The earliest efforts to classify solid tumors were derived in a simple and logical manner based upon clinical observation. There were 2 stages – early and late. At the turn of the twentieth century more complex systems of classification emerged. These were based on surgical and pathologic information since surgery was the only available definitive treatment at the time. In 1939 a clinico-pathological classification of breast cancer proposed by Mr. Ronald Raven of Great Britain represented a significant step-forward in the classification of breast cancer; staging the primary tumor, regional nodes and metastases.

The current system for the staging of lung cancer utilizes the TNM concept that emerged from years of classification efforts by Dr. Pierre Denoix of France. This system was formally adopted by the Union Internationale Contra Cancer (UICC) to provide a description of disease extent rather than stage of disease. The first TNM classification for lung cancer was published by the UICC in its Livre de Poche (1964). Notably, lymph node metastases were described either as no evidence of involvement (N0) or as intrathoracic lymph node enlargement (N1). Pleural effusion with malignant cells and cervical nodes were both classified as M1. The proposal was not database but was subject to 5 years of testing and possible revision.

The American Joint Committee on Cancer (AJCC), founded in 1959, placed a different emphasis on simplicity, practicality and credibility, insisting on databased systems. The first adopted proposal for lung cancer was published in 1973, with tumors classified in three stages. The first revision was published in 1986 with four stages and with Stage III divided into two parts, A and B. The current version, intended to reduce the heterogeneity within stages, was published in 1997, and identifies seven prognostic groups.

The current system has served the medical community exceptionally well and has contributed to our collective understanding of the biology of lung cancer. Increased insights have raised questions regarding improving the current staging system. All systems of classification are subject to change; lung cancer is no exception. The enormous potential of molecular markers to influence classification will someday profoundly affect staging systems. These scientific advances, however, must be measured against the existing database of anatomic classification. Accordingly, impending refinements in anatomic classification should not destroy the validity of current systems. A system of decimal point notation is proposed as a bridge between the present and the future.