

Q&A Session for Lung 2023: Part II

November 2, 2023

#	Question	Answer
1.	For the example of 4 synchronous tumors. Since the adenocarcinoma NOS would be the same primary as both the acinar and mucinous, would your AJCC stage be based on the adenocarcinoma NOS for both of those primaries since it larger than the acinar and mucinous tumors with T suffix being (m) for both?	The (m) in all sites (except thyroid) indicates multiple synchronous or simultaneous primaries; these are different cancers arising at the same time. In this particular situation, these would be classified as synchronous primaries (because they are different histologies.) When there are multiple synchronous primary tumors (or synchronous primaries), the T category represents the worst tumor, it is assigned to the highest category. Then the (m) is used to indicate there is a greater tumor burden than just that represented by the T category, that there is another tumor in that single abstract. It is so that when analyzing data, you don't compare these (m) cases with single tumors.
2.	You have M blank for poll#2. In our software our options are cM0 or cM1 only	You should be able to leave the T, N, and M fields blank. Your software options should also allow pM1 in the cM field. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx . A stage group is required, so you would enter 99.
3.	For poll #2, wouldn't the adenocarcinoma have a clinical classification even though it was not known to be adenocarcinoma yet? The PET was suspicious for malignancy which would mean it would have a clinical diagnosis of cancer prior to the resection that determined it was adenocarcinoma.	The physician's judgement was one tumor was an intrapulmonary met, which is why cT3 was assigned. Until surgery, we did not know anything about adenocarcinoma because it was assumed to be the same histology as the squamous carcinoma. We cannot use pathological timeframe information to go back in time to assign the clinical stage.
4.	T2a is >3cm but <4cm, this tumor was 2.5cm	Yes. But this tumor invaded the visceral pleura. The tumor was a T1c by size, but because of the invasion of the visceral pleura, it is a T2 tumor. T2 tumors are classified as T2a when they are ≤ 4 cm in greatest dimension.
5.	Poll #5: can "extending to" the pleura be considered invasion?	Yes. The tumor is extending to the visceral pleura. It has not gone through the visceral, but this tumor is involving the visceral pleura.

6.	Imaging right after resection of an area that wasn't imaged before resection reveals distant mets. We can use that in staging right?	Yes. Imaging after resection is allowed per AJCC chapter 1.
7.	Poll 6: If the hilar LN was not resected during surgery, wouldn't it be cN1 for the path instead of pN1?	No, because pathological N includes clinical information, too. pT was met, and at least 1 LN was microscopically examined, which allows us to include the hilar LN in the pN. Also, we cannot mix cN with pT in the lung chapter. There are certain situations that allow cN in the pN field; those are outlined in the Node Status Not Required In Rare Circumstances AJCC document, referring to circumstances where lymph node involvement is rare (this is further clarification of the basic discussion on page 21 of Chapter 1). This is limited to specific chapters. Click on the Node status link above to find those, or go to https://www.facs.org/media/qpygzh5/node_status_not_required_rare_circumstances.pdf
8.	For poll #2, would the clinical stage for the squamous cell carcinoma be cT3 cN0(f) cM0 as stated by the med onc then?	Yes. The clinical stage for the squamous carcinoma stands as provided by the oncologist. We don't go back and change the clinical stage based on information from the pathological timeframe.
9.	So, what would the LN Exam/LN Pos count be? Still 00/09? Case 6.	Yes. The LN examined positive would not change. That data item is based only on pathologically examined Regional LNs.
10.	For poll #6 we are using the p based on the fact they removed some RLN and we are using the N1 for the hilar based on the statement from the OR the suspicious LN on DI?	We are basing the pN1 on the fact they removed some LNs AND met the criteria for pT (resection), and the physicians stated they believed there was hilar LN involvement. In this post (see #8) (https://cancerbulletin.facs.org/forums/node/138519), Donna states If you meet the criteria of microscopic assessment of at least one node [and pT], you can add in those nodes from the clinical staging information[for pN] .
11.	Circling back to the pN1 when only mediastinal lns. were examined and hilar were noted only on imaging as involved. Per AJCC Chapter 1 pg. 20 requirements for pN category state you have to some type of pathologic confirmation whether that is resection, FNA or biopsy. I do not see that in the example presented and only	We had pathological examination of the mediastinal LNs and met the criteria for pT. We do not have to have pathologic examination of the hilar LN. There are a number of posts on the CANSWER forum that discuss this, including the one above. Here is another example in which LNs were examined pathologically, but all were negative. Then the patient had post-surgery imaging showing other regional LNs were positive. We assign the pN based on the imaging findings since the criteria for pT and pN were met.

	see imaging showing the involvement. Please explain again why we can use clinical if pN has these requirements per AJCC	https://cancerbulletin.facs.org/forums/node/125764
12.	Poll#6 - Is it because the MD recommended treating the hilar LN the reason that we can use the "suspicious" for N1 disease? I ask because previously, Donna Gress had stated that ambiguous terminology is not to be used for assigning AJCC staging.	It is not based on ambiguous terminology. The physician recommended RT to the hilar LN(s) because (s)he thought they were involved.
13.	Poll #5 Since path staging includes clinical the clinical time frame shouldn't it be N1 like the cancer committee assigned?	For this case, there was no pathologic examination of at least 1 RLN; therefore, we have not met the criteria to assign pN. It is pNX because no LNs were microscopically assessed.
14.	If a provider stages multiple tumors as one primary this would meet the M9 rule note 3?	The exception to M9 per note 3 is to abstract multiple primaries based on them being different histologies versus a single primary.
15.	Thank you	
16.	In reference to not going back to change clinical stage, if clinically nodes are positive on imaging, but the biopsy or resection is negative, would you leave cN as positive?	If the biopsy disproves the clinical findings and it is done in the clinical timeframe, the cN would be cN0.
17.	Could we please have additional clarification on the statement that lungs are not considered paired organs for the purpose of staging? Is this simply based on differences in anatomical structure?	This is ONLY for the purposes of TNM classification. This is a statement directly from the lung chapter in AJCC. Our registry rules consider the lungs to be paired organs. AJCC does not have to go along with our rules. The statement can be found on page 433 under the ANATOMY section.
18.	Could a hierarchy of concepts for lung multiple tumors be displayed?	AJCC provides guidance on the 4 patterns of multiple lung lesions. For intrapulmonary mets versus synchronous tumors or synchronous primaries, we would need to rely on the physicians.
19.	For poll #2 Adenocarcinoma, is it like an incidental finding of Adenocarcinoma?	Yes. This is an incidental finding at surgery.
20.	Do we assign pT(m) if there was a single mass found on resection if there was GG/L features on imaging?	We don't use (m) for a single mass. It's possible I don't understand your question, so please follow up if that is the case.

21.	For the lepidic histo, are we to use the m suffix in all cases? Even if it is mixed with another histology?	It is not only lepidic histology. This is outlined in Tables 36.5, 36.9, and 36.11. They are saying there is adenocarcinoma with predominant lepidic component with typically varying degrees of LPA, MIA, or AIS.
22.	In reference to “break points” in comparative genomic hybridization, what should we be looking for?	These are genome tests the physicians may be using to decide between a second primary tumor, synchronous tumors, or intrapulmonary mets. If they do this, since it is a genome test it would likely be sent to an outside lab, so you may or may not have access to that.
23.	For poll #8 we would not use the m suffix because the multiple tumors are accounted for in the T4 category or would we because T4 options are not exclusively based on separate tumor nodules?	The (m) suffix does not apply to intrapulmonary mets (separate tumor nodules). Those are described in the T category (T3 or T4) or the M category (M1a) when they are in the opposite lung.
24.	What would the clinical stages for poll#10 be?	Without clarification from the physician as to whether these are synchronous tumors or intrapulmonary mets, it would be best to assign cT blank, cN0 cM0 Stage Group 99.
25.	For Poll #9 wouldn't pN be assigned and not cN based on AJCC bottom of page 19?	The criteria for pN have not been met; therefore, we cannot assign pN. The information at the bottom of page 19 is only partial information about pN. The requirements for assigning pN are listed at the top of page 20.
26.	#9 We don't typically get this kind of detail on a CT report, there is a just a statement of nodules etc. with no growth pattern or statement of intrapulmonary mets and if there is pathology it is only the one tumor bx'd. Sometimes there is just RT to one lung. Are we to assume similar growth patterns if there are none mentioned?	I would not assume anything. The tables in the lung chapter provide guidance which the physicians use to determine whether the nodules are intrapulmonary mets or synchronous tumors. We do not make these determinations ourselves, we rely on the physician's statement. So you will need this kind of detail to make this kind of determination.
27.	#12 how do we get past M9 when an ambiguous terminology of "likely" is used? Is it the staging?	If ambiguous terminology is used, we have to abstract as a single primary per M9. Remember, M9 applies to synchronous multiple tumors in a single lung, both lungs, or a single tumor in one lung and multiple tumors in the other. Rule M9 does not apply to Case # 12, because the first rule that applies is M7 (synchronous tumors in the same lung that are on the same row in Table 3 = single primary). In Case #12, the physician and the pathologist considered them different primaries (and the pathologist staged them as different primaries), but we have to apply the

		M rules first, and we have to use the M rules in order, stopping at the first one that applies.
28.	So, if tumors are "synchronous" we don't use T3 or T4?	T3 or T4 (or M1a) can apply to intrapulmonary mets; however, T3 and T4 can also apply to synchronous tumors because both of these categories can be based on size or extension.
29.	#14 is the dx Dec 29/20 for this case? If so sx is almost 2 years later is this still first course tx?	The diagnosis date is 4/19/23. There is nothing diagnostic on 12/29/20 – there were GGN but those can be any number of things.
30.	Can you give examples of when you would use T3 and/or T4?	,.
31.	Query regarding poll question #14. Should it have been pt1c based on tumor size of 2.2 cm?	Typo... pT1c (m)
32.	For the case where you have 3 primaries, we ignore the adenoca tumor regardless of size or extension and just base our staging on the tumor in the same lobe?	For this particular case, we ignore the adenocarcinoma because it is a synchronous primary. However, each case is different so don't get too caught up on hypothetical questions.
33.	Rules are to round down	The rules for rounding down are referring to tumor sizes given in mm. Our tumor size was given in cm.
34.	page 20 in the actual manual	
35.	When spine MRI states LLL pleural based mass w/ invasion of T11 vertebral body and extension into T11-T12 neuroforamen would cT4 apply? This is a proven SCC per bx. Physicians were assigning M1.	Discontinuous tumor nodules in the ipsilateral visceral or parietal pleura are M1a per table 36.12. Tumors invading the vertebral body are T4.
36.	Can you clarify on how to differentiate between using Blank vs. X?	Donna Gress has a great presentation on blank versus X at https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
37.	My 3 primary questions had to do with the TNM stage and not EOD or Summary Stage Thanks,	
38.	For poll 2, would the SCC tumor be clinically staged with T3?	Yes. The physician assigned the stage that way based on the presence of intrapulmonary mets.

39.	Could you share the page number for the measurement sizes relative to AIS?	Page 447 under the T definitions
40.	I know this is review, but can you please go over the difference between X and blank (one more time?)	Donna Gress has a great presentation on blank versus X at https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/staging-education/registrar/
41.	Extends to visceral pleura is the same as invasion?	Yes. The elastic stain is used to confirm invasion beyond the elastic layer including invasion to the visceral pleural surface. PL1 includes invasion beyond the elastic layer.
42.	For Poll #6: How can you have pN1, when there were 9 nodes examined and all were negative? Wouldn't the visual exam be clinical??	We had pathological examination of the mediastinal LNs and met the criteria for pT, therefore, we can assign pN based on clinical information that was not disproved in the clinical or pathological timeframe. There are a number of posts on the CAnswer forum that discuss this, including the one above. Here is another example in which LNs were examined pathologically, but all were negative. Then the patient had post-surgery imaging showing other regional LNs were positive. We assign the pN based on the imaging findings since the criteria for pT and pN were met. https://cancerbulletin.facs.org/forums/node/125764
43.	The last poll - if it has 0/9 LN - does that not mean there aren't any positive nodes?	We had pathological examination of the mediastinal LNs and met the criteria for pT, therefore, we can assign pN based on any information that was not disproved in the clinical or pathological timeframe.
44.	Please explain when it is appropriate to use a post-op PET within 4 months of surgery for assigning stage.	Per Chapter 1, page 18, "Imaging studies performed after surgery are included in the pathological staging if they are within the time frame or staging window. " There is no statement about using post-op imaging within 4 months of surgery.
45.	For #2, I'm not sure I recall correctly about what the size was relative to, I didn't think it was the primary tumor itself?	The PET showed a 1.5 cm LUL nodule and a second 2.4 cm nodule in the LUL, both suspicious for malignancy.
46.	It's actually Poll #3 when they describe the AIS, where is that mentioned?	We have a 3.6 cm clinical size and a mixed ground glass and nodular lesion. AIS per the definitions in the lung chapter has to be 3 cm or less. The bx showed AIS.
47.	Can you apply Rule M11 when there is a single tumor in the right and a single in the left with left hilar nodes involved?	Yes. M11 applies when there is a single tumor in each lung. The LNs are not considered in the rule, they are only mentioned peripherally to make sure that lymph node involvement is recorded in the staging criteria (note 5).

48.	Does that 4-month rule for synchronous primaries also apply for solid tumor rules when trying to determine single vs multiple primaries?	The Solid Tumor Rules have these terms listed as synonyms (equal terms): Simultaneous; existing at the same time; concurrent; prior to first course treatment. Then, they use “synchronous” in the rules. Synchronous is a synonym of these other terms per the general instructions.
49.	EXTENT OF DISEASE (EOD) 2018 GENERAL CODING INSTRUCTIONS Published October 2023 Page 10 has a list of terms that mean involve and "extension to" is there.	Yes. That is correct. However, we do not use EOD instructions for AJCC staging.
50.	So, it sounds like we could say that if they are within four months (such as with AJCC) it would be considered a synchronous tumor.	Synchronous has the same meaning as simultaneous in the STRs. There is no statement about 4 months. The Lung equivalent terms state the following terms are equivalent: Simultaneous; existing at the same time; concurrent; prior to first course. The general instructions state synchronous is the same thing as simultaneous.
51.	Can we apply the EOD terms that Kathleen mentioned to our AJCC staging? I find terminology one of the hardest parts of staging lungs!	We should not use rules and guidelines in EOD to assign AJCC. Also, we are not supposed to use ambiguous terms that constitute involvement (the ones that used to be listed in FORDS/STORE) to assign AJCC.
52.	Under the solid tumor rules general equivalent or equal terms: "Simultaneous; synchronous; at the same time; prior to first course treatment"	Thank you for checking that for us. I wish they would put “synchronous” in all of the sets of STR.
53.	Per poll 11, doesn't the (m) usage require GG/L nodules or that sort of terminology to use (m)?	According to Chapter 1, page 12, “If multiple tumors of the same histology are present in one organ, the tumor with the highest T category is classified and staged, and the (m) suffix is used.
54.	polls 13, 14, why not pT1C because the largest measurement is greater than 2cm?	pT1c is correct – typos compounded by copy/paste!