Cancer Surgery Standards PROGRAM
AMERICAN COLLEGE OF SURGEONS

Commission on Cancer®
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Cancer Surgery Standards Program (CSSP)

Webinar on CoC Standard 5.7: Total Mesorectal Excision for Rectal Cancer

Background

- The ACS launched the CSSP in June 2020, recognizing growing evidence that adherence to specific operative techniques in cancer surgery leads to:
    - Better surgical outcomes
    - Improved patient quality of life
    - Longer patient survival

Rationale for Standard 5.7

- Total mesorectal excision (TME) is advantageous because it:
    1. leverages existing tissue planes, lending to a safe dissection which minimizes potential morbidity to nearby neurovascular structures
    2. allows for complete tumor excision *en bloc* with the adjacent draining lymph nodes
    3. optimizes the chance for negative pathologic margins
- TME decreases local recurrence rates, improves overall survival, and has become the standard of care amongst ASCRS, NCCN, and NAPRC.

Operative Standard 5.7 Measure of Compliance

- **All three** of the following must be met for a program to maintain compliance:
    1. TME is performed for patients undergoing radical surgical resection of mid and low rectal cancers
    2. TME results in a complete or near-complete mesorectal excision
    3. Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection (complete, near-complete, or incomplete) in synoptic format.
- Compliance will be assessed upon review of synoptic pathology reports for mid and low rectal tumors → if the report states the TME quality was complete or near-complete in synoptic format, compliance for that case was met

Compliance Timeline

- Programs should aim to achieve compliance rates of:
    - **70%** for year 2021
    - **80%** for all subsequent years
- Site visits in 2022 will begin to review synoptic pathology reports for 2021 compliance

Tips to Achieve Compliance

- Ensure pathology utilizes College of American Pathology synoptic reports (available online), which by default contain a section to grade the TME quality (mandatory in latest version)
- Documenting the indication (mid and low rectal tumors) in the operative report will help pathologists and registrars identify cases where TME should be expected
- Encourage communication amongst surgeons, pathologists, and registrars to optimize documentation for appropriate cases. Standard 5.7 applies 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 should be clearly documented in the operative report for any operation covered by these standards.

Frequently Asked Questions

Question	Answer
Will the synoptic report format be shared with CoC facilities for pathology to use?	The rectal synoptic pathology report can be accessed for free via the CAP website.
How can a registrar tell if the tumor location is low to mid rectal? Rectum has only one primary site code, does the CAP pathology report have a field for tumor location?	The CAP pathology report specifies rectum but does not distinguish between "high, mid, or low". This determination can be made based on MRI, clinical, or endoscopic evaluation.
Do you think the surgeon should take the pictures or pathologists for the rectal resection?	Pictures are not required to comply with CoC Standard 5.7. Only CAP pathology reports will be assessed.
If we follow CAP protocol should we be at 100% compliance with this standard or are some of these data items on the pathology report for Standard 5.7 optional?	CoC accredited programs must meet ALL of the measures of compliance under Standard 5.7 in *Optimal Resources for Cancer Care (2020 Standards)* for **70%** of cases starting January 2021 in order to be compliant with the standard.
If our hospital already follows CAP templates for 100% of our cases, would this meet documentation for the CoC Standard 5.7?	If for every mid and low rectal cancer case the CAP report is accurately documented, most of the standard is met. The standard does mandate that the specimen be "complete" or "near-complete", so there is a technical component based on the surgeon's quality of dissection.
Will there be certain fields that the surgeons have to complete as well or just the pathologist only for this standard?	No, surgeons will not have fields to complete on the CAP report. The quality of their submitted specimen, as graded by the pathologist on the CAP report, is the main contribution of the surgeon.
When there is no residual tumor in a neoadjuvant specimen and synoptic reporting is not required by CAP, how should this situation be handled?	The CoC has revised Standard 5.7 of the *Optimal Resources for Cancer Care (2020 Standards)* to align with the College of American Pathologists cancer protocol template for rectal cancer resections. These revisions show that Standard 5.7 does not apply to primary resection specimens with no residual cancer (e.g., following neoadjuvant therapy).
How will you rate compliance if a facility only has 4 or 5 rectal resections a year? The percentage will be difficult to address.	If a program has less than 7 patients that meet the patient criteria for a specific standard, then all patient charts available will be reviewed by the site reviewer.