

## Lung (ICD-O C34)

### Rules for Classification

The classification applies only to carcinomas. There should be histological confirmation of the disease and division of cases by histological type.

### Anatomical Subsites (Fig. 210)

1. Main bronchus (C34.0)
2. Upper lobe (C34.1)
3. Middle lobe (C34.2)
4. Lower lobe (C34.3)

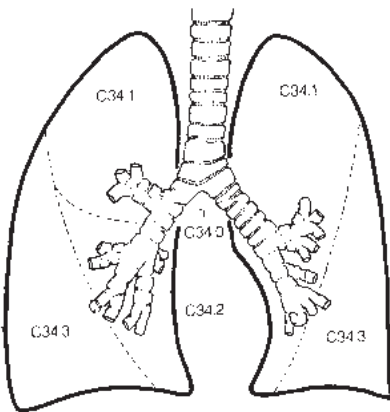


Fig. 210

### Regional Lymph Nodes

The regional lymph nodes are the intrathoracic, scalene, and supraclavicular nodes (see pp. 155–157).

## TNM Clinical Classification

### T – Primary Tumour

- TX Primary tumour cannot be assessed, *or* tumour proven by the presence of malignant cells in sputum or bronchial washings but not visualized by imaging or bronchoscopy
- T0 No evidence of primary tumour
- Tis Carcinoma in situ
- T1 Tumour 3 cm or less in greatest dimension, surrounded by lung or visceral pleura, without bronchoscopic evidence of invasion more proximal than the lobar bronchus (i.e., not in the main bronchus)<sup>1</sup> (Fig. 211)
- T2 Tumour with *any* of the following features of size or extent (Fig. 212):
- More than 3 cm in greatest dimension
  - Involves main bronchus, 2 cm or more distal to the carina
  - Invades visceral pleura
  - Associated with atelectasis or obstructive pneumonitis – that extends to the hilar region but does not involve the entire lung
- T3 Tumour of any size that directly invades any of the following: chest wall (including superior sulcus tumours), diaphragm, mediastinal pleura, parietal pericardium; *or* tumour in the main bronchus less than 2 cm distal to the carina<sup>1</sup> but without involvement of the carina; *or* associated atelectasis or obstructive pneumonitis of the entire lung (Fig. 213)
- T4 Tumour of any size that invades any of the following: mediastinum, heart, great vessels, trachea, oesophagus, vertebral body, carina; separate tumour nodule(s) in the same lobe; tumour with malignant pleural effusion<sup>2</sup> (Figs. 214–222)

#### Notes

<sup>1</sup> The uncommon superficial spreading tumour of any size with its invasive component limited to the bronchial wall, which may extend proximal to the main bronchus, is also classified as T1.

<sup>2</sup> Most pleural effusions with lung cancer are due to tumour. In a few patients, however, multiple cytopathological examinations of pleural fluid are negative for tumour, and the fluid is non-bloody and is not an exudate. Where these elements and clinical judgment dictate that the effusion is not related to the tumour, the effusion should be excluded as a staging element and the patient should be classified as T1, T2, or T3.

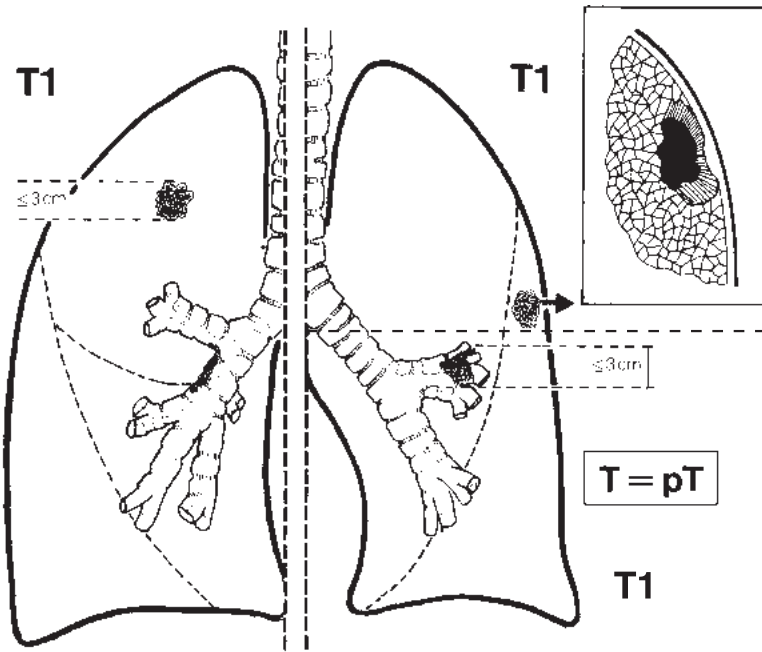


Fig. 211

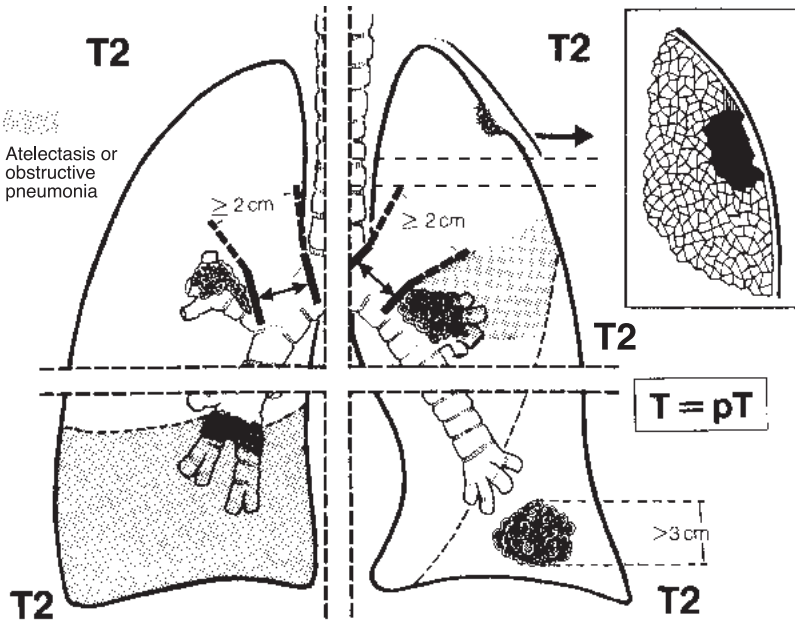


Fig. 212

Fig. 213

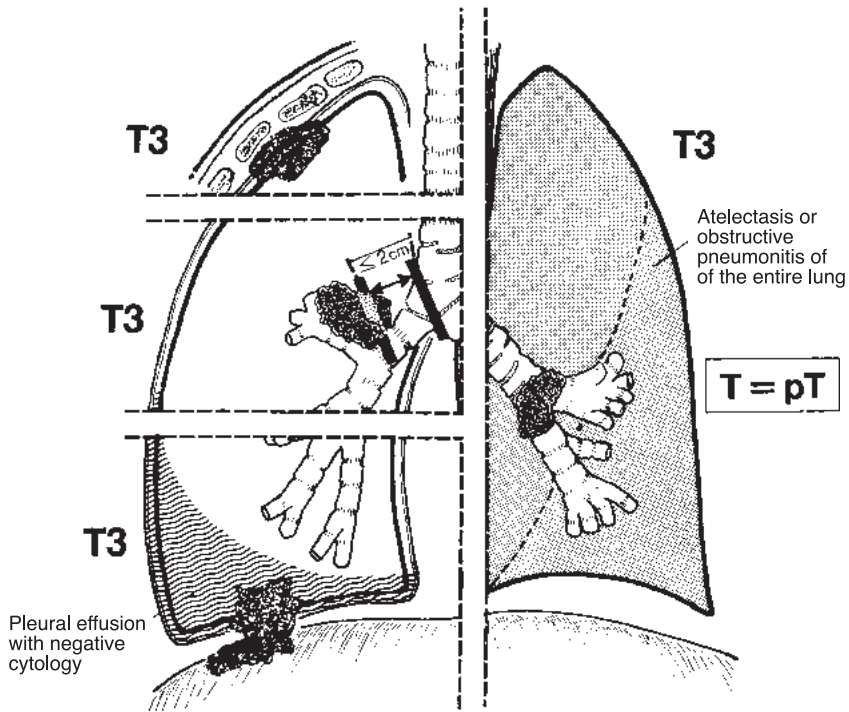
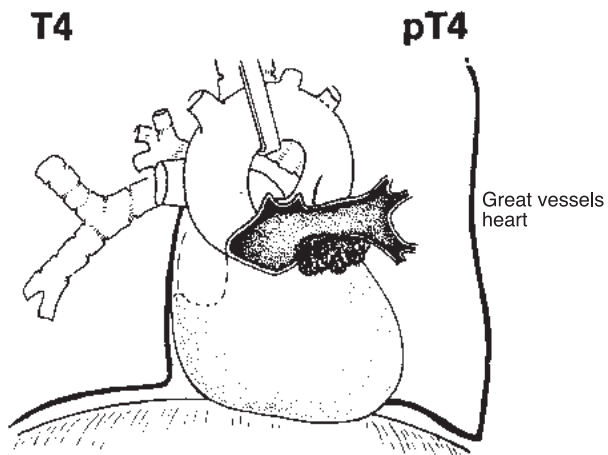


Fig. 214



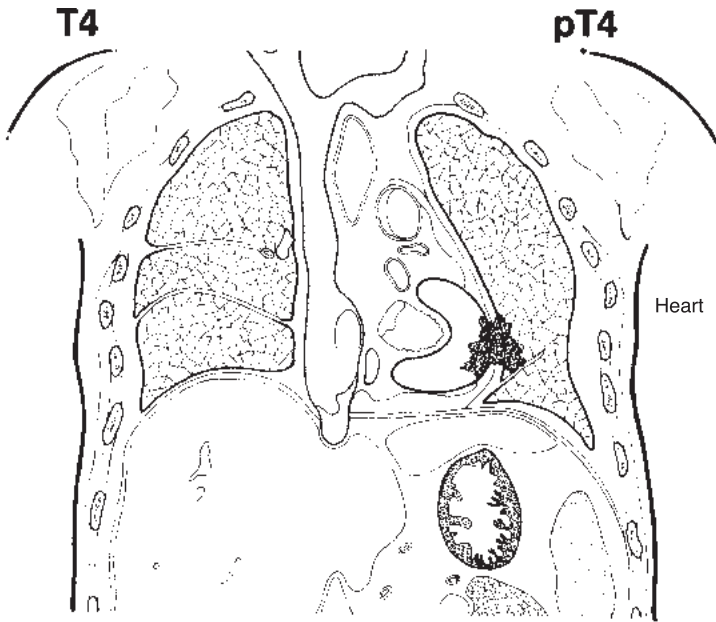


Fig. 215

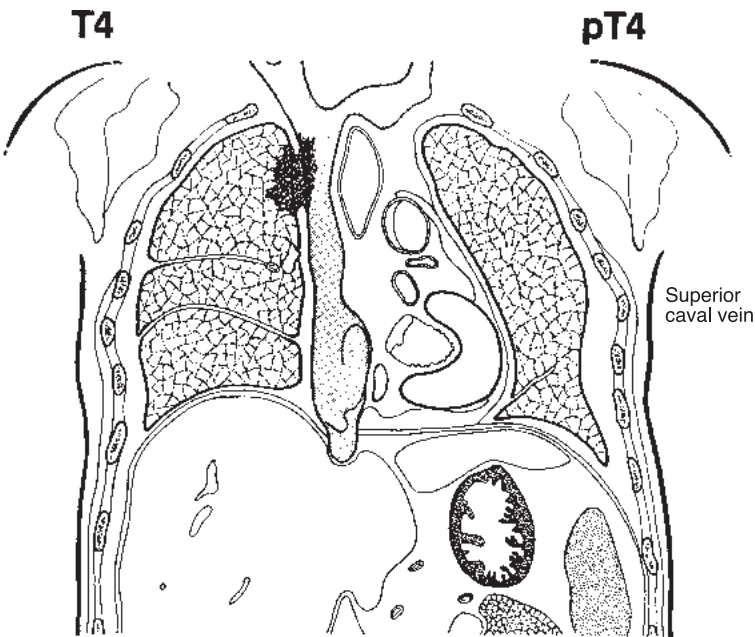


Fig. 216

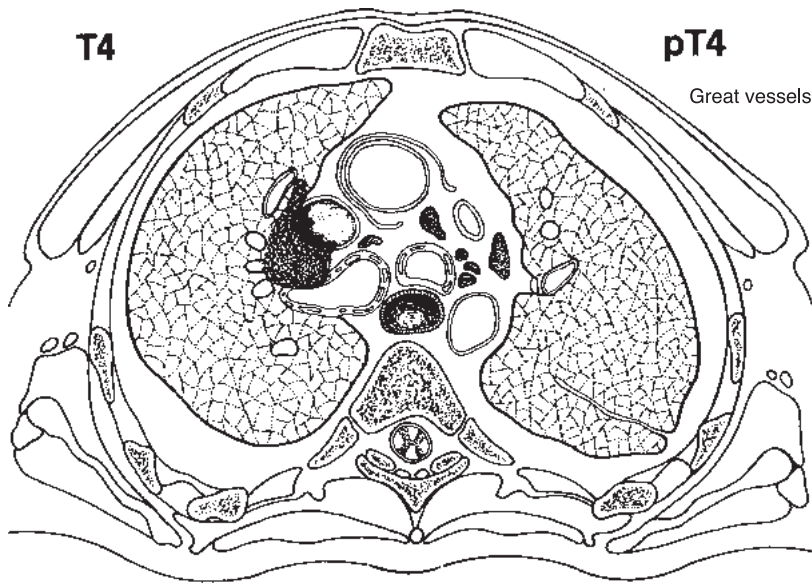


Fig. 217

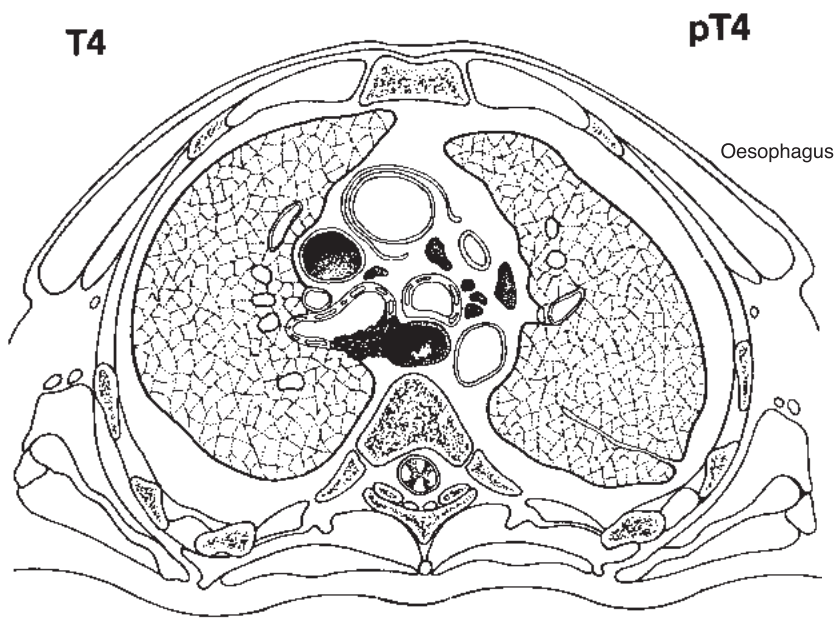


Fig. 218

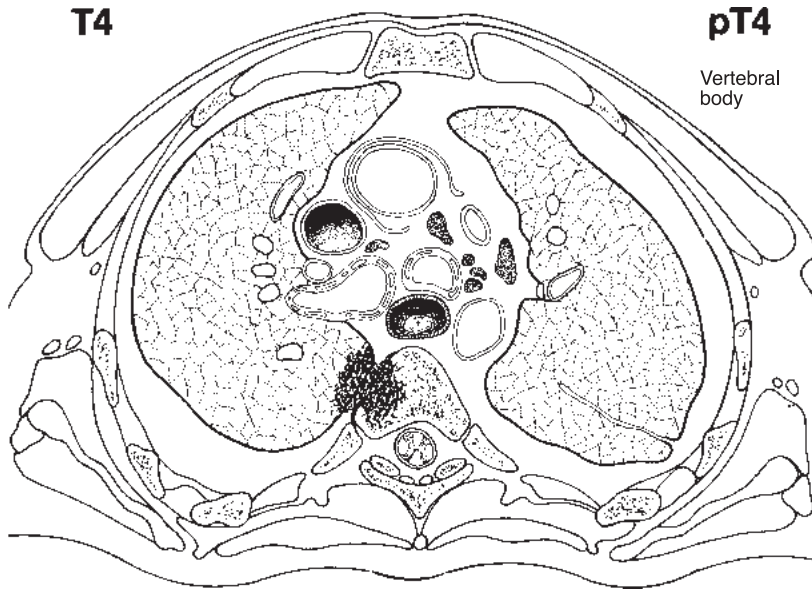


Fig. 219

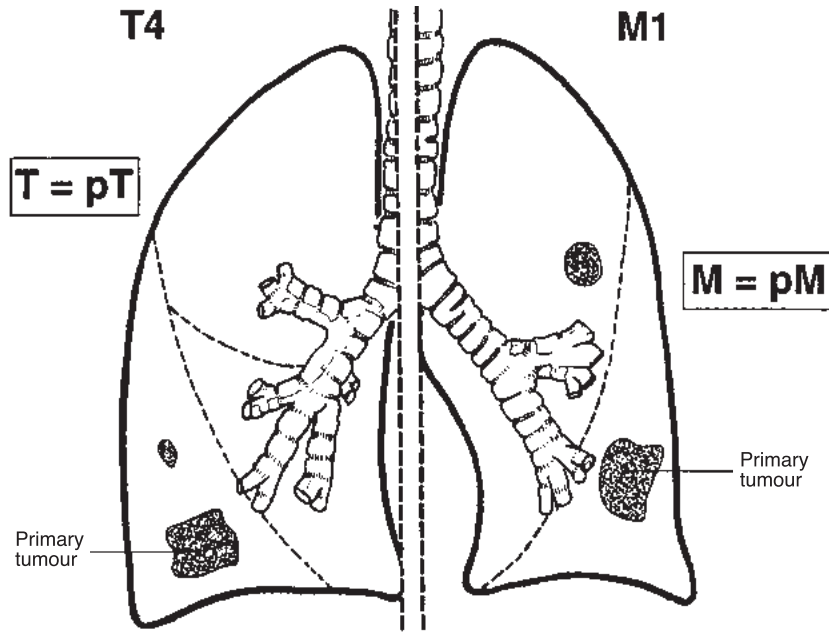


Fig. 220

Lung

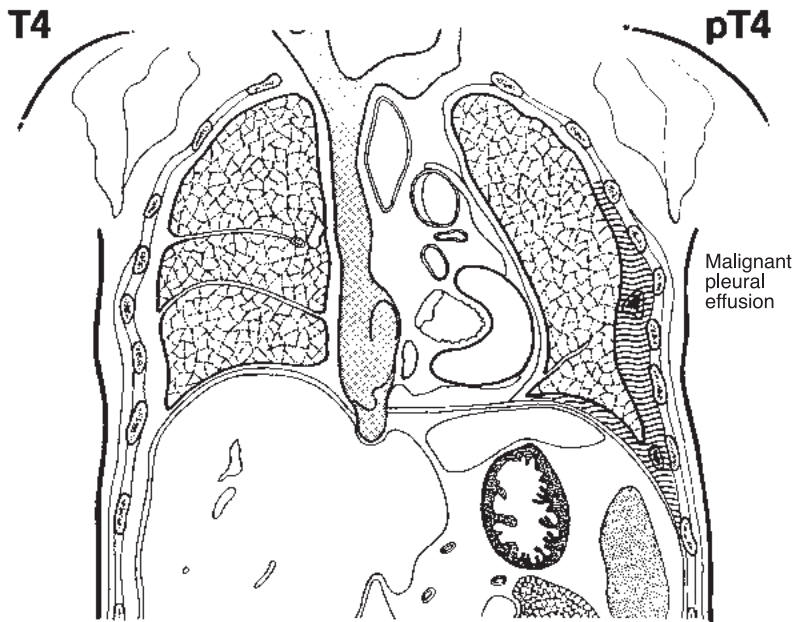


Fig. 221

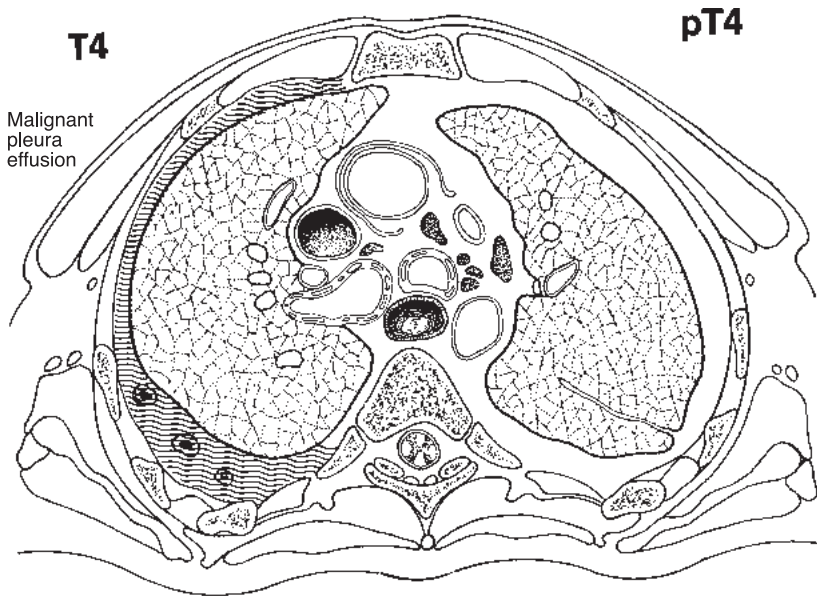


Fig. 222



## N – Regional Lymph Nodes

- NX Regional lymph nodes cannot be assessed
- N0 No regional lymph node metastasis
- N1 Metastasis in ipsilateral peribronchial and/or ipsilateral hilar lymph nodes and intrapulmonary nodes, including involvement by direct extension (Fig. 223)

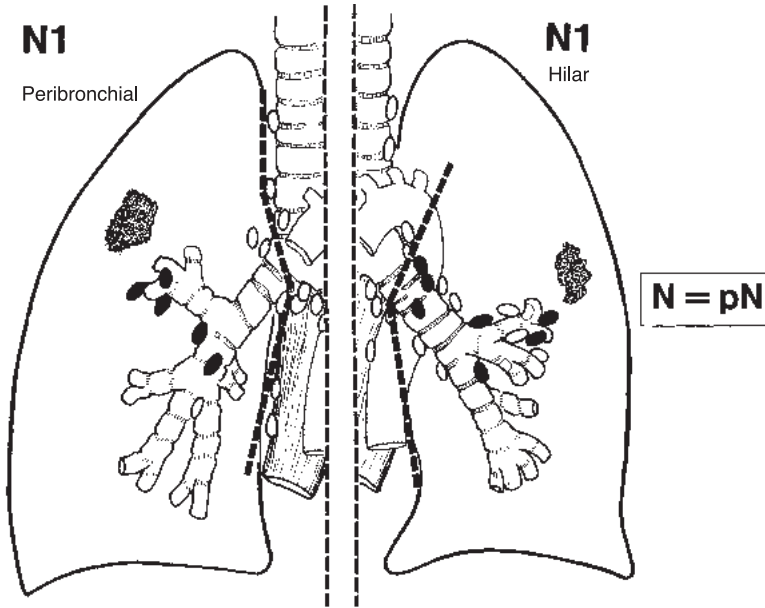


Fig. 223

N2 Metastasis in ipsilateral mediastinal and/or subcarinal lymph node(s) (Fig. 224)

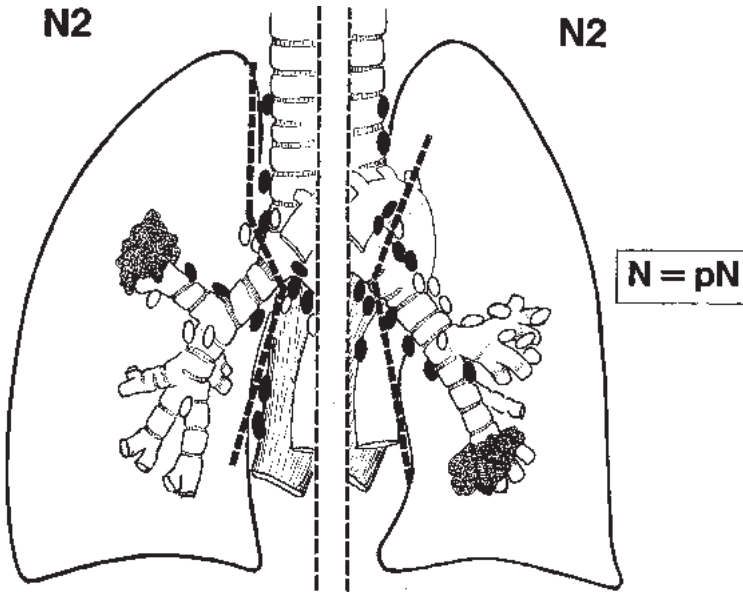


Fig. 224

**N3** Metastasis in contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene, or supraclavicular lymph node(s) (Fig. 225)

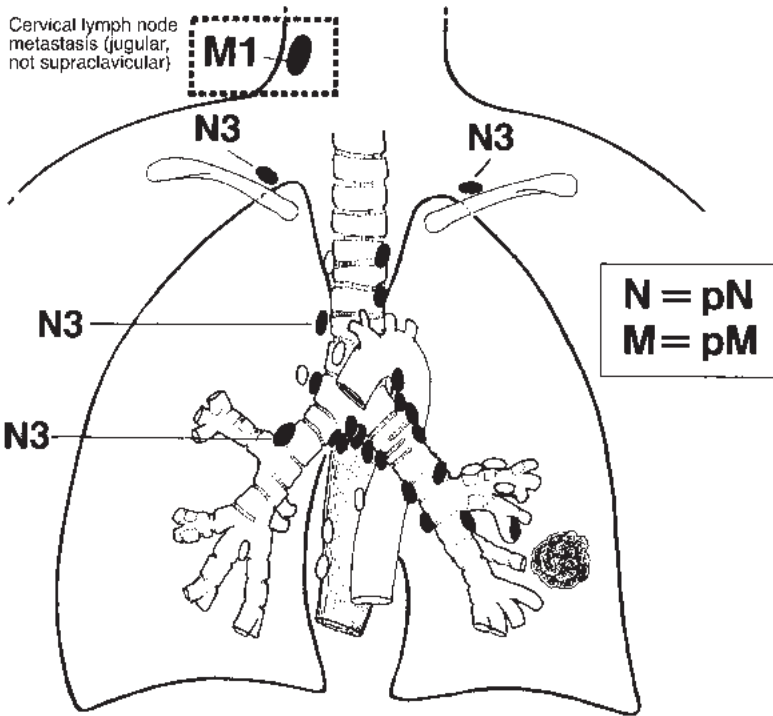


Fig. 225

### M – Distant Metastasis

- MX** Distant metastasis cannot be assessed
- M0** No distant metastasis
- M1** Distant metastasis, includes separate tumour nodule(s) in a different lobe (ipsilateral or contralateral) (Figs. 220, 225)

### pTNM Pathological Classification

The pT, pN, and pM categories correspond to the T, N, and M categories.

**pN0** Histological examination of hilar and mediastinal lymphadenectomy specimen(s) will ordinarily include 6 or more lymph nodes. If the examined lymph nodes are negative, but the number ordinarily resected is not met, classify as pN0. The number of lymph nodes should be recorded in the pathology report.