



Cancer Surgery Standards  
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## CoC Operative Standards (Standards 5.3–5.8) Frequently Asked Questions

### Compliance & Implementation

#### **What are the requirements for compliance with the operative standards? What year will compliance be enforced?**

Current ratings and compliance information for Standards 5.3 through 5.8 can be found on the [Operative Standards Timeline and Compliance Information](#) webpage along with the implementation timelines.

#### **How will site reviewers be evaluating compliance with the operative standards?**

Site reviewers will assess 7 charts for each operative standard (42 total) to determine whether reports meet the requirements outlined in Standards 5.3–5.8. Please refer to the [Timeline and Compliance Information](#) webpage for details.

#### **How many cases will be reviewed for a network? Is this determined by the number of facilities?**

Each hospital in an Integrated Network Cancer Program (INCP) will have 7 charts assessed per standard. The INCP will then be rated cumulatively. For example, an INCP with 10 hospitals would have 70 charts reviewed per standard (7 charts × 10 hospitals). 49 of the 70 charts assessed would need to meet all requirements to achieve 70 percent compliance, or 56 of the 70 charts to achieve 80 percent compliance. Compliance levels depend on the standard being assessed and the year of the site visit. Specific requirements can be found on the [Timeline and Compliance Information](#) webpage.

#### **If our facility rarely performs/does not ever perform a certain operation that is included in the operative standards, does that standard still apply to our facility?**

If a program has fewer than 7 charts within the scope of a specific standard, then all charts within the scope of the standard from the applicable timeframe will be reviewed by the site reviewer. For these programs, the threshold compliance level will be 70 percent for charts assessed at 2022 site visits and will increase to 100 percent starting with charts assessed at 2023 site visits. If a program has no charts within the scope of a specific standard, they are exempt from that standard.

#### **What is the penalty for not meeting compliance with the operative standards?**

If a program does not meet the compliance threshold, the program must complete a random sample review of 10 reports eligible for the noncompliant standard to determine whether the synoptic reporting format and technical requirements were met. Additional information can be found on the [Timeline and Compliance Information](#) webpage.

#### **What do I need to do to prepare for my next site visit? When do we need to start synoptic operative documentation?**

In 2022, programs must document their final plan for implementing Standards 5.3–5.6 at their institution. The [Implementation Plan Guidelines](#) outline recommendations for implementation plans for

Standards 5.3–5.6. Those plans should be documented in your cancer committee minutes and will be reviewed at site visits in 2023, 2024, and 2025. Sites should start synoptic operative documentation for compliance with Standards 5.3–5.6 by January 1, 2023. Assessment of operative reports will begin with site visits in 2024, which will review operative reports from 2023. The CSSP has developed an [Overview of Compliance Requirements & Site Visit Process](#) which further details compliance requirements for Standards 5.3–5.8 and the site visit process.

### **Can amended/addended reports meet the requirements of the CoC Operative Standards?**

While not recommended, amended or addended operative reports can meet the requirements of Standards 5.3–5.6. Likewise, amended or addended pathology reports can meet the requirements of Standards 5.7 and 5.8; however, reports should only be corrected when the change will affect clinical care.

### **Which date is used to determine case eligibility for the CoC Operative Standards?**

The date of the operative report (for Standards 5.3 through 5.6) or pathology report (for Standards 5.7 and 5.8) is used to determine whether a case is eligible for review for one of the CoC Operative Standards.

### **If a surgeon does a resection that would otherwise be within the scope of these standards, but does not know it is cancer at the time of the resection, and the resection ends up being cancer, do the standards apply to this case?**

If the cancer is unknown at the time of surgery, then the case is not included in the scope of these standards.

## Synoptic Reporting

### **What is a synoptic report?**

A synoptic report is a document that has standardized data elements organized as a structured checklist or template. The value for each data element is “filled in” using a pre-specified format. The purpose of the synoptic report is to format information in a manner where information can be easily collected, stored, and retrieved.

### **Why is synoptic reporting important?**

Synoptic reporting has repeatedly been shown to improve both the completeness and the accuracy of clinical documentation.<sup>1–3</sup> Reporting accuracy and completeness is of particular importance in cancer

<sup>1</sup> Eryigit Ö, van de Graaf FW, Lange JF. A Systematic Review on the Synoptic Operative Report Versus the Narrative Report in Surgery. *World J Surg*. 2019;43(9):2175-2185.

<sup>2</sup> Stogryn SE, Hardy K, Mullan MJ, Park J, Andrew C, Vergis A. Synoptic operative reporting: assessing the completeness, accuracy, reliability, and efficiency of synoptic reporting for Roux-en-Y gastric bypass. *Surg Endosc*. 2018;32(4):1729-1739.

<sup>3</sup> Messenger DE, McLeod RS, Kirsch R. What impact has the introduction of a synoptic report for rectal cancer had on reporting outcomes for specialist gastrointestinal and nongastrointestinal pathologists? *Arch Pathol Lab Med*. 2011;135(11):1471-1475.



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care where multiple providers are involved in the care of a single patient and any omissions or inaccuracies in surgery or pathology reporting may adversely impact downstream decisions. It has also been shown to improve the ability for downstream functions such as registry extraction and compliance. While more long-term experience and critical assessment is available for synoptic pathology reports, there are also abundant reports showing the benefits of synoptic operative reports. The [Operative Standards Toolkit](#) includes a number of publications on synoptic operative reporting. We encourage programs to review these references and share with pertinent staff.

### **Is the use of routine phrases the same as a synoptic report?**

In contrast to narrative reporting, synoptic reporting uses a checklist format—though synoptic reports may have data elements that allow for free form text to be entered. Routine narrative phrases are most commonly used to reduce the burden of reporting in narrative format when an activity or description is the same from one surgery to the next, and typically consist of sentences copied into a narrative operative report. Such phrases may include information about routine placement of incisions or ports, or they may be used to repeat information that is also documented by anesthesia or nurse providers. Although synoptic reports can be constructed using “smart text” phrases, routine phrases used within a narrative report generally do not serve the same function, nor do they typically ensure that information unique to the patient is captured in a standardized format.

### **Is the synoptic operative report different from the synoptic pathology report?**

The synoptic operative report documents details of a surgical procedure and is different from the synoptic pathology report, which collects pathologic information on specimens. Standards 5.3, 5.4, 5.5, and 5.6 require specific data elements/responses in synoptic format in the operative report. Standards 5.7 and 5.8 require specific data elements/responses in synoptic format in the pathology report.

### **Do the synoptic reports need to be a separate note, or can these elements be baked into a standard descriptive operative report as a separate section as long as it meets the language and specifications?**

The required elements and responses need to be in the operative note. It can be part of your standard operative note or embedded into your narrative operative report, but the synoptic section must be distinct and have all the required elements/responses together in synoptic format. A uniform synoptic reporting format should be used by all surgeons at the facility.

### **Can the required synoptic information be in the immediate post-op note/brief op note and still be compliant?**

No. To demonstrate compliance with CoC standards, the elements/responses required for CoC accreditation must be included in synoptic format in the operative report of record. The only exception is for programs utilizing the fillable PDF option, which is intended as a stop gap measure for institutions who cannot otherwise create synoptic reports to meet these standards for January 2023 requirements. Additional information can be found on the [Implementation Options](#) webpage.



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**Are we only required to put the elements/responses that are listed in each standard in the updated 2020 Standards Manual into the synoptic report? Or is there more information required to be in the synoptic report?**

To be compliant with CoC Standards 5.3–5.6, in addition to fulfilling the surgical/technical measures of compliance, the required elements and responses listed in the [2020 Standards](#) must be included in the operative note in synoptic format. No additional information is required to be in the operative note in synoptic format.

**Can my program modify the elements/responses from Standards 5.3–5.6 for our operative reports?**

To be found compliant with CoC Standards 5.3–5.6, synoptic operative reports must use the exact wording as the data elements and responses listed in the 2020 Standards. However, programs may add more data elements and responses as desired. These additional data elements would not impact compliance.

**Do you anticipate that the synoptic report will replace the narrative report or be added to the narrative report?**

A basic synoptic report that includes only the required CoC elements/responses cannot replace the narrative report. However, more generally speaking, synoptic reporting can be made fully comprehensive in a manner that can replace narrative reports. A more comprehensive report, such as that now offered through [third-party vendors](#), can replace the narrative report if a surgeon so chooses. The templates developed by the ACS CSSP are designed to capture the most important aspects of surgical care and meet many surgical reporting requirements. These templates allow for the addition of narrative text for purposes of capturing findings or other details the surgeon feels important to include.

**On the day of the site visit, how will the site reviewer review the operative reports?**

Operative and pathology reports may either be uploaded to a secure, HIPAA-compliant platform provided by the program OR a HIPAA-secure videoconference may be set up during which the program navigates through the required components of the medical record for each case selected by the site reviewer. Note: Pathology and/or operative reports cannot be uploaded into the Quality Portal (QPort). Medical record information must be uploaded to a HIPAA-secure platform.

**Is it expected that the synoptic format be built in such a way that data reports can be built/pulled to assess the compliance? It sounds like the review will be more manual by the CoC site reviewer.**

Yes, the review process will be more manual to assess the elements and responses. Ideally, for the future, the responses will be digitalized so sites can mine that data/information to assess quality metrics and for other purposes. However, for the purposes of assessing compliance with Standards 5.3–5.6, starting with site reviews in 2024 (looking at operative reports from 2023) as long as operative reports include the required elements/responses, that measure of compliance will be fulfilled. Please refer to the [Implementation Options](#) for all compliance criteria.



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**Are any of these options for CoC programs to meet the synoptic reporting requirements of Standards 5.3–5.6 free?**

Creating your own templates, by only including the required elements and responses from the CoC Standards Manual, does not involve any cost to programs. Additionally, the fillable PDF forms available for download from the Standards Resource Library (accessed through [QPort](#)), for programs unable to otherwise create synoptic reporting to meet these standards, are free of charge. Additional information can be found on the [Implementation Options](#) webpage.

**What EMR vendors will have the templates?**

Epic is offering the required data elements and responses for CoC Standards 5.3–5.6 in the Epic Foundation System starting in Q2 of 2022. In addition, a select number of [third-party vendors](#) have relationships with most of the major EMR vendors. Please contact them directly for more information and to see if their tools will work with your EMR system. In terms of integrating the templates directly into your existing EMR, we suggest that you reach out directly to your EMR contact to make this request. ACS is in discussions with additional major EMRs to get this content incorporated into their systems.

**Do you have any sense of timelines around when the major EMR vendors might have content available?**

We would encourage you to reach out to your EMR representative for timelines on availability of this content within their systems.

**Has any program estimated the cost of the complete implementation?**

To date, we do not have an estimate of the cost of complete implementation.

**Given the plans for future standards, how are you preparing EMR vendors to be agile for your future plans?**

The ACS has been in discussions with the EMR vendors about the requirements for these standards and the future of operative standards and synoptic reporting since early 2020.

**If my institution's EMR has a character limit on data elements/responses, are we able to shorten them and still be compliant with Standards 5.3–5.6?**

If your EMR has a character limit, your institution can abbreviate the element and/or responses. However, the original language of the standard should be replicated as closely as possible. This modification is only permitted if your EMR has these limitations, and we recommend a more comprehensive synoptic reporting tool in the long run.

**Are there plans for more than 2 pathology-based surgical standards, or additional pathology reported data elements? Or are plans to stick with the operative notes only in the future?**

While there are currently only two CoC accreditation standards that assess pathology reports (Standards 5.7 and 5.8), additional standards may be built in the future which are best evaluated by data in the pathology report. The CSSP is focusing on building out synoptic operative reporting templates, as synoptic pathology reporting templates are already developed by CAP.



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### **Are there articles published in surgical journals about these standards and the use of templates?**

Yes, two articles have been published in the *Annals of Surgical Oncology*: [Technical Standards for Cancer Surgery: Improving Patient Care through Synoptic Operative Reporting](#) and [Technical Standards for Cancer Surgery: Commission on Cancer Standards 5.3–5.8](#). These articles provide background on the operative standards, and their integration into synoptic operative report templates. Manuscripts on select operative standards from the CoC Standards Manual as well as the [Operative Standards for Cancer Surgery](#) manuals have also been published. In addition to these efforts, there already exists robust literature about the benefits of synoptic reporting in general. These references can be found in the “References and Suggestions for Further Reading” section of the [Operative Standards Toolkit](#).

## Cancer Surgery Standards Program (CSSP)

### **What is the Cancer Surgery Standards Program (CSSP)?**

The Cancer Surgery Standards Program (CSSP) is one of the seven ACS Cancer Programs. The CSSP aims to improve the quality of surgical care by setting evidence-based standards for the technical conduct of oncologic surgery and educating surgeons to help them meet those standards. To support implementation and adherence, the CSSP builds and disseminates tools, including synoptic operative report templates. You can read more about the CSSP at [facs.org/cssp](https://facs.org/cssp).

### **How is the CSSP related to the Commission on Cancer? Is it an accreditation program?**

The CSSP develops synoptic operative reporting templates and educational resources to help CoC-accredited facilities implement the operative standards. The CSSP is not an accreditation program and will not require programs to enroll.

## Other

### **What other cancer operations will be added to the operative standards in the future?**

For now, the focus is on Standards 5.3–5.8 and ensuring that CoC sites have the resources they need to be compliant with the existing standards. However, beginning in 2026, the CoC 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 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.

### **Are there plans for synoptic radiology reports in the future?**

There are no plans for incorporation of synoptic radiology reports into the CoC Standards at this time.

**Standard 5.3 – Sentinel Node Biopsy for Breast Cancer**  
**Standard 5.4 – Axillary Lymph Node Dissection for Breast Cancer****Do Standards 5.3 and 5.4 include all histologies for breast cancer (e.g., infiltrating ductal, lobular, inflammatory etc.)?**

CoC Standards 5.3 and 5.4 apply to all cases with breast cancer where a sentinel lymph node surgery or axillary lymph node dissection is performed. If a sentinel node is not removed due to an older age, then that case would not apply.

**Are the synoptic operative reports required only for breast cases with SLNB or axillary LND? (For example, if no LNs are removed, does this mean that no synoptic operative reports are required?)**

Both Standard 5.3 and 5.4 require specific data elements/responses in synoptic format in the operative report. If axillary nodal surgery (SLN or ALND) is not performed and if nodes are not removed, CoC Standards 5.3 or 5.4 do not apply.

**Will both blue and radioactive SLN be required for compliance with Standard 5.3?**

Dual tracer is not required by Standard 5.3 to remove all sentinel nodes. However, the most accurate method employs a dual tracer technique.

**Does Standard 5.3 require that patients who have undergone neoadjuvant chemotherapy and clip placement have the clipped node removed?**

Standard 5.3 does not require the clipped node to be removed. To achieve compliance, the documentation will need to include whether the clipped node was removed or was not removed.

**Do Standards 5.3 and 5.4 apply to DCIS cases?**

Yes, CoC Standards 5.3 and 5.4 apply for procedures done for DCIS.

**What is the standard for nodes outside of the axilla? Do these need to be removed for Standard 5.4?**

CoC Standard 5.4 does not cover nodes outside of the axilla. These do not need to be removed to meet the standard.

**What are the requirements for Standards 5.3 and 5.4 in cases of bilateral breast cancer?**

In cases of bilateral breast cancer, the synoptic elements and responses should be completed for each side. Each side should be clearly labeled as right or left.

**If a positive node is found on frozen section during the sentinel node procedure and an axillary dissection is performed, are both synoptic operative reports for sentinel node biopsy and axillary dissection required?**

Yes, if both procedures fall within the scope of the standards, the synoptic reporting requirements for both Standard 5.3 and 5.4 would apply.

**Does a targeted axillary dissection, defined as removal of a target/clipped node plus a sentinel lymph node biopsy, fall within Standard 5.4?**

Target axillary dissections would be included as part of Standard 5.3 (Sentinel Node Biopsy for Breast Cancer) and not for Standard 5.4 (Axillary Lymph Node Dissection for Breast Cancer).

**Standard 5.5 – Wide Local Excision for Primary Cutaneous Melanoma****If a surgeon takes a margin wider than recommended in Standard 5.5, is this a problem or issue with compliance? For example, a tumor with a 0.6mm Breslow thickness having a 2cm inked/excised margin when the standard only recommends 1cm margin.**

As indicated in the Measure of Compliance for Standard 5.5, clinical margin width for wide local excision should be 1 cm for invasive melanomas less than or equal to 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, e.g., presence of satellite lesions. However, margins wider than those set by Standard 5.5 are not compliant. The threshold compliance rate is less than 100% to account for these exceptions.

**Regarding melanoma in-situ cases, the NCCN guidelines have a range for the recommended clinical margins from 5 to 10 mm whereas CoC Standard 5.5 simply says, "at least 5 mm". Can margins be of any size and still fulfill the requirements of Standard 5.5?**

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 1cm.

**What do we do when a dermatologist has done a shave biopsy on melanoma?**

The definitive surgical resection margin is the goal of Standard 5.5 and is based upon the Breslow depth of the biopsy, even if it is a shave biopsy.

**What if the depth of melanoma was deeper on the final pathology than on the initial biopsy diagnosing the melanoma regarding the wide local excision margin?**

Standard 5.5 sets margins for wide local excision based on the Breslow thickness of the primary tumor as indicated on the initial biopsy pathology report. The CoC revised the language of Standard 5.5 in early 2021 to clarify this definition.

**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, and the case would be submitted for your hospital's analytic caseload, then the WLE would be included in the scope of Standard 5.5. This is regardless of who is performing the procedure.

**Can Mohs performed on invasive melanoma be compliant with CoC Standard 5.5?**



Standard 5.5 requires wide local excision for invasive melanoma to have the appropriate clinical margin width (based on the original Breslow thickness of the lesion, as detailed in the standard) and depth (full-thickness skin and subcutaneous tissue down to fascia). If these requirements are not met, whether because of Mohs procedure or otherwise, then the wide local excision would not be compliant.

**When a surgeon is performing reoperation for involved/close margins of a melanoma initially resected prior to referral, does Standard 5.5 apply?**

Repeat wide local excisions being performed for involved/close margins are outside the scope of Standard 5.5. However, this is distinct from performing a wide local excision after a diagnostic excisional biopsy, which is the index operation for Standard 5.5.

## Standard 5.6 – Colon Resection

**How are colectomies performed on an emergent basis measured and tracked? How does this standard apply to truly emergent operations for obstruction?**

Standard 5.6 applies to "all resections performed with curative intent for patients with colon cancer and applies to all approaches." An indication for emergent surgery, (e.g., obstruction) does not necessarily preclude the performance of proximal vascular ligation and en bloc lymphadenectomy. If the high ligation cannot be performed due to an "emergency situation", then it should be documented in the operative note (or in a narrative portion of the synoptic report).

**Do two colon primaries require two synoptic reports (if the surgery is at the same time)?**

If the surgeon performs one resection with two primary tumors, one synoptic report would be required. If two resections are performed with two primary tumors, two synoptic reports would be required.

**For the “Extent of colon and vascular resection” data element required for Standard 5.6, what should be documented if the resection that was performed does not correlate with any of the options listed?**

The focus of Standard 5.6 is on the proximal vascular ligation at the origin of the primary feeding vessel(s). Surgeons can use the “Other” response option any time the resection is not one of those described by the other listed response options and describe the extent of the colon and vascular resection as part of their explanation.

**If a neuroendocrine tumor occurs in the colon, does Standard 5.6 apply?**

Standard 5.6 applies to adenocarcinomas, not neuroendocrine tumors.

## Standard 5.7 – Total Mesorectal Excision

**Will the synoptic report format for Standard 5.7 be shared with CoC facilities for pathology to use?**

The rectal synoptic pathology report can be accessed for free via the [College of American Pathologists \(CAP\) website](#).



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**How will mid and low rectal cancer cases be selected for compliance with Standard 5.7? Will all rectal cancer cases need to be provided?**

Programs will provide an accession list of all eligible rectal cancer patients that underwent surgery during the period being reviewed. The site reviewer will preselect 7 cases for review. If any of the cases selected were for cancer in the high rectum, the program will notify the site reviewer to select additional cases so that only mid and low cancers are reviewed.

**How can a registrar tell if the rectal tumor location is low to mid since rectum only has one primary code site? Does the CAP pathology report have a field for tumor location?**

This information can be found in the NAPRC synoptic reports (if applicable) or in the CAP pathology report. In the NAPRC synoptic report, the “Location of tumor within rectum” data element will specify high, middle, or low. In the CAP pathology report, a response of “Entirely above anterior peritoneal reflection” to the “Rectal Tumor Location” data element indicates a high rectal tumor response.

**What surgery code ranges should be used to identify cases that need to be compliant with Standard 5.7?**

Standard 5.7 applies to surgical procedures assigned a Code 30 or higher. Please be sure that you are referencing the most current, recently updated versions of the CoC Standards and STORE manuals and refer to the Scope of the Standard section to help identify cases and evaluate compliance with Standard 5.7.

**Should surgeons or pathologists take pictures 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 the CAP protocol for all our cases, should our program be at 100% compliance with Standard 5.7?**

CoC-accredited programs must meet ALL of the measures of compliance under Standard 5.7 for 70% of cases starting January 2021 in order to be compliant with the standard. 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 is only the pathology report assessed for this standard?**

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. We also encourage communication amongst surgeons, pathologists, and registrars to optimize documentation for appropriate cases. 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.

**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 revised Standard 5.7 in early 2021 to align with the CAP cancer protocol template for rectal cancer resections. The revisions show that Standard 5.7 does not apply to primary resection specimens with no residual cancer (e.g., following neoadjuvant therapy).

**Do emergent cases due to obstruction count toward Standard 5.7?**

Although it is rare that an emergent rectal cancer operation (for bleeding, obstruction, or perforation) would be conducted for curative intent, if the operating surgeon states that the surgery is being conducted with curative intent then the standard will apply.

**Does Standard 5.7 apply to in situ lesions?**

No, in situ lesions are excluded from Standard 5.7.

## Standard 5.8 – Pulmonary Resection

**If a mediastinoscopy/EBUS is performed prior to the curative resection, can these procedures qualify for Standard 5.8, and do they have to be included within the curative resection pathology report or can they remain in a separate report to qualify?**

As endobronchial ultrasound (EBUS) does not remove nodes, those nodes do not count toward the requirements of Standard 5.8. Nodes biopsied during EBUS should be removed at surgery as additional confirmation of benign versus malignant pathology.

Nodes from mediastinoscopy must be included on the same pathology report as the lung resection to count toward the requirements of Standard 5.8. If nodes are sampled at the time of mediastinoscopy performed at a separate operation on a separate day prior to surgery, then those nodes would satisfy the requirement only if documented within the pathology report from the curative intent operation. It is recommended that when pathologists complete the CAP synoptic pathology report for the lung resection, they should also include mediastinal nodal histology results from any other setting. Nodal station must be identified. EBUS cytology alone does not comply for the standard.

In general, the surgeon should always strive to obtain lymph nodes from at least one hilar station and at least three distinct mediastinal stations. However, we recognize that there may be infrequent clinical situations in which the standard is not able to be achieved, which is why the threshold compliance rate is less than 100%.

**Do hilar nodes evaluated in the lobe with hilar nodes count as N1?**

Yes (which encourages pathology to do due diligence in their specimen dissection). Surgeons should not rely solely upon hilar nodes being found by their pathology colleagues and should conduct interlobar hilar nodal dissection as well (levels 10 and 11).

**Is needle biopsy with EBUS equivalent to removal or sampling of the nodes?**

Rarely, if ever, would EBUS be performed at the same setting as curative intent pulmonary resection because one cannot accurately rely upon needle specimen assessment with ROSE (rapid on-site evaluation) to change management in the minutes prior to moving on to major surgery. Furthermore, a



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negative EBUS assessment of a lymph node does not satisfy the requirement for surgical lymph node harvesting at the time of surgery (EBUS and mediastinoscopy always carry a risk of false negative sampling). This is, in fact, a specific intent of Standard 5.8; surgical lymph node harvesting minimizes the risk of false negatives by confirming nodes are truly benign or are in fact malignant despite preoperative clinical staging efforts.

**If the 2R and 4R packet is sent together, does this count as one N2 or two N2?**

The packet should be separated and labeled appropriately if the surgeon believes the nodes have been harvested from two separate lymph node stations (i.e., separate the 2R portion from the 4R portion if at all possible, and label accordingly). If the surgeon ultimately obtains mediastinal lymph nodes from at least 2 other stations (7, 8R, or 9R) then the point is moot given the goal of harvesting at least 3 different mediastinal nodal stations has been accomplished. The surgeon must take responsibility for appropriately and specifically labeling lymph nodes.

**If you send a fat pad from a station and label it but no nodes are found, does this count or not count as an N2 node?**

This will not satisfy the requirement for harvesting an N2 lymph node but is a realistic occurrence during these operations (one cannot always know for sure if a lymph node exists within a particular fat pad). Occasionally, lymph nodes will not be present or safely accessible during the conduct of an operation. The threshold compliance rate is less than 100% to take this infrequent occurrence into consideration. Surgeons should ideally document where they looked to harvest nodes, even if none were found in a particular station, to provide clarity to the extent of thoroughness during the surgery (e.g., “no lymph nodes were visible within the level 9L inferior pulmonary ligament station despite thorough dissection”).

**A pathologist-dissected intrapulmonary node is really quite different than a surgeon-dissected hilar node from a surgical quality metric. Can you confirm whether the pathologist-dissected intrapulmonary node satisfies the requirement?**

Yes, nodes dissected out from the primary lung specimen by the pathologist count as hilar lymph nodes for Standard 5.8. Ideally, however, the surgeon would obtain additional nodes from levels 10 and 11.

**When the 4R/2R packet is sent to pathology, surely it has to have a marker to determine the highest node and orientate?**

It is the surgeon’s responsibility to ensure harvested lymph nodes are labeled appropriately to allow for accurate pathologic assessment and documentation.

**We have found some situations where it was not appropriate to remove nodes (such as a small peripheral lesion wedged out in in a patient with significant comorbidities, or when nodes are densely adherent to a major vessel). Do you plan to publish some exceptions for these types of scenarios?**

We have set the threshold of compliance at 70% in the first year, and 80% in subsequent years to account for the inevitable and infrequent clinical situations in which the standard is not able to be achieved. Surgeons should always document when/why they could not obtain more lymph nodes (it happens to all of us on occasion, just as is implied in this particular question).



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**Will a fully completed CAP Pathology Checklist serve as compliance for 5.8? Are all the critical data elements in the CAP report?**

Programs must meet ALL measures of compliance under Standard 5.8 to satisfy the standard. This includes the surgical removal of the lymph nodes from the specific nodal stations listed in the standard.

**Does Standard 5.8 replace the 10RLN quality measure or will this still need to be monitored as well?**

The lung 10 node measure is not tracked in RCRS and has been retired.