

***Cancer Surgery Standards Program (CSSP)***  
***Webinar on CoC Standards 5.5 for Wide Local Excision for***  
***Primary Cutaneous Melanoma***

Background

- In 2020, the CoC introduced a new accreditation standard for wide local excision (WLE) for primary cutaneous melanoma (Standard 5.5), which includes requirements for synoptic operative reports

Rationale and Requirements for CoC Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

- Excision margin is a critical operative standard because it directly addresses competing factors: reduction of local recurrence with minimization of wound morbidity
- All operations performed for curative intent must achieve certain excision margins based on the Breslow thickness of the primary melanoma:
  - Clinical margin width for wide local excision is 1 cm for invasive melanomas <1 mm thick
  - Clinical margin width for wide local excision is 1–2 cm for invasive melanomas 1–2 mm thick
  - Clinical margin width for wide local excision is 2 cm for invasive melanomas >2 mm thick
  - Clinical margin width for wide local excision is at least 5 mm for melanoma in situ
- Proper depth of excision:
  - Invasive melanoma: full-thickness skin + subcutaneous tissue down to the fascia
  - In situ disease: only skin + superficial subcutaneous fat
- The operative report must include documentation of curative intent, the original Breslow thickness of the lesion, the clinical margin width measured from the edge of the lesion or the prior excision scar, and depth of excision
- [Standard 5.5 will take full effect on January 1, 2023](#). Site visits in 2024 will evaluate charts from 2023 to determine whether 70% of operative reports within the scope of the standards meet the requirements for compliance. The compliance rate will increase to 80% starting with site visits in 2025.

Synoptic Operative Reporting for Standard 5.5

- Synoptic reporting has been found to improve the accuracy of documentation, improve the efficiency of data entry and abstraction, and reduce costs.
  - Synoptic reports can also reinforce education (by emphasizing the critical elements of oncologic operations) and reduce variability in care, leading overall to improved quality of cancer care
  - Synoptic reports use standardized data elements structured as a checklist or template
    - Each response is pre-specified to ensure interoperability of information and easy interpretation
    - Synoptic operative reports allow for easy collection and retrieval of data with the operative notes
- Current options for synoptic operative reporting to meet the requirements of Standards 5.5:
  - Create institutional synoptic templates with required elements/responses from Standard 5.5
    - Can be done using smart phrases or smart tools and may supplement a traditional narrative operative report
  - Use a [commercial option](#) and integrate their synoptic operative reporting tool
  - Use fillable PDF forms downloaded from the Standards Resource Library in [QPort](#)

### Best Practices to Optimize Compliance

- While not required for these standards, it is recommended that CoC-accredited programs perform internal audits to identify gaps in compliance.
  - The CSSP recommends that CoC programs form review teams to identify cases using the case identification guidelines available on the [Operative Standards Toolkit](#) and evaluate their charts for compliance with CoC Standard 5.5
- Programs may encounter barriers to implementation such as identifying the best synoptic reporting solution for their institution, educating other specialists treating melanoma, and empowering patients
  - Sharing information and data during key meetings with stakeholders (e.g., cancer committee meetings, tumor boards, staff meetings) can improve engagement and education on these standards
  - Patients can be empowered to educate themselves on surgical standards of melanoma excision by using the internet and social media, printed material in medical offices, and input from patient advocates/support groups

### Frequently Asked Questions

Question	Answer
Will wide local excisions performed by a dermatologist or plastic surgeon in offices located on our CoC hospital's campus be within the scope of Standard 5.5?	We recommend identifying whether the office location in question is included in your accredited hospital's Tax ID. If the office where the WLE was performed is included in your hospital's accreditation, then the WLE would be included in the scope of Standard 5.5. This is regardless of who is performing the procedure.
For melanoma in situ, would margins of any size greater than 5 mm still fulfill this standard?	There is no deficiency for having too large of a margin for melanoma in situ; however, evidence-based recommendations would not recommend a gross margin at the time of resection over 1 cm.
If a surgeon takes a margin wider than the recommended in Standard 5.5, is this a problem or issue with compliance? For example, a tumor with a 0.6 mm Breslow thickness having a 2 cm inked/excised margin when the standard only recommends 1cm margin.	Clinical margin width for wide local excision should be 1 cm for invasive melanomas less than 1 mm in thickness. A 2 cm margin would therefore not fulfill this requirement. Overtreatment should be avoided and, in the rare situation when deviation from the standard is judged to be the best option for care, we encourage the surgeon to document why a wider margin was chosen. However, margins wider than those set by Standard 5.5 are not compliant.
What if the depth of melanoma was deeper on the final pathology than on the initial biopsy diagnosing the melanoma?	Standard 5.5 was revised in 2021 to clarify this definition. The margins required for this standard are based on the Breslow thickness of the primary tumor as indicated on the initial biopsy pathology report.
Should dermatologists comply with the synoptic reporting requirements?	Regardless of whether a surgical oncologist or dermatologist performs the wide local excision, as long as the procedure was done at your accredited facility (or at a location included in your hospital's accreditation) the case will need to comply with all requirements of Standard 5.5.
Do you anticipate synoptic operative reporting to be a requirement for other cancer operations in the future (in addition to the	Yes, starting in 2026 the CoC/CSSP will be working towards implementing expanded requirements for synoptic operative reporting with the goal of transitioning to full synoptic operative reports. Additional cancer features in synoptic format will likely be required, along with currently

<p>current breast, melanoma, and colorectal requirements)? If so, when?</p>	<p>required elements/responses. In the coming years, new operative standards will be implemented for disease sites not already represented in the CoC standards for accreditation.</p>
<p>Do you have any recommendations on how to deal with surgeons who are against implementation of the synoptic operative standards?</p>	<p>Each CoC Operative Standard is evidence-based, and the supporting data is cited in the <i>2020 Standards</i> manual. We suggest sharing these studies with the surgeons at your CoC facility. In addition, the CSSP recently shared <a href="#">recommendations on self-auditing the CoC Operative Standards</a> that include suggestions for addressing gaps in compliance.</p>
<p>A case can still be analytic but didn't have surgery at your accredited facility. Will those cases be applicable for the operative standards?</p>	<p>Only wide local excisions performed at your accredited facility (or at a location included in your hospital's accreditation) would be included in the scope of Standard 5.5.</p>