

# 5.8 Lung NODES Year 2 Kickoff

February 14, 2025

# Logistics!

- Please mute yourself!
- Don't put us on hold!
- This meeting is being recorded, and slides will be available on the project website approximately 5-7 days post webinar

# Agenda

- Welcome
- Programmatic Reminders
- Data Review Year 1
- Year End Reflection Reflections
- Common Q and A
- Adjourn



# Introducing our Speakers



**David Odell, MD, MS, FACS**  
Section Head, Thoracic  
Surgery  
Department of Surgery  
University of Michigan



**Kelley Chan, MD, MS**  
General Surgery Resident,  
Loyola  
Clinical Scholar, ACS Cancer  
Programs



**Ryan Jacobs, MD, MS**  
General Surgery  
Resident, Northwestern  
University  
Postdoctoral Research  
Fellow, NQUIRES

# Programmatic Reminders

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# The QI Framework for Participation

- **The problem:** Data from CoC site reviews conducted in 2022 and 2023 reveal that compliance with standard 5.8 is lower than the 80% benchmark
- **Aim:** Participating CoC programs will increase compliance with Standard 5.8 by 20% over (original) individual baseline, or up to at least 80%
- **Data source:** Chart audit of synoptic pathology reports from applicable pulmonary resections
- **Measures:** % of reports with oncologic status of lymph nodes for at least one (names and/or numbered) hilar station and at least three distinct (name and/or numbered) mediastinal stations.
- **Interventions:** 5.8 toolkit, local innovations from previous collaboratives tested over time, spread and scaled
- **Stakeholders:** Thoracic surgeons, pathologists, medical oncologist, ODS's, CLPs and other frontline champions

# The 2025 Plan

- Submit data and attend calls, engage in collaborative discussion!
- Address your root cause
- Focus on sustainability
- Share your successes
  - A template will be provided to report out
- **Surgeon engagement is REQUIRED for all teams**
  - At least 1 surgeon from each facility must attend/ listen to a recording of 4 of 4 calls over the course of the year
    - They will complete a very brief survey monkey form attesting that they listened to the meeting, share feedback on the content

# Resource Reminders:

## Educational Webinars

Programs interested in participating in this national QI project are encouraged to view these informational webinars for more detailed information about the project. Attendance is requested by at least one member of each QI team, unless clinical care interferes. Recordings and slides are available through the links below. Registration is required to listen to recorded webinars.

### Year 1

December 7, 2023 - Informational Webinar

[View the Recording](#) | [View Webinar Slides](#)

March 22, 2024 - Lung NODES: Next Steps

[View the Recording](#) | [View Webinar Slides](#) | [Webinar FAQ](#)

May 31, 2024 - Root Causes and Success Case

[View the Recording](#) | [View Webinar Slides](#)

August 2, 2024 - From Assessment to Action

[View the Recording](#) | [View Webinar Slides](#)

October 25, 2024 - Year End Wrap Up

[View the Recording](#) | [View Webinar Slides](#)

### Year 2

CANCER PROGRAMS

## Operative Standards Toolkit

5 Min Print Share Bookmark

This toolkit includes resources to assist with the implementation of the six [Commission on Cancer \(CoC\) Operative Standards](#) in the [Optimal Resources for Cancer Care \(2020 Standards\)](#). Standards 5.3 through 5.8. Resources are organized by category or standard. CoC-accredited programs should share these resources with their staff to increase awareness and understanding of these accreditation standards. Please send any questions to [cssp@facs.org](mailto:cssp@facs.org).

## Frequently Accessed Resources

[Frequently Asked Questions on the CoC Operative Standards](#)

[Quick Reference Guide – Standards 5.3-5.6 Synoptic Operative Reporting Requirements](#)

[Overview of Compliance Requirements & Site Visit Process for CoC Operative Standards](#)

[CoC Standard 5.8: Requirements & Best Practices \(Video\)](#)

Question	Answer
1. Is this NSCLC only?	This standard applies to all primary pulmonary resections performed with curative intent for non-small cell lung cancer (NSCLC), small cell lung cancer (SCLC), or carcinoid tumors of the lung.
Are there plans for implementation of Lung Operative Note synoptic reports?	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.
Is a biopsy confirmation of Adenocarcinoma required for case inclusion into the standard?	As in question 1, the standard would apply if there is a cancer Dx (NSCLC, SCLC, Carcinoid). For NSCLC this could be adenocarcinoma, squamous carcinoma, large cell, poorly differentiated, etc. Metastatic carcinomas (e.g. colon adeno) would be excluded.
Does the operative report and/or the surgery consult need to state "Curative Intent"?	Intent should be assigned postoperatively by the operating surgeon on the basis of preoperative evaluation and intraoperative management, and is to be clearly documented in the operative report for any "curative intent" operation covered by this standard.
Asking as a pathologists, what is considered curative intent so as to know what cases are excluded from the standard?	Standards 5.3 through 5.8 apply 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 is to be clearly documented in the operative report for any operation covered by these standards. Curative operations generally include complete resection of the primary tumor and nodal evaluation for therapeutic or staging purposes.
	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



# Timeline

Date	Event
Jan 30	“Intent to participate” due
Feb 14	Group call at 12pm CT (Registration link to come)
February 28	<b>NEW PROGRAMS ONLY- Submit baseline data</b>
March 31	All programs- Dec 2024-Feb 2025 data due
April 11	Group call 12pm CST
May	
June 30	March 1-May 31 data due
July	
August 15	Group call 12pm CST
September 30	June-August data due
October 10	Group Call 12pm CST
November	
December 31	Sept-Nov data due

# Application of Standard 5.8 Project Credit

Site Visit Year	Application of Standard 5.8 QI Project Credit
<p><b>2024</b> (Reviews years 2021, 2022, 2023)</p>	<p>Sites receiving a deficiency in Standard 5.8 may use successful completion of the 5.8 QI Project to resolve the deficiency.</p>
<p><b>2025</b> (Reviews years 2024, 2023, 2022)</p>	<p>If the site achieves the required compliance percentage during the medical record review, the site will receive a Compliant rating.</p> <p>Sites that do not achieve the required compliance percentage during the medical record review but successfully completed the QI project in 2024 will receive a Deficient but Resolved rating.</p> <p>(Deficient but Resolved acknowledges that the standard was deficient but does not require the program to submit corrective action).</p>
<p><b>2026</b> (Reviews years 2025, 2024, 2023)</p>	<p>Sites can choose to only provide 2025 cases in the patient list for selection by the site reviewer.</p>
<p><b>2027</b> (reviews years 2026, 2025, 2024)</p>	<p>Sites can choose to only provide 2025 and 2026 cases in the patient list for selection by the site reviewer.</p>

# Inclusion/Exclusion Criteria \*Same as last year

## Include:

- Patients aged 18-99 undergoing curative intent lung resection for lung cancer: wedge, segmentectomy, lobectomy, bilobectomy, pneumonectomy

## Exclude:

- Patients undergoing lung resections for non-cancer diagnoses
- Patients undergoing lung resection without curative intent (e.g., biopsy)
- Patients undergoing lung resection for metastatic cancer to the lung

## Noncompliance means:

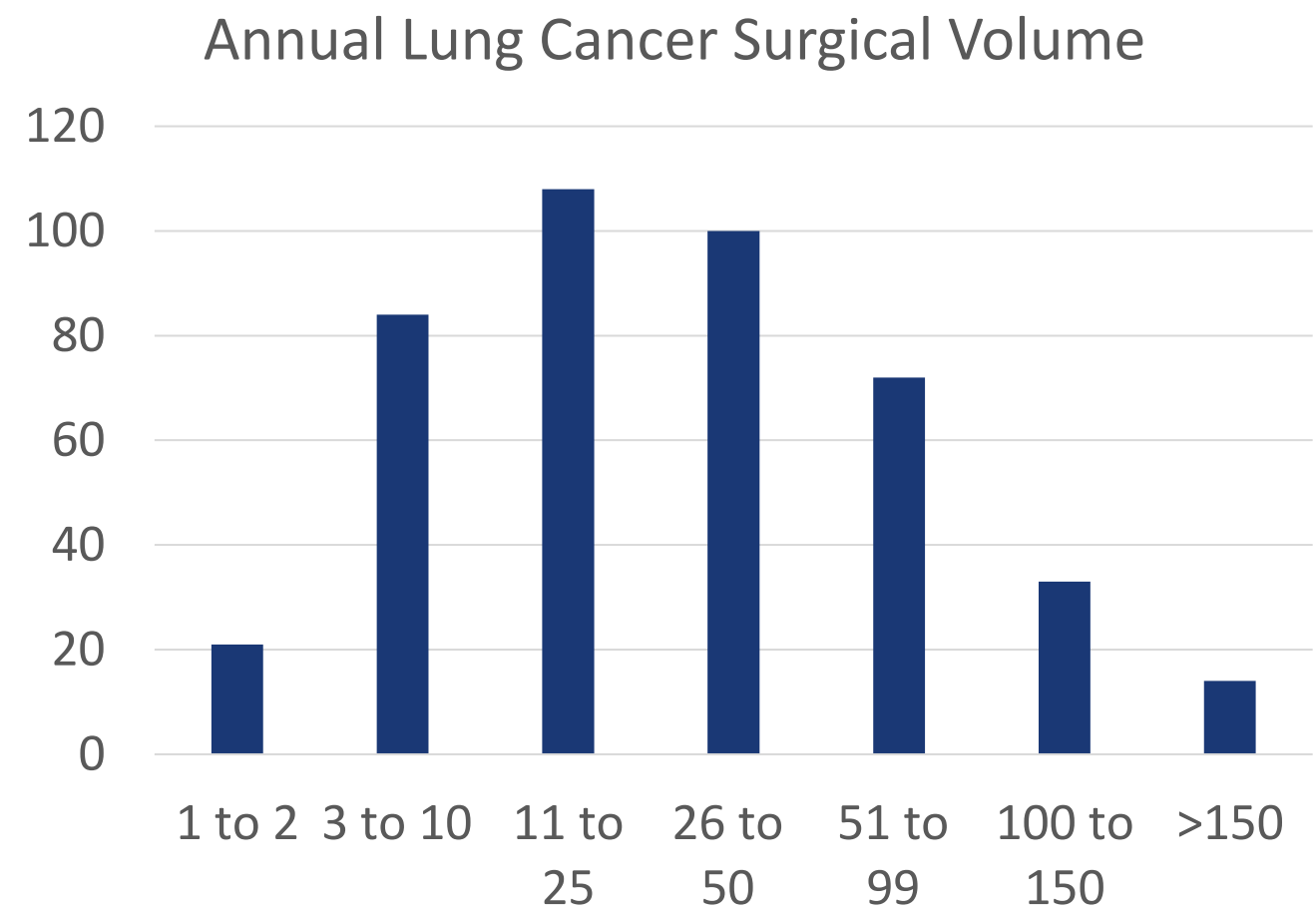
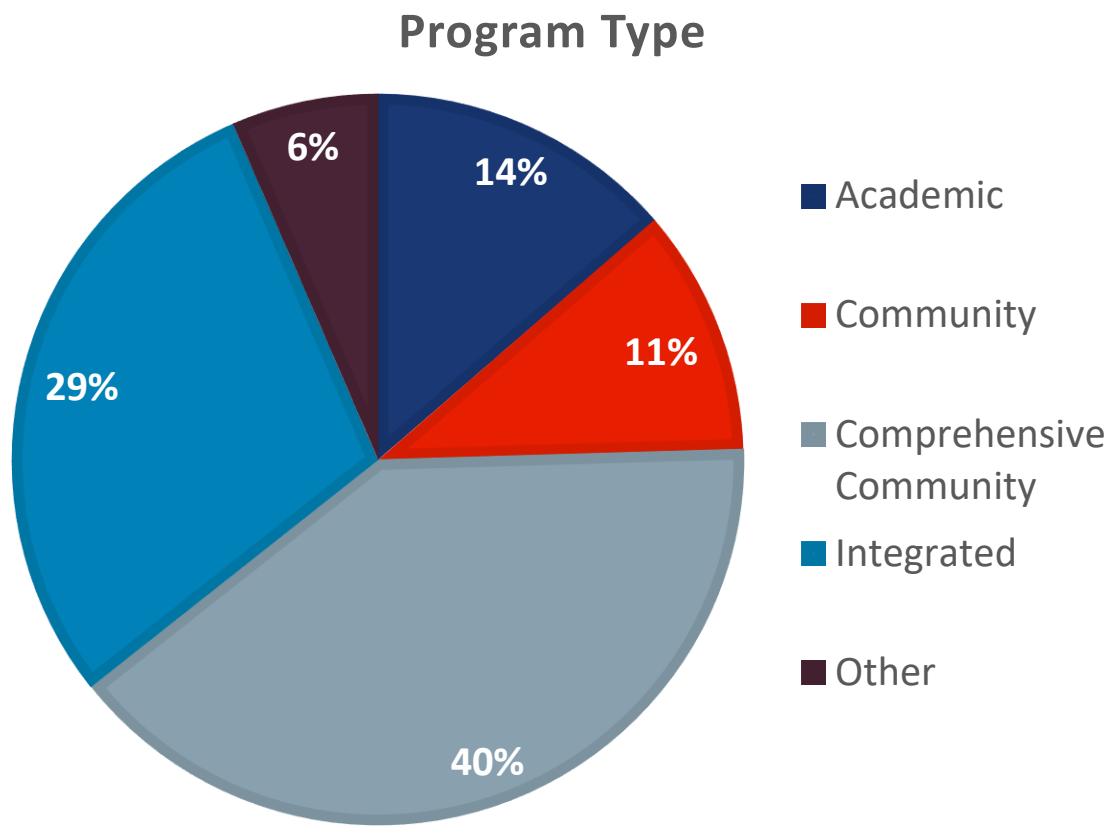
- Patient did not receive appropriate pulmonary nodal staging (at least one hilar station and at least three mediastinal stations)
- Required elements/responses were not documented in pathology report or not documented in synoptic format

# Program Accomplishments in Year 1

Kelley Chan, MD, MS

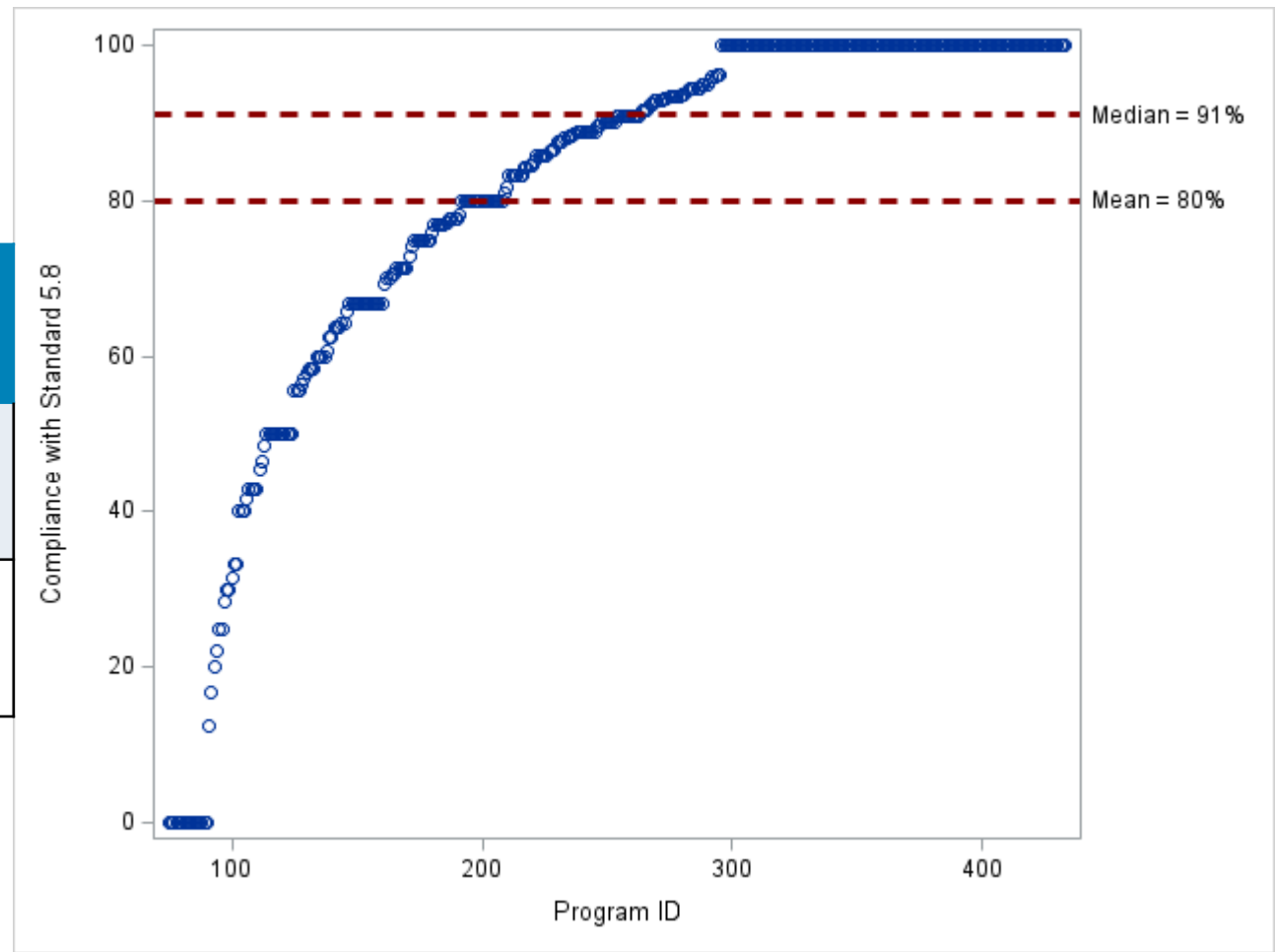
# Participating Programs Characteristics

- 432 programs



# Improvements in Program Level Compliance

	Base-line	March-May	June-Aug	Final	Difference
Median	65%	81%	87%	91%	26%
Mean	59%	72%	81%	80%	21%



# Program Level Compliance for Final Data Collection

- 359 programs submitted data
- Median compliance 90.9% from 87% (last data)
  - (IQR 70.6 to 100%)
  - **242 (67.4%) programs with compliance  $\geq 80\%$**
- 138 (40.6%) programs had an increase in compliance from last period
  - Median +17.0% (IQR 7.7 to 30.0%)
- 202 (59%) programs had no change or a decrease in compliance
  - 135 programs with compliance  $\geq 80\%$  [Median 0% (IQR -5.6 to 0%)]
  - 67 programs with compliance  $< 80\%$  [Median -16.4% (IQR -28.4 to -5.4%)]

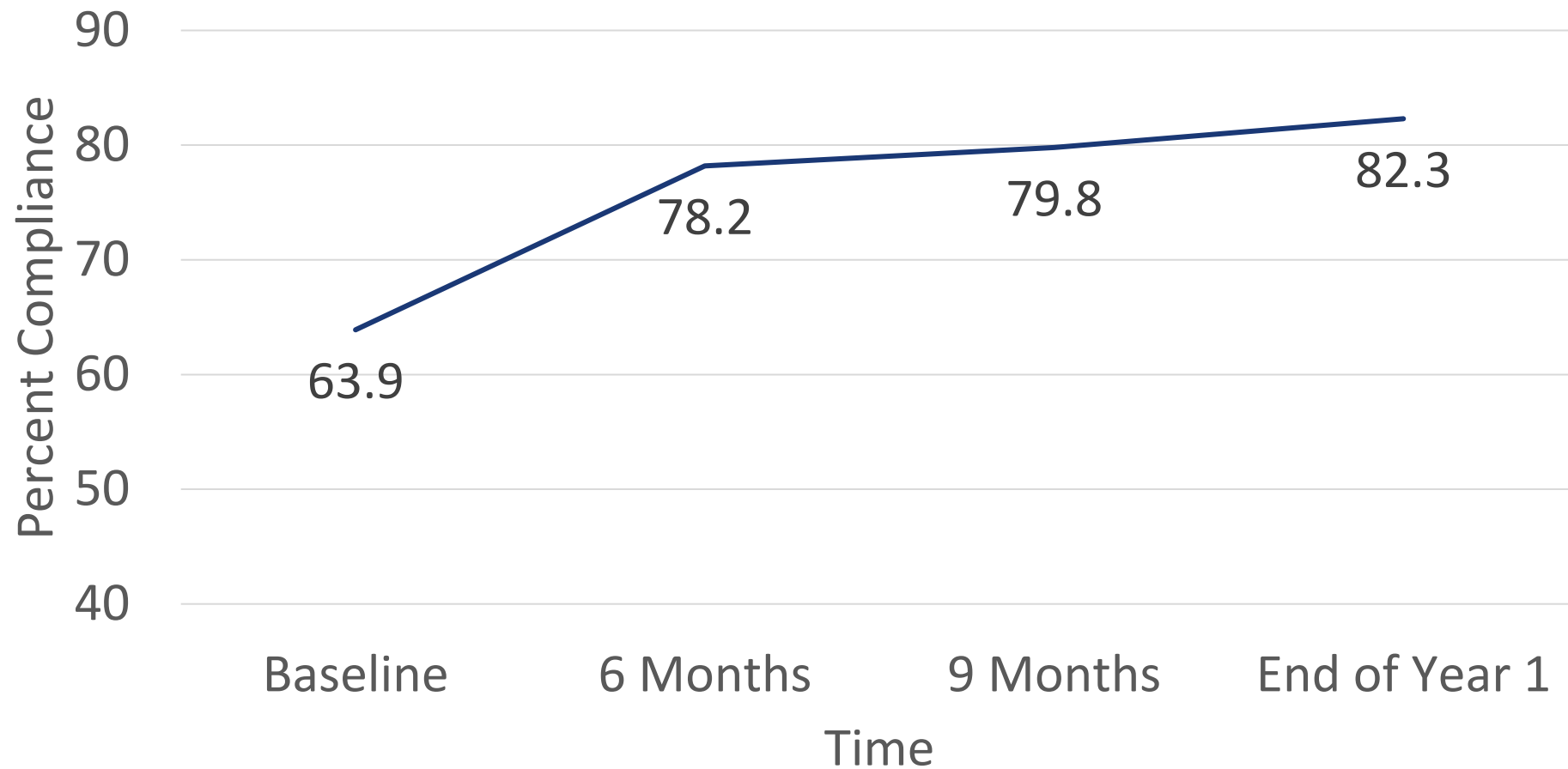
# Improvements by Annual Surgical Volume

Annual Case Volume	# Programs	Mean Baseline Compliance	# Programs	Mean Final Compliance
<b>1 to 2</b>	19	<b>40.5</b>	7	<b>92.9</b>
<b>3 to 10</b>	78	<b>45.2</b>	52	<b>75.8</b>
<b>11 to 25</b>	104	<b>62.2</b>	97	<b>79.2</b>
<b>26 to 50</b>	99	<b>65.5</b>	95	<b>82.7</b>
<b>51 to 99</b>	68	<b>66.0</b>	66	<b>78.8</b>
<b>100 to 150</b>	31	<b>75.8</b>	29	<b>88.1</b>
<b>&gt;150</b>	14	<b>72.4</b>	13	<b>76.2</b>



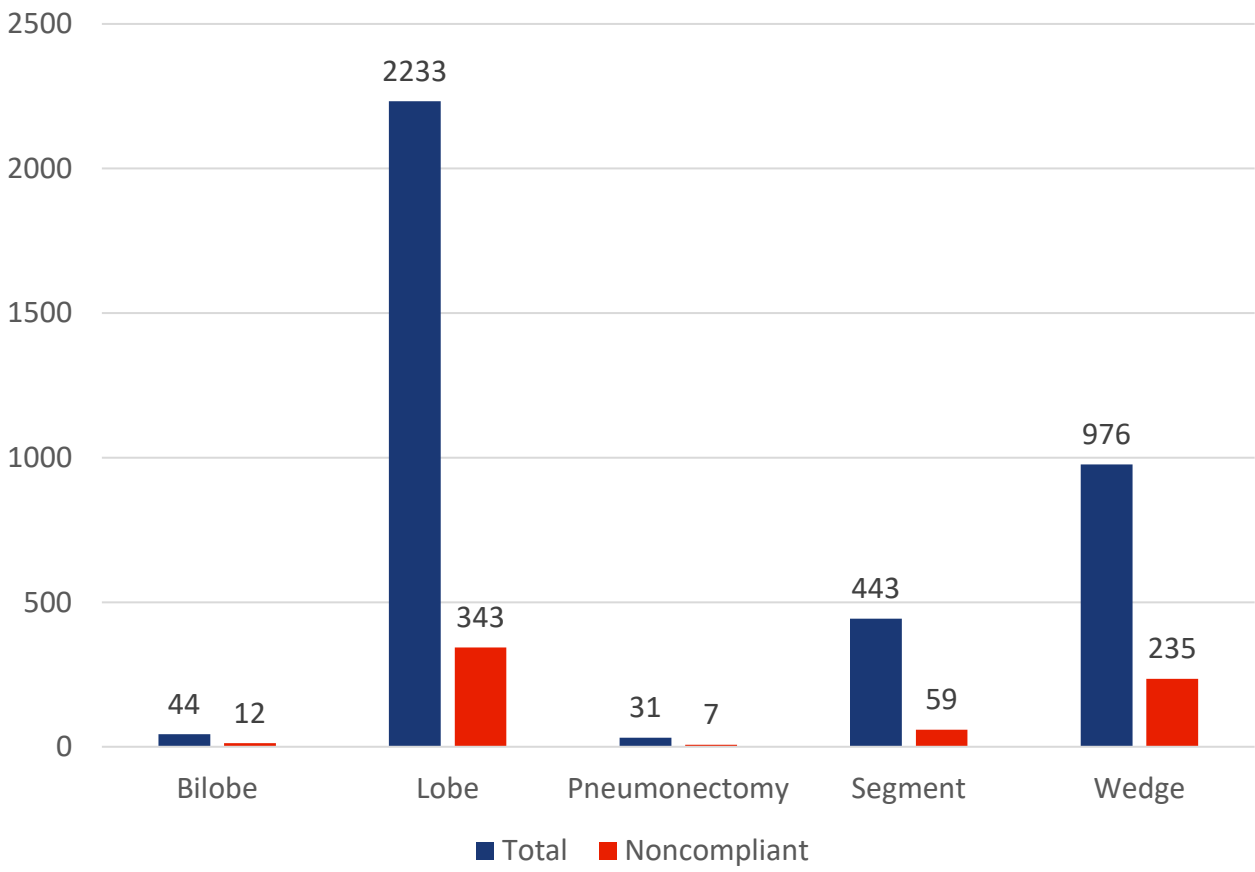
# Median Patient Level Compliance Over Time

- Total cases submitted over Year 1: 20,123



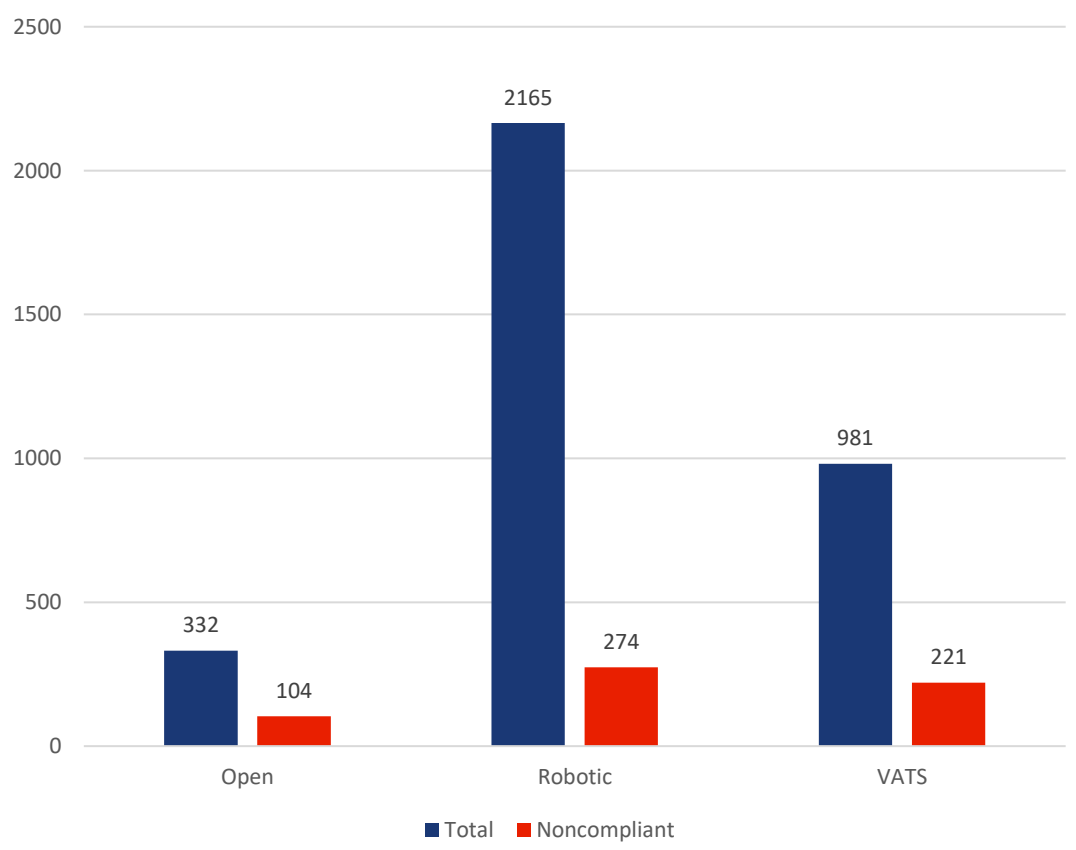
# Surgical Factors Associated With Noncompliance (Final Data Collection Period)

Surgery



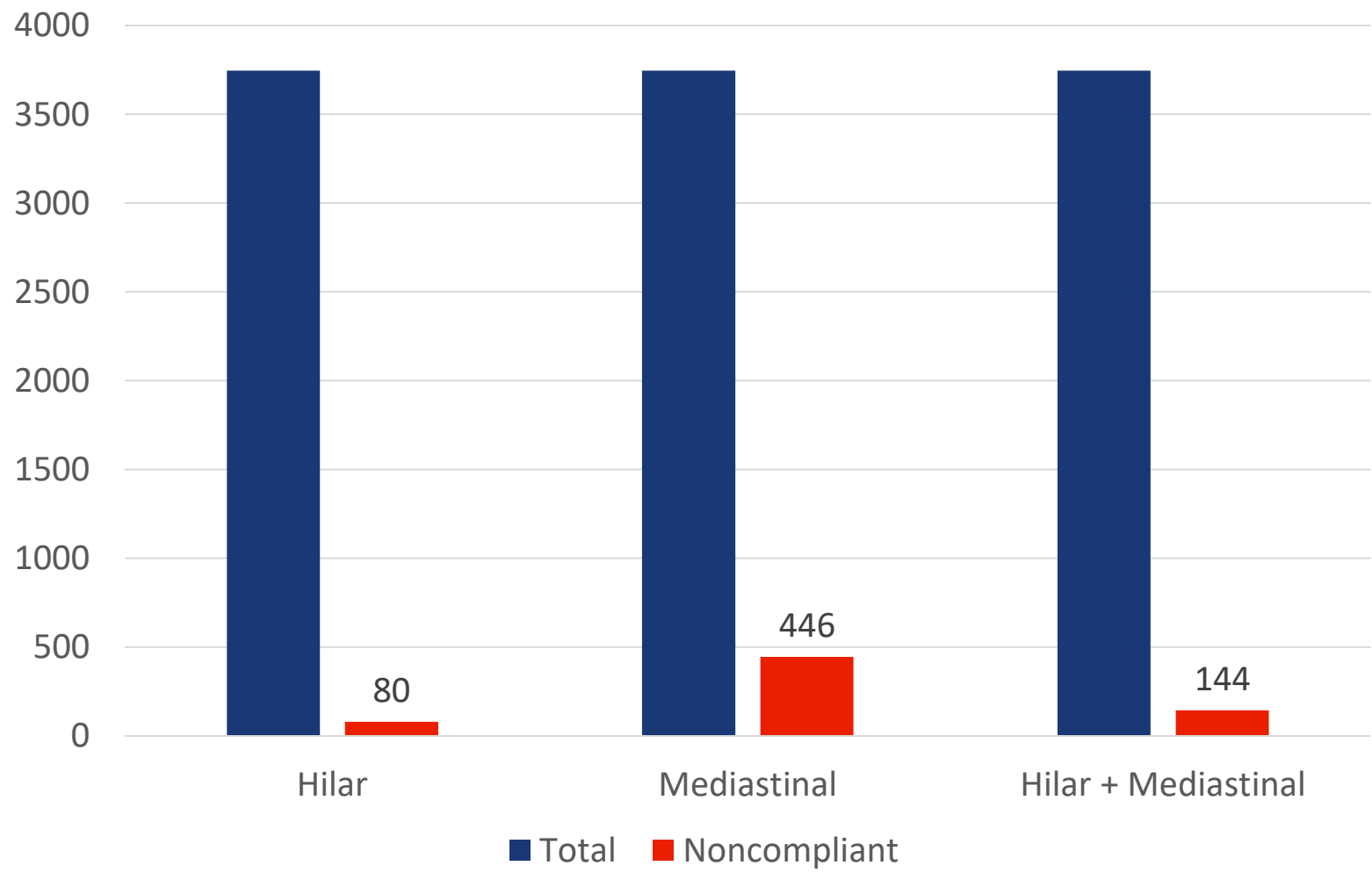
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Approach

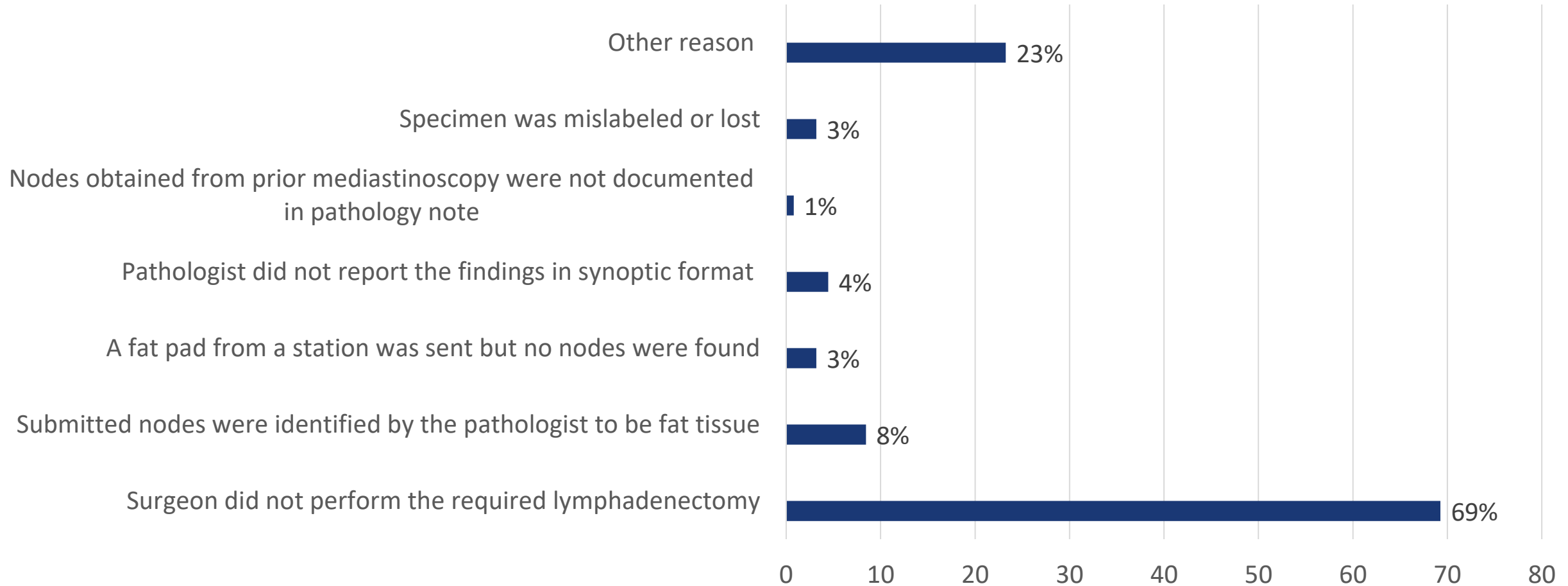


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# Lymph Node Stations Associated With Noncompliance (Final Data Collection Period)



# Reasons for Noncompliance



31 (4.7%) cases with >1 reason

# Other Listed Reasons for Noncompliance

- Patient factors: previous cancer resection, adhesions, bleeding
- Prior CT guided biopsy
- Prior ion bronchoscopy
- Exploration performed but could not identify lymph nodes
- No lymphadenectomy performed for carcinoid tumor
- Hilum dissection not performed for wedge resection

# Year End Reflection

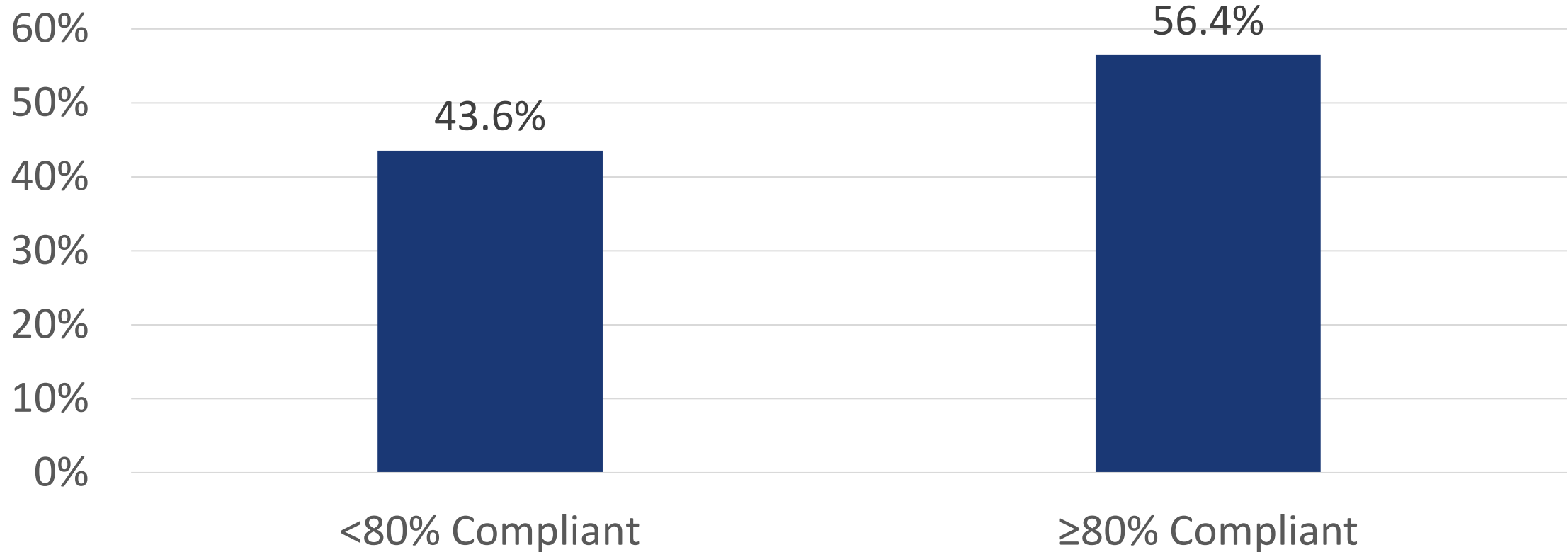
Ryan Jacobs, MD, MS

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# Demographics

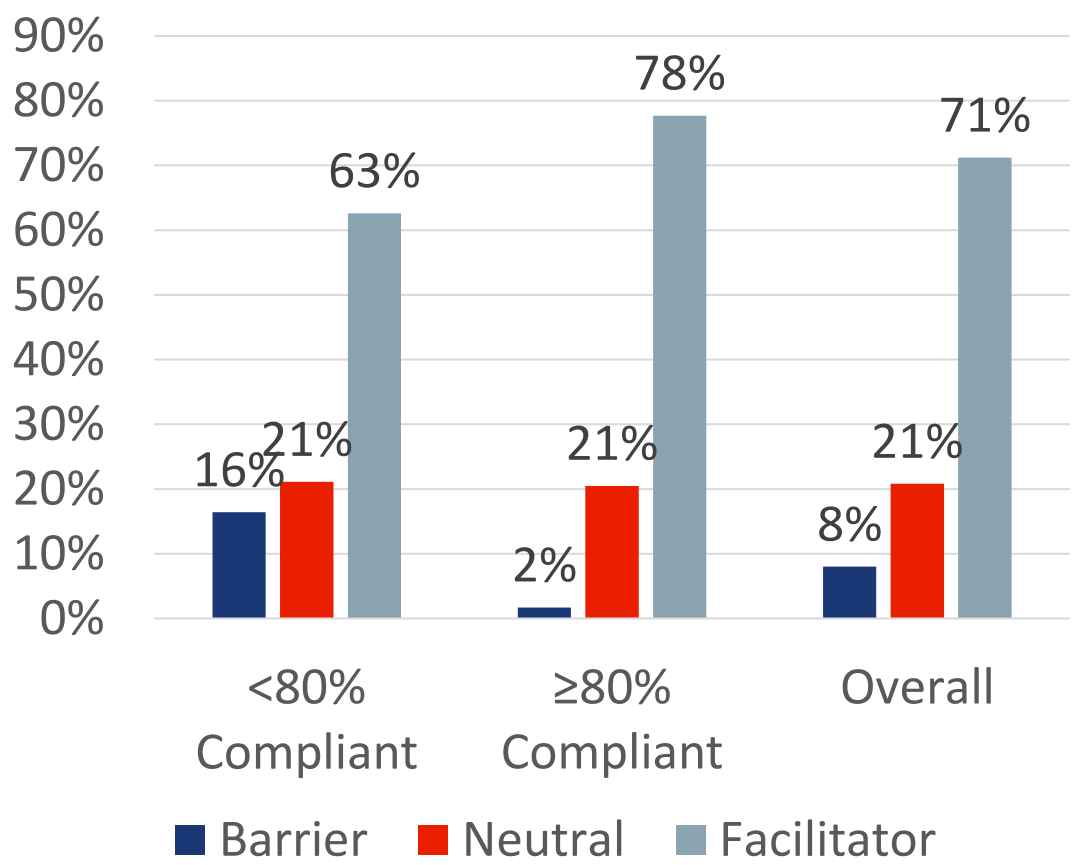
- N=411 responses (95% response rate)

Programs Compliant

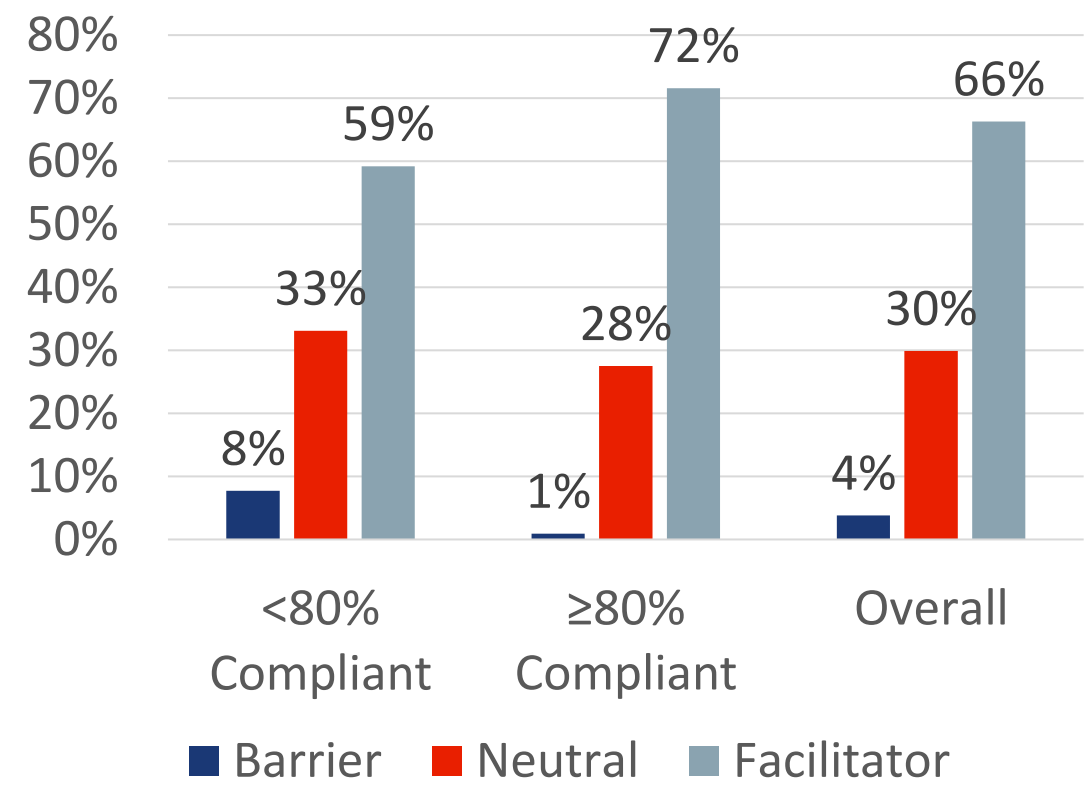


# Barriers and Facilitators

Surgeon Buy-In (p<0.001)



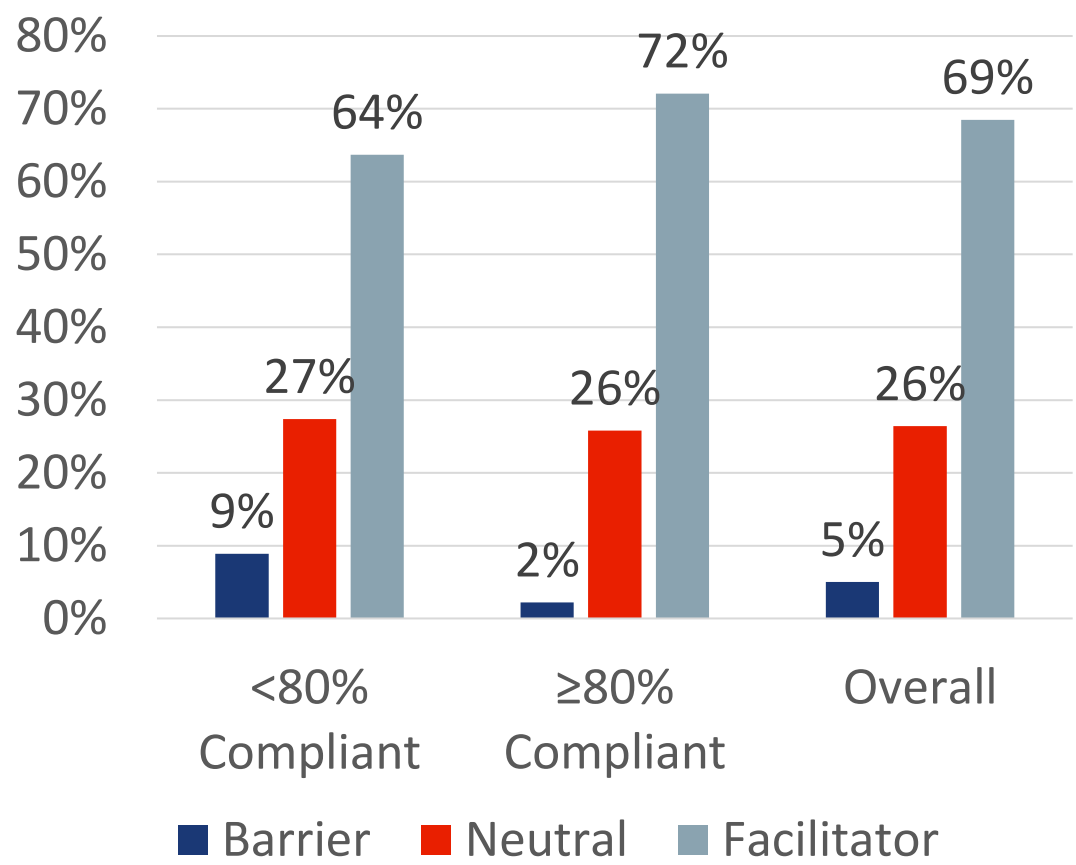
Surgeon + OR Team Communication (p<0.001)



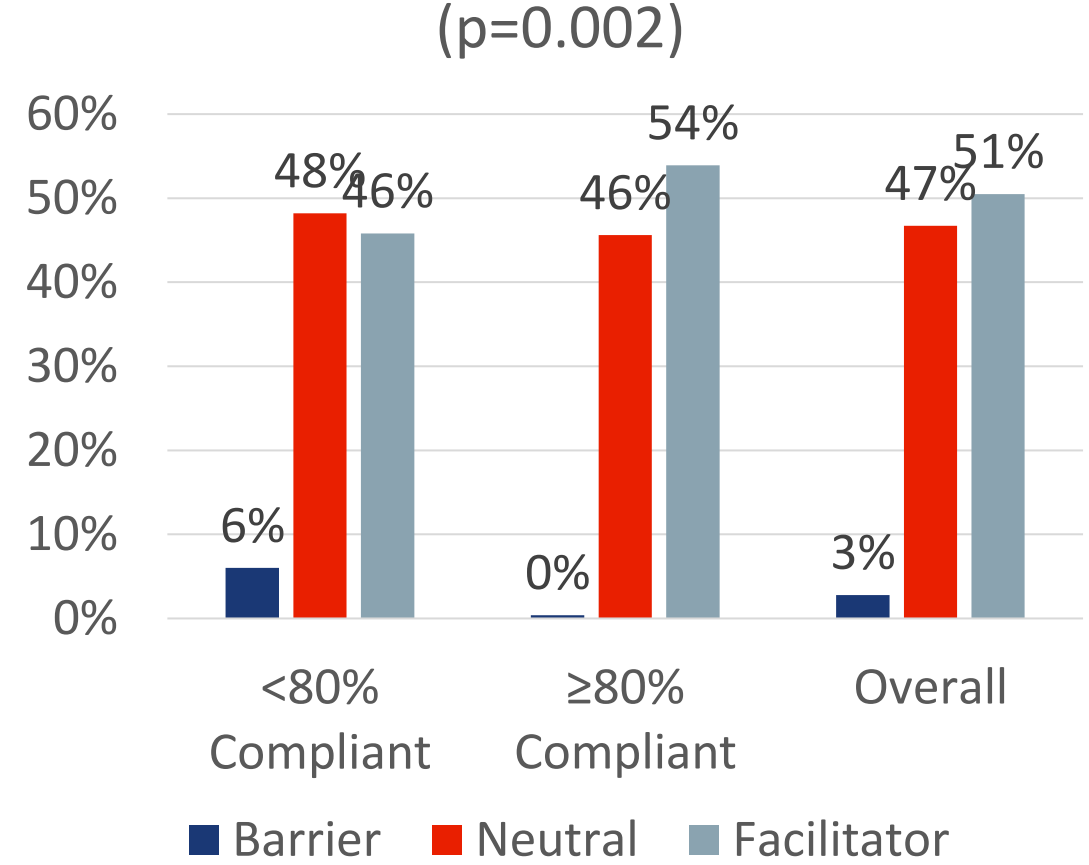


# Barriers and Facilitators (cont)

Specimen Labelling (p=0.007)

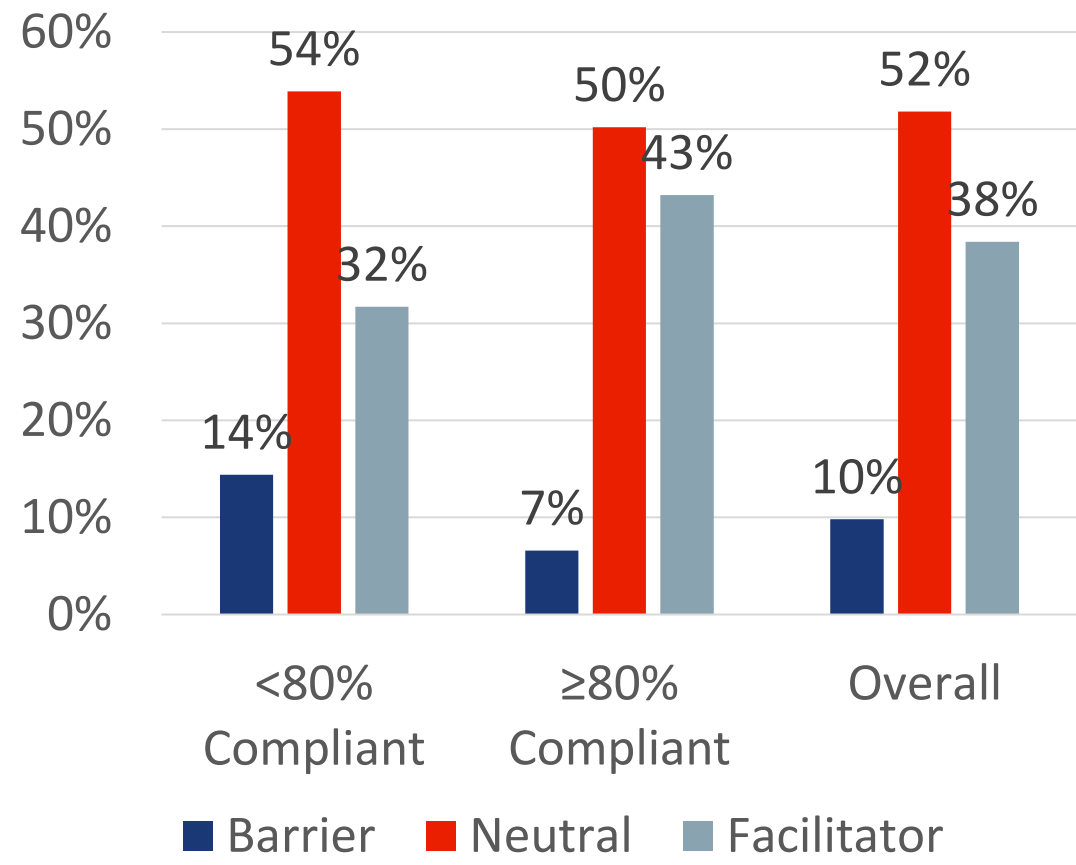


Anatomic Resection Cases (p=0.002)

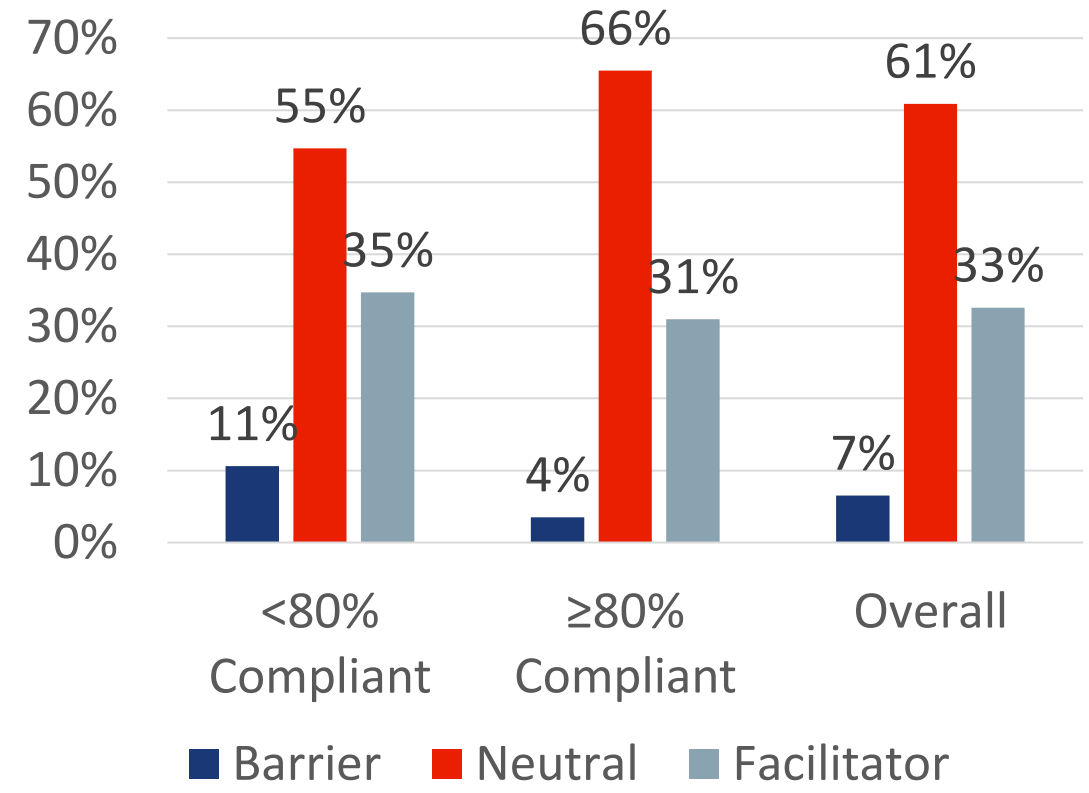


# Barriers and Facilitators (cont)

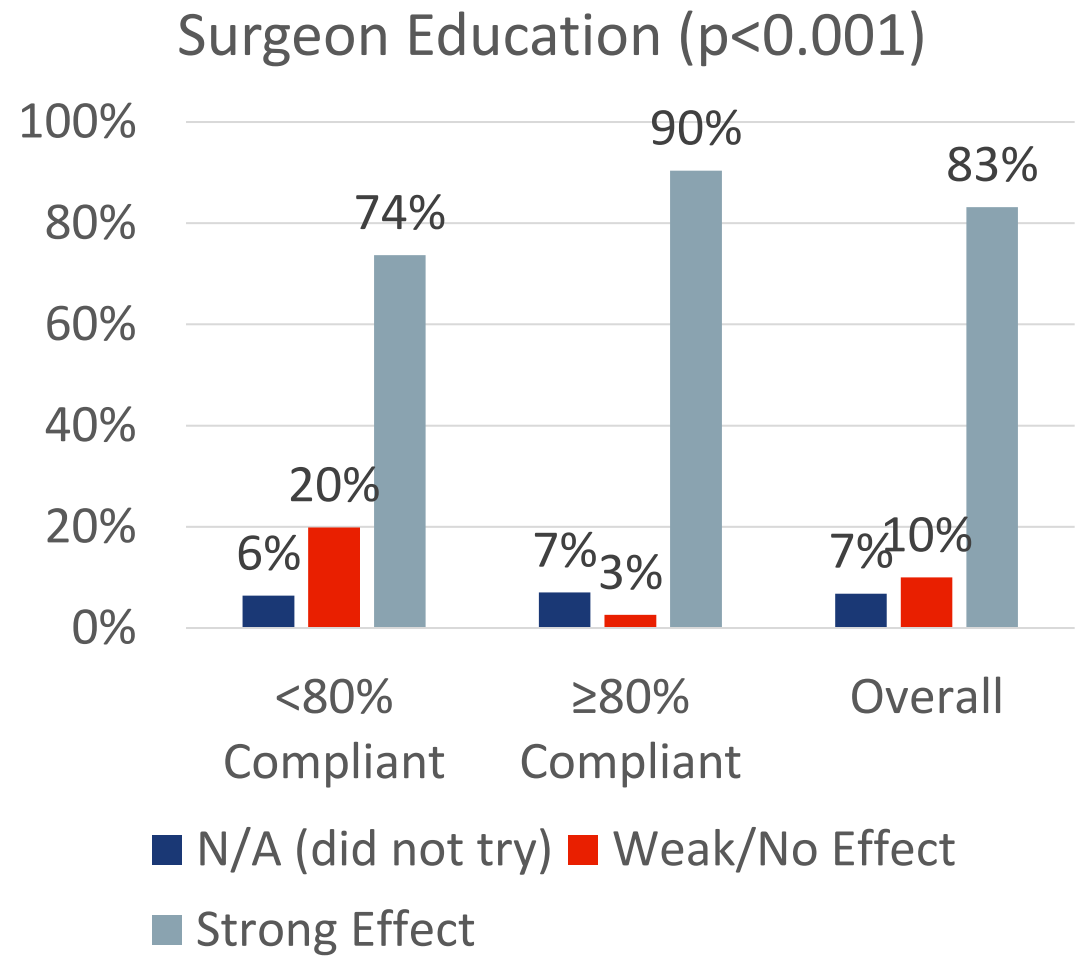
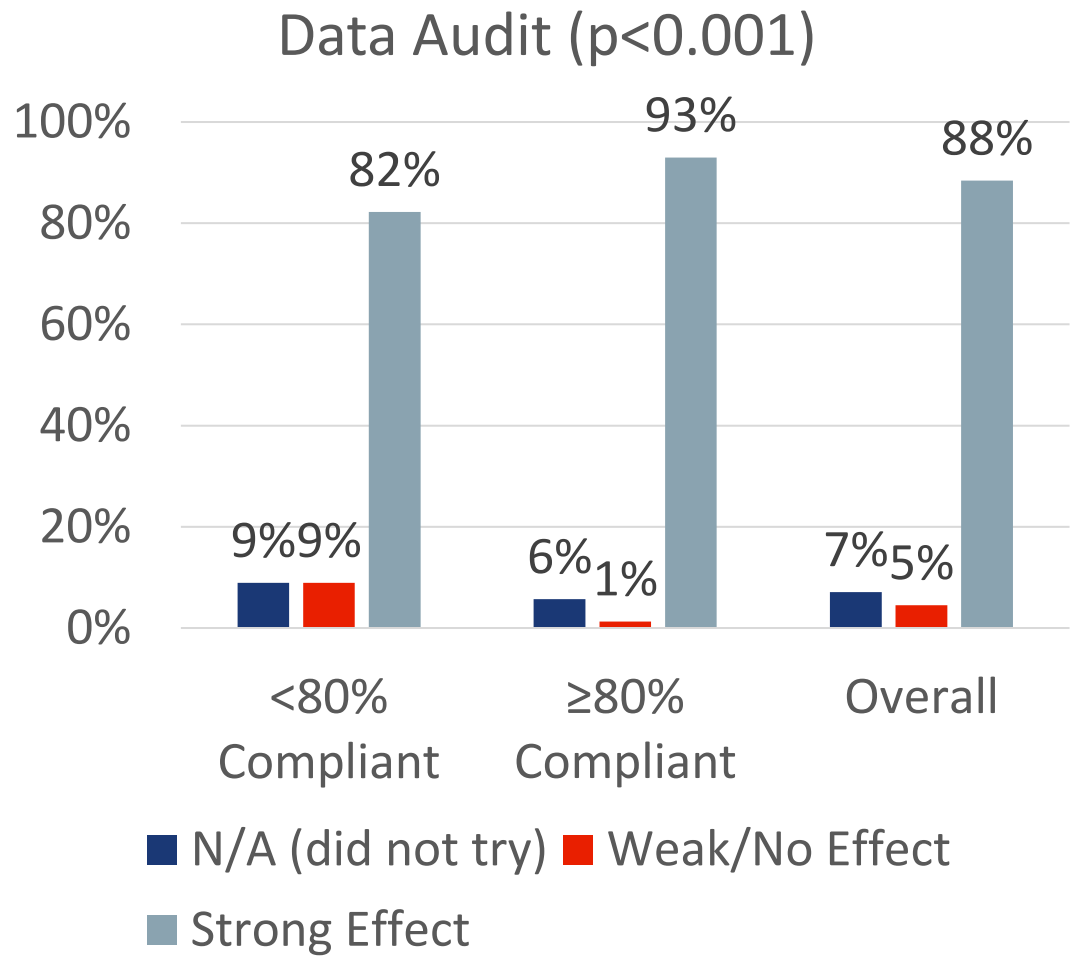
Wedge Resection (p=0.008)



Preop Staging (eg: EBUS) (p=0.007)

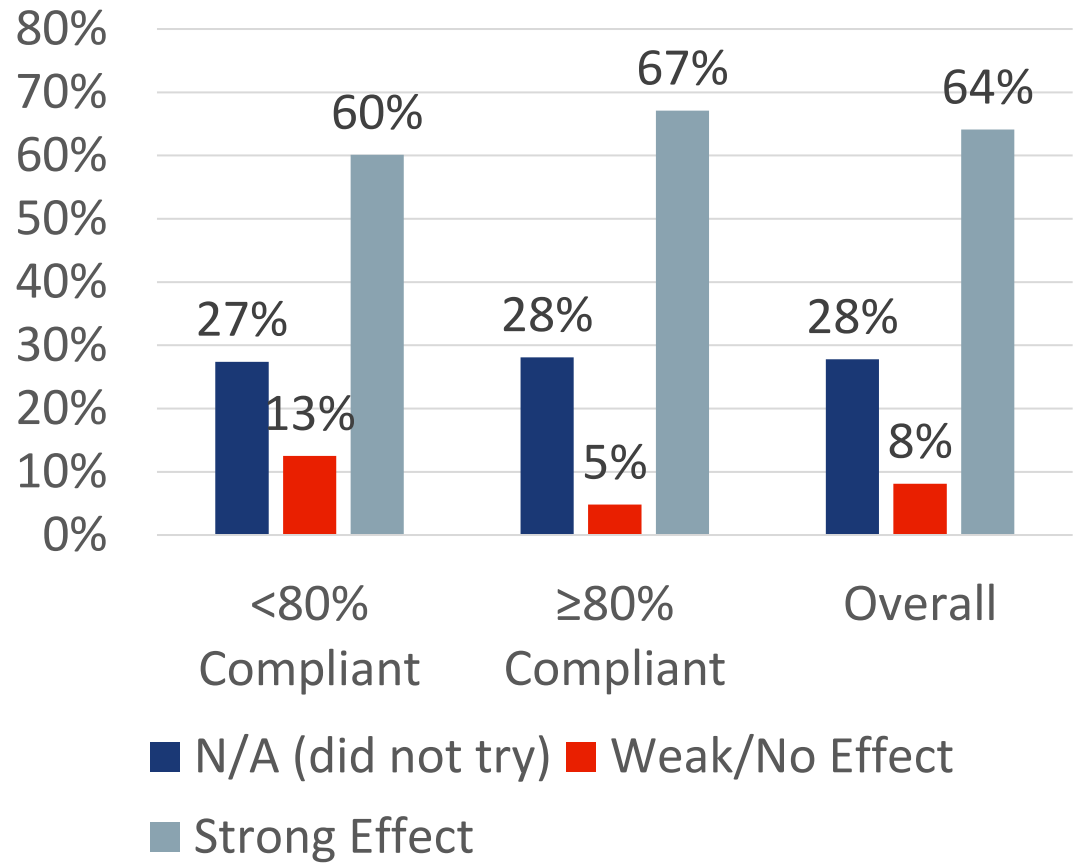


# Interventions Tried and Their Effects

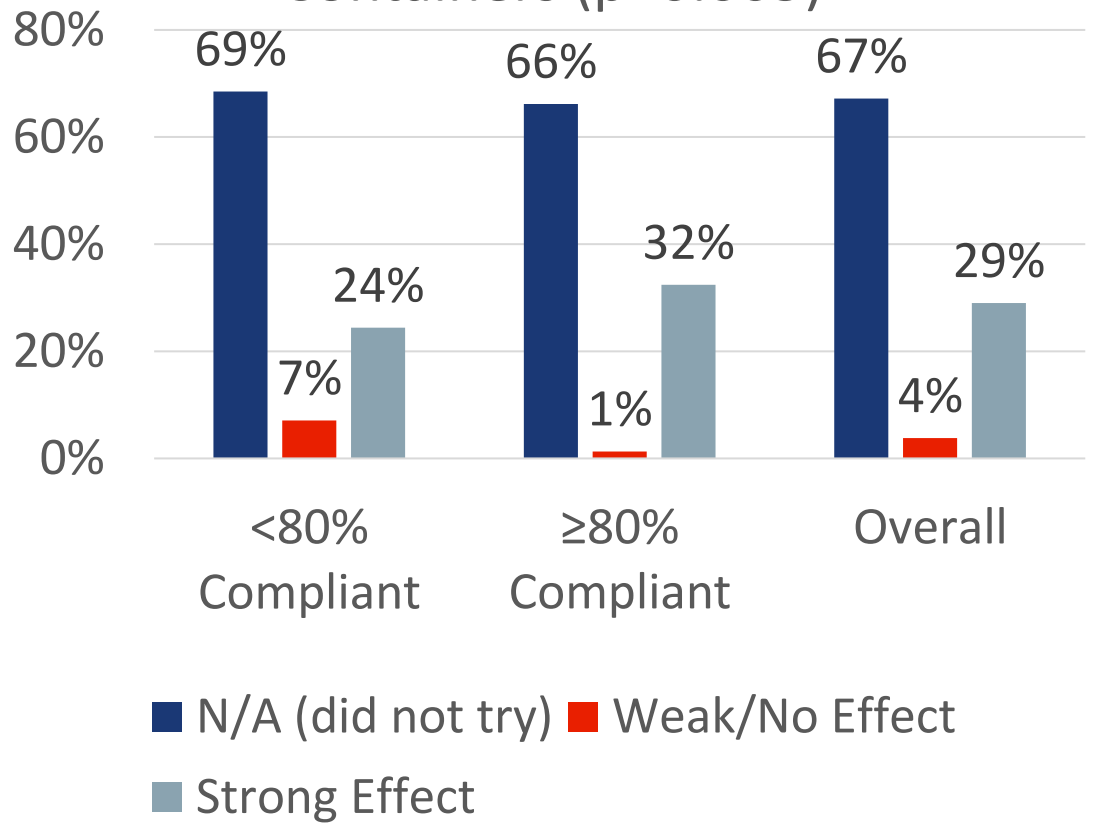


# Interventions Tried and Their Effects (cont)

OR Nurse Education (p=0.020)

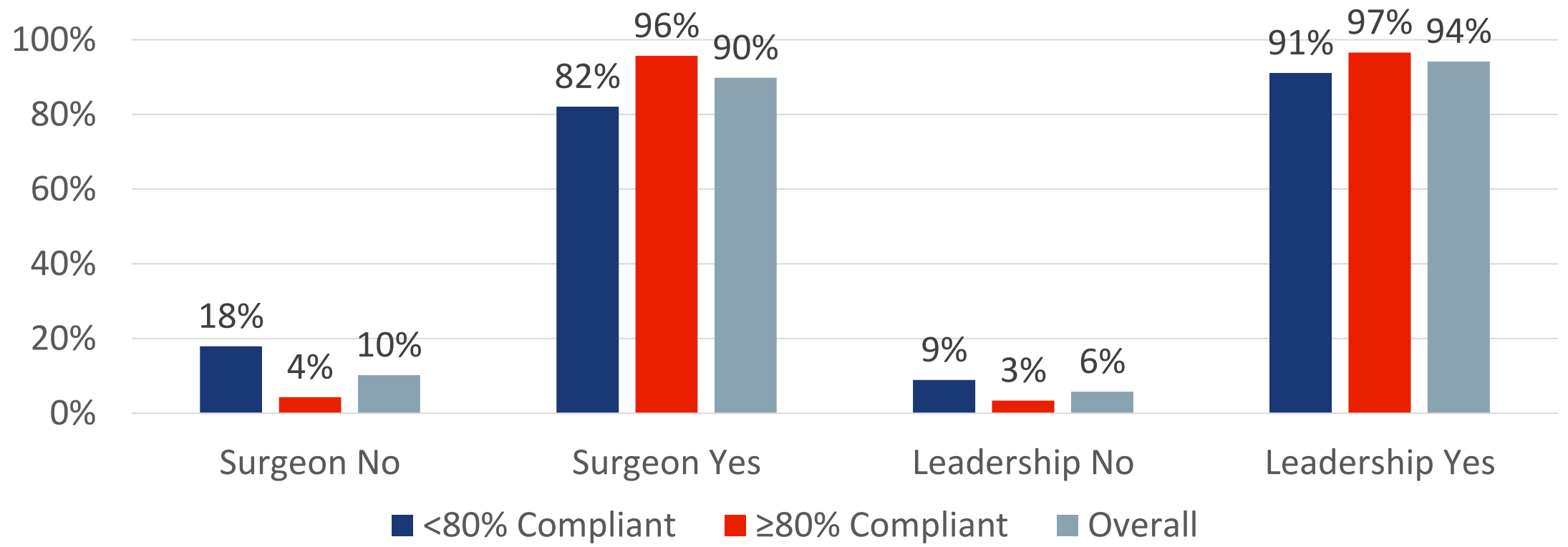


Pre-Labelled Specimen Containers (p=0.005)



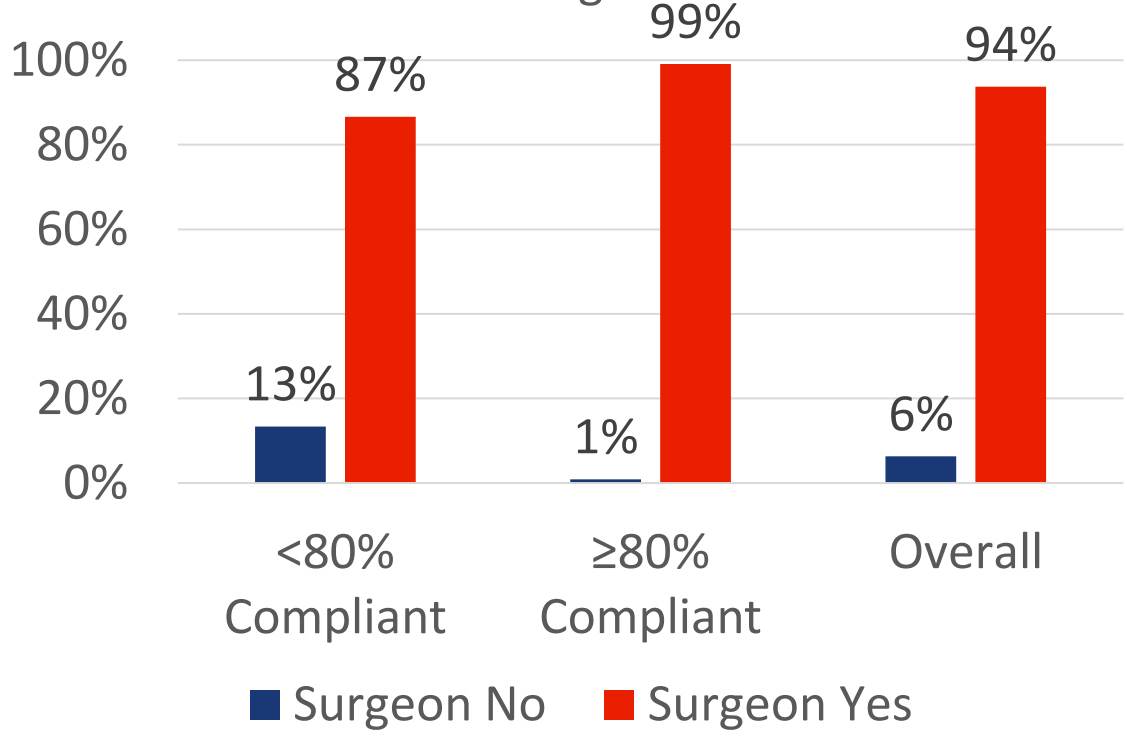
# Implementation Environment

[Role] Sees Advantage of Implementing the ACS CoC Operative Standard 5.8 vs Alternative Standard

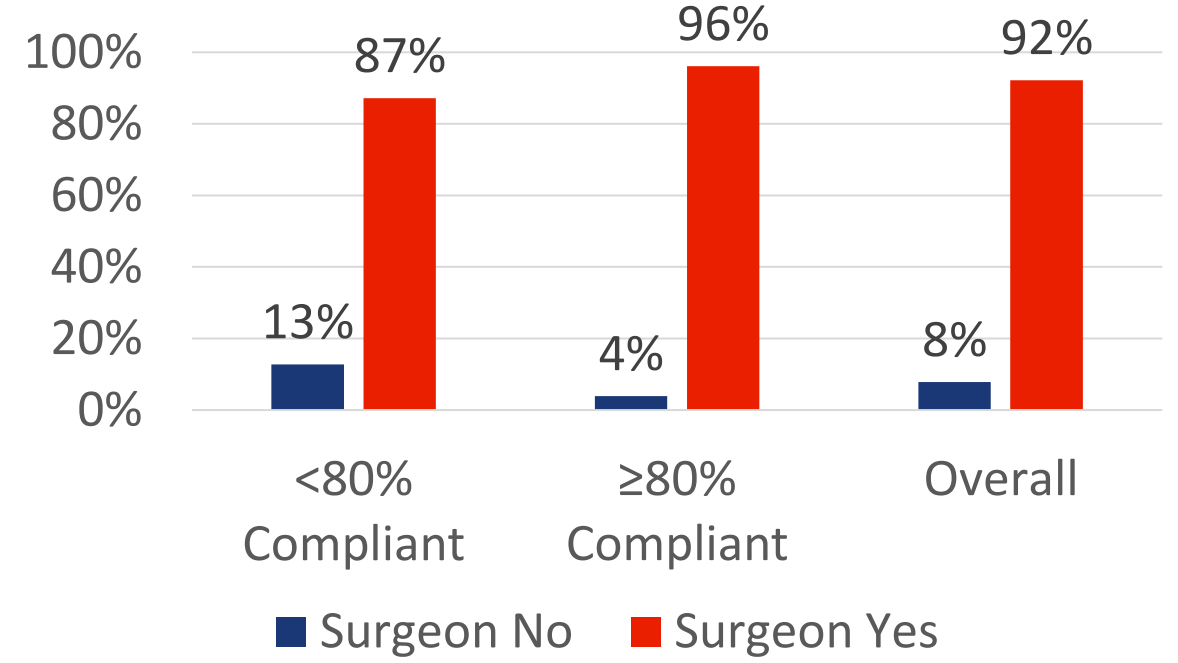


# Implementation Environment

The ACS CoC Operative Standard 5.8 is compatible with existing clinical processes for surgeons



The ACS CoC Operative Standard 5.8 is aligned with surgeons' values related to lymph node sampling and reporting during lung cancer resection



# Did 5.8 Meet Expectations?

- N=29 (7.1%) of programs said 5.8 did not meet expectations
- Surgeon buy-in
- Low volume sites, few/no lung resection cases
- Admin/data collection burden

# How to Improve 5.8

- N=29 (7.1%) of programs said 5.8 did not meet expectations
- Surgeon buy-in
- Low volume sites, few/no lung resection cases
- Admin/data collection burden



# Questions and Reflections For the Year Ahead



# Common Concerns

- Turnover and staffing has been a challenge for us
- Small program size, and few cases, impacts our compliance
- No nodes were found, or we cannot sample nodes because of patient factors. Why is this non compliant?
- We are struggling to understand what cases are done with curative intent/what cases to include for the standard.
- Our surgeon does not agree with the requirements of the standard. Can you share evidence for the standard?

View the 5.8 toolkit for a complete list



Commission on Cancer Standard 5.8: Pulmonary Resection: Evidence Behind the Standard

- [Invasive Staging Procedures Do Not Prevent Nodal Metastases From Being Missed in Stage I Lung Cancer](#) Resio BJ, Canavan M, Mase V, Dhanasopon AP, Blasberg JD, Boffa DJ. Invasive Staging Procedures Do Not Prevent Nodal Metastases From Being Missed in Stage I Lung Cancer. Ann Thorac Surg. 2020 Aug;110(2):390-397. doi: 10.1016/j.athoracsur.2020.03.026. Epub 2020 Apr 10. PMID: 32283084.
  - Researchers at Yale University used the Society of Thoracic Surgeons General Thoracic Surgery Database to demonstrate that even in experienced centers, both bronchoscopy (EBUS) and mediastinoscopy have real false negative rates when clinically evaluating early stage lung cancer patients, thus bolstering the recommendation for thorough lymph node assessment at the time of curative intent lung cancer surgery.
- [Confirmatory Mediastinoscopy after Negative Endobronchial Ultrasound-Guided Transbronchial Needle Aspiration for Mediastinal Staging of Lung Cancer \(Systematic Review and Meta-Analysis\)](#) Sanz-Santos J, Almagro P, Malik K, Martinez-Cambor P, Caro C, Rami-Porta R. Confirmatory Mediastinoscopy after Negative Endobronchial Ultrasound-guided Transbronchial Needle Aspiration for Mediastinal Staging of Lung Cancer: Systematic Review and Meta-analysis. Ann Am Thorac Soc. 2022 Sep;19(9):1581-1590. doi: 10.1513/AnnalsATS.202111-1302OC. PMID: 35348446.
  - While bronchoscopy with EBUS remains an essential tool for the clinical staging of lung cancer, surgical lymph node harvesting can help minimize false negatives while proceeding towards curative intent lung cancer surgery.
- [The International Association for the Study of Lung Cancer Staging Project for Lung Cancer: Proposals for the Revision of the N Descriptors in the Forthcoming Ninth Edition of the TNM Classification for Lung Cancer](#). Huang J, Osarogiagbon RU, Giroux DJ, Nishimura KK, Bille A, Cardillo G, Detterbeck F, Kerstine K, Kim HK, Lievens Y, Lim E, Marom E, Prosch H, Putora PM, Rami-Porta R, Rice D, Rocco G, Rusch VW, Opitz I, Vasquez FS, Van Schil P, Jeffrey Yang CF, Asamura H; Members of the Staging and Prognostic Factors Committee, Members of the Advisory Boards, and Participating Institutions of the Lung

# Q and A



# Wrap up and Reminders

- Data due Feb 28 (**new programs only**)
- Data due March 31 (all programs)
  - Links will be sent to primary contacts February 28<sup>th</sup>
  - Complete the “pre questions” first; you are automatically redirected to the data submission form
- Reach out to [cancerqi@facs.org](mailto:cancerqi@facs.org)

# ACS Cancer Conference 2025

March 12-14 | Phoenix, AZ

Save the Date



[facs.org/cancerconference](https://facs.org/cancerconference)

ACS Cancer Programs  
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