## NAACCR 2011-2012 Webinar Series

Collecting Cancer Data: Larynx

NAACCR

## Instructors

**Shannon Vann, CTR** **Jim Hofferkamp, CTR**

2

NAACCR

## Q&A

- Please submit all questions concerning webinar content through the Q&A panel.

3

NAACCR

## Fabulous Prizes

4 NAACCR

## Agenda

- Corrections and updates
- Coding Moment
  - Interpreting lab results
- Overview of laryngeal malignancies
- Quiz
- Collaborative Stage
- Quiz
- Multiple Primary Rules
- Review of Exercises

5 NAACCR

## Corrections and Updates

- Schedule changes
  - The February and May topics have been switched
    - 2/2/12
      Collecting Cancer Data: Lung
    - 5/3/12
      Collecting Cancer Data: Hematopoietic
  - The June and July webinars are the second week of the month
    - 6/14/12 (changed)
      Using and Interpreting Data Quality Indicators
    - 7/12/12 (not a change)
      ICD-10-CM and Cancer Surveillance

6 NAACCR

## Corrections and Updates

- Mature Teratoma (9080/0)
  - This is a question that was posed to our germ cell docs (we had GYN specialists and male germ cell specialists). They said that using age as a determination of malignant VS benign was not a valid premise. They said that the determination of **malignant VS benign should be made using the pathology report only**.

7

Coding Moment

## INTERPRETING LAB RESULTS

**Source: CS Manual Version 02.03.02 Part 1 Section 2 pages 11-17**

8

## Interpreting Lab Results

- When the site-specific factor asks for the interpretation of a lab test, code the clinician's/pathologist's interpretation, if available, as first priority.

9

## Interpreting Lab Results

- In the absence of a physician's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.

10 NAACCR

## Interpreting Lab Results

- When there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record the registrar should code 999 (not documented, unknown) to code the SSF.
- Do not code the lab value interpretation based on background information provided in this manual for the SSF.

11 NAACCR

## CARBOHYDRATE ANTIGEN 19-9 (CA 19-9)

- CA 19-9 is produced in excess by adenocarcinomas and released into the blood
  - It is elevated in pancreatic (70-80%), hepatobiliary (60%), and gastric (50-60%) malignancies
  - Levels above 1000 U/mL indicate the presence of metastases and probably unresectable tumor.
- ***Normal reference range:*** < 37 U/mL
- ***Source documents:*** clinical laboratory report (blood serum); history and physical

12 NAACCR

## CARCINOEMBRYONIC ANTIGEN (CEA)

- Used as a tumor marker especially for gastrointestinal cancers
- Most frequently tested on blood serum, but it may be tested in body fluids and/or biopsy tissue
- ***Source documents:*** clinical laboratory report, sometimes pathology or cytology report; H&P, operative report; consultant report; discharge summary

13

## CARCINOEMBRYONIC ANTIGEN (CEA)

- An abnormally high CEA level prior to tumor resection is expected to fall following successful removal of the cancer.
- An increasing value indicates possible recurrence.

14

## CARCINOEMBRYONIC ANTIGEN (CEA)

- ***Normal reference range:***
  - Nonsmoker: < 2.5 ng/ml (SI: < 2.5 µg/L)
  - Smoker: < 5 ng/ml (SI: < 5 µg/L)

15

## HUMAN PAPILLOMA VIRUS (HPV)

- Human papilloma virus (HPV) infection has been identified as a favorable prognostic factor in the development of a defined subset of head and neck cancers (oropharynx)
  - Human papilloma viruses have been divided into high-risk and low-risk types
  - HPV vaccine is designed to protect against types 16 and 18 (associated with cervical cancer) and types 6 and 11 (associated with genital warts).
- ***Source documents:*** pathology report (immunohistochemical staining), molecular analysis

16 NAACCR

## LACTATE DEHYDROGENASE (LDH)

- When cells (normal or tumor) are damaged or destroyed, an enzyme called lactate dehydrogenase (LDH) is released into the bloodstream
- LDH is an indirect indication of possible tumor burden or damage to an organ, which may be caused by metastatic involvement of liver or lung, or a myocardial infarction
- ***Source documents:*** clinical laboratory report; may be included in a liver or hepatic panel/profile, a cardiac panel, or a general metabolic panel of tests

17 NAACCR

## LACTATE DEHYDROGENASE (LDH)

- Test result is 155.
  - Normal range:
    - Lab A 105 to 333 IU/L;
    - Lab B Female: 46-100 IU/L Male: 46-232 IU/L
    - Lab C 45 - 90 U/L
  - For Labs A and B, that result is within the normal range (code 000).
  - For Lab C, the test result is elevated (upper limit of normal for Lab C is 90).

18 NAACCR

## MICROSATELLITE INSTABILITY (MSI)

- Microsatellite instability (MSI) is a molecular marker performed on tumor tissue to identify differences in length of sections of nonfunctioning DNA
  - A highly positive MSI test may be related to the development of hereditary nonpolyposis colorectal cancer
  - MSI may also be a predictive marker of a patient's response to chemotherapy as well as an indicator of the patient's prognosis.
- ***Source documents:*** pathology report, reference lab report, supplemental report, admitting note or consultation reporting a test done elsewhere

19 NAACCR

## MITOTIC COUNT

- Mitotic count is a way of describing the potential aggressiveness of a tumor.
  - For GIST tumors, the count is translated into a mitotic rate that is used with T, N, and M to stage group a case.
- ***Source documents:*** pathology report

20 NAACCR

## SERUM CHROMOGRANIN A (CGA)

- Chromogranin is a protein released from neuroendocrine cells found throughout the neuroendocrine system
  - The presence of elevated levels of chromogranin in blood or tissue is a marker for neuroendocrine tumors
  - Although a positive test can indicate a neuroendocrine tumor, it cannot identify which organ is the source
- ***Source documents:*** clinical lab report (blood serum) or pathology report (immunohistochemistry stain)

21 NAACCR

## SERUM CHROMOGRANIN A (CGA)

- ***Normal reference range:***
  - Path report: Positive/negative
  - Lab: 6.0 – 40.0 ng/mL
    - Results vary by laboratory

22

NAACCR

Collecting Cancer Data: Larynx

## OVERVIEW

23

NAACCR

## Statistics

- Estimated new cases and deaths from larynx in the United States in 2011:
  - New cases: 12,740 (laryngeal)
  - Deaths: 3,560 (laryngeal)

National Cancer Institute
http://www.cancer.gov/cancertopics

24

NAACCR

## Squamous Cell Carcinoma

- Nearly all laryngeal carcinomas of the larynx are epithelial
  - Primarily squamous cell carcinoma
  - Other types of epithelial carcinoma's of the larynx include
    - Basaloid squamoid carcinomas
    - Spindle-cell (i.e., sarcomatoid) carcinomas
    - Small-cell carcinomas
    - Nasopharyngeal-type undifferentiated carcinomas (i.e., lymphoepitheliomas)
    - Carcinomas of the minor salivary gland

25

## Mucosal Melanoma of the Head and Neck

- Occur in mucosal sites of the head and neck
  - Two thirds occur in nasal cavity and paranasal sinuses
  - One quarter occur in oral cavity
  - Remainder occur in other sites of the head and neck
- Highly Aggressive
  - Cancers limited to the mucosa are assigned T3 N0 M0 Stage III
  - In situ mucosal melanoma's very rare and are excluded from staging

AJCC Staging Manual 7th edition

26

## Anatomy of the Larynx

Larnyx

Hyoid bone
Thyroid cartilage
Cricoid cartilage
Trachea
Epiglottis
False vocal cords
Vocal ligament
Vocal cords
Tracheal cartilage

Image Source: SEER Training Website

## Anatomy

- Larynx
  - Supraglottis
    - Epiglottis
    - False Vocal Cords
    - Ventricles
    - Aryepiglottic folds
    - arytenoids
- Larynx
  - Glottis
    - True Vocal Cords
    - Anterior Commissures
    - Posterior Commissures
  - Subglottis
    - Begins 1cm below the vocal cords
    - Extends to the lower border

28

NAACCR

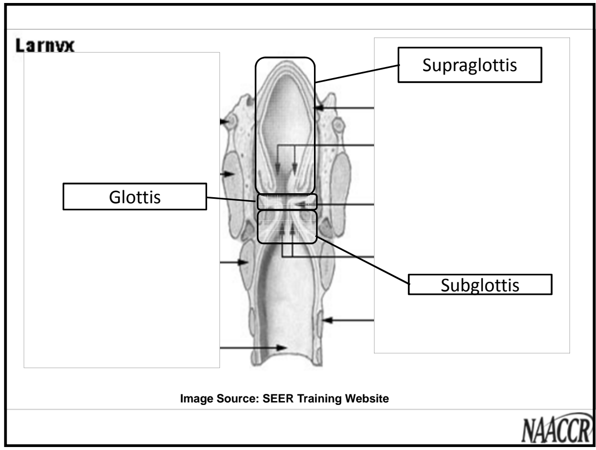


Image Source: SEER Training Website

## Regional Lymph Nodes Terminology

- Ipsilateral
  - Same side as tumor
- Contralateral
  - Opposite side as the tumor
- Bilateral
  - Same side and opposite side

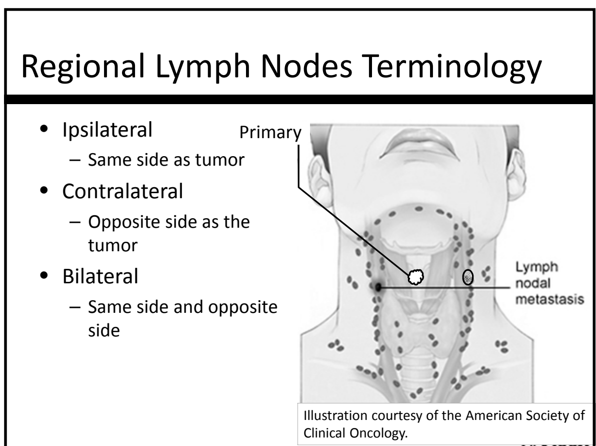
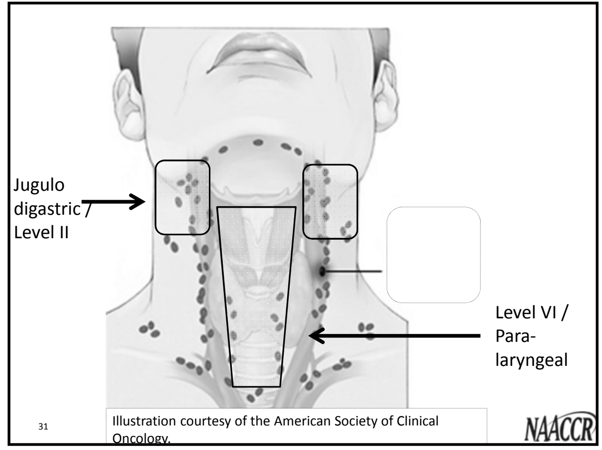
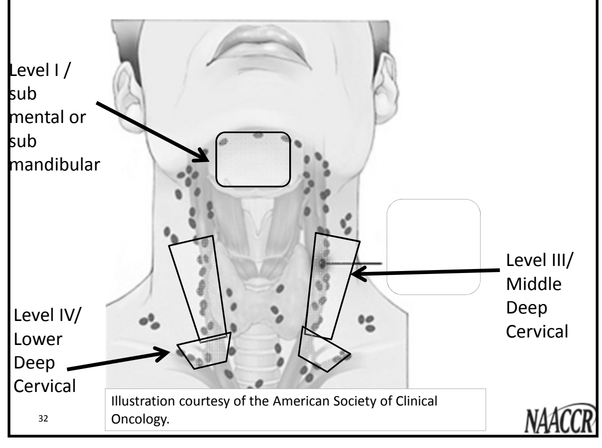
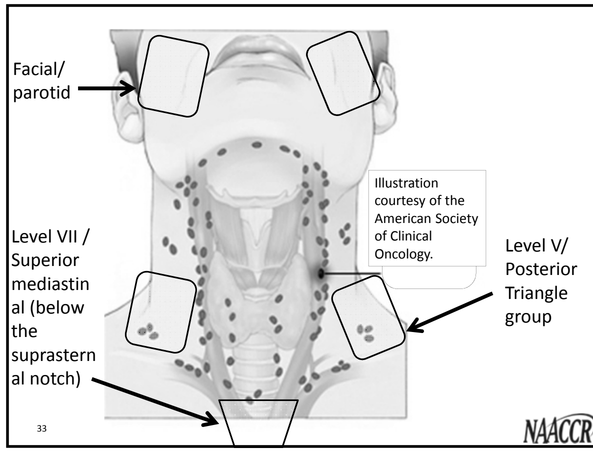
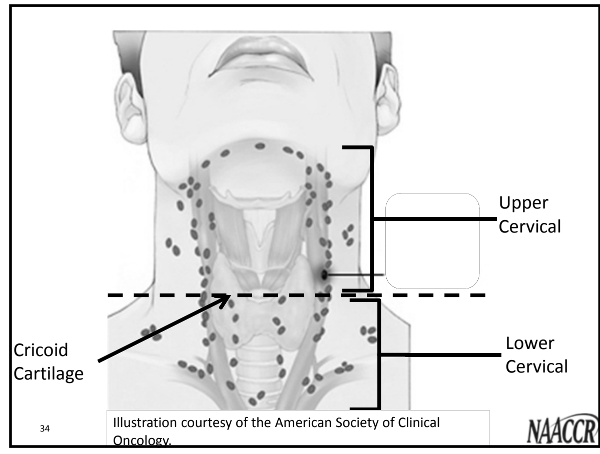


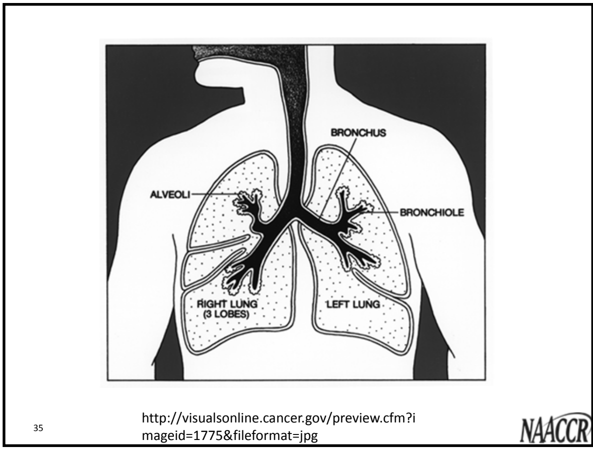
Illustration courtesy of the American Society of Clinical Oncology.


Jugulo
digastric /
Level II
Level VI /
Para-
laryngeal
31
Illustration courtesy of the American Society of Clinical Oncology.
NAACCR


Level I /
sub
mental or
sub
mandibular
Level III/
Middle
Deep
Cervical
Level IV/
Lower
Deep
Cervical
Illustration courtesy of the American Society of Clinical Oncology.
32
NAACCR


Facial/
parotid
Illustration
courtesy of the
American Society
of Clinical
Oncology.
Level VII /
Superior
mediastin
al (below
the
suprastern
al notch)
Level V/
Posterior
Triangle
group
33
NAACCR




## Diagnosing Larynx Cancer

- Physical exam
- Triple Endoscopy (also called panendoscopy)
  - Combination procedure that includes nasopharyngoscopy, laryngoscopy, pharyngoscopy, bronchoscopy and esophagoscopy
  - Used to investigate all mucosal surfaces of the upper respiratory tract for original or subsequent primaries.
- MRI/CT Scans

NAACCR

## Treatment-Squamous Cell Carcinoma

- In situ
  - Endoscopic removal
    - Stripping or Laser
  - Radiation
- Early stage (AJCC Stage I or II)
  - Surgery
    - Partial laryngectomy (may be open or endoscopic)
    - Radiotherapy

37

## Treatment-Squamous Cell Carcinoma

- AJCC Stage III or IV
  - Concurrent systemic therapy and Radiation
  - Laryngectomy with ipsilateral or bilateral neck dissection
  - Neoadjuvant chemotherapy (clinical trial) followed by either surgery or radiation

38

## Treatment-Mucosal Melanoma

- AJCC Stage III or IVA
  - Wide surgical excision and neck dissection
  - Postoperative radiation
- AJCC Stage IVB or IVC
  - Clinical trial
  - Primary radiation and/or systemic therapy
  - Best supportive care

39

## Surgery

- Hemilaryngectomy (30)
  - Left or right half of larynx including thyroid cartilage, false cord, ventricle, and true vocal cord.
- Partial laryngectomy (30)
  - Part of thyroid cartilage and corresponding portions of laryngeal mucosa.
- Supraglottic laryngectomy (33)
  - Part of larynx superior to the true vocal cord (transection through the ventricles).
- Total laryngectomy (41)
  - Entire larynx.
- Radical laryngectomy (42)
  - Entire Larynx and adjacent sites

NAACCR

## Surgery

- Unresectable tumor
  - Surgeon does to feel they can remove all gross tumor
  - Local control of the tumor will not be achieved
- Salvage surgery
  - Patients who do not have a complete clinical response to chemotherapy or radiation may have salvage surgery

41

NAACCR

## Quiz

42

NAACCR

Collecting Cancer Data: Larynx

## COLLABORATIVE STAGE

Adapted from the CSv2 education and training team materials for head and neck.

43

## CSv2 Larynx Schemas

| Larynx Schemas | ICD-O-3 Codes |
|---|---|
| Glottic larynx, vocal cord | C32.0 |
| Melanoma of glottic larynx, vocal cord | C32.0; 8720 – 8790 |
| Supraglottic larynx, epiglottis | C32.1 |
| Melanoma of supraglottic larynx, epiglottis | C32.1; 8720-8790 |
| Subglottic larynx | C32.2 |
| Melanoma of subglottic larynx | C32.2; 8720-8790 |
| Other larynx | C32.3, C32.8, C32.9 |
| Melanoma of other larynx | C32.3, C32.8, C32.9; 8720-8790 |

44

## Mucosal Melanoma of Larynx

- No Tis, TX, T1, or T2 categories in AJCC staging of melanoma of larynx
- Mucosal disease = T3
  - Confined to mucosa of larynx or extension to mucosa of adjacent regions
- Moderately advanced disease = T4a
  - Involvement of deep soft tissue, cartilage, bone, or overlying skin
- Very advanced disease = T4b
  - Involvement of brain, dura, skull base, lower cranial nerves, masticator space, carotid artery, pre-vertebral space, or mediastinal structures

45

## Mucosal Melanoma of Larynx

| Anatomic Stage/Prognostic Groups | | | |
|---|---|---|---|
| Stage III | T3 | N0 | M0 |
| Stage IVA | T4a<br>T3-T4a | N0<br>N1 | M0<br>M0 |
| Stage IVB | T4b | Any N | M0 |
| Stage IVC | Any T | Any N | M1 |

46

## CS Tumor Size: Larynx

- Record largest diameter of primary tumor of larynx
- Standard table is used
- ‘Stated as’ codes not included because extension determines the T category, not tumor size

47

## CS Extension: Larynx

- Use “stated as T_” codes only if no specific information is available
- Use the code for “localized tumor” only if no specific information
  - Code 450 – all larynx excluding melanoma schemas
  - Code 310 – melanoma of glottis larynx, melanoma of subglottic larynx, and melanoma of other larynx
  - Code 275 – melanoma of supraglottic larynx
- “Stated as T_” takes precedence over “localized NOS”

48

## CS Tumor Size/Ext Eval: Larynx

- T based on extension – CS TS/Ext Eval code describes how T value determined
  - If any one of multiple extension codes deriving the same T value determined pathologically
  - Even if higher code showing further clinical extension assigned to case
  - Use Tumor Size Size/Ext Eval code deriving a p descriptor

NAACCR

## Pop Quiz

- Primary tumor of glottic larynx resected and pathologically extends into the subglottis. Impaired vocal cord mobility was diagnosed clinically.
- What is the code for CS Extension?
  - 300 (involves subglottis; maps to T2)
  - 350 (impaired vocal cord mobility; maps to T2)
- What is the code for CS Tumor Size/Ext Eval?

50 NAACCR

## CS Lymph Nodes

| Standard Descriptions for Levels of Cervical Nodes | |
|---|---|
| Submental | Sublevel IA |
| Submandibular | Sublevel IB |
| Upper jugular | Sublevels IIA and IIB |
| Middle jugular | Level III |
| Lower jugular | Level IV |
| Posterior triangle group | Sublevels VA and VB |
| Anterior compartment group | Level VI |
| Superior mediastinal group | Level VII |

51 NAACCR

## CS Lymph Nodes: Larynx

- Code all lymph nodes defined as Levels I-VII and other by AJCC; complete definitions in Part I
- Additional information about nodes coded in Site-Specific Factors 1, 3-9
- Nodes assumed to be ipsilateral if not specified
  - Midline nodes considered ipsilateral
- Supraclavicular nodes considered Level V nodes if not specified as level IV

52 NAACCR

## CS Lymph Nodes: Larynx

- Description of lymph nodes standardized across head and neck schemas
- All lymph node levels/groups regional for AJCC staging
  - Summary Stage 1977 and Summary Stage 2000 divide nodes into regional and distant groups

53 NAACCR

## CS Lymph Nodes: Larynx (Excluding Melanoma)

- 000 No lymph node involvement
- 100, 110, 120 **Single ipsilateral** regional positive node
  - Grouped by regional and distant for Summary Stage
  - N1, N2a, or N3 depending on size
- 200, 210, 220 **Multiple ipsilateral** regional positive nodes
  - N2b or N3 depending on size
- 400, 410, 420 **Bilateral or contralateral** regional nodes
  - N2c or N3 depending on size

54 NAACCR

## CS Lymph Nodes: Larynx (Excluding Melanoma

| AJCC N | CS Lymph Node Code | | Summary Stage |
|---|---|---|---|
| N1 , N2a, or N3 based on size | 100<br>110<br>120 | Single | Regional<br>Distant |
| N2b or N3 based on size | 200<br>210<br>220 | Multiple | Regional<br>Distant |
| N2c or N3 based on size | 400<br>410<br>420 | Bilateral or Contralateral | Regional<br>Distant |

AJCC ↗ ↖ Summary Stage

55

NAACCR

## CS Lymph Nodes: Larynx (Excluding Melanoma)

- 300, 310, 320 Positive ipsilateral regional nodes, unknown single/multiple
  - N1, N2a, or N3 depending on size
- 500, 510, 520 Positive regional nodes, unknown single/multiple, unknown ipsilateral or bilateral/contralateral
  - N1, N2, or N3 depending on size
- 800 Positive node(s)
  - N1

56

NAACCR

## CS Lymph Nodes: Larynx (Excluding Melanoma)

- "Stated as" codes available
  - 180: Stated as N1, no other information
  - 190: Stated as N2a, no other information
  - 290: Stated as N2b, no other information
  - 490: Stated as N2c, no other information
  - 600: Stated as N2, no other information
  - 700: Stated as N3, no other information

57

NAACCR

## CS Lymph Nodes: Melanoma of Larynx

- 000 No lymph node involvement
- 100, 110, 120 Positive regional nodes
  - N1
  - Levels are subsite specific
- 180 Stated as N1 with no other information
- 800 Positive node(s)
  - N1

58

NAACCR

## CS Mets at DX: Larynx

- Supraclavicular and transverse cervical nodes
  - Coded in CS Lymph Nodes
  - Regional nodes for AJCC
  - Distant nodes for Summary Stage 2000 and 1977

59

NAACCR

## MX Eliminated

- MX has been eliminated from 7th Edition
  - Clinical M0
  - Unless clinical or pathologic evidence of metastasis
- cM only requires history and physical
- Infer cM0 unless known cM1

60

NAACCR

## CS Mets at DX: Larynx

| Code | Description |
|---|---|
| 00 | No distant metastasis |
| 10 | Distant lymph node(s)<br>Mediastinal<br>Distant lymph node(s), NOS |
| 40 | Distant metastases except distant lymph node(s)<br>Carcinomatosis |
| 50 | Distant metastasis (40) + distant lymph nodes (10) |
| 60 | Distant Metastasis, NOS<br>Stated as M1, NOS, with no other information |
| 99 | Unknown |

61

NAACCR

## SSF1: Size of Lymph Nodes

- Code largest diameter of involved regional nodes in mm
  - Measurement may be pathologic or clinical
  - Type of assessment coded in CS Reg Nodes Eval field
  - Assign code 000 if no regional nodes are involved
  - Code exact size 001 – 979 mm
  - Assign code 980 if lymph is 980 mm or larger
  - Assign codes 990-997 for non-specific sizes if an exact size of involve lymph node is not stated in the medical record
  - Assign code 999 if there is no information about size of involved regional lymph nodes

62

NAACCR

## SSF3 – SSF6: Node Levels

- Code presence or absence of node involvement in different node levels and groups
- One digit used to represent lymph nodes of a single level
  - SSF 3: Levels I-III
  - SSF 4: Levels IV, V, retropharyngeal nodes
  - SSF 5: Levels VI, VII, facial nodes
  - SSF 6: Other groups as defined by AJCC
- In each digit
  - Code 0 means No - nodes are not involved
  - Code 1 means Yes – nodes are involved

63

NAACCR

## SSF3: Levels I-III Lymph Nodes for Head and Neck

- 000 No lymph node involvement
- 100 Level I node(s) involved
- 010 Level II node(s) involved
- 001 Level III node(s) involved
- 110 Level I and II nodes involved
- 101 Level I and III nodes involved
- 011 Level II and III nodes involved
- 111 Level I, II and III nodes involved

64 NAACCR

## SSF4: Levels IV-V and Retropharyngeal Nodes for Head & Neck

- 000 No node involvement
- 100 Level IV node(s) involved
- 010 Level V node(s) involved
- 001 Retropharyngeal nodes involved
- 110 Level IV and V nodes involved
- 101 Level IV and retropharyngeal nodes involved
- 011 Level V and retropharyngeal nodes involved
- 111 Level IV and V and retropharyngeal nodes involved

65 NAACCR

## SSF5: Levels VI-VII and Facial Lymph Nodes for Head & Neck

- 000 No node involvement
- 100 Level VI node(s) involved
- 010 Level VII node(s) involved
- 001 Facial node(s) involved
- 110 Level VI and VII nodes involved
- 101 Level VI and facial nodes involved
- 011 Level VII and facial nodes involved
- 111 Level VI and VII and facial nodes involved

66 NAACCR

## SSF6: Parapharyngeal, Parotid, Sub-Occipital Nodes for Head & Neck

- 000 No node involvement
- 100 Parapharyngeal node(s) involved
- 010 Parotid node(s) involved
- 001 Suboccipital/retroauricular node(s) involved
- 110 Parapharyngeal and parotid nodes involved
- 101 Parapharyngeal and suboccipital/retroauricular nodes involved
- 011 Parotid and suboccipital/retorauricular nodes involved
- 111 Parapharyngeal, parotid and suboccipital/retroauricular nodes involved

67 NAACCR

## SSF7: Upper and Lower Cervical Node Levels

- Boundary between upper and lower levels
  - Lower border of the cricoid cartilage
  - Upper levels: Levels I, II, III, VA, all "Other Groups"
  - Lower levels: Levels IV, VB, and VII
  - Level VI nodes span both upper and lower levels
- Code upper and lower level involvement as stated by physician
- If no physician statement , assign by level involved
- Clarify with physician if nodal involvement is described as mid neck

68 NAACCR

## SSF7: Upper and Lower Cervical Node Levels

- 000 No regional lymph nodes involved
- 010 Upper level lymph nodes involved
- 020 Lower level lymph nodes involved
- 030 Upper and lower level lymph nodes involved
- 040 Unknown level lymph nodes involved

69 NAACCR

## SSF8: Extracapsular Extension Clinically Lymph Nodes for Head & Neck

- Code the status of extracapsular extension of involved regional nodes assessed clinically
- Clinical assessment by physical examination or imaging
  - ECS diagnosed clinically by
    - Matted mass of nodes adherent to skin/soft tissue
    - Clinical evidence of cranial nerve invasion
  - Radiologic signs of ECS include
    - Amorphous, spiculated margins of a metastatic node
    - Stranding of perinodal soft tissue

70 NAACCR

## SSF8: Extracapsular Extension Clinically Lymph Nodes for Head & Neck

- 000 No regional nodes involved clinically
- 010 Nodes involved clinically, no extracapsular extension clinically
- 020 Nodes involved clinically, extracapsular extension clinically (nodes described as fixed or matted)
- 030 Nodes involved clinically, unknown if extracapsular extension

71

## SSF9: Extracapsular Extension Pathologically Lymph Nodes Head & Neck

- Code the status of extracapsular extension assessed pathologically
- Code “microscopic” or “macroscopic” extranodal extension
  - As stated in pathology report
  - “Microscopic” if extranodal extension only in micro section
  - “Macroscopic” if extranodal extension in gross section
  - “Macroscopic” takes precedence over “microscopic”

72 NAACCR

## SSF9: Extracapsular Extension Pathologically Lymph Nodes Head & Neck

- 000 No lymph nodes involved pathologically
- 010 Nodes involved pathologically, no extracapsular extension pathologically
- 020 Nodes involved pathologically, microscopic extracapsular extension pathologically
- 030 Nodes involved pathologically, macroscopic extracapsular extension pathologically
- 040 Nodes involved pathologically, extracapsular extension pathologically, unknown if microscopic or macroscopic
- 050 Nodes involved pathologically, unknown if extracapsular extension

73 NAACCR

## SSF10: Human Papilloma Virus (HPV) Status

- Code the results of HPV testing on cancer tissue
- HPV divided into high-risk and low-risk types
  - Highest risks: Types 16 and 18
  - Other high risk types listed in table notes
  - HPV vaccine protects against types 16, 18, 6, 11

74 NAACCR

## SSF10: Human Papilloma Virus (HPV) Status

- 000 HPV test negative; not positive for any HPV types
- 010 LOW RISK positive
- 020 HIGH RISK positive, types other than HPV 16 or 18
- 030 HIGH RISK positive for 16, not positive for 18 or 18 unknown
- 040 HIGH RISK positive for 18, not positive for 16 or 16 unknown
- 050 HIGH RISK positive for HPV 16 and 18
- 060 HIGH RISK positive NOS, types not specified
- 070 Positive NOS, risk and types not stated

75 NAACCR

## SSF11: Measured Thickness (Depth) (*Only for melanoma of larynx)*

- Code the measured thickness (depth) of invasive tumor
  - Do not code size, diameter, or any other measurement
- Code actual thickness measurement in tenths of millimeters
  - From pathology report
- Code measurement labeled as thickness or depth
  - In absence of label
    - Use cut surface dimension
    - Or use third dimension from description of 3 dimensions (N1 x N2 x N3)

76

NAACCR

## Pop Quiz

- Microscopic description: Melanoma of larynx, 8.5 mm X 5.6 mm X 2.4 mm. Tumor thickness is 2.4 mm.
- What is the code for SSF11?

77

NAACCR

## SSF11: Measured Thickness (Depth) (*Only for melanoma of larynx)*

- 000 No mass/tumor found
- 001-979 Exact thickness in tenths of millimeters
- 980 98.0 millimeters or larger
- 987 Not applicable: In situ carcinoma
- 988 Not applicable: Information not collected for this case
- 990 Microinvasion, microscopic focus or foci only
- 998 No surgical specimen from primary site
- 999 Not documented, unknown

78

NAACCR

Collecting Cancer Data: Larynx

## MULTIPLE PRIMARY AND HISTOLOGY RULES

79

NAACCR

## Coding Primary Site

1. Tumor Board
   a. Specialty
   b. General
2. Staging physician's site assignment
   a. AJCC staging form
   b. TNM statement in medical record

NAACCR

## Coding Primary Site

3. If neither 1 or 2 available, based on whether tumor was resected
4. If total resection of primary tumor was done, code based on:
   a. Operative report – surgeon's statement
   b. Final diagnosis on pathology report

NAACCR

## Coding Primary Site

5. If a total resection was NOT done, code based on:
   a. Endoscopy
   b. Radiation oncologist
   c. Diagnosing physician
   d. Primary care physician
   e. Other physician
   f. Diagnostic imaging
   g. Physician statement based on clinical examination

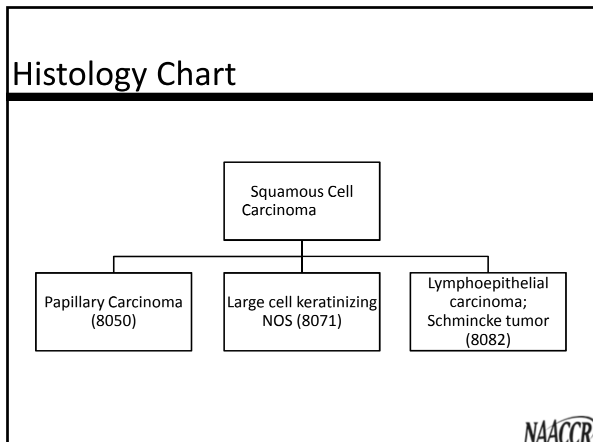
## Chart 1 – H&N Histology Groups and Specific Types

*See page 21 of your MPH Manual*

- Use this chart with the histology rules to code the most specific histologic term
- The tree is arranged in descending order
- Each branch is a histology group, starting with the NOS or group terms and descending into the specific types for that group
- As you follow the branch down, the terms become more specific

NAACCR

## Histology Chart



## Unknown if Single or Multiple Tumors

- Rule M1
  - When it is not possible to determine if there is a single tumor or multiple tumors, opt for a single tumor and abstract as a single primary.

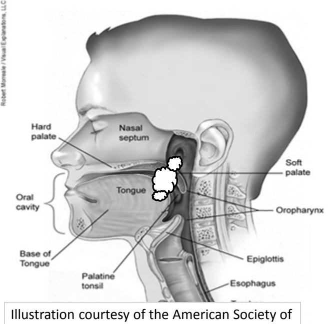



Illustration courtesy of the American Society of Clinical Oncology.

## Single Tumor

- Rule M2
  - A single tumor is always a single primary.

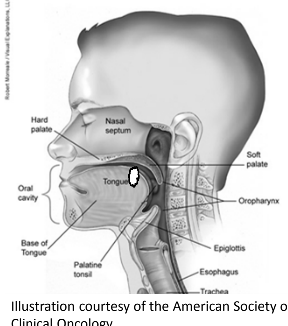



Illustration courtesy of the American Society of Clinical Oncology.

## Multiple Tumors

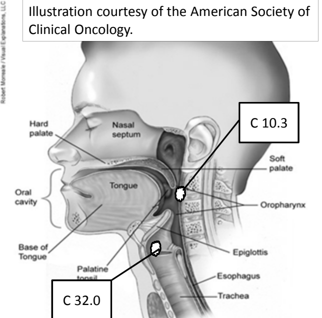
- Rule M3
  - Tumors on the right side and the left side of a paired site are multiple primaries.
- Rule M4
  - Tumors on the upper lip (C000 or C003) and the lower lip (C001 or C004) are multiple primaries.
- Rule M5
  - Tumors on the upper gum (C030) and the lower gum (C031) are multiple primaries.
- Rule M6
  - Tumors in the nasal cavity (C300) and the middle ear (C301) are multiple primaries.

NAACCR

## Multiple Tumors

- **Rule M7**
  - Tumors in sites with ICD-O-3 topography codes that are different at the second (Cxxx) and/or third (Cxxx) character are multiple primaries.

Illustration courtesy of the American Society of Clinical Oncology.



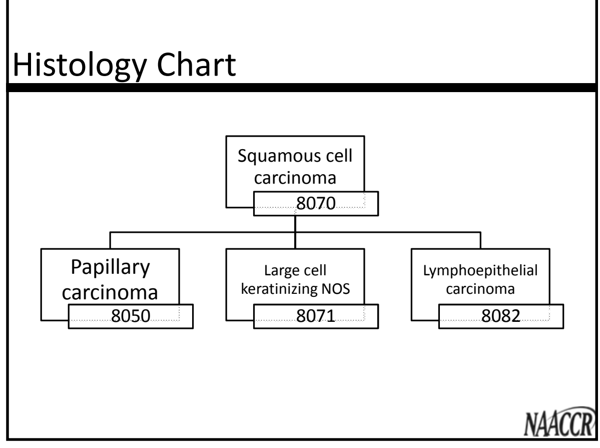

## Multiple Tumors

- Rule M8
  - An invasive tumor following an in situ tumor more than 60 days after diagnosis is a multiple primary.
- Rule M9
  - Tumors diagnosed more than five (5) years apart are multiple primaries.

## Multiple Tumors

- Rule M10
  - Abstract as a single primary when one tumor is:
    - Cancer/malignant neoplasm, NOS (8000) and another is a specific histology or
    - Carcinoma, NOS (8010) and another is a specific carcinoma or
    - Adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma or
    - Squamous cell carcinoma, NOS (8070) and another is specific squamous cell carcinoma or
    - Melanoma, NOS (8720) and another is a specific melanoma
    - Sarcoma, NOS (8800) and another is a specific sarcoma

## Histology Chart




## Multiple Tumors

- Rule M11
  - Tumors with ICD-O-3 histology codes that are different at the first (xxxx), second (xxxx) or third (xxxx) number are multiple primaries.
- Rule M12
  - Tumors that do not meet any of the above criteria are abstracted as a single primary.

NAACCR

## Histology Rules

NAACCR

## Histology Rules

- Rule H1
  - Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.
- Rule H2
  - Code the histology from a metastatic site when there is no pathology/cytology specimen from the primary site.
- Rule H3
  - Code the histology when only one histologic type is identified.

## Histology Rules

- Rule H4
  - Code the invasive histologic type when a single tumor has invasive and in situ components.
- Rule H5
  - Code the most specific histologic term using Chart 1 when there are multiple histologies within the same branch.
- Rule H6
  - Code the histology with the numerically higher ICD-O-3 code.

## Histology Rules

- Rule H7
  - Code the histology documented by the physician when there is no pathology/cytology specimen or the pathology/cytology report is not available.
- Rule H8
  - Code the histology from the metastatic site when there is no pathology/cytology specimen from the primary site.

## Histology Rules

- Rule H9
  - Code the histology when only one histologic type is identified.
- Rule H10
  - Code the histology of the most invasive tumor.

NAACCR

## Most Invasive

- Most invasive: The tumor with the greatest continuous extension. The least to the greatest extension for mouth and oral cavity:
  - epithelium
  - lamina propria
  - submucosa
  - muscularis propria

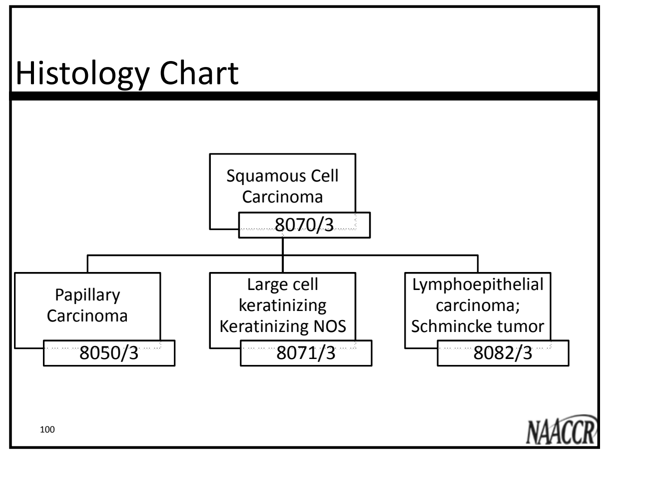
NAACCR

## Histology Rules

Rule H11 Code the most specific histologic term using Chart 1 when there are multiple histologies within the same branch.

- Cancer/malignant neoplasm, NOS (8000) and a more specific histology or
- Carcinoma, NOS (8010) and a more specific carcinoma or
- Squamous cell carcinoma, NOS (8070) and a more specific squamous carcinoma or
- Adenocarcinoma, NOS(8140) and a more specific adenocarcinoma or
- Melanoma, NOS (8720) and a more specific melanoma or
- Sarcoma, NOS (8800) and a more specific sarcoma

NAACCR




## Histology Rules

- Rule H12
  - Code the histology with the numerically higher ICD-O-3 code.

NAACCR

## Questions?

102

NAACCR

## Coming up!

- **11/3/11**
  Collecting Cancer Data: Ovary
- **12/1/11**
  Collecting Cancer Data: Thyroid and Adrenal Gland

103

NAACCR

## Thank You!

104

NAACCR