

**TABLE 108-1 STAGING OF BREAST CANCER**

Primary Tumor (T)			
T0	No evidence of primary tumor		
TIS	Carcinoma in situ		
T1	Tumor ≤2 cm		
T1a	Tumor >0.1 cm but ≤0.5 cm		
T1b	Tumor >0.5 but ≤1 cm		
T1c	Tumor >1 cm but ≤2 cm		
T2	Tumor >2 cm but ≤5 cm		
T3	Tumor >5 cm		
T4	Extension to chest wall, inflammation, satellite lesions, ulcerations		
Regional Lymph Nodes (N)			
PN0(i-)	No regional lymph node metastasis histologically, negative IHC		
PN0(i+)	No regional lymph node metastasis histologically, positive IHC, no IHC cluster greater than 0.2 mm		
PN0(mol-)	No regional lymph node metastasis histologically, negative molecular findings (RT-PCR)		
PN0(mol+)	No regional lymph node metastasis histologically, positive molecular findings (RT-PCR)		
PN1	Metastasis in one to three axillary lymph nodes, or in internal mammary nodes with microscopic disease detected by sentinel lymph node dissection but not clinically apparent		
PN1mi	Micrometastasis (>0.2 mm, none >2 mm)		
PN1a	Metastasis in one to three axillary lymph nodes		
PN1b	Metastasis in internal mammary nodes with microscopic disease detected by sentinel lymph node dissection but not <i>clinically apparent</i> <sup>a</sup>		
PN1c	Metastasis in one to three axillary lymph nodes and in internal mammary lymph nodes with microscopic disease detected by sentinel lymph node dissection but not clinically apparent. <sup>a</sup> (If associated with greater than three positive axillary lymph nodes, the internal mammary nodes are classified as pN3b to reflect increased tumor burden.)		
pN2	Metastasis in four to nine axillary lymph nodes, or in clinically apparent internal mammary lymph nodes in the <i>absence</i> of axillary lymph node metastasis		
pN3	Metastasis in 10 or more axillary lymph nodes, or in infraclavicular lymph nodes, or in clinically apparent <sup>a</sup> ipsilateral internal mammary lymph nodes in the <i>presence</i> of 1 or more positive axillary lymph nodes; or in more than 3 axillary lymph nodes with clinically negative microscopic metastasis in internal mammary lymph nodes; or in ipsilateral subcarinal lymph nodes		
Distant Metastasis (M)			
M0	No distant metastasis		
M1	Distant metastasis (includes spread to ipsilateral supraclavicular nodes)		
Stage Grouping			
Stage 0	TIS	N0	M0
Stage I	T1	N0	M0
Stage IIA	T0	N1	M0
	T1	N1	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
	T3	N1, N2	M0
Stage IIIA	T0	N2	M0
	T1	N2	M0
	T2	N2	M0
	T3	N1, N2	M0
Stage IIIB	T4	N0, N1, N2	M0
Stage IIIC	Any T	N3	M0
Stage IV	Any T	Any N	M1

<sup>a</sup>Clinically apparent is defined as detected by imaging studies (excluding lymphoscintigraphy) or by clinical examination.

**Abbreviations:** IHC, immunohistochemistry; RT-PCR, reverse transcriptase polymerase chain reaction.

**Source:** Used with permission of the American Joint Committee on Cancer (AJCC), Chicago, Illinois. The original source for this material is the *AJCC Cancer Staging Manual*, 7th ed. New York, Springer, 2010; [www.springeronline.com](http://www.springeronline.com).

diating the breast, result in a survival that is as good as (or slightly superior to) that after extensive surgical procedures, such as mastectomy or modified radical mastectomy, with or without further irradiation. Postlumpectomy breast irradiation greatly reduces the risk of recurrence in the breast. While breast conservation is associated with a possibility of recurrence in the breast, 10-year survival is at least as good as that after more extensive surgery. Postoperative radiation to regional nodes following mastectomy is also associated with an improvement in survival. Because radiation therapy can also reduce the rate of local or regional recurrence, it should be strongly considered following mastectomy for women with high-risk primary

tumors (i.e., T2 in size, positive margins, positive nodes). At present, nearly one-third of women in the United States are managed by lumpectomy. Breast-conserving surgery is not suitable for all patients: it is not generally suitable for tumors >5 cm (or for smaller tumors if the breast is small), for tumors involving the nipple-areola complex, for tumors with extensive intraductal disease involving multiple quadrants of the breast, for women with a history of collagen-vascular disease, and for women who either do not have the motivation for breast conservation or do not have convenient access to radiation therapy. However, these groups probably do not account for more than one-third of patients who are treated with