AJCC 8th Edition Staging

The following rules and associated rationale are for the Eighth Edition AJCC Cancer Staging Manual. Note that these are general rules described in Chapter 1 of the AJCC Cancer Staging Manual. Please refer to relevant disease site chapters to learn more about specific allowable disease site differences to correctly stage such patients and that are necessary for appropriate medical care of the patient.

KEY TERMINOLOGY
Classifications: Describes the points in time of the care of the cancer patient. Criteria include:
- Timeframe
- Specific medical assessments and practices

Categories: T, N, M, and any non-anatomic factors needed to assign the stage group
Stage group: Easily communicated summary of categories, groups patients with similar prognosis
Assigning stage: AJCC stage is assigned by the managing physician based on data from all relevant sources including history, examination, laboratory studies, imaging, and surgical and pathology findings

CLINICAL STAGING CLASSIFICATION RULES
- **General**: Clinical classification includes information from the date of cancer diagnosis until the start of definitive treatment, or within four months, whichever is shorter
- **T category** – includes information from clinical history, symptoms, physical exam, labs, imaging, endoscopy, biopsy, surgical exploration without resection
- **N category** – physical exam, imaging, FNA or core needle biopsy, excisional biopsy, sentinel node biopsy
- **M category** – clinical history, physical exam, imaging, FNA or biopsy

Rationale
- Diagnostic biopsies of the primary site, regional nodes, and distant metastatic sites are included in clinical classification
- Pathological exam of resected tissue (pathology report) does not necessarily make this pathologic staging
- Clinical N category is cN even if based on lymph node biopsy
- Clinical M category is cM if based on history, physical exam and imaging, pM1 if based on biopsy proven involvement

PATHOLOGICAL STAGING CLASSIFICATION RULES
- **General**: includes all information from the date of cancer diagnosis (clinical stage), surgeon's operative findings, and pathology report from resected specimen – must use all 3
- **T category** – must meet definitive surgical treatment specified in chapter
- **N category** – microscopic assessment of at least one node required, include imaging and diagnostic biopsy
- **M category** – history, physical exam, imaging, FNA or biopsy, resection

Rationale
- Include all findings even if not microscopically proven, i.e., physical exam, imaging, operative findings
- Pathological staging is based on synthesis of all information and not solely on resected specimen pathology report – pathologist cannot assign final stage
- Pathological M category is cM if based on physical exam and imaging, pM1 if based on biopsy proven involvement, "pM0" is NOT a valid category

POST NEOADJUVANT THERAPY STAGING CLASSIFICATION RULES
- **yc Clinical**: includes physical exam and imaging assessment after neoadjuvant systemic/radiation therapy
- **yp Pathological**: includes all information from yc staging, surgeon's operative findings and pathology report from resected specimen