INTEGRATE 7.0

QUALI ‘REGOLE’ NELLA GESTIONE INTEGRATA DELLA NEOPLASIA POLMONARE?

GAMES

Stadiazione TNM 9° edizione

K. Ferrari

VERONA

13-14 OTTOBRE

2025

General and Lung Cancer Specific Rules of Tumor, Node, Metastasis (TNM) Classification

Frank Detterbeck, MD

- Precisa descrizione anatomica della estensione di malattia
- Parametri T (Tumor), N (Node), M (Metastasis)
- C
  d

Non è sinonimo di prognosi!

- Supporto al clinico per la programmazione dei trattamenti
- Fornire indicazioni su prognosi/sopravvivenza
- Facilitare le informazioni tra i vari centri di cura
- Supportare attività nella cura del cancro

IASLC

IASLC
INTERNATIONAL ASSOCIATION FOR THE STUDY OF LUNG CANCER
Conquering Lung & Thoracic Cancers Worldwide in the 21st Century

CRITICITA'

- ❑ **Ambiente**
- ❑ **Paziente**
- ❑ **tumore**

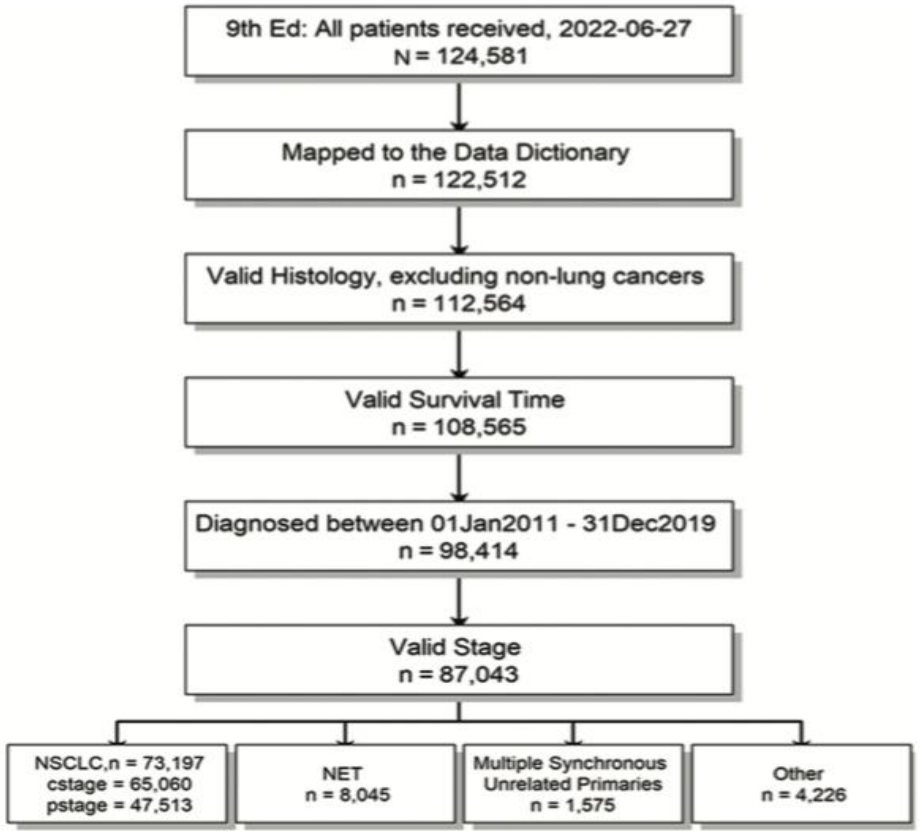
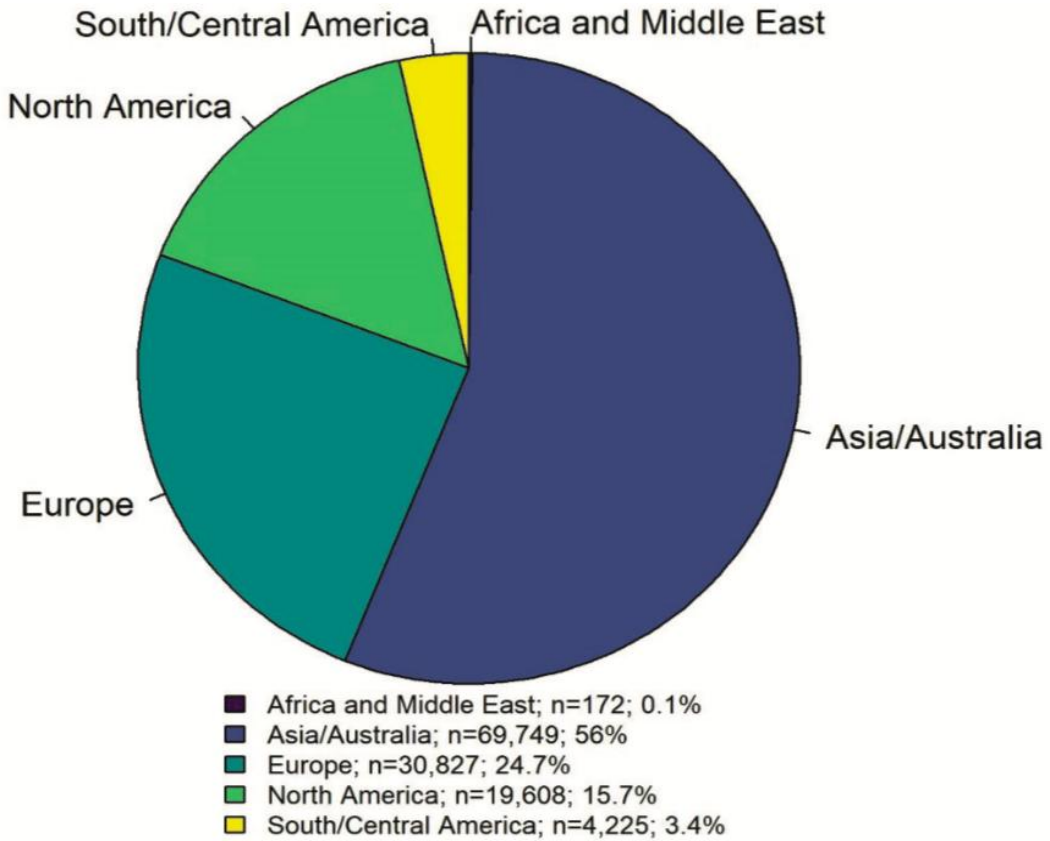


Figure 2. Case selection. The submitted data were mapped to a data dictionary and checked to verify if they included a valid histology, survival time, date of diagnosis window, and clinical and pathologic stages.

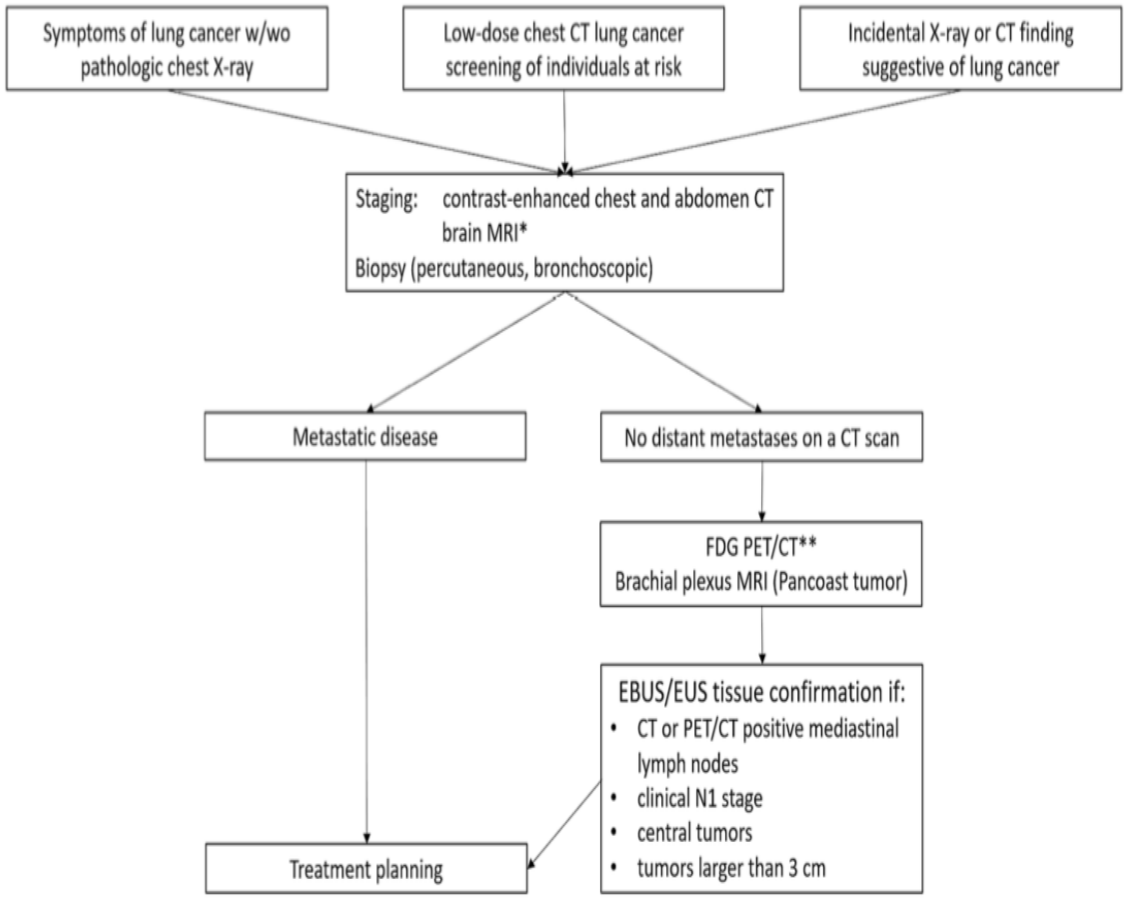


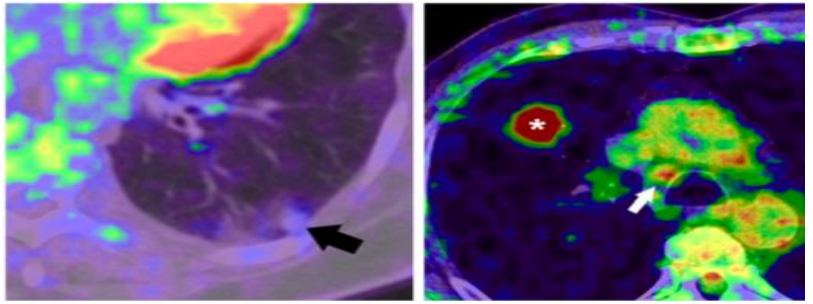
diagnostics

MDPI

Review

Clinical TNM Lung Cancer Staging: A Diagnostic Algorithm with a Pictorial Review





Imaging Method	Advantages	Limitations
PET/CT	• High sensitivity for distant metastases • High sensitivity for hilar and mediastinal lymph node metastases	• Low sensitivity for detection of brain metastases due to a high physiological glucose uptake in the brain • Limited effectiveness for low-FDG-avidity cancers (e.g., carcinoid tumors, indolent lung adenocarcinomas) • FDG avidity of lesions unrelated to lung cancer (e.g., inflammation, infection, other benign and malignant tumors)
MRI	• Superb soft-tissue contrast resolution enabling differentiation between the T3 and T4 categories in Pancoast tumors due to better evaluation of cervical and thoracic nerve roots, brachial plexus, or stellate ganglion invasion • High sensitivity for detection of metastases in the central nervous system	• Lower availability • Contraindications for MRI examinations • Long-lasting examinations • Patient cooperation required

FDG—fluorodeoxyglucose, PET/CT—fluorodeoxyglucose positron emission tomography/computed tomography, MRI—magnetic resonance imaging.

The American Cancer Society National Lung Cancer Roundtable strategic plan: Promoting guideline-concordant lung cancer staging

Farhood Farjah MD, MPH[1] | Julie A. Barta MD[2] | Douglas E. Wood MD[1] | M. Patricia Rivera MD[3] | Raymond U. Osarogiagbon MBBS[4] | Robert A. Smith PhD[5] | Timothy W. Mullett MD[6] | Lauren S. Rosenthal MPH[5] | Louise M. Henderson PhD[7] | Frank C. Detterbeck MD[8] | Gerard A. Silvestri MD, MS[9]



Cancer. 2024;130:4167–4176.

TABLE 1 Staging errors and associated consequences

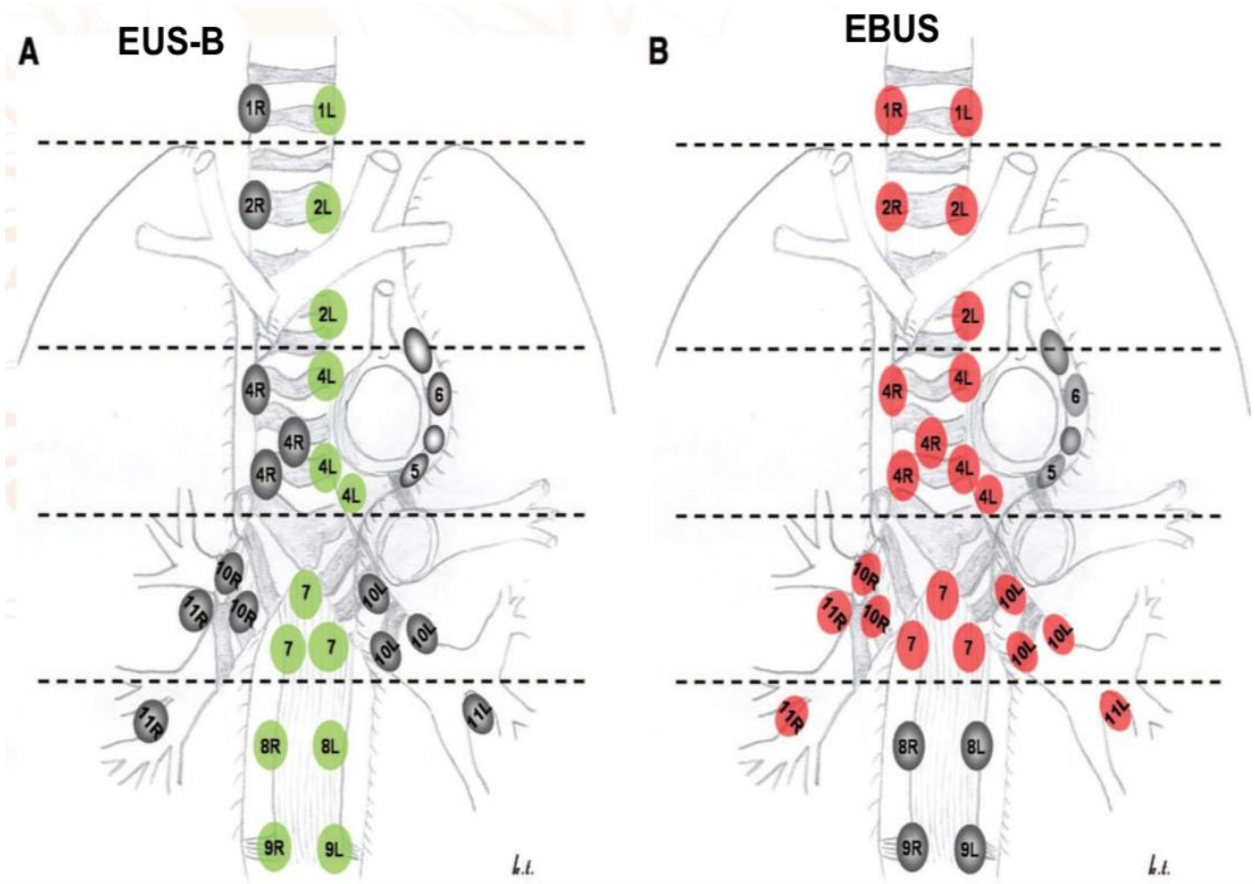
Understaging	Potential consequence(s)
Stage I–III (true stage IV)	Omission of comprehensive biomarker testing
	Omission of systemic therapy
	Unnecessary curative-intent surgery or radiation therapy
N2 disease (true N3)	Omission of radiation therapy to N3 nodes
Single station N2 (true multi-station N2)	Unnecessary surgery
	Delay initiating curative-intent multimodality therapy
N0 (true N1–N3)	Omission of comprehensive biomarker testing
	Omission of systemic therapy
	Unnecessary surgery (multi-station N2/N3 disease)
	Failure to elicit patient preferences for multimodality therapy (stage IIIA)[a]
Resectable T4N0-1 (true unresectable T4N0-1)	Delay initiating curative-intent multimodality therapy
Overstaging	**Potential consequence(s)**
Stage IV (true stage I–III)	Omission of curative-intent local (stage I) or multimodality therapy (stage II/III)
N3 disease (true N2 disease)	Unnecessary radiation to N3 nodes
Multi-station N2 (single-station N2)	Failure to elicit patient preferences for multimodality therapy (stage IIIA)[a]
N1–3 (true N0)	Unnecessary comprehensive biomarker testing
	Unnecessary systemic therapy
	Omission of curative-intent surgery or radiation therapy
Unresectable T4N0-1 (true resectable T4N0-1)	Omission of surgery

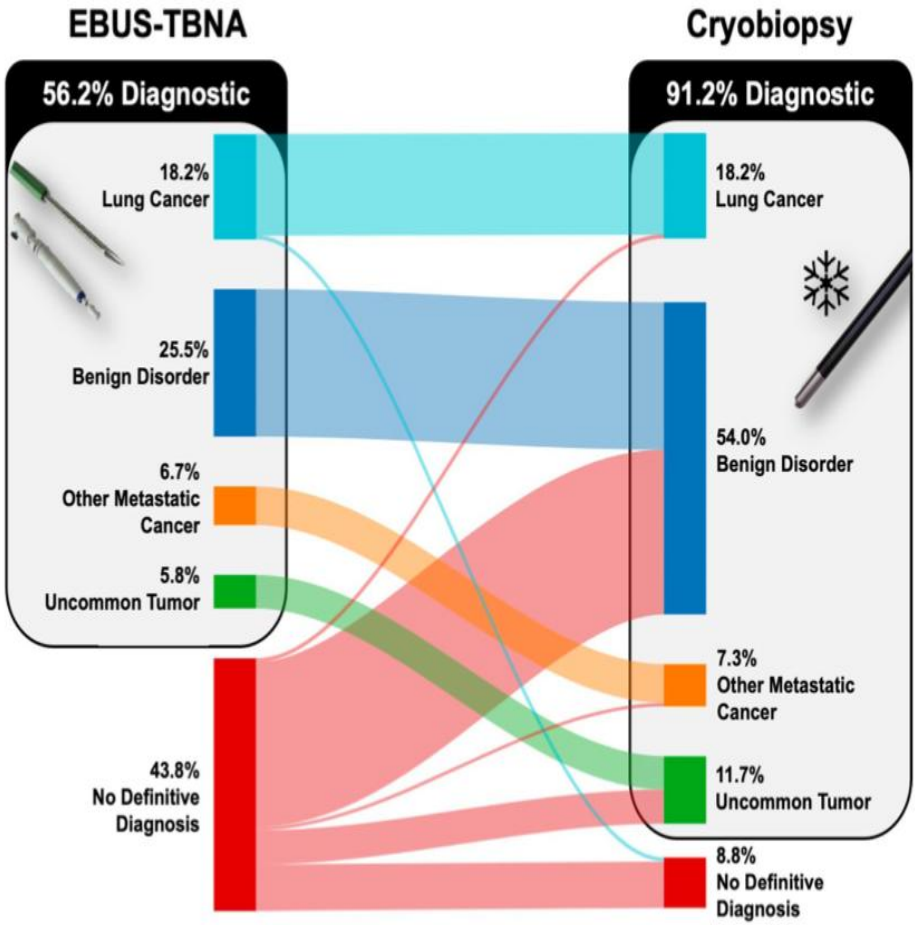
[a]Patient with single-station, nonbulky N2 disease defining stage IIIA disease has the option of induction systemic therapy followed by resection versus definitive chemoradiation therapy followed by immunotherapy.



BMJ Open Respiratory Research

Ultrasound-guided transbronchial cryobiopsy of mediastinal and hilar lesions: a multicenter pragmatic cohort study with real-world evidence





Mangold MS, *et al. BMJ Open Respir Res* 2024;**11**:e002617. doi:10.1136/bmjresp-2024-002617

Table 3 Adverse events

	Summary
N	137
Overall adverse events	32 (23.4%)
Diagnostics	
Lung ultrasound	103 (75.2%)
Chest X-Ray	44 (32.1%)
Bleeding	
Mild	4 (2.9%)
Moderate	10 (7.3%)
Severe	0 (0%)
Cough	10 (7.3%)
Haemoptysis	6 (4.4%)
Fever	3 (2.2%)
Chest pain	3 (2.2%)
Dyspnoea	2 (1.5%)
Pneumothorax*	1 (0.7%)
Pneumomediastinum*	1 (0.7%)
Airway tube dislocation	1 (0.7%)
Pneumonia	1 (0.7%)
Desaturation	0 (0%)
Mediastinitis	0 (0%)
Death	0 (0%)

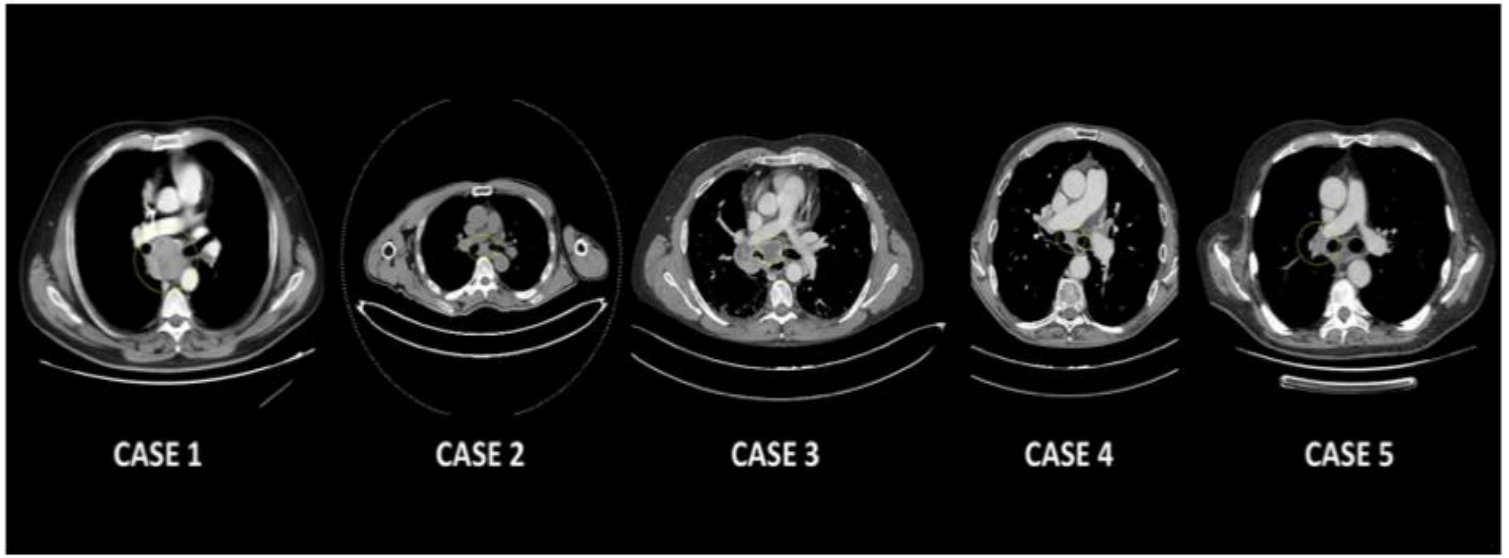


Fig. 1 Relevant scans of the lymph nodal stations approached with cryobiopsy in each case presentation



Genova *et al. BMC Pulmonary Medicine* (2022) 22:5

Mangold MS, *et al. BMJ Open Respir Res* 2024;**11**:e002617. doi:10.1136/bmjresp-2024-002617

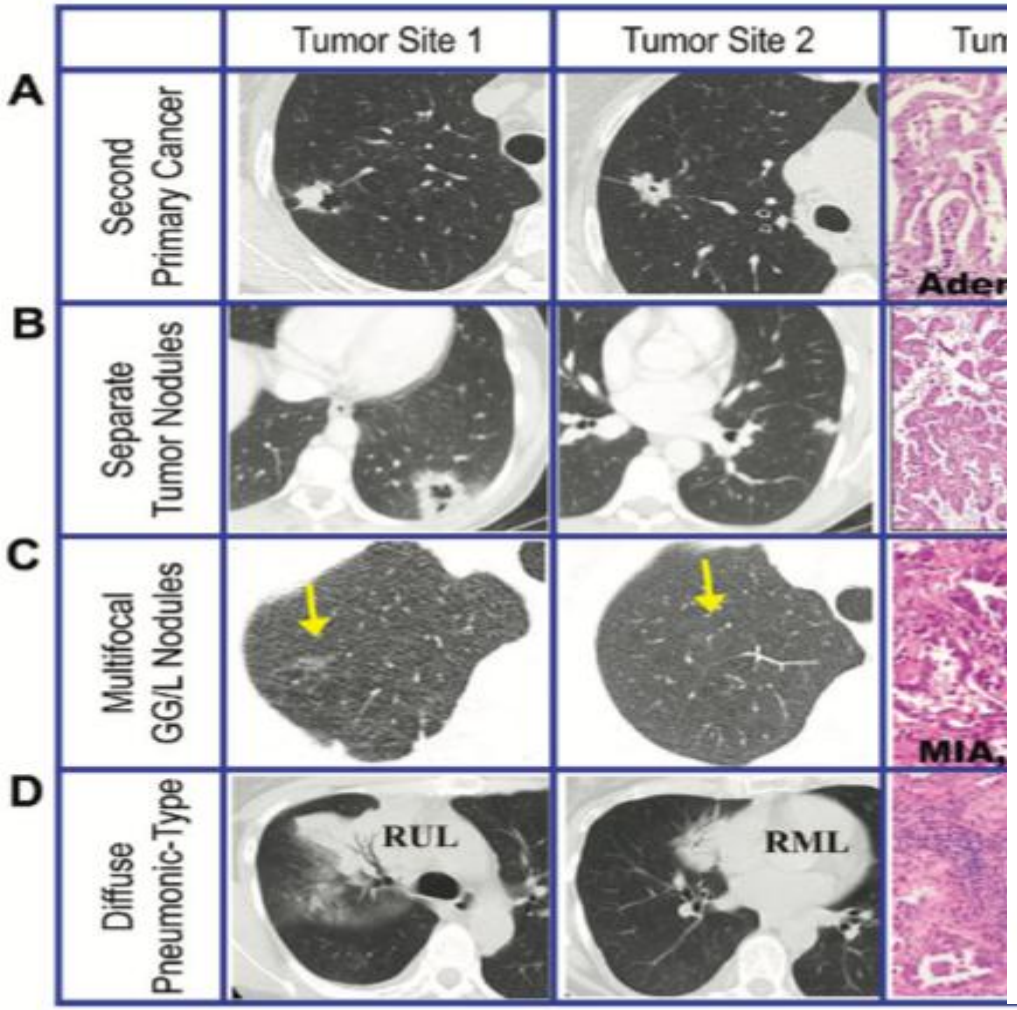
IASLC

Ground-Glass Opacities, Adenocarcinoma *In Situ*, and Minimally Invasive Adenocarcinoma

William D. Travis, MD

Multiple Pulmonary Sites of Lung Cancer

Frank Detterbeck, MD



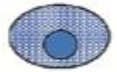
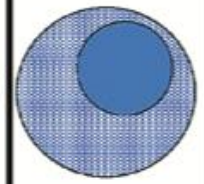
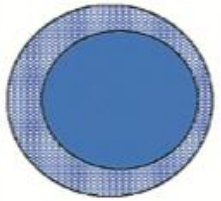
cT*	CT image on HRCT						
	Solid part	0 cm	0 cm	≤0.5 cm†	0.6-1.0 cm†	1.1-2.0 cm†	2.1-3.0 cm†
	Total tumor size including GG	≤0.5 cm	0.6-3.0 cm‡‡	≤3.0 cm‡‡	0..6-3.0 cm††	1.1-3.0 cm††	2.1-3.0 cm††
	Pathologic Differential Diagnosis	AAH‡, AIS, MIA	AIS, MIA, LPA	MIA, LPA, AIS	LPA, Invasive AD, MIA	LPA, Invasive AD	Invasive AD
	Clinical Stage*		cTis‡‡	cT1mi‡‡	cT1a	cT1b	cT1c
pT	Invasive part	0 cm	0 cm	≤0.5 cm‡‡	0.6-1.0 cm†	1.1-2.0 cm†	2.1-3.0 cm†
	Total tumor size including lepidic growth part	Usually ≤0.5 cm‡	≤3.0 cm‡‡	≤3.0 cm‡‡	0.6-3.0 cm††	1.1-3.0 cm††	2.1-3.0 cm††
	Pathology	AAH	AIS	MIA	Lepidic predominant AD or Invasive AD with lepidic compnent	Invasive AD with a lepidic component or lepidic predominant AD	Invasive AD with lepidic component
	Pathologic Stage		pTis‡‡	pT1mi‡‡	pT1a	pT1b	pT1c

Figure 1. Clinical and pathologic T descriptor classification of small (≤3 cm) lung adenocarcinomas with a ground-glass and lepidic component by CT and pathology.*

8th Ed TNM Categories

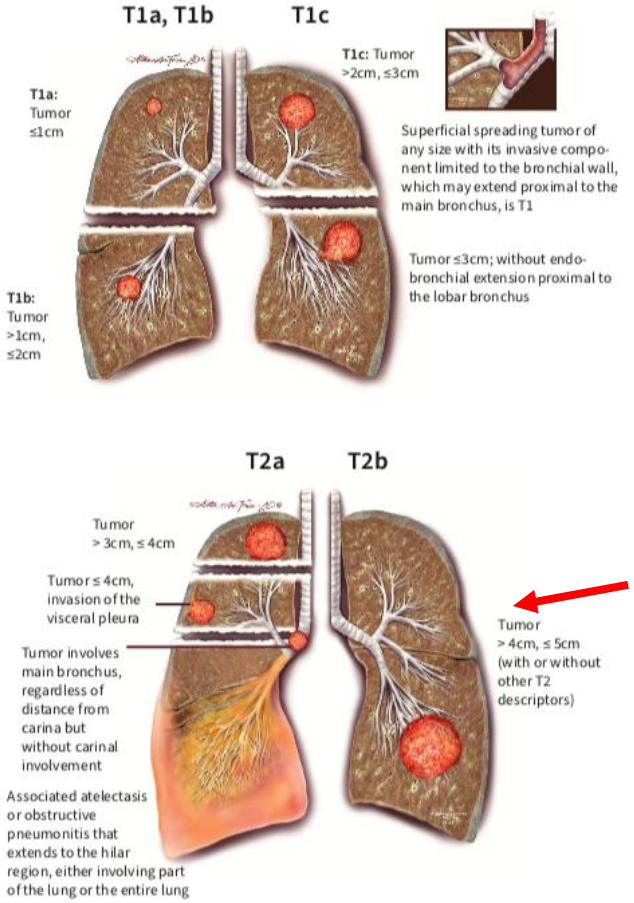
8th Ed TNM Categories					
T/M	Label	N0	N1	N2	N3
T1	T1a	IA1	IIB	IIIA	IIIB
	T1b	IA2	IIB	IIIA	IIIB
	T1c	IA3	IIB	IIIA	IIIB
T2	T2a Inv	IB	IIB	IIIA	IIIB
	T2a >3-4	IB	IIB	IIIA	IIIB
	T2b >4-5	IIA	IIB	IIIA	IIIB
T3	T3 >5-7	IIB	IIIA	IIIB	IIIC
	T3 Inv	IIB	IIIA	IIIB	IIIC
	T3 Same Lobe Nod	IIB	IIIA	IIIB	IIIC
T4	T4 >7	IIIA	IIIA	IIIB	IIIC
	T4 Inv	IIIA	IIIA	IIIB	IIIC
	T4 Ipsi Nod	IIIA	IIIA	IIIB	IIIC
M1	M1a Pl Dissem	IVA	IVA	IVA	IVA
	M1a Contr Nod	IVA	IVA	IVA	IVA
	M1b Single Les	IVA	IVA	IVA	IVA
	M1c Mult Les	IVB	IVB	IVB	IVB

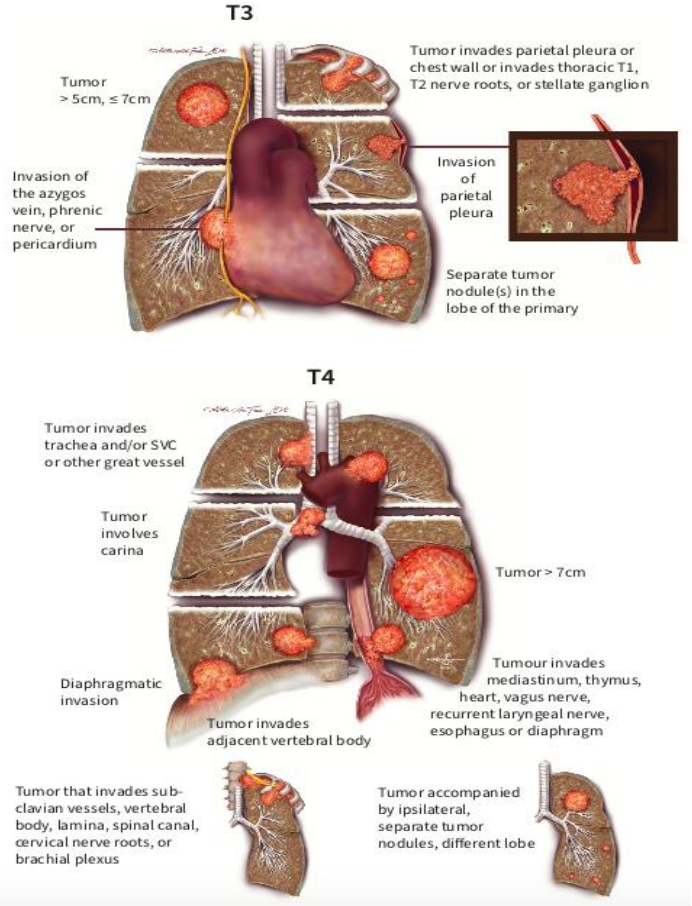
Proposed 9th Ed TNM Categories

Proposed 9th Ed TNM Categories						
T/M	Description	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤1 cm	IA1	IIA	IIB	IIIA	IIIB
	T1b >1 to ≤2 cm	IA2	IIA	IIB	IIIA	IIIB
	T1c >2 to ≤3 cm	IA3	IIA	IIB	IIIA	IIIB
T2	T2a Visceral pleura / central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a >3 to ≤4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b >4 to ≤5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 >5 to ≤7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe tumor nodule	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 >7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invasion	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Ipsilateral tumor nodule	IIIA	IIIA	IIIB	IIIB	IIIC
M1	M1a Pleural / pericardial dissemination	IVA	IVA	IVA	IVA	IVA
	M1a Contralateral tumor nodule	IVA	IVA	IVA	IVA	IVA
	M1b Single extrathoracic lesion	IVA	IVA	IVA	IVA	IVA
	M1c1 Multiple lesions, 1 organ system	IVB	IVB	IVB	IVB	IVB
	M1c2 Multiple lesions, >1 organ system	IVB	IVB	IVB	IVB	IVB

Figure 2. Proposed ninth edition TNM stage groups. Mult, multiple.

Parametro T: NO Changes





IASLC

Node (N) Component

James Huang, MD

Table 1. Regional Lymph Nodes Definitions

NX	Regional lymph nodes cannot be assessed
N0	No regional lymph node metastasis
N1	Metastasis in ipsilateral peribronchial and/or ipsilateral hilar and/or intrapulmonary lymph nodes, including involvement by direct extension
N2	Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s)
	N2a – Single N2 station involvement
	N2b – Multiple N2 station involvement
N3	Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene or supraclavicular lymph node(s)

SPLIT

IASLC

Parametro **N**:
cN vs **pN**

Edizioni a confronto

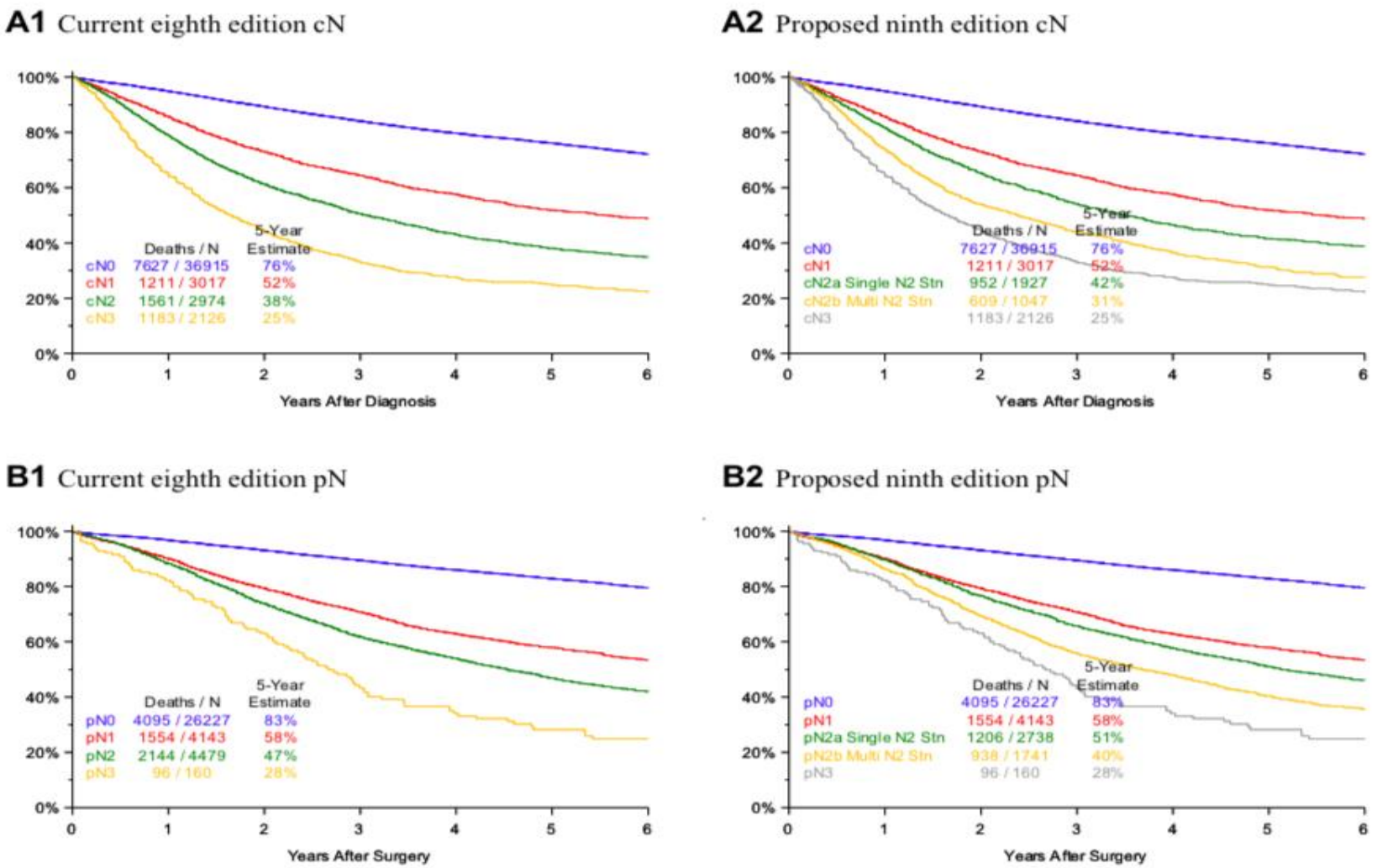


Figure 5. Comparison of current (eighth edition) to proposed ninth edition N categories; (*A*1-2) overall survival by cN categories, and (*B*1-2) pN categories. cN, clinical node; pN, pathologic node.

IASLC

8th Ed TNM Categories

8th Ed TNM Categories					
T/M	Label	N0	N1	N2	N3
T1	T1a	IA1	IIB	IIIA	IIIB
	T1b	IA2	IIB	IIIA	IIIB
	T1c	IA3	IIB	IIIA	IIIB
T2	T2a Inv	IB	IIB	IIIA	IIIB
	T2a >3-4	IB	IIB	IIIA	IIIB
	T2b >4-5	IIA	IIB	IIIA	IIIB
T3	T3 >5-7	IIB	IIIA	IIIB	IIIC
	T3 Inv	IIB	IIIA	IIIB	IIIC
	T3 Same Lobe Nod	IIB	IIIA	IIIB	IIIC
T4	T4 >7	IIIA	IIIA	IIIB	IIIC
	T4 Inv	IIIA	IIIA	IIIB	IIIC
	T4 Ipsi Nod	IIIA	IIIA	IIIB	IIIC

Proposed 9th Ed TNM Categories

Proposed 9th Ed TNM Categories						
T/M	Description	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤1 cm	IA1	IIA	IIB	IIIA	IIIB
	T1b >1 to ≤2 cm	IA2	IIA	IIB	IIIA	IIIB
	T1c >2 to ≤3 cm	IA3	IIA	IIB	IIIA	IIIB
T2	T2a Visceral pleura / central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a >3 to ≤4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b >4 to ≤5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 >5 to ≤7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe tumor nodule	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 >7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invasion	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Ipsilateral tumor nodule	IIIA	IIIA	IIIB	IIIB	IIIC

SPLIT N2a N2b CHANGES in Early Stages

T1N1 DOWNSTAGED from IIB to IIA

T1N2a (single station) DOWNSTAGED from IIIA to IIB

Figure 2. Proposed ninth edition TNM stage groups. Mult, multiple.

IASLC

8th Ed TNM Categories

8th Ed TNM Categories					
T/M	Label	N0	N1	N2	N3
T1	T1a	IA1	IIB	IIIA	IIIB
	T1b	IA2	IIB	IIIA	IIIB
	T1c	IA3	IIB	IIIA	IIIB
T2	T2a Inv	IB	IIB	IIIA	IIIB
	T2a >3-4	IB	IIB	IIIA	IIIB
	T2b >4-5	IIA	IIB	IIIA	IIIB
T3	T3 >5-7	IIB	IIIA	IIIB	IIIC
	T3 Inv	IIB	IIIA	IIIB	IIIC
	T3 Same Lobe Nod	IIB	IIIA	IIIB	IIIC
T4	T4 >7	IIIA	IIIA	IIIB	IIIC
	T4 Inv	IIIA	IIIA	IIIB	IIIC
	T4 Ipsi Nod	IIIA	IIIA	IIIB	IIIC

Proposed 9th Ed TNM Categories

Proposed 9th Ed TNM Categories						
T/M	Description	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤1 cm	IA1	IIA	IIB	IIIA	IIIB
	T1b >1 to ≤2 cm	IA2	IIA	IIB	IIIA	IIIB
	T1c >2 to ≤3 cm	IA3	IIA	IIB	IIIA	IIIB
T2	T2a Visceral pleura / central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a >3 to ≤4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b >4 to ≤5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 >5 to ≤7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe tumor nodule	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 >7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invasion	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Ipsilateral tumor nodule	IIIA	IIIA	IIIB	IIIB	IIIC

SPLIT N2a N2b CHANGES in STAGE III:

T1N2a (single station) DOWNSTAGED from IIIA to IIB

T3N2a (single station) DOWNSTAGED from IIIB to IIIA

T2N2b (multiple station) UPSTAGED from IIIA to IIIB

IASLC

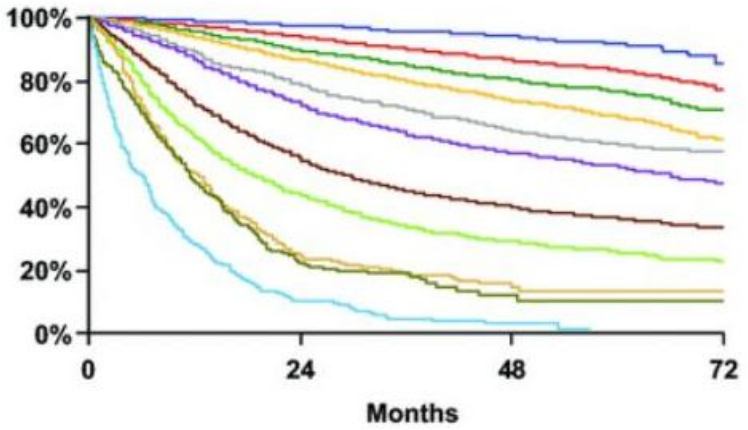
Diagnosi, stadiazione e gestione terapeutica di NSCLC

35% EARLY

25% LOCALLY

40% ADVANCED

Stadio	T	N	M
Stadio IA1	T1a(mi)	N0	M0
	T1a	N0	M0
Stadio IA2	T1b	N0	M0
Stadio IA3	T1c	N0	M0
Stadio IB			
Stadio IIA	T2b	N0	M0
Stadio IIB	T1a, b, c	N1	M0
	T2a, b	N1	M0
	T2b	N1	M0
	T3	N0	M0
Stadio IIIA	T1a, b, c	N2	M0
	T2a, b	N2	M0
	T3	N1	M0
	T4	N1	M0
Stadio IIIB	T1a, b, c	N3	M0
	T2a, b	N3	M0
	T3	N2	M0
	T4	N2	M0
Stadio IIIC	T3	N3	M0
	T4	N3	M0
Stadio IVA	Qualunque T	Qualunque N	M1a
	Qualunque T	Qualunque N	M1b
Stadio IVB	Qualunque T	Qualunque N	M1c



Proposed	Events / N	MST	24 Month	60 Month
IA1	68 / 781	NR	97%	92%
IA2	505 / 3105	NR	94%	83%
IA3	546 / 2417	NR	90%	77%
IB	560 / 1928	NR	87%	68%
IIA	215 / 585	NR	79%	60%
IIB	605 / 1453	66.0	72%	53%
IIIA	2052 / 3200	29.3	55%	36%
IIIB	1551 / 2140	19.0	44%	26%
IIIC	831 / 986	12.6	24%	13%
IVA	336 / 484	11.5	23%	10%
IVB	328 / 398	6.0	10%	0%

9th Edition TNM Categories

T/M	Description	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤ 1 cm	IA1	IIA	IIIB	IIIA	IIIB
	T1b > 1 to ≤ 2 cm	IA2	IIA	IIIB	IIIA	IIIB
	T1c > 2 to ≤ 3 cm	IA3	IIA	IIIB	IIIA	IIIB
T2	T2a Visceral pleura/ central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a > 3 to ≤ 4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b > 4 to ≤ 5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 > 5 to ≤ 7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe tumor nodule	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 > 7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invas					
	T4 Ipsil					

ASCO Reccomendations for pts suitable for Neoadj CTX

- Complete Resection (R0) of the primary tumour and involved lymph nodes is deemed possible
- N3 lymph nodes are deemed to be not involved by MTD
- Perioperative mortality is expected to be low (<5%)
- Pts fitness for surgery and induction CTX

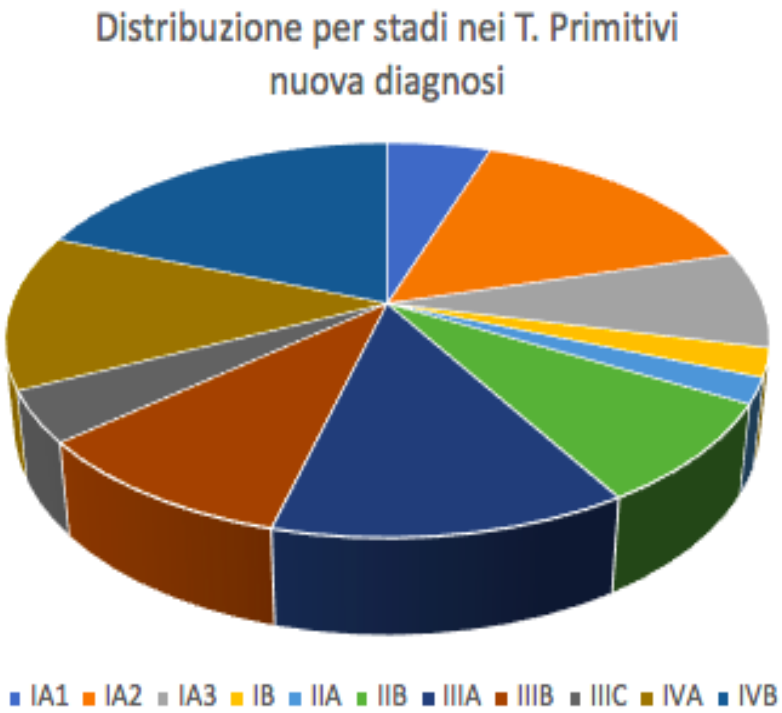
Pazienti con NSCLC in stadio II-IIIB (N2):

- dopo stadiazione con TC-TB con mdc +/- PET-FDG;
- dopo stadiazione linfonodale con EBUS TBNA e raccolta di materiale sufficiente per eseguire istologia, IHC e analisi molecolare;

✓ Stage IIIA, N2 Single vs Multi station

✓ Stage IIIB generally unsuitable, with occasional exceptions according to MDTs decision

GOM Neoplasie del torace AOU-CAREGGI: 2024



Early stage:
198 pz (**41.3%**)

Pot. resecabili IIIA:
61 pz (**12.7%**)

ANNO 2024

INCONTRI	**49**	
CASI DISCUSSI (verbali)	**781**	
PAZIENTI DISCUSSI (nuovi casi e no)	**646**	
MASCHI	392	60,00%
FEMMINE	254	40,00%
CASI PRESENTATI PER SOD:		
CHIRURGIA APPARATO DIGERENTE	1	
CHIRURGIA EPATOBILIOPANCREATICA	1	
CHIRURGIA TORACICA	23	
EMATOLOGIA	23	
ONCOLOGIA CLINICA	135	
ORTOPEDIA ONCOLOGIA	2	
PNEUMOLOGIA (di cui 3 Pneumologia Interventistica)	474	
RADIOTERAPIA	114	
ALTRO: Malattie Infettive e Tropicali, Neurologia 2, Oncologia della Mammella, Oncologia Ginecologica, Oncologia Traslazionale, ORL, Radiodiagnostica Emergenza-Urgenza, Trapianto	8	
		Tot 781

GOM AOUC: Studi clinici condivisi

CheckMate 816: Neoadjuvant Nivolumab + CT for Resectable Stage IB-IIIA NSCLC

- Randomized, oper

Stratified by sex, disease sta

Adults with newly diagno
resectable, stage IB (≥4
to IIIA NSCLC†; no sensiti
EGFR mutations or *AL*
alterations; ECOG PS ≤
(N = 358)

- **Primary endpoint**

AEGEAN study de

Study population

- Resectable NSCLC* (stage IIA–IIIB[N2]; AJC
- Treatment-naïve
- ECOG PS 0 or 1
- Lobectomy, sleeve rese
  bilobectomy as planne
- Confirmed PD-L1 status
- No documented *EGFR/ALK* aberrations*

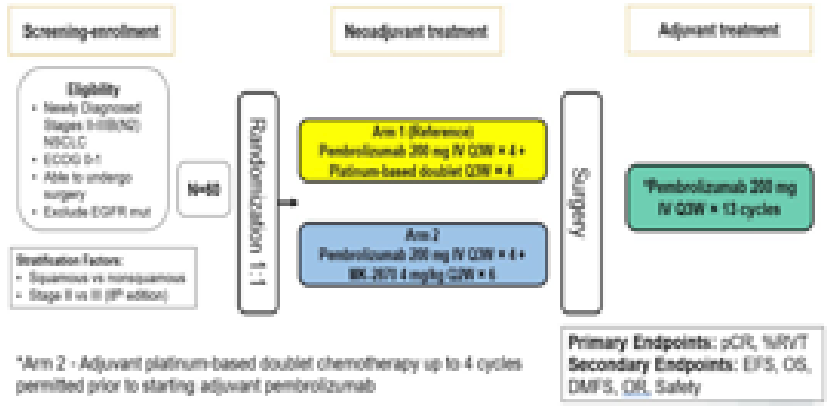
randomized

Efficacy analyses were performed in the mITT population (or its resected subpopulation), which excluded patients with documented EGFR/ALK aberrations¶

Primary endpoints: pCR, evaluated centrally (IASLC 2020[1]), and EFS per BICR (RECIST v1.1)

Key secondary endpoints: MPR, evaluated centrally (IASLC 2020[1]), DFS per BICR (RECIST v1.1) in the resected subpopulation, and OS

Rationale for Study: MK3475-01E Study Design

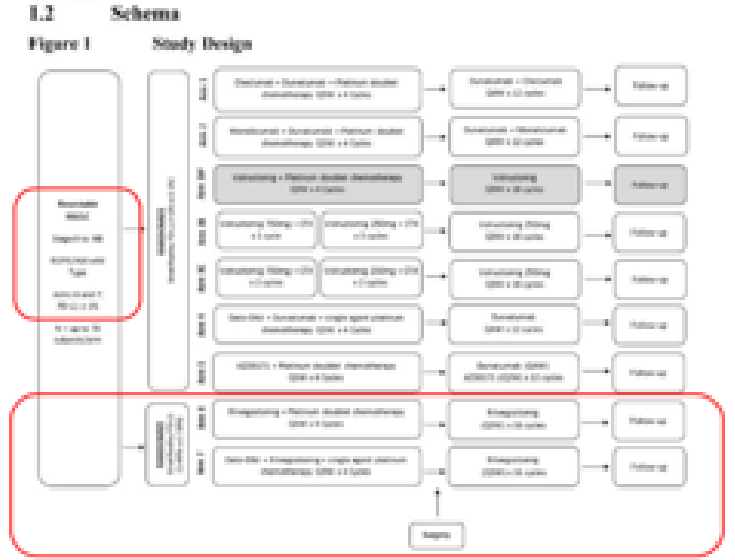


*Arm 2 - Adjuvant platinum-based doublet chemotherapy up to 4 cycles permitted prior to starting adjuvant pembrolizumab

Primary Endpoints: pCR, %RVT
Secondary Endpoints: EFS, OS, DMFS, OR, Safety

KEYNOTE-671: Neoadjuvant and Adjuvant Pembrolizumab in Resectable NSCLC

NEOCOAST-2



brolizumab
mg IV Q3W
p to 13 cycles

Placebo
IV Q3W
p to 13 cycles

EAP)

rapy prior to Surgery
tients with Resectable

Patient Follow Up

- 12 week follow up or in accordance with local regulations
- Treatment will end if discontinuation criteria met

segmentectomy, wedge resection
- EGFRwt/ALKwt or unknown

PORT

Metastasis (M) Component

Kwun M. Fong, MD, PhD

Table 1. Distant Metastasis Definitions

M0	No distant metastasis
M1	Distant metastasis
M1a	Tumor with pleural or pericardial nodules or malignant pleural or pericardial effusions[1], separate tumor nodule(s) in a contralateral lobe
M1b	Single extrathoracic metastasis in a single organ system[2]
M1c	Multiple extrathoracic metastases
M1c1	Multiple extrathoracic metastases in a single organ system[3]
M1c2	Multiple extrathoracic metastases in multiple organ systems

SPLIT

IASLC

8th Ed TNM Categories

8th Ed TNM Categories					
T/M	Label	N0	N1	N2	N3
T1	T1a	IA1	IIB	IIIA	IIIB
	T1b	IA2	IIB	IIIA	IIIB
	T1c	IA3	IIB	IIIA	IIIB
T2	T2a Inv	IB	IIB	IIIA	IIIB
	T2a >3-4	IB	IIB	IIIA	IIIB
	T2b >4-5	IIA	IIB	IIIA	IIIB
T3	T3 >5-7	IIB	IIIA	IIIB	IIIC
	T3 Inv	IIB	IIIA	IIIB	IIIC
	T3 Same Lobe Nod	IIB	IIIA	IIIB	IIIC
T4	T4 >7	IIIA	IIIA	IIIB	IIIC
	T4 Inv	IIIA	IIIA	IIIB	IIIC
	T4 Ipsi Nod	IIIA	IIIA	IIIB	IIIC
M1	M1a Pl Dissem	IVA	IVA	IVA	IVA
	M1a Contr Nod	IVA	IVA	IVA	IVA
	M1b Single Les	IVA	IVA	IVA	IVA
	M1c Mult Les	IVB	IVB	IVB	IVB

Proposed 9th Ed TNM Categories

Proposed 9th Ed TNM Categories						
T/M	Description	N0	N1	N2		N3
				N2a	N2b	
T1	T1a ≤1 cm	IA1	IIA	IIB	IIIA	IIIB
	T1b >1 to ≤2 cm	IA2	IIA	IIB	IIIA	IIIB
	T1c >2 to ≤3 cm	IA3	IIA	IIB	IIIA	IIIB
T2	T2a Visceral pleura / central invasion	IB	IIB	IIIA	IIIB	IIIB
	T2a >3 to ≤4 cm	IB	IIB	IIIA	IIIB	IIIB
	T2b >4 to ≤5 cm	IIA	IIB	IIIA	IIIB	IIIB
T3	T3 >5 to ≤7 cm	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Invasion	IIB	IIIA	IIIA	IIIB	IIIC
	T3 Same lobe tumor nodule	IIB	IIIA	IIIA	IIIB	IIIC
T4	T4 >7 cm	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Invasion	IIIA	IIIA	IIIB	IIIB	IIIC
	T4 Ipsilateral tumor nodule	IIIA	IIIA	IIIB	IIIB	IIIC
M1	M1a Pleural / pericardial dissemination	IVA	IVA	IVA	IVA	IVA
	M1a Contralateral tumor nodule	IVA	IVA	IVA	IVA	IVA
	M1b Single extrathoracic lesion	IVA	IVA	IVA	IVA	IVA
	M1c1 Multiple lesions, 1 organ system	IVB	IVB	IVB	IVB	IVB
	M1c2 Multiple lesions, >1 organ system	IVB	IVB	IVB	IVB	IVB

Figure 2. Proposed ninth edition TNM stage groups. Mult, multiple.

Ann Surg Oncol (2025) 32:4569–4571
https://doi.org/10.1245/s10434-025-17327-4

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

EDITORIAL – THORACIC ONCOLOGY AND ESOPHAGEAL CANCER

Updates on the Version 9 American Joint Committee on Cancer Staging System for Lung Cancer

Hisao Asamura, MD[1], Masaya Yotsukura, MD[2], Ramón Rami-Porta, MD[3,4], and Valerie W. Rusch, MD[5]

[1]Department of Thoracic Surgery, Hakuhokai Tokyo Hikifune Hospital, Tokyo, Japan; [2]Department of Thoracic Surgery, National Cancer Center Hospital, Tokyo, Japan; [3]Department of Thoracic Surgery, Hospital Universitari Mutua Terrassa, University of Barcelona, Terrassa, Barcelona, Spain; [4]Network of Centres for Biomedical Research in Respiratory Diseases (CIBERES) Lung Cancer Group, Terassa, Barcelona, Spain; [5]Department of Surgery, Memorial Sloan-Kettering Cancer Center, New York, NY

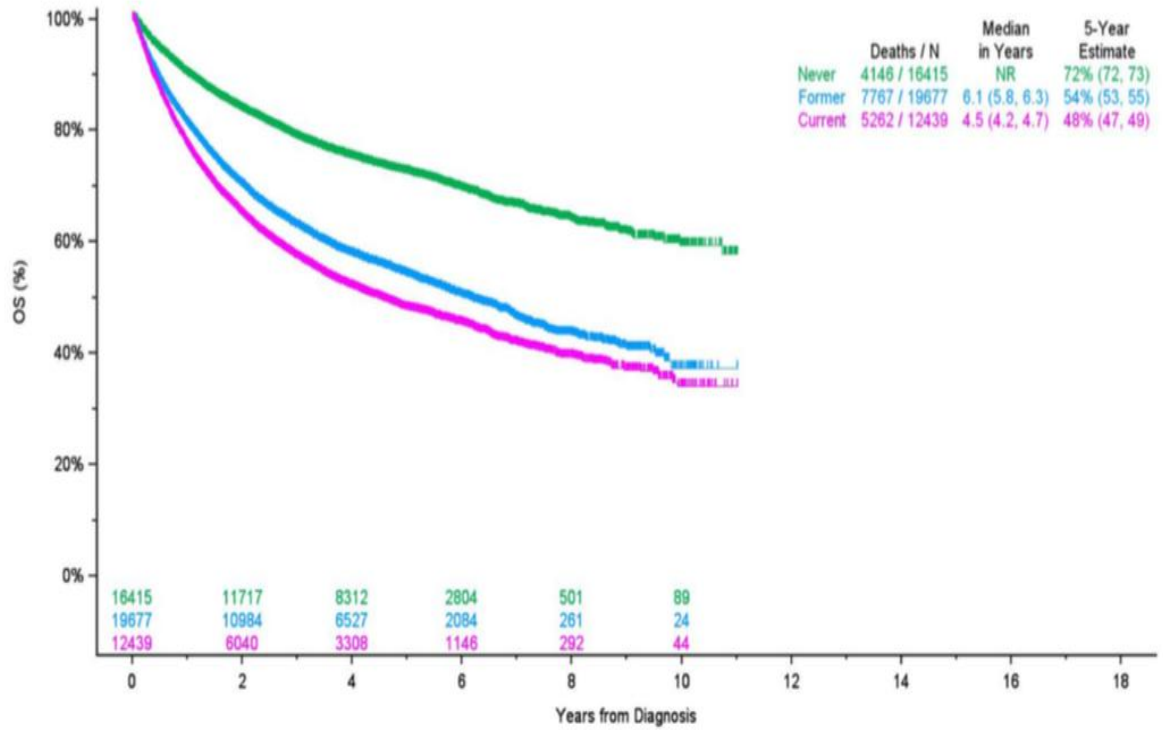
- Differenze Geografiche
- Differenze di Genere
- Sottogruppi T3
- Malattia avanzata
- Biomarcatori
- Parametri NON-Anatomici
- Cicli settennali di revisione?

IASLC



October 2025

Smoking and Ninth Edition Lung Cancer Staging



Variable	Comparison	n/N (%)	aHR (95% CI)	P Value
Stage	IB (vs IA)	4,773/48,531 (9.83%)	1.77 (1.66-1.89)	<.0001
	IIA (vs IB)	2,963/48,531 (6.11%)	1.17 (1.08-1.27)	0.0002
	IIB (vs IIA)	3,150/48,531 (6.49%)	1.20 (1.10-1.30)	<.0001
	IIIA (vs IIB)	3,130/48,531 (6.45%)	1.28 (1.19-1.39)	<.0001
	IIIB (vs IIIA)	1,312/48,531 (2.70%)	1.49 (1.36-1.63)	<.0001
	IIIC (vs IIIB)	554/48,531 (1.14%)	1.59 (1.40-1.81)	<.0001
	IVA (vs IIIC)	6,635/48,531 (13.67%)	1.11 (0.99-1.24)	0.0775
	IVB (vs IVA)	6,038/48,531 (12.44%)	1.63 (1.56-1.70)	<.0001
Age	> 65 vs < 65	27,142/48,531 (55.93%)	1.35 (1.30-1.39)	<.0001
Sex	Male vs Female	24,677/48,531 (50.85%)	1.18 (1.15-1.22)	<.0001
Region	Europe vs Asia	9,916/48,531 (20.43%)	1.20 (1.16-1.25)	<.0001
	North America vs Asia	5,511/48,531 (11.36%)	1.07 (1.01-1.13)	0.0165
	Rest of World vs Asia	1,241/48,531 (2.56%)	1.43 (1.29-1.58)	<.0001
Histologic type	Adenocarcinoma vs Squamous	36,223/48,531 (74.64%)	0.76 (0.74-0.79)	<.0001
	Other non-squamous vs Squamous	2,043/48,531 (4.21%)	0.94 (0.87-1.02)	0.1456
ECOG Score	1+ vs 0	16,959/48,531 (34.94%)	1.76 (1.70-1.82)	<.0001
Smoking Status	Current vs Never	12,439/48,531 (25.63%)	1.39 (1.34-1.46)	<.0001
	Former vs Never	19,677/48,531 (40.55%)	1.32 (1.27-1.38)	<.0001
	Current vs Former	12,439/48,531 (25.63%)	1.05 (1.02-1.09)	0.0052

J Thorac Oncol. 2025;20:1441-1458.

Take Home



- L’aggiornamento della 9a edizione TNM si avvale di una casistica più omogenea con studio accurato e numero di pazienti elevato rispetto alle edizioni precedenti
- La separazione per N2 in singola stazione vs multipla modifica la prognosi nei due sottogruppi
- Ad oggi, nessuna variazione per le dimensioni dell’N e l’estensione extracapsulare
- I trattamenti perioperatori sono da considerare in tutti i pazienti in stadio II-IIIB (N2) ritenuti resecabili da valutazione multidisciplinare
- Il chirurgo è la figura professionale che definisce resecabilità e operabilità
- L’introduzione dei parametri non anatomici nelle future edizioni sarà determinante





INTEGRATE 7.0

QUALI 'REGOLE' NELLA GESTIONE INTEGRATA DELLA NEOPLASIA POLMONARE?

GAMES

Azienda Ospedaliero Universitaria Careggi

UNIVERSITÀ DEGLI STUDI FIRENZE

Da un secolo, oltre.



