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■ Commission On Cancer Requires New Staging Requirements for 1995

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In the early 1980s, the Commission on Cancer introduced a requirement that cancers of the breast should be staged according to the TNM scheme of the American Joint Committee on Cancer (AJCC). The AJCC staging system was to be phased in for other appropriate primary sites in subsequent years.

Currently, all sites, excluding pediatric tumors, must be staged using the fourth edition of the *AJCC Manual for Staging of Cancer*. The registry abstract is required to contain the clinical or pathologic staging basis (both are not required); the elements T, N, and M; and the AJCC stage grouping. The requirement does not mandate using an AJCC staging form, and recording the T, N, and M elements on the medical record is an optional practice to date.

More often than not, registrars have staged the cases based on a review of information that was available in the medical record. In a 1992 study of the quality of cancer data, AJCC staging accuracy was low, apparently because of insufficient information in the medical record.

The Committee on Approvals believes that staging is a physician responsibility. Therefore, to improve the quality of staging information and to enhance the accuracy of outcome data stratified by stage, the Commission on Cancer will require that all analytic cases diagnosed and/or treated in an approved program be staged by the managing or treating physician using the AJCC system.

The Committee long ago recognized that the physician is central to proper staging because the physician has access to all clinical information. The physician is the person best able to interpret and integrate the laboratory and other data needed for staging. The pathologist may be asked to assign the T element at the time of pathologic evaluation of the surgical specimen. Other specialists may contribute to the staging, depending on the need for multimodality involvement in establishing the diagnosis or treatment plan. Each facility must assess its own resources, involve all members of the medical staff who diagnose and treat cancer patients, and implement its own procedures.

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BENEFITS

Because staging is important for patient care, physician staging will have many advantages. For patients, it means documentation of the extent of disease and some estimate of outcome. For the registry, it means the availability of uniform data and reduces the time spent in seeking extent of disease information. While staging may not measure the competence of care, it clearly indicates the dedication and thoughtfulness of physicians in patient management and may improve the quality of care.

APPLICATION

Specifically, the elements T, N, and M must be assigned by the physician and appear in the medical record. Reportable cases must include inpatient and outpatient admissions. Analytic cases are those diagnosed and/or receiving all or part of the first course of cancer-directed therapy at a facility. Staging may be recorded on the face sheet, discharge summary, or other appropriate area of the medical chart. The use of a staging form continues to be an optional practice. The form is simply a tool to ensure compliance, assist the physician in providing the necessary information, and enhance the quality control effort. The physician should sign or initial the document used to record the AJCC stage. If more than one physician is involved in staging, each should sign or initial the form. Some facilities may choose to include physician staging as a deficiency item for chart completion. This implementation technique has been successful when physician cooperation is less than optimal.

RELATED REQUIREMENTS

The cancer committee should continue to review at least 10 percent of the annual analytic accessions for staging quality. At the time of consultation or survey, medical records will be reviewed against cancer registry abstracts for accuracy, completeness, timeliness, and consistency in physician staging. In the event a stage grouping is not assigned by a physician, the registrar should record the stage grouping on the abstract based on the T, N, M elements. It is further recommended that the registrar continue to independently stage each case when abstracting. This practice will not only contribute to data reliability, but will ensure that staging discrepancies are identified and resolved in a timely manner. The cancer liaison physician or physician advisor to the registry is the ideal choice to lead the problem resolution effort.

Procedures for physician staging and corrective action are established by the cancer committee and incorporated into the procedure manual of the cancer program maintained in the registry. ■

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