Seventh Edition Staging 2017 Colorectum

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AJCC
American Joint Committee on Cancer
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Overview

- Provide key information for colorectum 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

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

Colorectum Staging

Clinical T Category

- Colonoscopy with biopsy
  - Provides diagnosis of cancer
  - TX commonly assigned due to lack of tissue layer information
- Imaging may provide T category assignment
- NCCN Guidelines & ACR Appropriateness Criteria
  - Pelvic CT for colon cancer
  - Pelvic MRI or endorectal/transrectal US for rectal cancer

Clinical N and M Categories

- Clinical N
  - Must estimate nodal involvement to assign
  - Includes tumor deposits
    - With nodal involvement or
    - Without nodal involvement
- Clinical M category
  - Important to use subcategories: a, b
  - May be cM or pM
  - Only one of multiple sites must have microscopic proof for pM1b

Pathologic T Category

- Question
  - When is T4a appropriate
    - T4a - penetrates to surface of visceral peritoneum
- Answer
  - T4a appropriate only in areas with peritoneum
  - Ascending/descending colon
    - Could have T4a on peritoneal side
    - If tumor on retroperitoneal side, could be T3 & positive radial margin
  - Rectum
    - Sometimes upper rectum has peritoneum
    - Never rectum below peritoneal reflection, could be T3 & positive margin
  - Unequivocal extension into other organs would be T4b
- T4b direct invasion vs. adherence
  - If no microscopic tumor in adhesion, assign pT1-pT4a
  - Gross adherence is used in cT4b only

Pathologic N and M Categories

Mesenteric nodes Q&A

- Question
  - Why isn't "mesenteric" listed in regional nodes for colon subsites
  - Why do pathologists use generic term not in AJCC chapter
- Answer
  - Probably because surgeons main authors of definitions and chapter
  - Pathologists use mesenteric, more general term, because
    - Don't usually localize nodes as "right colic", "middle colic", etc
    - Can't tell nodal location for sure in excised specimen, landmarks are not there for precise localization
  - Any mesenteric node in resection specimen is regional node
- M category assessment
  - Multiple metastatic sites: microscopic proof of one site is pM1b
  - Do not need microscopic proof of all met sites

Polyps: Types and T Category

- Polyp: abnormal growth projecting from mucous membrane
  - Sessile: mostly a flat growth, no stalk
  - Pedunculated: attached by a narrow elongated stalk

Polyp pathology report Q&A

- Question
  - Polyp pathology report: invasive adenoca
  - No info about intraepithelial, lamina propria, or submucosa
- Answer
  - If report says invasive, that is at least involvement of submucosa
  - Assign T1
  - Anatomy is distorted so it can be hard to assess
  - But if confined to mucosa, it would not be called invasive

Polyps: Diagnosis vs. Treatment

- Sessile polyp
  - Colonoscopy bx is usually diagnostic, incomplete resection, cTX
  - Surgical resection is treatment, pT
- Pedunculated polyp
  - Colonoscopy snare polypectomy is treatment, pT
  - No diagnosis prior to snare, therefore no clinical stage assigned
- General guideline for polyp removal during colonoscopy
  - Incomplete resection – cTNM
  - Complete resection of polyp, treatment – pTNM
  - Not dependent on margins, but on purpose/intent of resection

Criteria for Clinical Classification

- Patient undergoing diagnostic workup
  - Medical history and physical examination
  - Colonoscopy
  - Sigmoidoscopy
  - Diagnostic biopsy
  - Imaging based on guidelines
- Incidental finding during surgical resection
  - Resection most likely for emergency bowel obstruction
  - No clinical stage assigned
  - Never assign stage in retrospect, cannot go back in time

Diagnosis vs. Treatment

- Diagnostic procedures
  - Biopsies
  - Sampling of polyp (no intent for surgical treatment resection)
- Surgical treatment of primary site
  - Resection of colorectal tumor
  - Extent of resection depends on size and location
    - Local excision
    - Segmental resection
    - Partial colectomy
    - Hemicolectomy
    - Total colectomy
  - Nodal dissection is important, commonly performed

Treatment Satisfying Stage Classification

- Pathologic staging
  - Resection of colorectal tumor
    - Intent is treatment not sampling
  - Nodal dissection is standard, but not required to qualify for staging
- Postneoadjuvant therapy staging
  - Common for rectal cancer
  - Chemo and radiation therapy
  - NPCR: **NO** requirement for postneoadjuvant therapy staging
    - NPCR does **NOT** require or request submission of yp staging data
    - If neoadjuvant Rx, NPCR requires path stage group to be unknown

Blanks vs. X

- Tell patient's story through staging
- Clinical staging – story of pt's diagnosis and workup
  - cTX = physician did not examine patient, no imaging or colonoscopy
  - 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

Case Scenario

Diagnostic Workup

- History/chief complaint
  - Iron deficiency anemia
- Physical exam
  - No information provided by registrar
- Imaging
  - CT abd/pelvis: transverse colon markedly abnormal may be colitis, no adenopathy, no mets in liver/adrenals, likely pleural scarring rt lung
- Procedure
  - Colonoscopy, bx: likely malignant, fungating, ulcerated, partially circumferential mass 65-70cm from anus; sessile polyp proximal ascending colon removed
- Pathology report
  - Inflammation,cecum bx. Adenomatous polyp fragments,50cm & 25cm
  - No mention by registrar of bx pathology from 65-70cm mass

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Clinical Staging Information

- Physical exam
  - No information for staging
- Imaging
  - Abnormal transverse colon
  - No adenopathy
  - No distant mets in liver or adrenals
- Procedure
  - No staging information
  - Info does not match path report: polyps in wrong location, no mention cecal bx, no path on transverse colon bx
- Pathology report
  - Registrar did not provide transverse colon mass bx info
  - Potentially not pathology report for this case
  - No staging information

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Clinical Staging Answer & Rationale

- cTX
  - No information on tissue layer involved
  - Likely malignant on colonoscopy
  - Biopsy results missing
- cN0
  - No adenopathy on imaging
- cM0
  - No signs or symptoms of mets
  - No mets in liver or adrenals on imaging
- Stage unknown

Treatment

- History & physical
  - Iron deficiency anemia, transverse colon mass seen at colonoscopy, no mets on imaging
- Operative report
  - Partial transverse colectomy, partial omentectomy: no findings documented by registrar
- Pathology report
  - Adenocarcinoma, invasion through muscularis propria into pericolonic tissue, transverse colon segmental resection
  - Two small satellite mets & one tubular adenoma, transverse colon
  - Metastatic adenoca in 19/23 pericolic nodes
  - Multiple nodes appear to involve radial surgical margin
  - No tumor seen, partial removal omentum
  - NOTE: No documentation of grade by registrar

Pathologic Staging Information

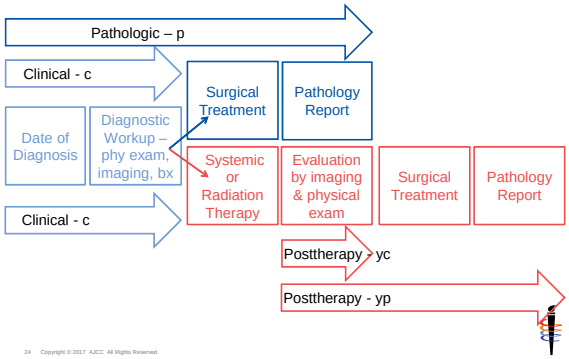
- Surgery
  - Patient had surgical resection qualifying for pathologic staging
- Clinical staging information
  - cTX cN0 cM0
- Operative report
  - No information provided by registrar
- Pathology report
  - Adenoca through muscularis propria into pericolonic tissue
  - Two small satellite mets in transverse colon
  - Omentum not involved
  - 19 pericolic nodes involved

Pathologic Staging Answer & Rationale

- pT3
  - Through muscularis propria into pericolorectal tissue
- pN2b
  - 19 pericolic nodes involved
- cM0
  - No signs or symptoms of mets
  - No mets in liver or adrenals by imaging
- Stage IIIC

Information and Questions on AJCC Staging

Stage Classifications



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 modules consists of 7 lessons, including recorded webinar with quizzes
  - Presentations
    - Self-study or group lecture materials, including blank vs. X

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

AJCC Cancer Staging Manual and Atlas

Order at
http://cancerstaging.net

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/

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