NCI SEER BREEZE SESSION
HEAD AND NECK MULTIPLE PRIMARY AND HISTOLOGY CODING RULES PRACTICUM
January 19, 2007

Note: There was a brief introduction followed by the loss of audio for the presenter. After some adjustments, the audio returned. That brief introduction does not appear in this transcript as it was not pertinent and the session was restarted. Some background noise can be heard at times in the recording, so the session will be re-recorded and posted to the Web site at a later date. We apologize for any inconvenience.

Today we're going to go over the cases for the Head and Neck sites rules. I plan to go through the cases one by one and talk to you about how we came up with the number of primaries and the histology codes. I want to let you know that Carol and I went over these cases this week because I thought there were some typos in the answer sheet and we believe there are. So you'll get some corrections to your answer sheet as we go along. So let's look at case number one.

Head and Neck Case #1
The first thing you want to ask yourself is: "How many tumors are there?" And in reading this case we determined that there were two tumors. And I will show you how we got there. It's pretty clear in the "Assessment and Plan" section. They give us a nice description right here: "Patient is a 64-year old gentleman who has two areas of concern, one on his tongue and on the left side and the other on the mandibular alveolus each warranting biopsy." When you come down and look at the pathology report you can see that they both had cancer; they were both malignant.

So there are two tumors in this case. They are tongue and mandibular alveolus. Those code to different characters at the second character in the ICD-O-3 topography code so they are two primaries. And going down and looking at the histology codes you have for the first one, which is the mandibular alveolus, it clearly says "squamous cell carcinoma in situ." So the answer should be 8070/2 for the first primary and that is squamous cell carcinoma. And the second one clearly says: "squamous cell carcinoma in situ, no evidence of invasion—of invasive carcinoma." So the answer to that one is also 8070/2, squamous cell carcinoma in situ.

Are there any questions about case number one?

Questions
Question 1 Head and Neck Case One
1. Peggy? [Yes] Can you please also say the site code like 30 or whatever rather than just saying the histology code?

Response to Question 1 Head and Neck Case One

I can do that. It's also on your answer sheet. If there is any change to those site codes on your answer sheet I'll be sure and point that out to you.

Question Two Head and Neck Case One
2. Peggy? On your answer sheet it's 8070/3.

Response to Question Two Head and Neck Case One
That's incorrect.

Okay.

It should be 8070/2. They are both in situ and they are both squamous cell.

Okay. Let's look at case number two.

Head and Neck Case #2
This one is a single tumor. So we always, whenever we have a single tumor we know that's going to be a single primary. So then we try to determine what the primary site is for the Head and Neck cases and this one is parotid. I don't think there's any controversy about that. Parotid gland is C079.

Then we are looking to determine the histology code and we come down to the pathology report. And it's pretty good. It says adenocystic carcinoma arising in pleomorphic adenoma and then there's a little bit of extra information here: carcinoma ex-pleomorphic adenoma. That is your histology. It is a single histology so you code it. And the code is 8200/3.

Are there any questions about case number two?

Questions

Question 1 Head and Neck Case Two
1. *Is there a question?* Yes; it's about case number two, the morphology code. We want to know: How can you make a difference between coding 8200/3—adenoid cystic carcinoma-- or 8941, which is carcinoma arising in a pleomorphic adenoma? What can tell us which one is better?

Response to Question 1 Head and Neck Case Two
Okay. The code that we came up with is 8200, which is adenoid cystic carcinoma arising in a pleomorphic adenoma. And what was it that you were proposing as a code?

8941 because I think 8200 is only adenoid cystic carcinoma and 8941 it says: "carcinoma arising in pleomorphic adenoma." I don't see in the code 8200, I don't see that they're saying "in pleomorphic adenoma."

I see what you're saying. But the problem with the other code, it doesn't say adenoidcystic. So we went with the adenoidcystic, 8200.

That's my question. Why do you go with "adenoidcystic" instead of "in pleomorphic adenoma"?

That's a very good question. I think we did not use the information in parentheses. We felt that the adenoidcystic carcinoma was the diagnosis and the information in parentheses was for clarification if needed. But if you would find the code 8941, I believe you said? You don't get the fact that it's adenoidcystic carcinoma and that seems to be important.

Does that help?

Yes, thank you, but I don't see. The "in pleomorphic adenoma" is not in parentheses and my question was, "What tells me that 'adenoidcystic' is more important than 'in pleomorphic adenoma?'" That was my question, but thank you.

Okay. Carol, did you have something to add?

Carol Johnson: I think one of the things, in colon, we tell them to always code the polyp because it's very important. This is different. So, I guess I would point out that the different sites do have different rules. In the Head and Neck it doesn't have the importance that it has in the digestive system so we don't give you a rule that says code the polyp above all things. So I just wanted to point out that there is a difference between the colon and the Head and Neck rules in that the polyp isn't coded preferentially above any other code.

Case Two Question Two

2. Carol, is that in the General Rules anywhere?

Response to Question Two

I guess what I would have to say, I was thinking about how to say this. And the General Rules do not give preference to a polyp. The only time you see that is in colon.

Case Two Question Three

3. Okay. So are we to assume then that for all other sites, we would not give preference to the adenoma?

Response to Case Two Question Three

Yes.

Okay, thank you.

Peggy: Thank you, Carol. That clarifies that a little better.

Any more questions on case number two?

Let's look at case number three.

Head and Neck Case #3
Case number three we have multiple tumors. We have, "Multiple biopsies were done which confirmed invasive carcinoma in the left tonsil involving the retromolar trigone to soft palate and most likely the gingival area. He has a separate lesion over the left hemitongue, mainly the lateral surface and biopsy shows squamous cell." So, there we have at least two lesions. We have one in the tonsil and a separate lesion over the left tongue. So we know we have multiple tumors.

We are trying to figure out if they are going to be different at the second/third character of the topography code. Tonsil is a C099. Tongue is a C029 so those are different at the third character of the topography code. So we have two primaries, one of the tonsil and one of the tongue. Now we are going to look a little further and see what the histologies were.

We don't have the path report but we have a mention of what was found on biopsy. It says multiple biopsies were done which confirmed invasive carcinoma in the left tonsil so for that one the code should be 8010/3 for the tonsil. [Comment: "On your answer sheet that was coded as 8070/3."] That's correct. That's why I'm telling you the answer should be 8010/3. That's a difference from what you have on your answer sheet. And for the second primary of the tongue the information here is: "He has a separate lesion over the left hemi-tongue…biopsy shows squamous cell carcinoma." So for the tongue lesion the histology is correct on your answer sheet; it's 8070/3.

How about some other questions? Anything else on case three?

Okay. Let's look at case number four.

Head and Neck Case #4
Case number four is a very large lesion. It involves a lot of sites but the information is pretty clear that it's just one large mass. The part that I want….okay here it is. "There was a granular exophytic mass very suspicious for squamous cell carcinoma starting on the soft palate, left of uvula and extending along the free margin of the soft palate fully involving the left tonsil and extending down through the tonsillar fossa with extension into the base of the tongue adjacent to the tonsil." So here's a really big mass. But it's one mass; it's one

tumor and a single tumor is always a single primary. So this is a case of a single primary.

And we have a pretty clear statement here as to where this tumor originated. It says: "…starting on the soft palate." So with that clear statement I would make this a soft palate primary and Carol and I talked about it and we agreed. Instead of what it says on your answer sheet. It's not left tonsil primary, it's a soft palate primary. So let me give you a code for that. I didn't write that down. If somebody has it, just shout it out. [C051]. Thank you very much. C051, soft palate primary and the histology code comes from the pathology report. It's a single histology, squamous cell carcinoma. They didn't actually biopsy the soft palate but all of the biopsies showed the same thing, squamous cell carcinoma and we can use that information to apply our histology code, 8070/3 and it is on your answer sheet.

Do you have any questions about case number four?

Question One Head and Neck Case Four

1. Why would the soft palate take priority over what it says in the first paragraph where they are describing the tumor; where it says, "left tonsillar lesion?"

Response to Question One Head and Neck Case Four

In the first paragraph? [Yes] *"…left neck mass and a left tonsillar lesion.." Yes because that doesn't tell you that the tonsil was the place where it originated. This statement in the second paragraph, "starting on the soft palate," seems to be a pretty good indication of soft palate being the primary.* [Okay] *And if you have a statement like that versus something less specific or less definitive, go with the more definitive statement.*

Question Two Head and Neck Case Four

2. Peggy, I have a question about that soft palate as the primary site. We went over this when we had the reliability study for Head and Neck. And how can you tell the difference when they say "starting on the soft palate" meaning that that was the upper portion of the tumor as opposed to originating there?

Response to Question Two, Head and Neck Case Four

Well, hopefully in the real world you will have information to back this up and you will be able to make that determination much better than you can with a one-page case. I know that doesn't really answer your question.

Comment on Question Two, Head and Neck Case Four

I understand that point; it's like that's where they first start to see it but because it does fully involve the tonsil I guess that's why some of us thought it was tonsil.

Carol Johnson: I think this is a very difficult call without a doubt. It's one of the things that's always so messy about Head and Neck. It's impossible for us to do a word list that says: "If it says 'originating' take it; if it says, 'starting on,' don't." The fact is that really physicians don't use standard nomenclature. We can make lists but that's not how they really dictate. So, as I say, it doesn't do much good and it isn't much help because we can't include or exclude everything either. So the fact is when you see the Head and Necks we tried to help you by giving you, number one: a priority in how to use documentation. So when you look at your Equivalent Terms and Definitions there's a priority and it says if you have what seems to be conflicting information, use the information from this document in preference to this one. So that's helpful if you don't have something like this where you only have an Operative Summary and the discrepancy is on that Operative. So I think when you're talking about, as far as: "I coded tonsil" and "I coded soft palate," I think one could, in all truth, make good arguments for both. The best that you could do is to use what seems to be the most clear information. It talks about starting on the soft palate. Your problem is that you don't know if this is a physical exam or if it's part of the laryngoscopy. Now my guess if you look at this is that the first description that you have, the one where they're talking about a left tonsillar lesion—they talk about a necrotic anterior lymph node and they talk about a necrotic mass in the posterior triangle. And I find it a little difficult or hard to believe they would be seeing that with a laryngoscopy or bronchoscopy. So I more tended to think that the second paragraph may have come from the laryngoscopy than the first paragraph because when they're talking about positive neck nodes I find it a little hard to believe that came from a scope looking from the inside out. If you look at the Equivalent Terms and Definitions you will see that the vision by the scope has a priority. So this is one of the reasons we chose that.

Comment
I think that would be something that you'd have to be a really advanced abstractor to catch all that. Hopefully, there would be more information.

Peggy: There's the key. These are very short cases.

Carol Johnson: Yes, they are. We can't give you ten page cases, you know? That just wouldn't be too …

You wouldn't like us very much if we did.

Carol: No, you wouldn't truly. I guess I was trying to explain to you that when we looked at it, we looked at our priorities and found that the priority was using the scope. And we felt like a physical exam of the lymph nodes, that part probably wasn't scoped it was the pre-op that they were dictating under those findings.

So the answer is there's really not a whole lot we can point to for what's makes the case to say definitively this is the primary site. But to the best of our ability to

interpret what we have here in front of us—this condensed case-- if you see something like "starting on the soft palate" you take that as the primary site.

We need to move on. Time's ticking away. Let's look at case number five.

Head and Neck Case #5

We have lots of interesting things here. The Head and Neck cases are all lots of fun. But let's see. We have tumors of the tonsil and tumor of the aryepiglottic fold. And let me see if I can find the right stuff here to help you see how we got that. Since endoscopy has the first priority, this statement right in here that says, "flexible nasopharyngoscopy reveals a second lesion involving the right aryepiglottic fold," that's tells us pretty clearly that that's one of our tumors—"aryepiglottic fold." Then it goes on to say that it extends "into the arytenoids area, carcinoma." So it looks like there's one of our sites. Then we have to figure out how to read the rest of this case. We have to look at our priority list for determining our primary site. That's the only endoscopy information that we have. The imaging doesn't really give us a site of origin for the other tumor. But this statement up here says: "Tumor appears to extend onto the soft palate from the region of the anterior tonsillar pillar." There's a pretty clear statement right there—"from the region"—that's telling me that it started on the anterior tonsillar pillar. So that would be the primary site for your other tumor. So you have two tumors: one tonsillar pillar and one aryepiglottic fold. And those are different at the third character, actually there're different at the second character, of the ICD-O-3 topography codes. Tonsillar pillar is a C091 and aryepiglottic fold is C131.

This is another one of those cases where we have a lot of information condensed into one page. But the best way that we found to interpret it was taking the one tumor from the flexible nasopharyngoscopy and taking the statement of "from the region of the anterior tonsillar pillar" for the other tumor.

The histology is pretty straightforward. They're both carcinoma. We don't have a pathology report. So we take the physician's indication of the histology. The tonsillar one is carcinoma and the other one is also stated to be carcinoma. So that's all we have and that's 8010/3. I am sure you have questions about the primary site. There're a lot of different ways to read this. What are some of your thoughts?

Carol Johnson: I guess one thing I might say is this is probably more common in Head and Neck, having big problems figuring out what was the primary site. That was one of the problems that was targeted by the Histology Group and that's why we worked with the physicians, the ENT physicians and we worked with the AJCC Head and Neck Team to give a priority for how you would code these. The problem we had was just as you heard with that first case, Chris was saying that "We don't want to use this word"; someone else was saying, "But we want to look at this" and we all ran in a different direction. The reason for giving that priority code first from here, secondly from here, was to try to get us to code consistently

so that everyone would come up with the same answer. And using the physician's expertise in determining which documents you would use in which order to give us the best answer we could get.

Peggy: And that's going to really help, I think, with consistency for Head and Neck cases. We will have something we can all look at and try to come up with the same answer instead of each of us trying to make sense of it sort of on our own. So that's the advantage to these rules.

Question One Head and Neck Case Five

1. Peggy, just before you get into that, I'm having trouble interpreting the physical exam with the scope where it's stated there in the General Rules—the final, the "g" [point] —physical exam basically?

Response to Question One Head and Neck Case Five

Okay. You should be looking at the Terms and Definitions for Head and Neck. And in that document, if there is no resection your priority order for using documents to determine the primary site starts with endoscopy [point 4a] *and then it says physical exam with scope. Is that what you're asking about?*

I guess I'm having trouble with that definition versus "g." ["Physician statement based on clinical examination"]

G? Okay. I hear you now. Okay, yeah, there's-- I guess the "g" would be when there is no scope.

Carol Johnson: What usually happens with the ENT is their first visit to the doctor's office they literally open the mouth, and [they are] looking down with a tongue depressor and a little light and they're saying, "Gee, look what I see!" And that is a physical exam. When they do the scope they are also doing a physical exam because they are describing all the landscapes and everything they see as the scope progresses down the throat, the nasal cavity, the whatever. So that's why they asked us to list it as a physical exam with the aid of a scope and a physical exam without a scope. And they were afraid that the word "endoscopy" itself—that maybe new registrars wouldn't know that would include a nasopharyngoscopy; it could include an esophagoscopy or any other.

So that's the difference between the "a" and the "g." [The] "a" is physical exam when they use the scope also and "g" would be there's no scope. Good question. Okay. Let's look at six.

Head and Neck Case #6

Case Number Six is a case of two vocal cord primaries. One was by history in 2007 and that's found right here: "Patient has history of verrucous carcinoma of left vocal cord diagnosed June 3, 2007." One of the most important parts of that sentence is "left" because when you look at the rest of the report there is a

second vocal cord tumor but it's of the right vocal cord. No, I'm wrong. The reason why this is two primaries is because it's more than 5 years apart. The first one is 2007 and the second one's in 2012. These are "tumors diagnosed more than five years apart are multiple primaries." So we have one vocal cord tumor in 2007 and a second one in 2012. Sorry about that, I got off on the wrong foot. And they are both verrucous carcinoma so they are both 8051/3. You have the histology of the first one here in this first paragraph; you can use that. And for the second one you have a final diagnosis from a pathology report giving you the histology.

Are there any questions about case six? Okay.

Let's look at case number seven.

Head and Neck Case #7

Case number seven is a single tumor. And the primary site seems to be maxillary alveolar ridge, which is C030. And it's pretty clear in here. It says: "There was an area of granular papillary mass on the left maxillary alveolar ridge." And then it tells you where it extends to and above that it also says: "…noticed an exophytic lesion of the left maxillary alveolar ridge." So we have one lesion and we have a primary in the alveolar ridge.

Now, when we go to code the histology, we're going to look for the path report, of course, which we have below. Then we have several biopsies and then we have a resection. And according to the information that we have here, the resection is the most representative specimen. That's the specimen with the most tumor tissue as best we can tell from this short little case. So, we'll code it from that "G: Left maxillary alveolar ridge" because it's a resection, because it has the most tumor tissue, "papillary squamous cell carcinoma, no invasion seen." So your code is correct on your answer sheet; it's 8052/2. If you coded it that way because it's the most specific histology, that's fine; you got to the right answer. If you coded it because that's the most representative specimen, that's also fine and that is the right answer.

Does anybody have any questions about case number seven? Okay. Let's look at case number eight.

Head and Neck Case #8

In case number eight we have starting down here, we have a tongue biopsy with squamous cell carcinoma. And that was the first thing. Then we have an operative report and we have a little bit of operative description here: "the left lateral tongue lesion was 2x1 cm in diameter… the left floor of the mouth lesion appeared to be approximately 1 x 0.5 cm." So there we have a hint of two lesions: a left lateral tongue lesion and a left floor of mouth lesion. That's pretty clear. We've got two lesions. The site codes, the topography codes are different

at the second or the third character. The tongue is C019 and floor of mouth is C041. So according to our rules that's two primaries.

And we have a very nice pathology report here that gives us the histology for each. The tongue is keratinizing squamous cell carcinoma, so that's 8071/3. Your answer sheet is correct.

Questions

Question 1 Head and Neck Case 8

1. Can I interrupt real quick? [*Sure*] On the site code, I coded it to lateral tongue which is C029 not C019.

Response to Question 1 Head and Neck Case 8

Okay. Yes. That sounds correct to me.

So "lateral tongue" is what it should be?

You did C0.. which code did you use?

I used C029 which is lateral tongue because that's the one on the final diagnosis.

Oh. For the site, though, you wouldn't take that from the final diagnosis. Your priority for site would be endoscopy first, which we don't have. I am still seeing "lateral tongue" everywhere.

Yes. I see "lateral tongue" everywhere so that's why I am saying I coded it to C029.

I think you're right. I don't see posterior tongue anywhere. You are correct.

That's case eight. The site code for the first primary should be C029. Thank you.

Comment

Okay. I did find "posterior tongue." It's in the clinical history. The clinical history says: "Patient with posterior tongue leukoplakia." But still all the biopsies show lateral.

Response to Comment

Yes. I think it's lateral; there's much more definitive information for the "lateral tongue" being the site. Thank you. I agree with you.

And for the second primary site, the floor of the mouth, we have: "carcinoma in situ with superficial invasion." That should be 8010/3 and your answer sheet is correct on that.

Are there any other questions on case number eight? Good. I'm glad you brought that up about the primary site; good point.

[Several people spoke at once. Peggy said: "Try again. I didn't hear the question. Try again. The response was "never mind."]

Question Two Head and Neck Case 8

2. I'm sorry. I'm asking again. On the second lesion how come it's not C049, because it's just floor of mouth.

Response to Question Two Head and Neck Case 8

We have C041. [Right] *Now let's see; why did we do that? We did "lateral floor of mouth."*

But I don't see "lateral" anywhere in the….

It's says "left" but again I don't, I wouldn't….here it says "left floor of mouth." That's why we did it. Okay? Can you see my highlighting? It says, "left floor of mouth" here in the operative report.

So you're saying the left side automatically means it's "lateral?"

Yes.

Okay. Thank you.

Sure thing. I'm just making a note about that, but "Yes."

Okay. Let's look at case number nine.

Head and Neck Case #9

Okay, case number nine is a pathology report basically. And you have "Specimen A" which is an excision and it shows malignancies. "Specimen B" is an excision and it shows malignancies and also [Specimens] "C" and "E." So, all these sites—retromolar trigone, right tonsillar fossa, left tonsillar fossa and ventral tongue—show malignancy. But we don't have any statement here that tells us how many tumors there were or any help because, you know, we just have this one page. Hopefully in the real world you all would have a lot more information to go on. But for this case we don't know if we have single or multiple tumors. So to determine the number of primaries using the Multiple Primary Rules, we used that first rule, M1, the default rule: When you don't know how many tumors you have, if you don't know whether you have a single or multiple tumors, you default to a single tumor and make it a single primary.

So case number nine is a single primary. And when Carol and I went over these cases we decided that we would code the primary site for this one, C148, which

is overlapping lesion of the lip, oral cavity and pharynx. And that's on page two of the Terms and Definitions. We felt that that was a better answer for the primary site than what your answer sheet says. Are there any comments about that?

Question One Head and Neck Case 9

1. We thought there were separate lesions because they were calling them "extensive." And on Part B they even said that the surgical resection margins were negative for tumors so we assumed that they excised the whole lesion, at least for Specimen B.

Response to Question One Head and Neck Case 9

So you're saying that you made it multiple primaries based on that?

Yes. I'm saying that we made it multiple primaries based on the fact that they called each separate one an "extended" rather than biopsy or something to that effect. And then, as I mentioned before, in Part B you even had negative margins, which indicated that there was no invasive tumor.

Well, I wouldn't feel comfortable putting that much emphasis on such a little bit of information. I would really want to use this as a case of defaulting to a single primary. Because you just don't have any statement here at all that tells you whether you have one tumor or more than one tumor.

Question Two Head and Neck Case 9

2. Up at the top in the "Operative Diagnosis" it gives some information that looks like there is indeed more than one tumor. They even give you a size of one of them: "excision of superficial carcinoma of right retromolar trigone and tonsillar fossa, (3 x 2 cm)." And, "excision of superficial carcinoma left tonsillar fossa. Excision of leukoplakia left ventral tongue (2 cm diameter)."

Comment

I agree with that as well. They even give a size for the second excision so to me that looks like they excised two separate lesions at least.

Comment

We agree with that, too.

Carol Johnson: I have a question to ask you. You're saying they give a size for the excisions. What statement are you talking about?

At the top under, "Operative Diagnosis," the third and fourth lines: The third line says, "Excision," well the second line, says excision of superficial carcinoma on

the right side and it gives a size and then underneath that it says excision of superficial carcinoma left tonsillar fossa and it gives a size for that as well.

Carol: Are you just seeing a size for the tonsillar fossa?

I'm sorry. It gives a size for the leukoplakia of the left ventral tongue, which comes back as positive for cancer. So to me it looks like there's actually probably at least three separate lesions.

Peggy: I think before you would make that assumption you would really need some more information. Based on this very brief case I really think you have to default to a single primary using the M1 rule. If you had more information in the record, if you had a physical exam, if you had something else, then, "Yes," definitely I would agree with you. But there's just not enough here. And in the absence of being able to really put your finger on it, I think you have to default to a single primary. Carol, what do you think?

Carol: I'm just so surprised because of all the people who've looked at this case. No one has ever, ever said anything but default on this one. So you kind of blew me away when you said that; that's why I was asking questions. So I had to go back and look at what you were seeing and I think the tonsillar fossa misled me; I kept looking for a size there so I got a little behind. But anyway, I can hear what you're saying because the word "excision" means "an *in toto* resection of." My problem was that I had seen those words used inappropriately so many times. I have seen an excisional biopsy described as an "incisional." I have seen an "incisional" described as an "excisional." So the words just don't quite do it for me. I am a little more impressed with the sizes and with the free margins.

But is that enough?

Carol: No. I admit that back in the registry field this is one that I would have been hunting people down on because I wouldn't have felt comfortable coding with this.

Peggy: I hope not; I mean I would hope anybody who had a case like this would really dig for more information.

Comment
But at the central registry level it's going to be difficult because you don't get all that information.

Carol: That's why we put this one. That's all you get for a lot of them. We particularly wanted to do that.

Peggy: Say that again, Carol. You cut out; part of it was gone.

Carol: I'm so sorry; I didn't know. I said she's correct. At the central registry this is likely all you would have. And this is what you would have to use to code it.

Peggy: The new data item for the number of tumors, the multiplicity counter, will help the central registry quite a bit, though, because if the hospital sends this in and they tell you that there is more than one tumor in the multiplicity counter, you're good to go. You know you have more than one tumor and you don't have to use that default rule. We just don't have enough information here. The case is too brief.

Question 3 Head and Neck Case 9

3. So for the "B" where it says "surgical resection margins are negative" then, you don't think that that counts?

Response to Question 3 Head and Neck Case 9

Wow. If that's all I had, I just wouldn't feel comfortable making this more than one primary without some other information to back it up.

Question 4 Head and Neck Case 9

4. I have a question about choosing the correct primary site? [*Yes*] The terms that are listed under the Terms and Definitions, those three codes? Are those the only three codes we should be using?

Response to Question 4 Head and Neck Case 9

For Head and Neck, yes. Why? Do you see another one that might apply?

No. Well, it was coded, the answer sheet had a different overlapping code.

Carol: We know. We saw that. What we tried to list in the Equivalent Terms and Definitions were those overlapping lesions that extended into several sites, not just subsites. So we've got .8 code that does say "oral cavity, NOS." What's listed on your sheet are those that extend to more than one site because that's where Head and Neck really gets messy. And we wanted to make sure, especially for new registrars, that they knew that there were codes that said this extends into more than one of the Head and Neck sites.

Question 5 Head and Neck Case 9

5. When do you use the rule M3 which is [tumors of] the right and left sides of a paired site?

Response to Question 5 Head and Neck Case 9

You use rule M3 in tandem with the Table in the Terms and Definitions: Table 1. That's on page 3. And if you have tumors on the left and right side of any one of these sites listed in Table 1 then you would use rule M3.

I made it two primaries because the right side because the right side tonsillar fossa diagnosis says: “The tumor involves the right inferior tonsillar fossa, retromolar trigone and base of tongue.” Then the left tonsillar fossa was excised and also shows squamous cell carcinoma so I made it two primaries based on M3.

Carol: You’re absolutely correct.

Peggy: Well, you know…

Carol: One way or another, because truly you’ll come to M3 before…

Peggy: Only if you have more than one tumor. Only if you know for sure that you’ve got more than one tumor.

Carol: Oh, I see what she’s saying here; I got you! I’m sorry.

You would have to know for absolute certain that you had two tumors to use M3—at least two tumors. And, again, this case is so vague and there is so little information, I think it’s more correct to default to M1 and say you just don’t know how many tumors you have. But, again….

Comment
Well, can we agree to disagree and say this case should be used for training?

We might be there. We really might be there. There are a lot of opinions I’m hearing and I respect that.

Carol: We didn’t want to go real simplistic because we know Head and Necks are not real simplistic, you know? But we didn’t want to give one that didn’t have an ending answer, either.

No, we didn’t really want to do that but I think you all pointed out a very valid point about this case. It’s a little too iffy to really be able to defend any answer so that’s not a good training case.

Well, if you took the sizes off and you took the margins being negative and everything off, then you could keep it as “not knowing.”

Okay. That’s a good suggestion.

Because it is, you know, a case that you might see.

It’s a good case in theory to test rule M1 but you’re right it needs a little change here and there to make that a better training tool. So thank you all. Your input is very valuable. We do appreciate it.

Let's go on to case ten so we can fit it in and get questions in.

Head and Neck Case #10
Case number ten is the last case. And we have a history of left tonsillar carcinoma from December of 2007 and now he's coming in with a lesion involving the soft palate, etc. Let's look at the endoscopy, which is our first priority, of course. And it says there's a massive lesion involving the right tonsil. So, since we now are very familiar with Table 1 in the Terms and Definitions we know that tonsil is one of our sites on Table 1 which is a paired site. And we know that rule M3 tells us that if we have tumors on the left side and tumors on the right side of a paired organ in Table 1, we have multiple primaries. So this is a case of a left…of one primary being the left tonsil and the second primary being the right tonsil.

The histology codes…the only thing you know about the left tonsil is that-- it's the statement of carcinoma. That's the only histology information you have. Take it and code 8010/3 as indicated on your answer sheet. You have better information for the right tonsil, yes, the right. We have pathology, which gives histology of squamous cell carcinoma. And that is 8070/3 as indicated on your answer sheet. That case is pretty straightforward. Are there any questions on it?

Are there any questions about anything we've talked about today?

General Questions
Question One

1. I have a question about the overlapping site codes that are in the Terms and Definitions. Are you saying that we shouldn't be using other overlapping codes?

Carol Johnson: No.

Then why do you point those particular site codes out?

Carol: It was done actually because so many registrars, particularly new ones, don't realize there are multi organ codes. They think the only ones are like oral cavity, NOS or nasal cavity NOS. They don't know there are some that are multiple cavities. And so this was just trying to point that out. Do you suggest that in another edition that we add the single site overlapping codes?

I don't know that you should have all of them or none of them or just refer to an overlapping site code? I don't know.

Carol: We are going to listen because if you feel we should revise it somewhere we'll put it on our list for the first revision. I was just explaining that our intent was

to make sure people understood that there were multi site group codes; that you may need, especially in the Head and Neck.

Peggy: Maybe we could put something in the next edition that says, "for example;" either that or list all of them. It kind of gives the impression that those are the only three we want you to use and that's not true.

Carol: No, no. We don't want to. That's why I was saying, what do we need to do to correct that because that's not what we wanted you to see or to think.

Peggy: We didn't look at it that way obviously so we didn't know how others are viewing it. That really helps.

I think if you mention what you just did that these overlapping codes should be used when the codes that describe a lesion that's overlapping within one site aren't sufficient that it might make it more understandable.

Peggy: That's a very good suggestion.

Carol: I like that! We could probably even lead off saying: A lot of times a lesion will overlap several sites, not just subsites of…you know? And then explain these are the key codes you use when that happens.

Peggy: That's an excellent suggestion.

Carol: I like that a whole lot, yeah! Let's put that in our notes for revisions.

Peggy: We're keeping a list of things and that's definitely going on the list. Thank you very much.

Are there any other questions, comments, suggestions?

Question Two

2. Yes. Could we go back to Case Number One? We just had an abstractor here that for the site code for the tongue, interior/anterior tongue, she used C022 instead of C023 because she was using the term "inferior" as the same as "ventral." What's your opinion on that?

Response to Question Two

Let me catch up with you. C022 ventral [surface of tongue] *and we had C023 anterior 2/3 of tongue, and she was thinking ventral because? What was the term?*

Inferior; because of its being called "inferior/anterior tongue."

Inferior, so she's going for the underside of the tongue. Is that correct?

Yes, which would be the ventral surface, correct?

That sounds reasonable to me. I'm just looking at the case to see if I can find some of the terminology and where we took the primary site. "The inferior anterior portion of the left side of the patient's tongue." Yes, I'm kind of going along with that, too.

So really then that one could be coded as C022 and that would probably be a better reflection of…

Yes.

Okay. Thank you.

I like that; thank you very much. That's a good catch. You people have the "eagle eyes" out there. We really respect your input so thank you for that.

Are there any other comments or questions? You all are full of good information today.

Question Three

3. I have a question. You made the comment that left means lateral? Where does that come from? Is that something that's documented in your SEER Manual?

Response to Question Three

I'd have to look.

Because "lateral" just means "side." I've always just…like "bilateral;" it just refers to side. I didn't know that it always meant "left."

Well, no. I don't think it always means "left," but I think the term "left" indicates that you are not on the midline.

Oh, I see what you're saying.

Sorry. I didn't mean to confuse you.

Oh, I see what you're saying. It's just that "two o'clock Friday moment." I've got it now.

I'm glad you asked because I didn't want.. I'm glad I could straighten that out.

Thank you.

Thank you for giving me the chance to straighten that out.

Anything else?

Question Four

4. Peggy could you explain to us a little bit why you decided that endoscopy would have priority over CT? Because when you look at an endoscopy they are just looking at the superficial aspects.

Response to Question Four

We talked with the physicians for that kind of input. To the best of my recollection their impression or their opinion, what they advised us was that when you're doing an endoscopy you can see more about the tumor and where it started than you can on CT.

Carol Johnson: That's the same input from the specialty physician at Emory University who is one of the advisors that we did [consulted] from the AJCC Site Team. And they all said that, truly, MRIs are not a very good source of coding site-- coding the primary site. They all kind of equally said that was not high on their list at all. So trust me, I would have expected it to be higher, too.

It tells you—the imaging tells you where the tumor is but it doesn't give, according to the physicians, it doesn't give them a good idea of where it started; that's what I'm recalling. Does that help?

Carol: That's exactly what they said, Peggy.

Okay. That's a good question.

Carol: …when you're staging, yes, but for determining the origin of the tumor that it was not one of the definitive methods at all. And they were in total agreement. They weren't on at the same time. We had the Emory physician quite early in the process; AJCC physicians at the terminal end, really, and they both completely agreed on this.

Conclusion

We're over our time a little bit. It's been a really good session. Head and Neck cases are just really, really fun –I'm being facetious—but I think these rules really help us all kind of come together closer on coming up with the same answer. And that's what the rules are all about. Thank you all very much for joining us today. We'll catch you on the next training session. Have a good weekend.