, such as cM0(i+), M1a

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### General Rules

1. All cases should have microscopic confirmation

- Applies to all classifications, even clinical classification
- Without confirmation, possible to
  - Presume cancer when it is not
  - Wrongly apply stage based on presumed site and histology
- Cases without confirmation
  - Only rarely should cases not have biopsy or cytology
  - Can be staged using presumed histology
  - Survival must be analyzed separately for these cases
    - Do not include in overall disease survival analyses
    - If presumption of histology is incorrect, will confound/confuse survival data

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### General Rules

2. Eligible time period for clinical and pathologic staging

- Time period for clinical staging
  - Information before start of definitive treatment, or
  - Within 4 months after date of diagnosis
  - Use which of above is shorter time period
  - As long as no progression
- Definitive treatment includes
  - Surgical resection
  - Systemic therapy (chemo, hormone, immuno therapies)
  - Radiation therapy
  - Active surveillance
  - Palliative care

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**General Rules**

2. Eligible time period for clinical and pathologic staging

- Time period for pathologic staging
  - All information including definitive surgical resection, or
  - Within 4 months after date of diagnosis
  - Use which of above is longer time period
  - As long as no systemic or radiation prior to surgery
  - As long as no progression
- Definitive surgical resection
  - Must meet criteria for that specific chapter

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**General Rules**

3. Staging with neoadjuvant or primary systemic/radiation

- Neoadjuvant therapy definition
  - Systemic or radiation therapy is first treatment
  - Followed by surgical resection
- Clinical stage assigned
  - Only information prior to start of systemic/radiation
  - Used for comparative purposes
  - Used to determine response to therapy

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**General Rules**

3. Staging with neoadjuvant or primary systemic/radiation

- Postneoadjuvant therapy stage is y
  - y must always be modified as yc or yp
- yc
  - After systemic/radiation BUT prior to surgical resection
- yp
  - After systemic/radiation AND after surgical resection

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**General Rules**

4. Progression of disease

- Evidence of disease progression
  - If before start of any treatment
  - Do not use this information for assigning stage
- Evidence of disease progression before treatment
  - Use only information before progression to assign stage

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**General Rules**

5. Uncertain information

- Assign the lower (lesser) category or stage group
  - If uncertain or unclear information
  - Not enough information to definitely choose
- Commonly called “downstaging”
- Does NOT apply to unknown information
  - Unknown information does NOT use lowest category or group

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**General Rules**

5. Uncertain information

- Examples
  - Imaging unclear if one node (N1) or two nodes (N2) are involved
    - Use N1 which is lower category
  - Colonoscopy does not provide information on T category for colon
    - Use TX since information is unknown
    - Cannot assign T1 as this falsely skews data
  - Lung clinical stage group for T2a NX M0
    - Use stage group unknown since no information on nodes
    - Cannot assign stage group using N0 as this falsely skews data
- Physician may make clinical judgments for patient care

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### General Rules

6. Nonanatomic factors not available

- Not available nonanatomic factor required for stage group
  - Case assigned based on lowest or least advanced factor
- Use nonanatomic factor as X in stage table
- If X not available
  - Use lowest level of the factor
  - Use least advanced category, least amount of factor

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### Required Nonanatomic Prognostic Factors

- Nonanatomic prognostic factors required for stage
  - Some AJCC chapters require these factors for assigning stage
  - Clearly defined and listed in stage tables, for example
    - Thyroid, Chapter 8 – age and histology
    - Gastrointestinal Stromal Tumor, Chapter 16 – mitotic rate
    - Soft Tissue Sarcoma, Chapter 28 – grade
- Factors collected separately from T, N, and M
  - Not part of TNM definitions
  - Separate additional information essential for prognosis in these sites
- Factors needed to accurately assign stage group
  - Critical in some chapters, and no alternative to the information
  - Some chapters provide alternatives

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### Required Nonanatomic Prognostic Factors

- Some chapters provide alternatives to situations of
  - Factor is not available
  - Physician desires to assign group ignoring factor
  - Factor is not needed for that individual stage group
- Factors NOT available and needed to assign stage group
  - Factor is assigned X
  - Allows stage group to be assigned
  - Allows physician to assign group ignoring factor
- Individual stage groups within table do not require factor
  - Any is factor option for some individual stage groups
  - Any means factor is not needed to assign that stage group
    - Factor can be known and documented
    - Factor can be unknown

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### Use of Unknown X Designation

- X used when
  - Information is **unknown** for specific category
- Clarification of unknown
  - Unknown to physician providing patient care
  - Not unknown to one physician, but known to other physicians
  - Not unknown to registrar from lack of documentation in chart
- Misuse of X from registrar lacking chart information
  - Can skew data analysis
  - Can lead to
    - Inaccurate studies
    - Wrong conclusions about national status of patient care

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### Use of Unknown X Designation

- TX and/or NX cases usually cannot have stage assigned
- X category only used for T and N
  - When absolutely necessary
- Exception examples (not exhaustive list of every option)
  - Any T and/or Any N with M1 is stage IV
    - Any T N2 M1, T3 Any N M1, Any T Any N M1
  - TX and/or NX with M1 is stage IV
    - TX N2 M1, T3 NX M1, TX NX M1
  - Category combinations belong in one and only one stage group
    - Lung TX N3 M0 is stage IIIB
      - Every combination of T with N3 M0 is stage IIIB
    - Urethra T4 NX M0 is stage IV
      - T4 M0 with every combination of N is stage IV

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### Use of Unknown X Designation

- MX is NOT valid option for AJCC staging
- MX eliminated from AJCC 7<sup>th</sup> Edition
- Always cM0 unless clinical or pathologic evidence of mets
- Pathologists should not use MX
  - CAP agreed pathologists should not comment on M unless pM1
  - Pathologist cannot assign stage group unless case is pM1

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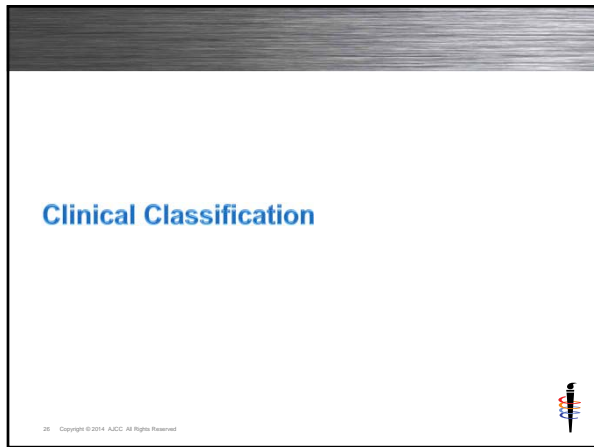
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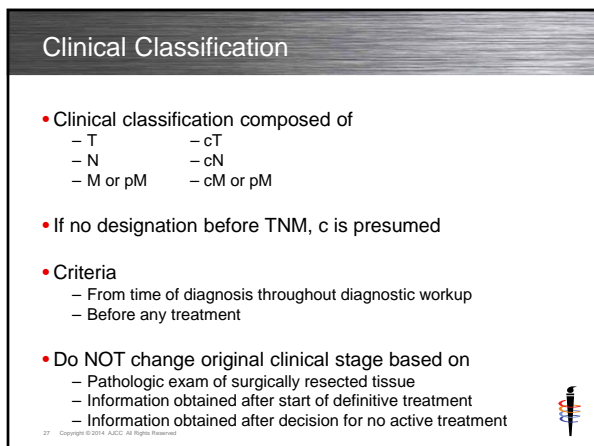
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**Clinical Classification**

- Information included and timing
  - All information during diagnostic workup
  - From time of diagnosis up until first treatment
  - Or within 4 months after diagnosis, whichever is shorter
  - With no systemic/radiation therapy prior to surgery
  - With no progression of disease
- Clinical assessment – diagnostic workup
  - Clinical history
  - Physical examination
  - Imaging
  - Scopes and other invasive diagnostic procedures
  - Lab tests and biologic markers
  - Biopsy of primary site
  - Surgical exploration only
  - Diagnostic biopsy of lymph nodes, sentinel nodes
  - Diagnostic biopsy of metastatic sites
  - Related methods and other relevant examinations

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**Clinical Classification**

- Clarifications of clinical assessment methods
  - Surgical exploration
    - Can include biopsy
    - Cannot continue on to surgical resection in same procedure
  - Biopsy for T category
    - If tissue establishes highest possible T category, CAN use for pT
    - Also use for cT
  - Biopsy of nodes is cN
    - Single node or sentinel nodes as diagnostic workup, and
    - In absence of pathologic evaluation of primary tumor
  - Imaging
    - Extensive imaging NOT required to assign cT, cN or cM
  - Biopsy of metastatic sites is pM
    - Discussion on M category follows

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**Clinical Classification**

- cM0 special considerations
  - No symptoms or signs of mets is cM0
  - No MX category, must be M0 or M1
  - Only H&P is needed to assign cM0
    - Means patient must have history & physical
    - Does NOT mean registrar must have access to H&P report to assign
  - Extensive imaging not necessary to assign cM0
- pM0 does not exist
  - Not even in autopsy are all tissues in body sampled
  - Negative biopsy of suspected metastatic site is cM0

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**Clinical Classification**

- **cM1 special considerations**
  - Evidence on physical exam of mets
  - Evidence on imaging of mets
  - Evidence seen during scopes of mets not biopsied
  - Operative findings during surgical resection not biopsied
- **pM1 special considerations**
  - Positive biopsy of metastatic site
  - WITH cT and cN
  - Staged as both
    - Clinical stage IV – cT cN pM1
    - Pathologic stage IV – cT cN pM1

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**Clinical Classification**

- **Use of clinical classification**
  - Select primary therapy
  - Treatment guidelines based on clinical classification
  - Critical for case comparisons
    - Differences in treatment make future comparisons impossible
  - Only point in time where ALL cases can be compared
- **Documentation**
  - Physician records in medical record
  - Recorded in cancer registry abstract clinical data fields
  - Essential for abstract to contain

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**Pathologic Classification**

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**Pathologic Classification**

- Pathologic classification composed of
  - pT
  - pN
  - cM or pM
- Criteria
  - From time of diagnosis through surgical resection findings
  - Use all clinical staging information AND
  - Add to it or change it by evidence from
    - Operative findings
    - Pathology report on resected tissue
- Pathologic classification made up of 3 components
  - Clinical classification information
  - Operative findings during surgical resection
  - Pathology report on resected specimen



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**Pathologic Classification**

- Information included and timing
  - All information during diagnostic workup and surgical treatment
  - From time of diagnosis until end/completion of surgical treatment
  - Or within 4 months after diagnosis, whichever is longer
  - With no systemic/radiation therapy prior to surgery
  - With no progression of disease
- Clinical classification information
- Operative findings during surgical resection
- Pathology report on resected specimen



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**Pathologic Classification**

- Clarifications of pathologic assessment methods
  - Clinical classification information
    - Same physical exam and diagnostic studies from clinical stage
  - Operative findings during surgical resection
    - Surgeon's statements of viewed/palpated involvement
    - Do NOT need biopsy to include in pT
    - Do NOT need biopsy to include in pN, unless NO nodes biopsied
  - Pathology report on resected specimen
    - May overrule clinically suspected involvement
    - Clinical or operative findings are used for stage UNLESS
      - Histologic exam of resected tissue disproves those findings
  - Pathology report is NOT final stage
    - Pathology report is only 1/3 of necessary information
    - Report does NOT take into consideration other 2/3 of information



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**Pathologic Classification**

- Primary tumor (pT) assessment for pathologic classification
  - Resection of primary tumor, generally
  - Some chapters require
    - More extensive resection of tumor
    - Partial or complete organ resection
  - Generally from single specimen
- T special considerations
  - Physicians estimate size from several partial resections
  - Size recorded in whole millimeters
    - Round as necessary to whole millimeter
    - Whole millimeter used to assign pT
    - Fractions of millimeters NOT used to increase pT category
  - Evaluation of highest T category
    - Biopsy of primary tumor is adequate, then
    - pT can be assigned without resection

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**Pathologic Classification**

- Regional node (pN) assessment for pathologic classification
  - Resection of regional nodes
  - Require pathologic exam of ONE node
- N special considerations
  - Number of nodes resected
    - Minimum number to assure sufficient sampling
    - Expected number of nodes defined in chapters
    - If fewer than minimum nodes, pN is still assigned
    - Sentinel node procedure substitutes for expected minimum number
  - Do NOT need pathologic confirmation of highest N category
  - pT generally necessary for pN
  - Microscopic evaluation of highest N category
    - May use pN regardless whether T is pT or cT

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**Pathologic Classification**

- pN0(i+) special considerations
  - Isolated tumor cells (ITC) in lymph nodes
    - Single tumor cells or small clusters of cells
    - Not more than 0.2mm in greatest diameter
  - Designated as pN0 – negative nodes
    - ITC are considered negative nodes in all sites except two
    - Melanoma and Merkel cell consider ITC as positive nodes
    - Some chapters use pN0(i+) when common in that site
    - Other chapters use pN0
  - pN0(i+) for detected by immunohistochemistry (IHC)
  - pN0(i-) for IHC done and no tumor cells found
  - pN0(mol+) for detected by molecular techniques
  - pN0(mol-) for molecular technique done and no tumor cells found
  - Also can be detected by flow cytometry and DNA analysis
  - Uncertain prognostic significance of these cells
  - Use i+ and i- to denote status of ITC & gather data

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**Pathologic Classification**

- **Mets assessment for pathologic classification may be**
  - Clinical using cM0 or cM1
    - pT pN cM0 or pT pN cM1
  - Pathologic using pM1
    - pT pN pM1
- **pM1 special considerations**
  - Requires biopsy positive for cancer at metastatic site
  - Meets criteria for pathologic classification without resection of primary site
- **pM0 does NOT exist**
  - pM0 is undefined concept
  - Autopsy may not satisfy since EVERY tissue must be sampled
  - pM0 may not be used

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**Pathologic Classification**

- **cM0 special considerations**
  - No signs or symptoms of mets
  - Only H&P performed on patient is needed to assign
- **cM0(i+) special considerations**
  - Biopsy shows isolated tumor cells (ITC)
  - Detected by immunohistochemistry (IHC) or molecular techniques
  - CTCs – circulating tumor cells in blood
  - DTCs – disseminated tumor cells in bone marrow or distant organs
  - Uncertain prognostic significance of these cells
  - Categorized as M0, use i+ to denote these cells & gather data
- **cM1 special considerations**
  - Evidence from clinical assessment
  - Operative findings during surgical resection not biopsied

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**Pathologic Classification**

- **Use of pathologic classification**
  - Select adjuvant therapy
  - Treatment guidelines for adjuvant therapy based on pathologic classification
  - Significant additional prognostic information
  - More precise than clinical classification
  - Commonly used for survival studies due to precise data
    - Only used for cases with surgical resection as first treatment
- **Documentation**
  - Physician records in medical record
  - Recorded in cancer registry abstract pathologic data fields
  - Essential for abstract to contain in surgically resected cases

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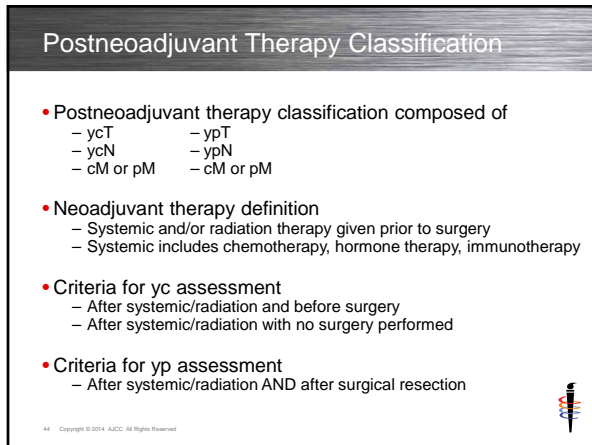
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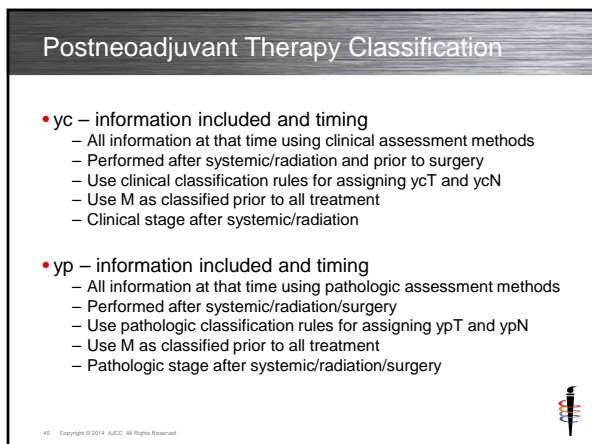
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### Postneoadjuvant Therapy Classification

- Provides information on **response to therapy**
  - Classification useful to physicians
  - Measured against clinical classification to show response
  - Response noted as: complete, partial, or no response
  - Provides important prognostic information to patients
- yc
  - Shows response to systemic/radiation and is prognostic
  - Directs type and extent of surgery to be performed
- yp
  - Surgical resection removes any remaining cancer
  - Verifies response to systemic/radiation through pathology assessment of tissue and is prognostic
  - Directs subsequent systemic and/or radiation therapy
- Neoadjuvant therapy is increasingly common
  - Important to assess response and document
  - Analyze outcomes



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### Postneoadjuvant Therapy Classification

- M category for yc and yp
  - Use M status defined PRIOR to therapy
  - May be either clinical (cM) or pathologic (pM)
- Positive biopsy of metastatic site
  - pM1 is recorded for all classifications
  - Clinical stage IV
  - yc stage IV
  - yp stage IV
- Must assign clinical classification
  - Estimate of disease prior to all treatment
- Clinical stage used for
  - Case comparisons, studies, clinical trials
  - Surveillance analysis



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### Postneoadjuvant Therapy Classification

- Use of postneoadjuvant therapy classification
  - Critical to assess response to therapy
  - Monitor success of neoadjuvant as it grows in use
- Documentation - physician
  - Physician records both yc and yp in medical record
- Documentation – registrar – yc
  - yc NOT recorded in cancer registry abstract
  - No data fields available for yc classification
  - Cannot use clinical data fields
- Documentation – registrar – yp
  - yp recorded in cancer registry abstract pathologic data fields
  - Must code 4 in pathologic stage descriptor data field
  - Identifies stage as yp and NOT p



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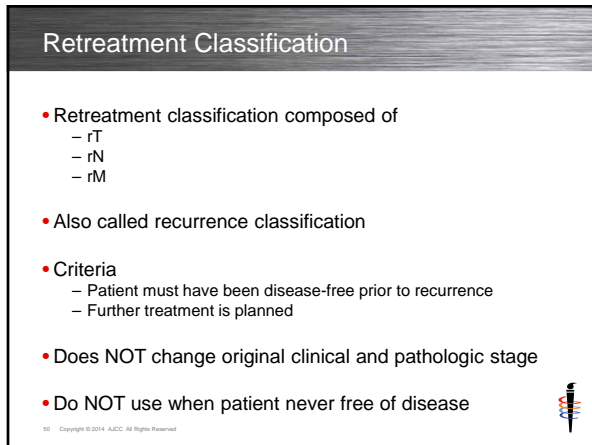
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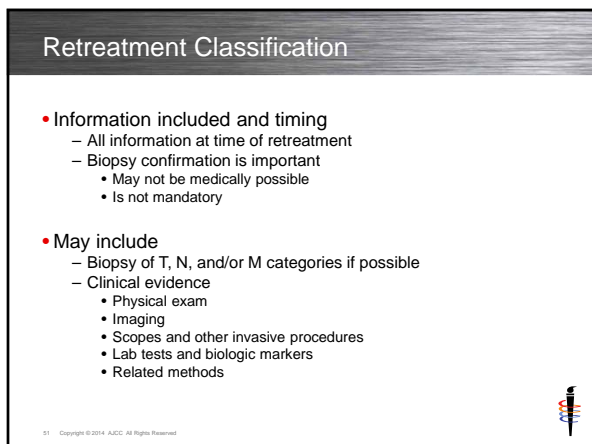
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### Retreatment Classification

- Use of retreatment classification
  - Extent of current disease used to guide new therapy
  - Prognostic information from clinical extent and therapeutic procedures
  - Cannot be compared to other stage classifications
- Documentation
  - Physician records in medical record
  - NOT recorded in cancer registry abstract
  - No data fields available for retreatment classification
  - Cannot use clinical or pathologic data fields

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### Autopsy Classification

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### Autopsy Classification

- Autopsy classification composed of
  - aT
  - aN
  - aM
- Criteria
  - NO evidence of cancer prior to death
  - NO possibility or suggestion of cancer prior to death
  - Incidental finding on autopsy
- Information included and timing
  - All clinical and pathologic information obtained at time of death
  - Autopsy information
- Do NOT use when known cancer patient has autopsy

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### Autopsy Classification

- Use of autopsy classification
  - No opportunity for physician to intervene in course of disease
  - Cannot be compared to other stage classifications
- Documentation
  - Physician records in medical record
  - NOT recorded in cancer registry abstract
  - No data fields available for autopsy classification
  - Cannot use clinical or pathologic data fields



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### Stage Groupings



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### Purpose of Stage Groupings

- Anatomic stage/prognostic groups
  - Comprised of T, N, and M
  - Nonanatomic factors sometimes required to supplement TNM
  - Disease specific groups
  - Similar prognosis for each group
  - Useful for guideline development
  - Facilitate communication regarding types of patients
  - Commonly referred to as stage groups
- Data tabulation and analysis
  - Depends on grouping patients into a few categories
  - Need fewer groups of larger numbers for meaningful data
- Stage groups are summary of staging information that is
  - Reproducible
  - Easily communicated



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### Principles of Stage Groupings

- Classified by Roman numerals I-IV, indicates
  - Increasing severity of disease
  - Worsening prognosis
- General definitions
  - Stage I – smaller or less deeply invasive with negative nodes
  - Stage II and III – increasing tumor or nodal extent
  - Stage IV – distant metastases at diagnosis
- Additional stage group designated for
  - Stage 0 – carcinoma in situ with no metastatic potential
- Expanded into subsets for
  - More refined prognostic information
  - Example stage II becomes stage IIA, stage IIB



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### Standard Composition of Stage Groupings

- Clinical Stage Group
  - cT
  - cN
  - cM or pM
- Pathologic Stage Group
  - pT
  - pN
  - cM or pM
- Postneoadjuvant Therapy Stage Group
  - ypT
  - ypN
  - cM or pM



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### Stage Grouping Principles

- Standard stage group principle defined for each case
  - Pure clinical stage group
  - Pure pathologic stage group
- Pure stage group does NOT mean
  - Every category must be c
    - cT cN cM
  - Every category must be p
    - pT pN pM
- Pure stage group does mean following AJCC rules
  - Using c or p for categories according to established rules
  - Examples
    - cT cN pM clinical stage group
    - pT pN cM pathologic stage group



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### Stage Grouping Principles

- Working stage
  - Used by physicians in clinical setting of patient care
  - Only partial information available according to staging rules
  - Must combine clinical and pathologic information
  - Combination allows assignment of stage group
  - Used for treatment decisions and patient care
  - NOT documented by cancer registry



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### CIS Exception to Stage Grouping

- Carcinoma in situ (CIS) definition
  - Does not involve any structures that allow tumor spread
  - Cells cannot spread to
    - Other parts of primary site/organ
    - Regional tissues outside primary site/organ
    - Regional nodes
    - Distant sites
- CIS exception to stage grouping principles
  - pTis cN0 cM0 clinical stage 0
  - pTis cN0 cM0 pathologic stage 0
- Caution for pathologic stage 0
  - Requires chapter specific criteria is met
  - Cannot assign based on small sample
  - Potential sampling error if less than chapter criteria



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### Stage Grouping Guidelines

- Assign stage group according to
  - Timing
  - Appropriate rules
  - Do not change due to subsequent information after time frame
- Documenting stage group in medical record
  - All appropriate groups recorded in chart, not just one group
- Uncertainty general rule #5 also applies to stage group
  - Assign lower or less advanced group with uncertain information
  - Do NOT apply to unknown information such as TX and/or NX in order to assign group



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### Stage Grouping Guidelines

- Exception for pCR
- pCR
  - Pathologic complete response to neoadjuvant therapy
  - After systemic/radiation followed by surgery
    - No evidence of active invasive cancer cells
    - Based on resection pathology report
    - May have in situ disease
- Stage categories and group assigned for pCR is
  - ypT0 ypN0 cM0
  - NOT stage 0 (used for in situ disease only)
  - NO stage group assigned



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### Additional Guidelines



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### Multiple Tumors

- AJCC rules for multiple primary tumors
  - May not agree with registry MPH rules
- Multiple simultaneous tumors of same histology in 1 organ
  - Tumor with highest T category is used for classification & staging
  - Multiplicity or number of tumors is in parentheses
    - T2(m) shows multiple tumors or T2(5) shows there are five tumors
- Simultaneous bilateral cancers in paired organs
  - Tumors classified separately
  - Stage as independent tumors in different organs
- Multiple tumor criteria is part of T category for
  - Thyroid, liver, and ovary



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### Multiple Tumors in Registry Data Field

- Registry software data field for m descriptor
- FORDS Clinical Stage (prefix/suffix) Descriptor
  - Code 3 M-Multiple primary tumors in a single site
  - NAACCR Item #980
- FORDS Pathologic Stage (prefix/suffix) Descriptor
  - Code 3 M-Multiple primary tumors in a single site
  - Code 6 M&Y-Multiple primary tumors & initial multimodality therapy
    - Meets criteria for code 3 and code 4 (y-classification for neoadjuvant)
  - NAACCR Item #920



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### Metachronous Primaries

- Metachronous – developing at a later interval
- Second or subsequent primary cancers
  - Occurring in same organ, or
  - Occurring in different organs are
  - Staged as NEW cancer
- Second cancers do not use y prefix
  - Unless treatment of second cancer is neoadjuvant therapy
- AJCC rules for metachronous primaries
  - May not agree with registry MPH rules



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### Unknown Primary

- Staging based on clinical suspicion of primary site
  - No evidence of primary tumor, or
  - Site of primary tumor is unknown, then
  - T category assigned as T0
- Example 1
  - Axillary node bx shows metastatic ca consistent with breast cancer
  - No tumor seen in breast on mammogram, US, and MRI
  - Stage assigned as breast cancer T0 N1 M0
- Example 2
  - Cervical node bx shows metastatic squamous cell ca consistent with head and neck cancer
  - History of sores in oral cavity, especially hard palate
  - Stage assigned as oral cavity cancer T0 N1 M0



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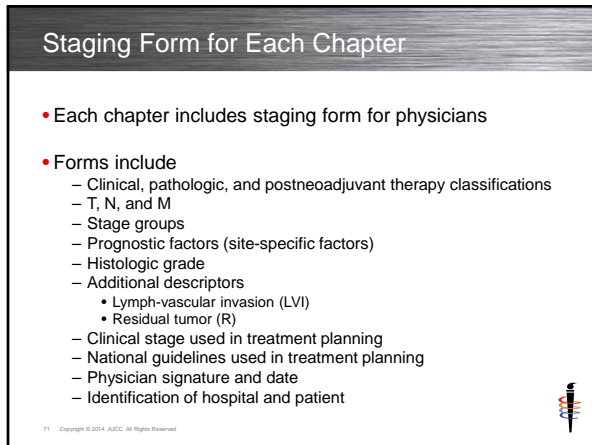
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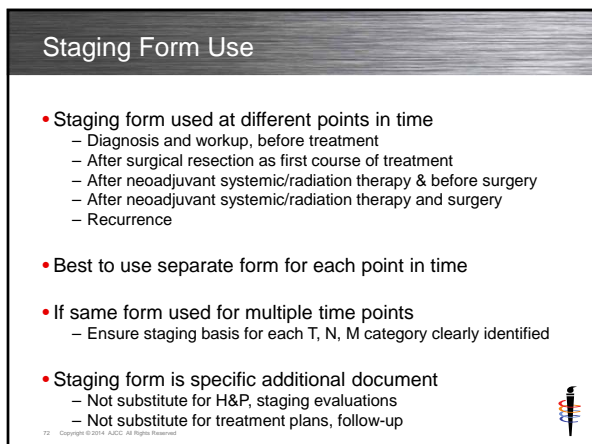
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### AJCC Staging Form

- Incorporation of forms into electronic record or system
  - Requires appropriate permission from AJCC and publisher
- Modification of forms whether paper or electronic
  - Requires appropriate permission from AJCC and publisher
- Paper cancer staging forms in AJCC Manual
  - May be duplicated for individual or institutional use
    - Includes only immediate institution or work environment
  - Without permission from AJCC or publisher
- Permission requests submitted to
  - <http://cancerstaging.net>



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### Recording Cancer Stage in Medical Record



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### Recording Stage in Medical Record

- Physician recording stage in medical record
  - Critical for communication between physicians
  - Useful to communicate data to cancer registry
  - Stage in every record, all admissions and outpatient encounters
- Physician options for documenting stage
  - Initial clinical evaluations: H&P, consults
  - Operative reports
  - Discharge summaries
  - Staging Form
- Staging Form
  - Paper form included in each AJCC chapter
  - Electronic forms also available (e-staging tool)



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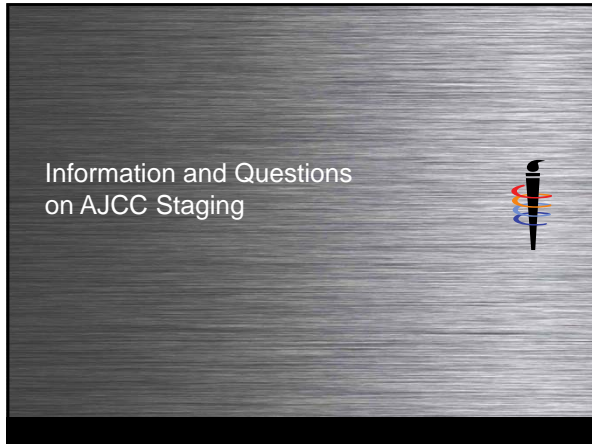
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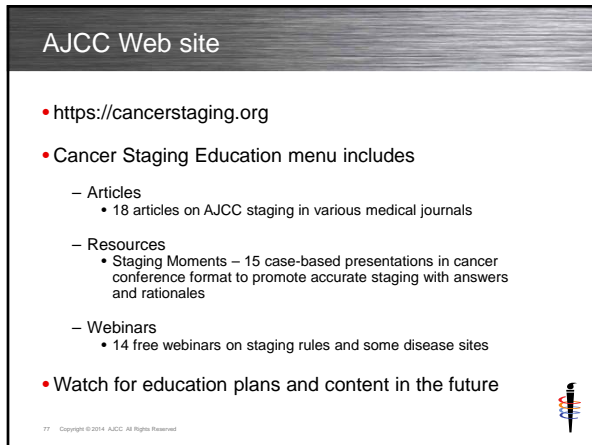
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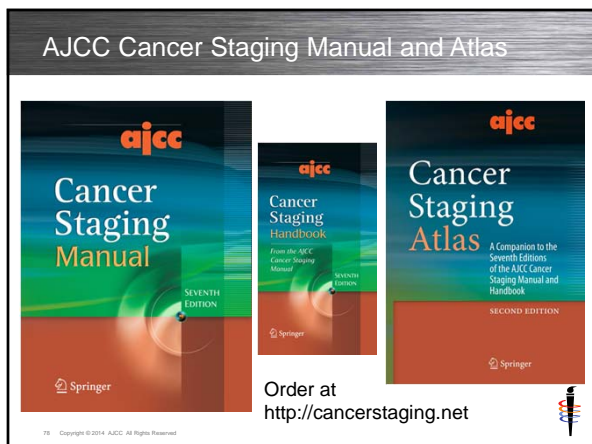
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**CAnswer Forum**

- Submit questions to AJCC 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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**Summary**

- Articulate intent and purpose of AJCC staging
- Apply AJCC rules, principles, and guidelines accurately
  - General rules for AJCC staging
  - Stage classification and T, N, M category principles
  - Stage grouping principles
  - Additional guidelines available
- Recommend and operationalize
  - Cancer staging data form
  - Stage documentation in medical record
- Identify resources for AJCC staging
  - Information, guidance, and education
  - Obtain answers to questions



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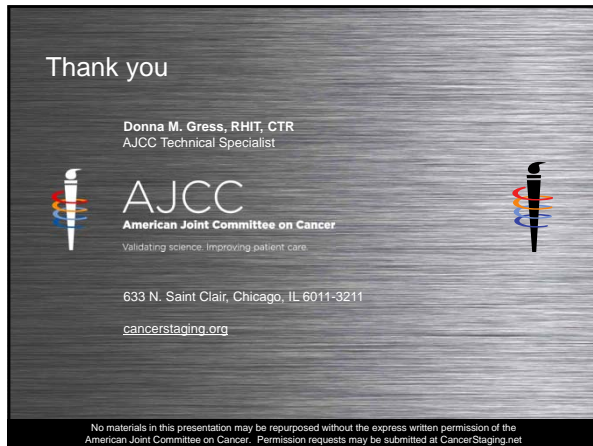
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Registrar's Guide to  
Chapter 1, AJCC Seventh Edition



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