Q&A Session for Collecting Cancer Data: Pharynx
February 5, 2009

Q1: In MP/H rules (pg 18) that list overlapping sites, are these just examples as there are other overlapping codes such as c058, c068 etc. that are not listed?

A: This refers only to the sites listed because for those sites there are multiple 3 digit rubrics that refer to the site.

Q2: Why would the Radiation Oncologist take priority over the ENT physician, who is usually the diagnosing physician?

A: If the ENT physician is the physician that assigns the stage, then the ENT physician takes precedence. If the ENT does not assign the stage, my guess is that the thinking was that the radiation oncologist has more info than the primary care physician.

Q3: Jim stated M3 not applicable for pharynx but aren't tonsils part of oropharynx?

A: The tonsils (C09) and the pharynx are different sites even though the tonsil and oropharynx use the same schema for collaborative staging.

Q4: In scenario of the MP/H rules quiz, if a pathologist had been at tumor board and stated that it was a recurrence, would we then code as a single primary?

A: No. The general rules tell us to ignore the term recurrence and follow the rules.

Q5: So, even if the pathology is reviewed and stated to be a recurrence based on the path, we still ignore the recurrence?

A: We have referred this question to the NCI-SEER QI team for clarification.

Q6: Re Multiple primary rule M9 - Since follow up appointments are often scheduled at yearly intervals, do we go by the month of diagnosis rather than the day? (week could be a week or a few days short of 5 yrs).

A: I believe you would go with the day rather than the month.

Q7: On case 2 of the MP/H quiz, would you stop at the first applicable rule which was M7 instead of going on to M11.

A: You would stop. Then you would have to make a second pass through the rules with the first and second tumors.

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Q8: The general instructions say to not use physician statement of recurrence unless a pathologist compares the current tumor to the original tumor and states that it is a recurrence of the original tumor. Would that not indicate that path doesn't have to say metastasis?

A: We have referred this question to the NCI-SEER QI team for clarification.

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Q9: Nasopharynx CS ext code: my physician often describes a nasopharyngeal tumor as involving the base of skull and stage as T4, without any other information. What CS extension code should I use?

A: You have to code CS data items based on the information in the record, not the physician stage. This is something that probably needs to be reconciled with the staging physician.

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Q10: Tip for Determining Single/Multiple Primaries for Pharynx: It is very important in the Nasopharynx schema to look at how a CS Extension code maps as not all the CS Extension codes are listed in hierarchical order. Example: Extension to the hard palate and bone of skull. Hard palate (CS Ext 57) maps TNM T4, SS77 D, SS2000 RE; and bone of skull (CS Ext 60) maps TNM T3, SS77 RE, SS2000 RE). The hierarchy rule is not used in this case as CS Ext 57 maps to a higher stage than CS Ext 60. The correct CS Ext code is 57 for this case.

A: Great tip! Thanks for sharing.

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Q11: Following the description for CS TS/Ext Eval code 3, could you not still use the clinical information and assign eval code 3 when surgery is done, even if the clinical information showed further extension?

A: No. If the FURTHEST involvement is documented by clinical information and that is the information reflected in the CS extension/tumor size code, then the eval code should reflect that even if there was also pathologic confirmation.

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Q12: CS lymph nodes = 80; you indicated unknown if regional or distant lymph nodes. Would CS SSF 1 need to be 999 if you suspected they might be distant?
A: No. The note that follows the CS lymph nodes codes for the oropharynx, anterior surface of the epiglottis, nasopharynx, and hypopharynx CS schemas states that 'for codes 10-12, 20-22, 30-32, 40-42, 50-52, and **80** ONLY, the N category is assigned based on the value of SSF1, size of lymph nodes, using the extra table, lymph nodes size table, for this site.' So, if the code for CS lymph nodes is 80 and there is a documented size of the involved regional nodes, the size should be coded in CS SSF1.

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Q13: Are we to assume if there is no mention of extracapsular extension of nodes that there is none and should code to 000?

A: No. Note 2 with CS SSF2 states ‘if nodes are involved but there is neither a clinical assessment of extranodal extension nor a statement about it in pathology report, use 999.'

Q14: If you have multiple primaries in the H&N and there is + lymph node(s) involvement, how do you determine which primary the nodes are assigned to?

A: Following general coding rules, code the involvement of nodes for both primary sites.

Q15: If the tumor size is 7 to 8 cm, what size do you code? 997 is too generic when you have an approximate size.

A: We have asked for clarification on this in the past, but I don't remember the answer. We will send the answer with the Q&A document.

Q16: When no comment on vocal cord, do you assume normal and use Code 10?

A: Yes.

Q17: If CT shows lymphadenopathy 4 months after XRT & chemo, and neck dissection is done at that time, is it FCOT?

A: Neck dissection following radiation and chemotherapy may be the standard of care for some head/neck primaries. If that is the treatment protocol that the physician was using, then the neck dissection would most likely be first course treatment.

Q18: What is the primary site code for a head and neck cancer that starts at the base of the tongue and extends to the larynx? The physician described the mass as swallowing a large potato.

A: I would assign C14.8.

Q19: Sorry. What if you have positive LNs as follows: 3 LNs listed in code 10 and 1 LN listed in code 12. Which code would you choose? If you code to the farthest one involved, it would be the one in code 12. Would you choose code12, 22 or other?

A: We have referred this to the CS team for clarification.

Q20: Where can we get the tables you are referring to?

A: http://www.cancerstaging.org/cstage/schemaselect.html

Q21: Previous question regarding multiple lymph nodes in code 10 and single lymph node in code 12. You gave the answer 20. My understanding is the answer should be 22. The nodes are divided due to

Summary Staging. Summary Staging does not worry about multiple nodes or size of nodes.

A: We have referred this to the CS team for clarification.