





**De nieuwe TNM-  
klassificatie  
2009**


*TOGA 17-03-2009  
Danny Galdermans  
ZNA Middelheim*



**Wat is het juiste woord?**


Het bepalen van de anatomische uitbreiding van een maligne tumor heet in het Nederlands:

1. Stagering/stageren
2. Stadiëring/stadiëren
3. Staging/stagen
4. Alle voorgaande zijn juist




**Definitie**

- Coêlho: Zakwoordenboek der Geneeskunde 24<sup>o</sup> druk , 1993
  - p 756: '*classificatie van (maligne) tumoren*
  - geen vermelding van staging of stadiëring
- Van Dale, 2008: **stageren**: bepalen van de uitbreidbaarheid van een kwaadaardig gezwel, Afgeleid van het engels woord "stage".



**DEFINITIE**

- Staging is the measurement of the *anatomical* extent of a tumour in a patient,
- In order to allow logical grouping of that patient with others who have similar disease for prognostic, analytic or therapeutic purposes.



**descriptors en categorieën**

Minimaal: naargelang verdere uitbreiding

- T: tumor 0 1 2 3 4 X is
- N: regionale lymfeklier 0 1 2 3 X
- M: metastase\* 0 1 X


pTNM: 0: geen; 1: microscopisch; 2 macroscopisch; X: ?

- R: residuele tumor 0 1 2 X
- L: lymfevat invasie 0 1 2 X
- V: veneuse permeatie 0 1 2 X
- P: pleurale invasie 0 1 2 X

PA-verslag: 1: goed; 2: matig; 3: weinig; 4: niet; X: ?

- G: histolog.differentiatiegraad 1 2 3 4 X


\* En niet regionale lymfeklier




**Stadia en substadia**

Minimaal 24 combinaties mogelijk indien 4T's 3N's, 2M's = onwerkbaar


- vandaar homogene stadia:
  - Romeinse cijfers
  - 0: in situ ca
  - I, II, III: progressief toenemende uitbreiding
  - IV: distale metastasen
- Onderverdeling in substadia: A, B (hoofdletter)
  - a, b, c: subcategorieën van descriptors
    - T1a, T2b, M1b
  - m: multipole tumoren
  - diffuus bac: T4 (m)

**Prefixen** 

- **c:** klinisch: gebaseerd op evidentie vóór enige behandeling
  - Essentieel voor therapie keuze en evaluatie
- **p:** pathologisch: evidentie verkregen door PA onderzoek na een chirurgische resectie
  - Van de primaire tumor, voldoende om de hoogste pT te evalueren
  - Van voldoende regionale LN om de afwezigheid van lymfeklier invasie te valideren (pN0)
  - de hoogste pN te evalueren
  - Essentieel voor prognose en vergelijkingen van resultaten


**prefixen** 

- **r:** recidief tumor na ziektevrij interval
- **a:** autoptisch
- **y:** bij herstagering tijdens of na multimodale behandeling
- **s:** chirurgisch: o.b.v. intra-operatieve bevindingen


**De C factor (1)** 

The C-factor, or certainty factor, reflects the validity of classification according to the diagnostic methods used.

- C1 Evidence from *standard diagnostic means* (e.g. inspection, palpation and standard radiography)
- C2 Evidence obtained by *special diagnostic means* (e.g. ultrasonography, lymphography, angiography; scintigraphy; CT; MRI; endoscopy, biopsy and/or cytology)
- C3 Evidence from *surgical exploration*, including biopsy and/or cytology


**De C factor (2)** 

- C4 Evidence of the extent of disease following *definitive surgery and pathological examination* of the resected specimen
- C5 Evidence from *autopsy*
- *Examples: Degrees of C may be applied to the T, N and M categories. A case might be described as T3C2, N2C1, M0C2*
- The clinical TNM classification is, therefore, equivalent to C1, C2 and C3 in varying degrees of certainty, while the pTNM classification is generally equivalent to C4


**geschiedenis** 

De eerste UICC- TNM-classificatie van longkanker dateert van:

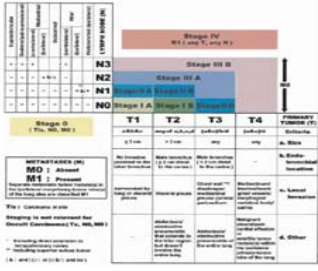
1. 1968
2. 1974
3. 1987
4. 1997

**geschiedenis** 

- UICC manual 1st editie: *TNM Classification of Malignant Tumours*
- 1974: 2<sup>o</sup> editie: eerste TNM-longca
  - 2155 patienten (AJCC 1973, C Mountain)
  - Geen stadium IV (any M1 = stage III)
- 1978: 3<sup>o</sup> editie: III -> IV
- 1986: 4<sup>o</sup> editie: IIIA/B : 3753 patienten
- 1997: 5<sup>o</sup> editie: 5319 patienten

**UICC-TNM classificatie van Mountain 1997** 

**TNM STAGING OF LUNG CANCER**



**STAGE I (T1, N0, M0)**


**STAGE II (T2, N1, M0)**

**STAGE III (T3, N1-2, M0)**


**STAGE IV (T4, N3, M1)**

**Metastases (M):**  
 M0: Absent  
 M1: Present

**Fig 1. Categories in the TNM Staging System for Lung Cancer**

**Huidige controversies in de TNM** 

- Cut-off T1/T2
- Multipele nodules zelfde kwab/long andere kwab/long
  - T3 vs. T4
- Maligne pleura/pericard vocht:
  - T4 vs. M1
- Lymfekliermap
  - 4R/10R
  - Station 1 & 3
- Substagering: IIA/B

**methodologie** 

Hoe ontstaat een TNM-classificatie?

1. Retrospectieve dataset
2. Kaplan Meier overleving
3. Logistische regressie analyse
4. 1-2-3 zijn juist


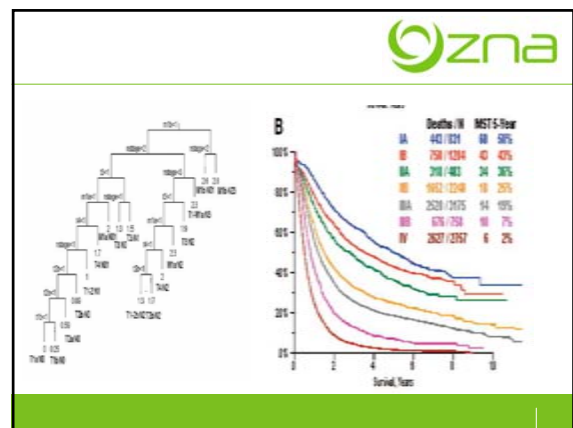
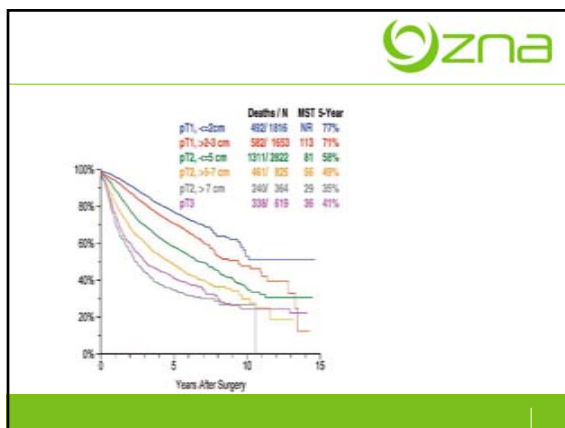

**Goldstraw 2006** 

Table 2.2 Screened NSCLC Cases, by Type of Contributing Group


Clinical Trial Groups	Registries	Consortia	Surgical Series
MacCallum 183	Amsterdam 8897	Japan 6931	China 1730
MRC 1659	Flemish 3590	IFCT 2539	Korea 832
IFCT 920	Rotterdam 1133	GOCC-S 2894	Sydney 1572
ELCWP 1385			Prince Charles 773
IALT 1867			St. Vincent's 17
SLOG 438	Institutional Registry: Heidelberg 4455		Gdansk 1231
FORTC 1125		Series	Torino 1137
CALGB 1630		Taiwan 721	Grenoble 677
NCOCTG 1111	Surgical Registry: Norway 2112	ORR 2452	Ankara 543
ECOG 1737		Western 275	Belgrade 344
SWOG 1859		Faculty Hosp. Pilsen 1486	Warsaw 213
RTOG 1768		Leuven 770	Perugia 99
NCIC 550		Jukes-Bordot 547	MSKCC 880
		MDACC-RT 844	MDACC-TCVS 489
		Bolns 851	Prince Margaret 191
		Hopkins 851	Wayne State U 72





**Sterktes**

- Groot aantal patiënten en medewerkers
  - Verschillende herkomst
  - Wereldwijd
- Solide methodologie en statistiek (CRAB)
- Interne en externe validering
  - Unicum in TNM geschiedenis
- Ook toepasbaar op SCLC en carcinoïd



**Zwaktes**


- Retrospectief : hoewel >100.000 patiënten, geen uitspraak mogelijk over
  - Andere T2/3 descriptors
  - Herindeling van mediastinale lymfekliermap
  - R/ prospectieve database
- Geen biologische informatie

J Thorac Oncol. 2007 Aug;2(8):706-14. 

IASLC STAGING ARTICLE


The IASLC Lung Cancer Staging Project: Proposals for the Revision of the TNM Stage Groupings in the Forthcoming (Seventh) Edition of the TNM Classification of Malignant Tumours


Peter Goldstraw, FRCS,\* John Crowley, PhD,† Kari Chansky, MS,‡ Dorothy J. Giroux, MS,‡ Patti A. Groome, PhD,§ Ramon Rami-Porcia, MD;† Pieter E. Postmus, PhD|| Valerie Rusck, MD¶ and Leslie Selkin, MD,‡ on behalf of the International Association for the Study of Lung Cancer International Staging Committee and Participating Institutions



**T- stagering voor endoscopisch zichtbare tumoren**

- Bronchoscopie dient niet alleen voor diagnose, maar ook voor T-stagering.
- Vermeld een T-stagering op je endoscopie rapport
- Met de nieuwe stagering verandert er evenwel niets voor de endoscopische T-stagering






**T- stagering voor endoscopisch zichtbare tumoren**

- T1 : geen bronchoscopische evidentie van invasie meer proximaal dan de lobaire bronchus
- T2 : tumor zit in hoofdbronchus, maar  $\geq 2$ cm van de hoofdcarina verwijderd
- T3 : cfr T2, maar <2cm van de hoofdcarina
- T4 : cfr T2, maar met invasie van hoofdcarina


AJCC Cancer Staging Handbook Lung Rush V. 2009



**T- stagering voor endoscopisch zichtbare tumoren**

- Tx : primaire tumor niet aantoonbaar bij bronchoscopie (hoewel er tumorcellen zijn aangetoond – bijv sputum)
- T0 : geen evidentie van een primaire tumor

AJCC Cancer Staging Handbook Lung Rush V. 2009




**T- staging voor endoscopisch zichtbare tumoren**

Uitzonderingen ?

Oppervlakkige endoscopisch zichtbare tumor met de invasieve component beperkt tot de bronchuswand is **T1a**  
**Zelfs al zit dit tot in de hoofdbronchus**

AJCC Cancer Staging Handbook Lung Rush V. 2009

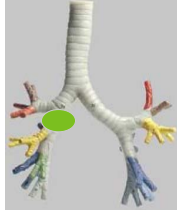



**T- staging voor endoscopisch zichtbare tumoren**

De tumor bevindt zich thv de intermediair bronchus.

T-stadium ?

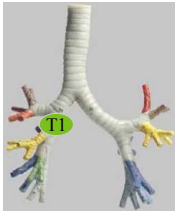
1. Tx
2. Tis
3. T1
4. T2






**T- staging voor endoscopisch zichtbare tumoren**


“T1 ≤3 cm, surrounded by lung or pleura AND...without bronchoscopic evidence of invasion more proximal than the lobar bronchus” (i.e. not in the main bronchus)”  
 De Br-I wordt als lobaire bronchus beschouwd bij endoscopische staging






**T-staging**

- **T1**  
**T1a ≤ 2 cm**  
**T1b > 2 to ≤ 3 cm**
- **T2**  
**T2a > 3 to ≤ 5 cm or T2 by other factor ≤ 5 cm**  
 ✓ Any size, invasion in visceral pleura,  
 ✓ main bronchus >2 cm free  
 ✓ Atelectasis / obstructive pneumonitis HILAR REGION  
**T2b > 5 to ≤ 7 cm**

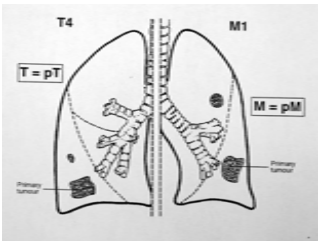


**T-staging**


- **T3 > 7 cm or additional nodule in 1ary lobe**  
 ✓ invasion chest wall, diaphragm, phrenic nerve, mediastinal pleura, parietal pericardium  
 ✓ Atelectases / obstructive pneumonitis ENTIRE LUNG  
 ✓ <2cm distal to carina (but no involvement of carina)
- **T4 additional nodule ipsilateral, different lobe**
- **M1a pleural (or pericardial) dissemination or additional nodule contralateral lung**

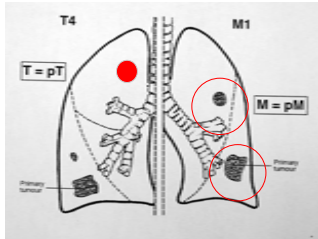


**Multipele letsels**




T4 wordt T3 en M1 wordt T4

**Multipete letsels** 



M1a

**Vraag** 

Eén van de volgende karakteristieken wordt NIET gebruikt bij het bepalen van de T-status op CT


1. Ingroei in de fissuur
2. Necrose van de tumor
3. Ingroei in het diafragma
4. Pleuraal vocht






**Welk venster gebruik je om te meten?** 





Welk venster op CT gebruiken om te meten

1. Als de tumor slecht omljnd is: mediastinale vensters
2. Altijd de mediastinale vensters gebruiken.
3. Altijd hetzelfde venster gebruiken om te vergelijken.
4. Altijd de longvensters gebruiken.

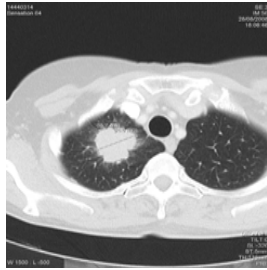



"The same windows should be used on subsequent examinations to measure any lesions. Some favor soft-tissue windows..."

RECIST J Nat Canc Unst 2000

- "Measurements obtained using lung settings were highly accurate irrespective of collimation while measurements obtained using soft tissue settings were inaccurate..."


Harris et al Med Phys 2006




**T- staging** 

Voor het meten van de tumor gebruik je het beste

1. De langste doormeter van de tumor
2. De kortste doormeter van de tumor
3. Je telt de kortste en langste doormeter van de tumor samen
4. Je vermenigvuldigt de langste met de kortste doormeter


**Nodal involvement** 

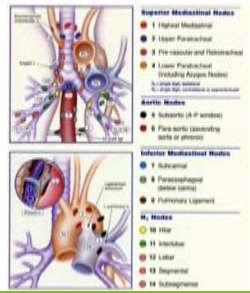
- Nx regional lymph nodes cannot be assessed
- N0 no lymph node metastases
- N1 hilar lymph nodes
- N2 ipsilateral mediastinal lymph nodes positive
- N3 supraclavicular/ contralateral mediastinal

**N - staging** 

Om de grootte van een klier te meten gebruik je

1. De langste doormeter
2. De kortste doormeter
3. Beiden

**1997 Mountain: mediastinal map** 



**Superior Mediastinal Nodes**

- 1 Hilar Mediastinal
- 2 Upper Paratracheal
- 3 Prevascular and Retrovascular
- 4 Lower Paratracheal (Including Azygos Nodes)

**Subcarinal Nodes**


- 5 Subcarinal (A/P window)
- 6 Para-aortic (anterior/superior/superior)

**Inferior Mediastinal Nodes**

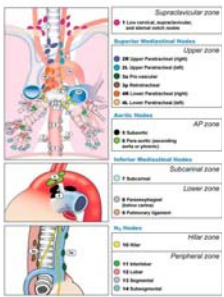
- 7 Subcarinal
- 8 Paraesophageal (below carina)
- 9 Pulmonary Ligament

**H. Nodes**

- 10 Hilar
- 11 Hilar/Carinal
- 12 Lobar
- 13 Segmental
- 14 Subsegmental

**IASLC 2009** 

- No changes in LN stations
- Zones vs stations



**Voorgestelde veranderingen N-staging** 



PROPOSED BORDER BETWEEN RIGHT AND LEFT PARATRACHEAL NODES

**TABLE 3. Proposed Definitions for T, N, and M Descriptors**

**T (Primary Tumor)**

TX	Primary tumor cannot be assessed, or tumor proven by the presence of malignant cells in sputum or bronchial washings but not visualized by imaging or bronchoscopy
T0	No evidence of primary tumor
Tis	Carcinoma in situ
T1	Tumor ≤3 cm 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)*
T1a	Tumor ≤2 cm in greatest dimension
T1b	Tumor >2 cm but ≤3 cm in greatest dimension
T2	Tumor >3 cm but ≤7 cm or tumor with any of the following features (T2 tumors with these features are classified T2a if ≤5 cm) Involves main bronchus, ≥2 cm 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
T2a	Tumor >3 cm but ≤5 cm in greatest dimension
T2b	Tumor >5 cm but ≤7 cm in greatest dimension
T3	Tumor >7 cm or one that directly invades any of the following: chest wall (including superior sulcus tumors), diaphragm, pleural nerve, mediastinal pleura, parietal pericardium, or tumor in the main bronchus <2 cm distal to the carina <sup>†</sup> but without involvement of the carina, or associated atelectasis or obstructive pneumonitis of the entire lung or separate tumor nodule(s) in the same lobe
T4	Tumor of any size that invades any of the following: mediastinum, heart, great vessels, trachea, recurrent laryngeal nerve, esophagus, vertebral body, carina, separate tumor nodule(s) in a different mediastinal lobe

**N (Regional Lymph Nodes)**

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

**M (Distant Metastasis)**

MX	Distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis
M1a	Separate tumor nodule(s) in a contralateral lobe; tumor with pleural nodules or malignant pleural (or pericardial) effusion <sup>‡</sup>
M1b	Distant metastasis

\* The uncommon superficial spreading tumor of any size with its invasive component limited to the bronchovascular wall, which may extend proximally to the main bronchus, is also classified as T1.  
† Intra-pleural (and pericardial) effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathologic examinations of pleural (pericardial) fluid are negative for tumor, and the fluid is nonbloody and is not an exudate. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the patient should be classified as T1, T2, T3, or T4.  
‡ The uncommon superficial spreading tumor of any size with its invasive component limited to the bronchovascular wall, which may extend proximally to the main bronchus, is also classified as T1.  
\* Intra-pleural (and pericardial) effusions with lung cancer are due to tumor. In a few patients, however, multiple cytopathologic examinations of pleural (pericardial) fluid are negative for tumor, and the fluid is nonbloody and is not an exudate. When these elements and clinical judgment dictate that the effusion is not related to the tumor, the effusion should be excluded as a staging element and the patient should be classified as T1, T2, T3, or T4.

**TABLE 4. Descriptors, Proposed T and M Categories, and Proposed Stage Groupings**

Sixth Edition T/M Descriptor	Proposed T/M	N0	N1	N2	N3
T1 (≤2 cm)	T1a	IA	IIA	IIIA	IIIB
T1 (>2-3 cm)	T1b	IA	IIA	IIIA	IIIB
T2 (≤5 cm)	T2a	IB	IIA	IIIA	IIIB
T2 (>5-7 cm)	T2b	IIA	IIIB	IIIA	IIIB
T2 (>7 cm)	T3	IIIB	IIIA	IIIA	IIIB
T3 invasion	IIIB	IIIA	IIIA	IIIB	IIIB
T4 (same lobe nodules)	IIIB	IIIA	IIIA	IIIB	IIIB
T4 (extension)	T4	IIIA	IIIA	IIIB	IIIB
M1 (ipsilateral lung)	IIIA	IIIA	IIIB	IIIB	IIIB
T4 (pleural effusion)	M1a	IV	IV	IV	IV
M1 (contralateral lung)	IV	IV	IV	IV	IV
M1 (distant)	M1b	IV	IV	IV	IV

Cells in bold indicate a change from the sixth edition for a particular TNM category.

**TNM classification of lung cancer**

Stage grouping	TNM Subsets		
Occult Carcinoma	TX	N0	M0
Stage 0	Tis	N0	M0
Stage IA	T1a, b	N0	M0
Stage IB	T2a	N0	M0
Stage IIA	T1a, b	N1	M0
	T2a	N1	M0
	T2b	N0	M0
Stage IIB	T2b	N1	M0
	T3	N0	M0
Stage IIIA	T1, T2	N2	M0
	T3	N1, N2	M0
	T4	N0, N1	M0
Stage IIIB	T4	N2	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1a, b

Source: P. Goldstraw et al. JTO, Vol 2, Number 8, August 2007, 706-714

**Complete resection**


*depending on R = residual disease*

- R0 no residual tumor
- R1 microscopic residual tumor
- R2 macroscopic residual tumor

**R0 resection**

- free resection margins proved microscopically bronchial, venous, arterial stumps, peribronchovascular soft tissue, any peripheral margin near tumor or of additionally resected tissue
- systematic or lobe-specific systematic nodal dissection : ≥ 6 nodes (3 mediastinal)
- no extracapsular extension in nodes removed separately or at the margin of the lung specimen
- highest mediastinal lymph node must be negative




**R1 and R2 resection** 

R1

- tumor involvement of resection margins
- extracapsular extension in nodes removed separately or at the margin of the lung specimen
- + nodes that were not removed


R2 if recognized by surgeon

- + cytology of pleural or pericardial effusions

**Uncertain resection Ru** 


Resection margins free of disease microscopically but one of the following applies :

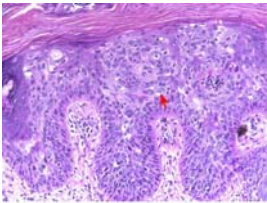
- less rigorous LN evaluation
- intracapsular involvement highest mediastinal node  
if extracapsular = R2
- bronchial margin : ca. in situ
- + pleural lavage cytology R1 cy+

**vraag** 

In de nieuwe classificatie bestaat stadium IB uit de volgende T en N categorie


1. T2aN0
2. T2bN0
3. T1bN0
4. T1bN1

**APD: carcinoma in situ** 




Intraepidermal atypical squamous cells

Verhevenheid thv hoofdbronchus op meer dan 2 cm van de hoofdcarina verwijderd. Verdere stagering is negatief.  
**cTisN0M0**

**Welke stagering?** 

1. Stadium 0
2. Stadium occult carcinoma
3. Stadium IA
4. Stadium IIB


**vraag** 

Een NSCLC linker hoofdbronchus (meer dan 2 cm van de hoofdbronchus verwijderd) wordt gestageerd en blijkt operabel te zijn.


Pneumonectomie links wordt uitgevoerd.

De tumor dient intrapericardiaal te worden verwijderd en er is invasie van de *vena pulmonalis*. De tumor komt juist niet aan het linker atrium. De tumor wordt volledig verwijderd met vrije snijranden. *De lymfeklieren zijn allen negatief* maar 1 intrapulmonale LN is aangetast door *rechtstreekse ingroei* van de tumor.

Het postoperatieve TNM stadium is:




1. pT2N1
2. pT3N0
3. pT4N0
4. pT4N1



**Grote vaten**


The great vessels include:

- Aorta
- Superior vena cava
- Inferior vena cava
- Main pulmonary artery
- Intrapericardial segments of the trunk of the right and left pulmonary artery
- Intrapericardial segments of the superior and inferior right and left pulmonary veins



**Vraag**

NSCLC tumor re bk van 3 cm vertoont een 7 LN die vergroot is, meer dan 10 mm, PET positief. EBUS-EUS onderzoek toont een tumorale aantasting aan van de 7 LN. Inductie CT wordt gegeven. Herevaluatie toont een respons aan thv de tumor: deze is verkleind tot 2 cm. Mediastinoscopie toont vrije lymfeklieren aan. Welke stadium vinden we terug na inductie CT?




**cT1bN2 = stadium IIIA**

1. c T1aN0
2. s T1aN0
3. y T1aN0
4. r T1aN0



**Welke T-staging hebben we hier?**



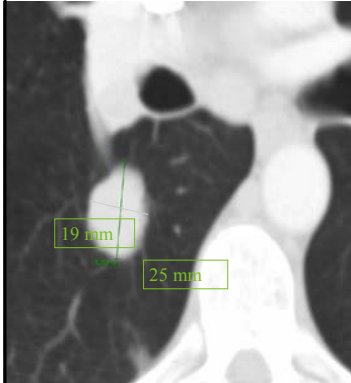
**Welke T-staging: enkel tumor in de hoofdbronchus.**

1. T3
2. T1a
3. T4
4. T2

Man van 69 jaar:  
toevallige vondst op pre-operatieve Rx  
thorax

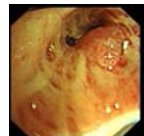


The image shows a chest X-ray on the left and a corresponding axial CT scan on the right. A white circle on the X-ray highlights a small, well-defined nodule in the right lung. The CT scan shows a more detailed view of the same area, confirming the presence of a solid nodule.



19 mm  
25 mm

Ingang apex re ok



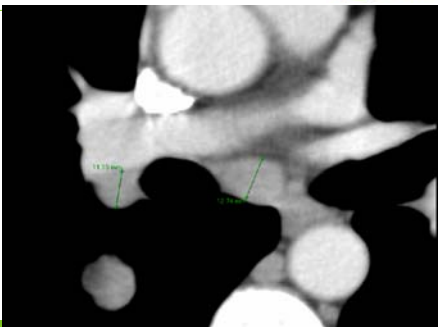
The image shows an axial CT scan of the chest with two green boxes indicating measurements of 19 mm and 25 mm. To the right, there is a small inset image showing an endoscopic view of the bronchus, labeled 'Ingang apex re ok'.

QUIZ

welke T-descriptor kent u toe met deze gegevens ?

Antwoord 1 : T1a  
Antwoord 2 : T1b  
Antwoord 3 : T2a  
Antwoord 4 : T2b


N1: 11 x 8 mm en N2: 13 op 9 mm



11 mm  
8 mm  
13 mm  
9 mm

The image shows an axial CT scan of the chest with two lymph nodes highlighted. The first node is measured as 11 mm x 8 mm (N1), and the second node is measured as 13 mm x 9 mm (N2).

Combinatie EUS 4L en 7 en EBUS 4R:  
geen maligne cellen




The image shows a combination of EUS (Endoscopic Ultrasound) and EBUS (Endobronchial Ultrasound) images. The EUS image shows a lymph node in the 4L position, and the EBUS image shows a lymph node in the 4R position. The text indicates that no malignant cells were found.

Cervikale mediastinoscopie: negatief


welke N-descriptor kent u toe met deze gegevens?

Antwoord 1 : Nx  
Antwoord 2 : N0  
Antwoord 3 : N1  
Antwoord 4 : N2

**Pathologie** 


Pathologie verslag :

- Matig gedifferentieerd plaveiselcelcarcinoom met max diameter 30 mm en minstens 20 mm van de viscerale pleura.
- Rechtstreekse invasie in klier 11R.
- Lymfatische en veneuze carcinoompermeatie.

**pT stagering** 


welke pT-descriptor kent u toe met deze gegevens?

Antwoord 1 : pTis  
 Antwoord 2 : pT1b  
 Antwoord 3 : pT2a  
 Antwoord 4 : pT2b

**type van resectie** 

Om welk type resectie gaat het hier?

Antwoord 1 : Ru  
 Antwoord 2 : R0  
 Antwoord 3 : R1  
 Antwoord 4 : R2

**Klinische stagering is geen kookboek** 

- Therapiekeuze hangt niet alleen af van cT
- Er zijn T4's die geopereerd kunnen worden
  - Mits zorgvuldige selectie
- Hou rekening met gebrekkige accuraatheid van klinische stagering
- Twijfel interpreteren ten voordele van lagere classificatie
- Belang van multidisciplinair overleg

**En de winnaar is.....?** 



