

Seventh Edition Staging 2017
Breast

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National Center for Chronic Disease Prevention and Health Promotion
National Program of Cancer Registries

Overview

- Provide key information for breast on
 - Common staging issues and questions
 - Exceptions and cautions for T, N, M
 - Diagnostic procedures vs. treatment
 - Treatment satisfying stage classification criteria
 - Blank vs. X




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Learning Objectives

- Analyze common staging issues and questions
- Determine exceptions and cautions for T, N, M
- Distinguish diagnostic procedures vs. treatment
- Identify treatment satisfying stage classification criteria
- Recognize difference between blank vs. X

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Breast Staging



Clinical T Category


- Determining size for T category
 - Most accurate size needed
 - Don't just choose largest
 - Review physical exam, mammogram, and ultrasound
 - Physician statement
- Multiple simultaneous ipsilateral tumors
 - T category based on largest of multiple tumors
 - Must use (m) suffix
- Skin dimpling or nipple retraction not used for staging

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Clinical T Category


- Chest wall structures
 - Ribs
 - Intercostal and serratus anterior muscles
- Skin involvement
 - Ulceration
 - Satellite nodules
 - Edema or peau d'orange not meeting inflammatory criteria
- Inflammatory carcinoma
 - Diffuse erythema and edema (peau d'orange) in 1/3+ of skin
 - Clinical diagnosis, microscopic evidence not required
 - Rare, progresses quickly within days/weeks



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Clinical N and M Categories


- Important to note physical exam and imaging for nodes
 - Negative exam or imaging
 - Clinically detected on imaging or physical exam
 - Nodes fixed
 - No description implies movable
 - Level of nodes involved
- M category assessment
 - Based on physical exam signs or symptoms of mets
 - Imaging is not required
 - Assign cM0 or cM1 based on physical exam or imaging
 - Assign pM1 based on FNA or biopsy of involved metastatic site



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Pathologic T Category

- Size for T category
 - Nearest mm used, tenths of mm rounded to assign T
 - Do not add core biopsies to residual tumor in resection
 - May need to use either core biopsy or resection to assign T
- Complex shapes may represent one tumor
 - Macroscopically distinct tumors that are very close together
 - May find microscopic subtle areas of continuity between foci
 - Need contiguous uniform tumor density in intervening tissue
 - Does not apply to macroscopic tumor with microscopic satellites
 - Determined by pathologic and imaging findings
 - Need physician and pathologist statements
- Multiple simultaneous ipsilateral tumors
 - T category based on largest of multiple tumors
 - Must use (m) suffix




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Pathologic N Category

- pN category
 - **Must** have microscopic assessment of at least 1 node to assign
 - Microscopic assessment includes
 - FNA or core needle biopsy
 - Sentinel node procedure
 - Axillary node dissection
 - Include nodes not microscopically confirmed to assign pN
 - No microscopic assessment is pNX
- Isolated tumor cells (ITC) is pN0(i+)
 - Not greater than 0.2mm
- Micrometastasis is pN1mi
 - Greater than 0.2mm but none greater than 2.0mm


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Pathologic N and M Categories

- Metastasis in lymph node
 - At least **one** metastasis greater than 2.0mm
 - Applies to all pN subcategories except pN1mi
- M category assessment
 - Based on physical exam signs or symptoms of mets
 - Imaging is not required
 - Assign cM0 or cM1 based on physical exam or imaging
 - Assign pM1 based on FNA or biopsy of involved metastatic site
 - Assign cM0(+) for CTC or DTC
- M category for postneoadjuvant therapy staging (yp)
 - Same as M category assigned for clinical stage
 - If M1 before Rx, M1 for yp stage even if mets no longer detected
 - Progression: distant mets identified after Rx when preRx eval neg


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Criteria for Clinical Classification


- Patient undergoing diagnostic workup
 - Exam of breast, skin, and lymph nodes
 - Imaging of breast: mammogram, ultrasound, MR
 - Diagnostic FNA, core needle biopsy, or surgical biopsy of breast
 - Diagnostic FNA or sentinel biopsy of nodes
 - Diagnostic FNA or biopsy of metastatic sites
 - Imaging of other sites, see NCCN or radiology guidelines
- Incidental finding during excision benign tumor
 - Start of diagnostic workup for malignant tumor
 - Not considered treatment for malignant tumor

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Diagnostic vs. Treatment


- Diagnostic procedures
 - Sampling of breast tumor
 - Not intended to remove entire tumor
 - Not known if entire tumor is removed at this point
 - Do NOT change staging based on subsequent info
- Surgical treatment of primary site
 - Resection of breast tumor
 - Margin status does not determine whether considered resection
 - Margin status may necessitate re-excision
 - 20% of lumpectomies have re-excision
 - If nodal dissection not done, still considered treatment



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Treatment Satisfying Stage Classification


- Pathologic staging
 - Excision of tumor
 - Intent is treatment, not sampling
 - Usually no macroscopic tumor left behind
 - Re-excision for margin involvement, both surgeries are treatment
 - Nodal dissection not required to qualify for staging
- Postneoadjuvant therapy staging
 - **Must** meet standard guidelines, such as NCCN or ASCO
 - Usually 4-6 cycles of chemo, sometimes more
 - Usually 4-6 months of endocrine therapy, may be up to 1 year
 - Short course endocrine therapy does **NOT** qualify
 - Rule for staging, not for registry treatment data items



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Blank vs. X

- Tell patient's story through staging
- Clinical staging – story of pt's diagnosis and workup
 - cTX = physician did not examine patient, no mammogram/US
 - cT blank = registrar had no access to information
 - cT blank = no workup for pt, incidental finding at surgical treatment
- Pathologic staging – pt's story through surgical treatment
 - pTX = someone lost specimen between OR and path dept
 - pT blank = pt didn't have surgical treatment
 - pT blank = registrar had no access to information




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Case Scenario



Diagnostic Workup


- History/chief complaint
 - 57 year old female with abnormal mammogram
- Physical exam
 - No breast mass, skin changes, or nipple discharge
- Imaging
 - Mammogram: microcalcifications UOQ rt breast
- Procedure
 - Core needle biopsy UOQ rt breast
- Pathology report
 - Ductal carcinoma in situ, no invasive carcinoma identified



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Clinical Staging Information


- Physical exam
 - No mass detected in breast
 - Axilla exam:
 - Did physician not mention, which implies nodes not involved
 - Did registrar fail to document axilla exam
- Imaging
 - Microcalcifications does not provide staging information
- Procedure
 - No staging information
- Pathology report
 - In situ carcinoma



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Clinical Staging Answer & Rationale


- pTis
 - In situ carcinoma identified, no invasive ca
 - AJCC rules state pTis for clinical T category
 - Must have microscopic evidence, cannot diagnose in situ on imaging
- cN0
 - No axillary involvement
 - Standard for in situ tumors
- cM0
 - No signs or symptoms of mets
- Stage 0



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Treatment


- History & physical
 - 55 year old female noted lump in right breast
- Operative report
 - Right modified radical mastectomy
 - Sentinel nodes and completion axillary dissection
- Pathology report
 - Breast tumors' size and location
 - 1.1cm UOQ, 1.1cm subareolar, 1.2cm subareolar, 0.9cm LOQ
 - Infiltrating ductal and mucinous carcinoma
 - Mets in 2/2 sentinel nodes
 - Mets in 3/13 axillary nodes



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Pathologic Staging Information

- Surgery
 - Patient had surgical resection qualifying for pathologic staging
- Clinical staging information
 - Bx: pTis, physical exam: large mass encompassing 1/3 breast
 - Axillary and supraclavicular nodes negative on physical exam
 - No signs or symptoms of mets
- Operative report
 - No additional information
- Pathology report
 - Infiltrating ductal and mucinous carcinoma
 - Four tumors, largest 1.2cm
 - Involvement 2/2 sentinel and 3/13 axillary nodes




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Pathologic Staging Answer & Rationale

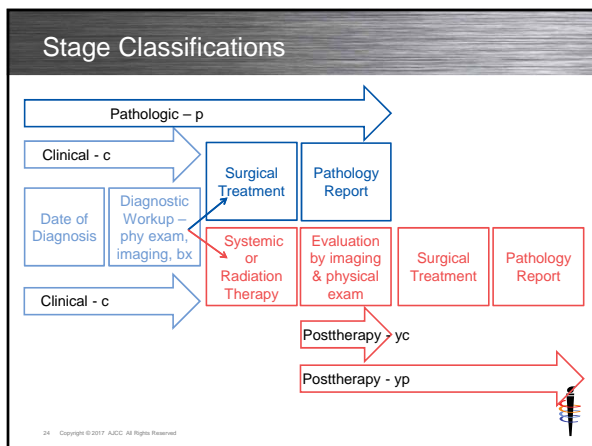
- pT1c(m)
 - Largest invasive tumor >10mm but < 20mm
 - In situ on bx with large mass in breast
 - (m) for multiple synchronous tumors
- pN2a
 - 5 axillary nodes involved
 - Presume >2mm since not stated as micromets
- cM0
 - No signs or symptoms of mets
- Stage IIIA

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Information and Questions on AJCC Staging






AJCC Web site

- <https://cancerstaging.org>
- Cancer Staging Education **Registrar menu** includes
 - Timing is Everything – Stage Classifications
 - Critical Clarifications for Registrars
 - Disease Site Webinars
 - 5 sites: melanoma, lung, breast, prostate, colorectum
 - AJCC Curriculum for Registrars
 - 4 free self-study modules of increasing difficulty on staging rules
 - Each module consists of 7 lessons, including recorded webinar with quizzes
 - Presentations
 - Self-study or group lecture materials, including blank vs. X


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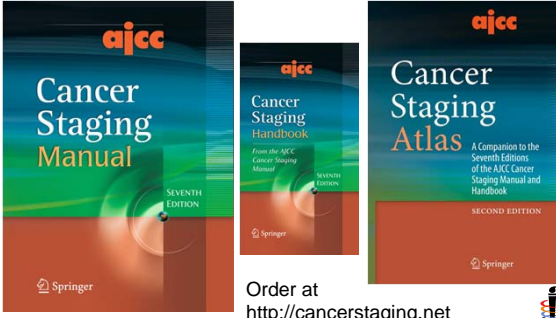
AJCC Web site

- <https://cancerstaging.org>
- Cancer Staging Education **Physician menu** includes
 - Articles
 - 18 articles on AJCC 7th edition staging in various medical journals
 - Webinars
 - 14 free webinars on 7th edition staging rules and some disease sites
- Cancer Staging Education **General menu** includes
 - Staging Moments
 - 15 case-based presentations in cancer conference format to promote accurate staging with answers and rationales

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AJCC Cancer Staging Manual and Atlas




Order at <http://cancerstaging.net>

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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



Summary

- Employ critical thinking to understand disease site
 - Analyze common staging issues affecting stage assignment
 - Determine exceptions and cautions for T, N, M
 - Utilize guidelines available to registrars
- Tell patient's story through accurate staging
 - Utilize correct stage classifications
 - Distinguish diagnostic procedures vs. treatment
 - Identify treatment satisfying stage classification criteria
 - Recognize difference in story between blank vs. X
- Identify resources for AJCC staging



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Thank you

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Upcoming Webinar

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