Cancer Surgery Standards PROGRAM

AMERICAN COLLEGE OF SURGEONS

2022 CoC Site Visit Preparation for Standard 5.7 & Standard 5.8

August 30th, 2021 @ 4pm CT

facs.org/cssp

American College of Surgeons

Inspiring Quality: Highest Standards, Better Outcomes

100+years

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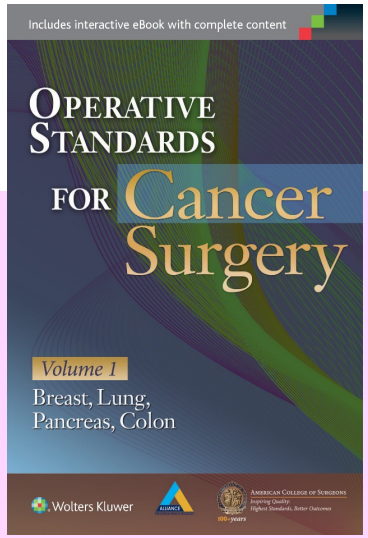
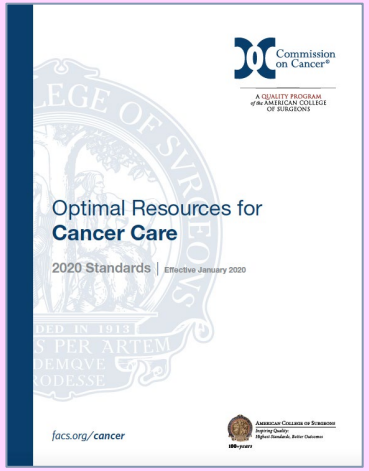
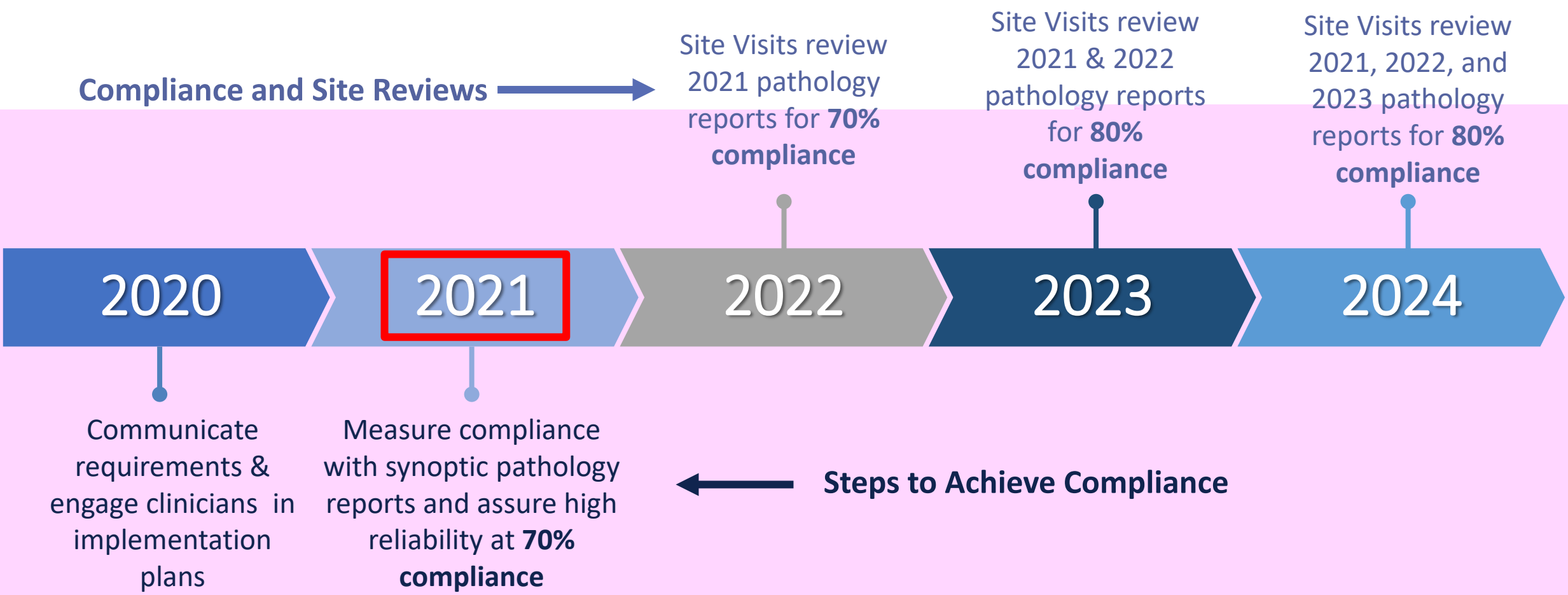
The CoC Operative Standards





Standard	Disease Site	Procedure	Documentation
5.3	Breast	Sentinel node biopsy	**Operative report**
5.4	Breast	Axillary dissection	**Operative report**
5.5	Melanoma	Wide local excision	**Operative report**
5.6	Colon	Colectomy (any)	**Operative report**
5.7	Rectum	Mid/low resection (TME)	Pathology report (CAP)
5.8	Lung	Lung resection (any)	Pathology report (CAP)

Implementation Timeline for Standards 5.7 & 5.8



Compliance levels for 5.7 & 5.8

Visit Year	Standard	Materials Assessed	Requirement
2022	5.7	7 rectal pathology reports from 2021	70% compliance
	5.8	7 lung pathology reports from 2021	70% compliance
2023	5.7	7 rectal pathology reports from 2021-2022	80% compliance
	5.8	7 lung pathology reports from 2021-2022	80% compliance
2024	5.7	7 rectal pathology reports from 2021-2023	80% compliance
	5.8	7 lung pathology reports from 2021-2023	80% compliance
2025	5.7	7 rectal pathology reports from 2022-2024	80% compliance
	5.8	7 lung pathology reports from 2022-2024	80% compliance

Measures of Compliance

Standard 5.7: Total Mesorectal Excision

- Total mesorectal excision is performed for patients undergoing radical surgical resections of mid & low rectal cancers, **resulting in complete or near-complete total mesorectal excision**
- Pathology reports for resections of rectal adenocarcinoma document the **quality of TME resection** in synoptic format

Standard 5.8: Pulmonary Resection

- Pulmonary resections for primary lung malignancy include lymph nodes from **at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations**
- Pathology reports for curative pulmonary resection document the **nodal stations examined by the pathologist** in synoptic format

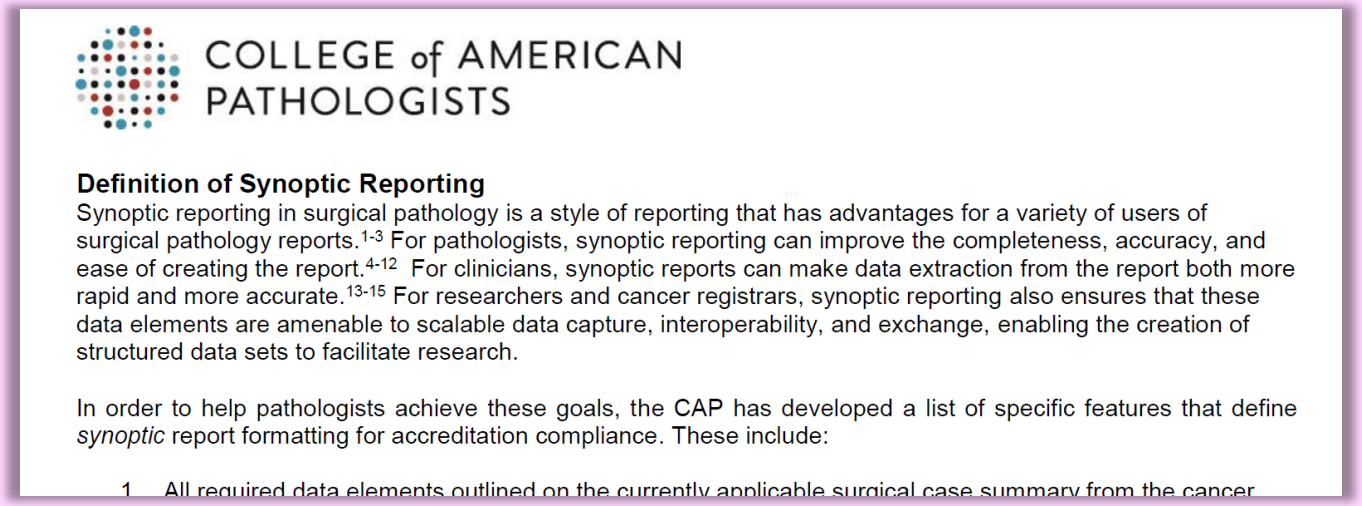
Synoptic format vs. Narrative format

- Synoptic reporting presents information in a **paired "data element: response" format**.
  - *Example:*
    Procedure: Total thyroidectomy
    Tumor focality: Single focus

- Narrative reporting presents information in a **prose format** that can be read as phrases or sentences.
  - *Example:*
    No lymph nodes submitted, adrenal gland uninvolved, lymphatic invasion present.

CAP Definition of Synoptic Reporting

- CAP's website provides definitions and guidelines for ensuring compliance with synoptic reporting requirements
- Each CAP protocol also summarizes these requirements in the first few pages under "**Synoptic Reporting**"



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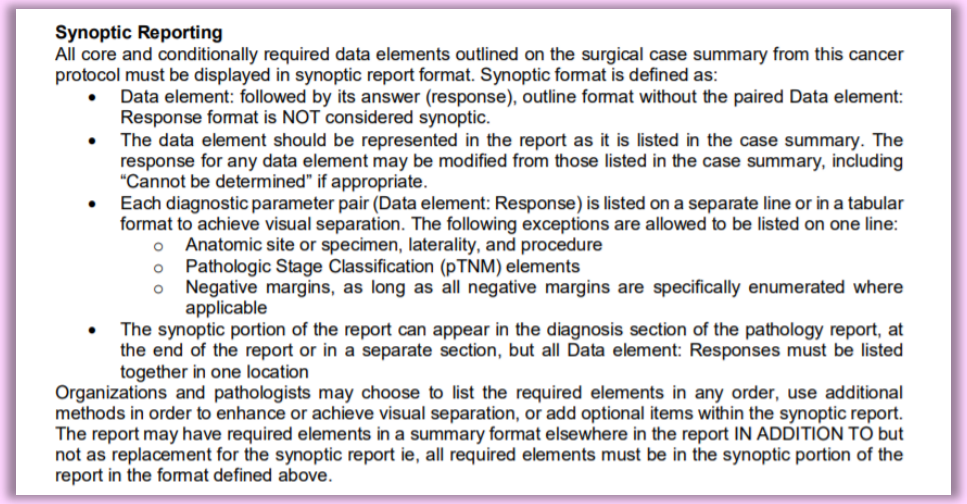
Definition of Synoptic Reporting

Synoptic reporting in surgical pathology is a style of reporting that has advantages for a variety of users of surgical pathology reports.[1-3] For pathologists, synoptic reporting can improve the completeness, accuracy, and ease of creating the report.[4-12] For clinicians, synoptic reports can make data extraction from the report both more rapid and more accurate.[13-15] For researchers and cancer registrars, synoptic reporting also ensures that these data elements are amenable to scalable data capture, interoperability, and exchange, enabling the creation of structured data sets to facilitate research.

In order to help pathologists achieve these goals, the CAP has developed a list of specific features that define *synoptic* report formatting for accreditation compliance. These include:

1. All required data elements outlined on the currently applicable surgical case summary from the cancer



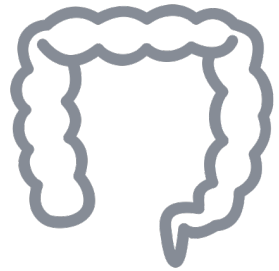
Synoptic Reporting

All core and conditionally required data elements outlined on the surgical case summary from this cancer protocol must be displayed in synoptic report format. Synoptic format is defined as:

- Data element: followed by its answer (response), outline format without the paired Data element: Response format is NOT considered synoptic.
- The data element should be represented in the report as it is listed in the case summary. The response for any data element may be modified from those listed in the case summary, including "Cannot be determined" if appropriate.
- Each diagnostic parameter pair (Data element: Response) is listed on a separate line or in a tabular format to achieve visual separation. The following exceptions are allowed to be listed on one line:
  - Anatomic site or specimen, laterality, and procedure
  - Pathologic Stage Classification (pTNM) elements
  - Negative margins, as long as all negative margins are specifically enumerated where applicable
- The synoptic portion of the report can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all Data element: Responses must be listed together in one location

Organizations and pathologists may choose to list the required elements in any order, use additional methods in order to enhance or achieve visual separation, or add optional items within the synoptic report. The report may have required elements in a summary format elsewhere in the report IN ADDITION TO but not as replacement for the synoptic report ie, all required elements must be in the synoptic portion of the report in the format defined above.

Examples of compliant vs. noncompliant pathology reports



Compliant ✓

Macroscopic Evaluation of Mesorectum: Near complete

Macroscopic Evaluation of Mesorectum: Complete

Noncompliant ✗

Macroscopic Evaluation of Mesorectum: Incomplete ← *Does not meet technical requirement*

"The TME specimen is complete, with a smooth and regular appearance and no defects deeper than 5 mm." ← *Not in synoptic format*

Examples of compliant vs. noncompliant pathology reports

Compliant ✓

Specify nodal station(s) examined: 4R, 7, 9R, 11R

Nodal Site(s) Examined: 5 Subaortic
6 Para-aortic
7 Subcarinal
10L Hilar

Noncompliant ✗

Specify nodal station(s) examined: 2R, 4R, 7, 9R ← *Does not meet technical requirement*

"5 lymph node stations were examined." ← *Not in synoptic format*

Site Review Process for 5.7 & 5.8

Programs generate a list of all cases from specified years eligible for Standard 5.1 (CAP Synoptic Reporting), which includes rectal and lung cases eligible for Standards 5.7 and 5.8

Site visit reviewer selects:
7 rectal cancer cases* to assess for compliance with Standard 5.7
7 lung cancer cases* to assess for compliance with Standard 5.8

Site visit reviewer assesses whether all measures of compliance have been met for each selected case then chooses a rating for each standard

*A portion of the 14 patients reviewed for Standards 5.7 and 5.8 may be included in the sample to determine compliance with Standard 5.1.

Selection of Eligible Cases

- Programs must determine whether the cases selected by the site reviewer were performed with **curative intent**.
  - If any are NOT for curative intent, the program must inform the site reviewer so that other cases may be selected instead.
- For Standard 5.7, the program will need to determine whether the cases selected by the site reviewer were for **mid/low rectal tumors**. This information can be found in the NAPRC synoptic report (if used) or in the CAP pathology report:

	NAPRC Synoptic Report	CAP Pathology Report
Data element name	Location of tumor within rectum	Rectal Tumor Location
"High" rectal tumor response	High	Entirely above anterior peritoneal reflection
"Mid" rectal tumor response	Middle	Straddles anterior peritoneal reflection
"Low" rectal tumor response	Low	Entirely below anterior peritoneal reflection

Additional Compliance Information

- Amended/addended pathology reports can meet the requirements of Standards 5.7 & 5.8
  - Reports should only be corrected when the change will affect clinical care.
- For Standard 5.7, the quality of the TME resection must be reported using the **Macroscopic Evaluation of Mesorectum** data element in the CAP protocol for Colon and Rectum Resection.

Macroscopic Evaluation of Mesorectum (required for rectal cancers) (Note A)

___ Not applicable *A different case should be selected by the site reviewer.*
___ Complete ✓ *Compliant*
___ Near complete ✓ *Compliant*
___ Incomplete ✗ *Noncompliant*
___ Cannot be determined: _____ ✗ *Noncompliant*

Integrated Network Cancer Programs

- Each hospital in an Integrated Network Program (INCP) will have 7 charts assessed per standard. The INCP will then be rated cumulatively.
- Example: For an INCP with 10 hospitals, 70 reports will be reviewed per standard (7 reports × 10 hospitals).
  - 49 of the 70 charts assessed would need to meet all requirements to achieve 70% compliance for that standard.

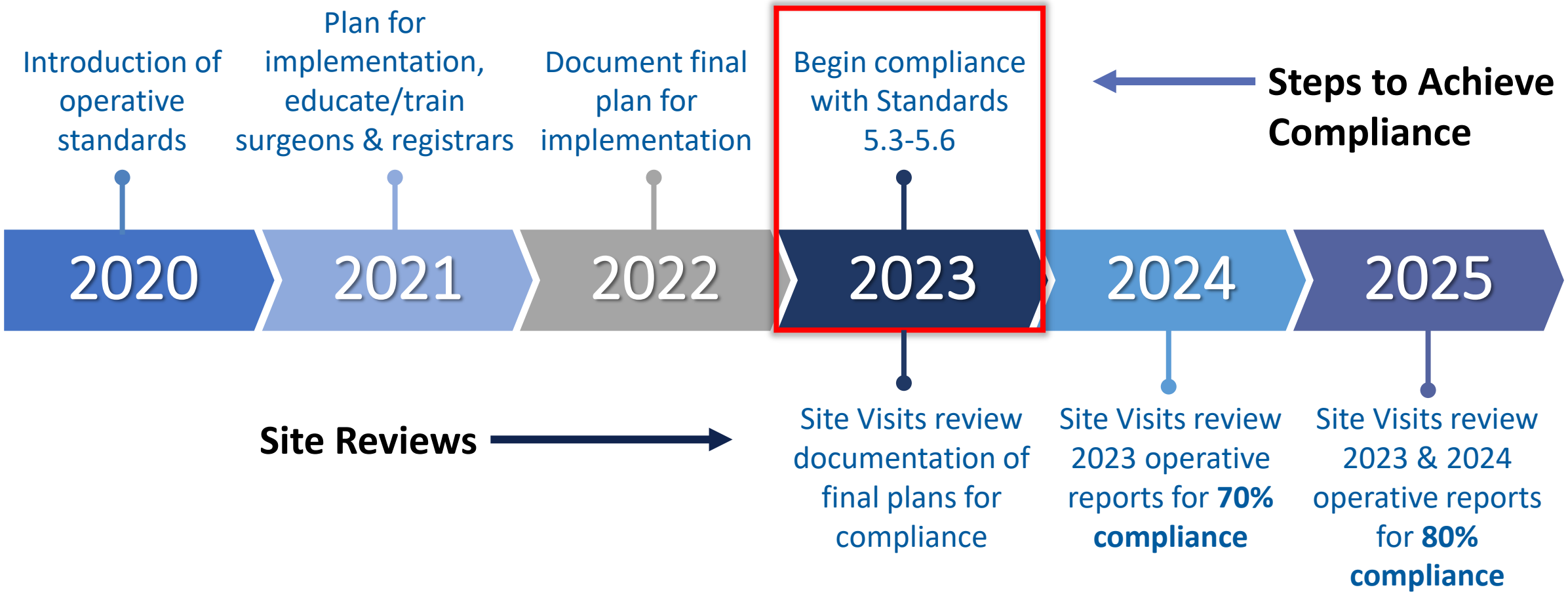
What if a program has fewer than 7 cases for Standard 5.7 or 5.8?

- If a program has fewer than 7 cases that meet the criteria for a specific standard, then **all cases meeting the criteria will be reviewed by the site reviewer**.
- If a program has NO cases that meet the criteria for a specific standard, they are exempt from that standard.
  - Programs should make a comment in the PRQ to indicate that the operation is not performed at their institution. Site reviewers will discuss with the program and assign a “Not Applicable” rating for that standard.

What if a program is deemed noncompliant?

- If a program does not meet the compliance threshold, the program must complete a **random sample review of 10 pathology reports** eligible for the noncompliant standard to determine whether the synoptic reporting format and technical requirements were met.
  - The cancer committee should designate who should conduct the audit.
- The review must be documented in the cancer committee minutes. The number of reports reviewed and the number that were compliant is documented. The outcome **must meet the 70% threshold of compliance to resolve the standard**.
  - The pathology reports reviewed for the deficiency resolution must be from procedures occurring after the period reviewed during the site visit.

Implementation Timeline for Standards 5.3–5.6



Standards 5.3–5.6 in 2022

- There are no requirements for Standards 5.3 through 5.6 for site visits in 2022.
- During 2022, CoC-accredited programs will need to document their final plan for how they plan to achieve compliance with Standards 5.3, 5.4, 5.5, and 5.6 beginning in 2023. Documentation of final plans will be reviewed at site visits in 2023.

Resources for CoC-accredited programs

- Brief videos on the CoC Operative Standards:
  - Introduction to the CoC Operative Standards
  - CoC Standard 5.7: Requirements & Best Practices
  - CoC Standard 5.8: Requirements & Best Practices
- Comprehensive FAQ on Standards 5.3-5.8 and Synoptic Reporting
- SurgOnc Today® Podcast Series

- Webinars
  - Implementation Strategies for Synoptic Operative Reporting (recording, slides, summary)
  - Best Practices for Compliance with CoC Standards 5.7 & 5.8 (recording, slides, summary)
  - CoC Standard 5.7: Total Mesorectal Excision (recording, slides, summary)
  - CoC Standard 5.8: Pulmonary Resection (recording, slides, summary)
- Visual Abstracts on Standard 5.7 and Standard 5.8
- Guidelines for registrars to identify eligible cases for Standard 5.7 & Standard 5.8

All resources can be found on the Operative Standards Toolkit, organized by topic.

Frequently Asked Questions

If a nodal station taken during an operation is documented by the surgeon but then noted by pathology not to be nodal tissue, why does this count against Standard 5.8?

Fat pads without nodal tissue do not count toward the requirements of Standard 5.8. This standard is based on the growing body of evidence that systematic mediastinal lymph node evaluation improves survival.

The threshold compliance rate is less than 100% to take these infrequent occurrences into account.

Frequently Asked Questions

Will the review be based on 10% of the analytic caseload?

While other CoC Standards require reviews based on percentages of the analytic caseload, CoC Standards 5.7 and 5.8 are specifically assessed using 7 cases per standard.

Frequently Asked Questions

Will the pathologist need to be present at the review of the pathology reports during the site review?

No, but we recommend that a pathologist is available for any questions.

Frequently Asked Questions

Do surgeons need to document whether the surgery was curative and which nodal areas nodes were removed from (for thoracic cases)?

Can you confirm whether the site reviewer will review BOTH the operative report and the pathology report?

The site reviewer will only review pathology reports. There are no requirements for operative reports for Standards 5.7 and 5.8. However, we recommend that surgeons incorporate these best practices to help your program optimize compliance with these standards.

Q&A