# Q&A for Collecting Cancer Data: Lip and Oral Cavity

Thursday, April 13, 2017

Q1. Regarding MPH H10, what is meant by “most invasive”? Does it mean size, depth, etc.

A1. In the MPH manual, Head and Neck Equivalent Terms, Definitions, Charts, Tables and Illustrations p. 18 the definition of “most invasive” is the tumor with the greatest continuous extension. The least to the greatest extension for mouth and oral cavity: epithelium, lamina propria, submucosa, and muscularis propria.

­­Q2. On Quiz 2 what ICD-O code do you use for left lateral portion of anterior tongue?

A2. Per SINQ 20041032 – code lateral tongue without mention of dorsal or ventral surface to C023 (anterior 2/3 tongue, NOS)

Q3. What is the recommendation for assigning a primary site when all that was found was enlarged cervical lymph nodes which are biopsy positive for squamous cell carcinoma? When would you choose an oral cavity site vs C148 overlapping lesion lip, oral cavity, pharynx?

A3. Per the SEER Coding Manual 2016 C148 is used when there is an unknown head and neck primary. This is based on the note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. This is a more specific code than C760.

Q4. Radiation modality coded as 41 yet text just states stereotactic beam, doesn’t specifically state IMRT or 3D conformal on case scenario 1?

A4. Stereotactic beam radiation (SBRT) is coded as 41 if the mode of delivery is not specified. Most SBRT is delivered via a linear accelerator and if that is the mode of delivery use code 42.

Q5. If final diagnosis is lip but somewhere in the pathology report it mentions skin, is the site coded to C44 instead of C00?

A5. Basal Cell Carcinoma of lip (C00\_) is rare and requires a statement that the tumor is on the vermilion border (rather than skin) to be coded to C00\_ and to be reported (Refer to article in American Academy Dermatology 2004; 50(3):384-387). Review operative and pathology reports, and the physical exam for mention of “mucosal surface” (reportable) or “skin” (not reportable). If neither are mentioned, lip, NOS is reportable per the ICD-O-3 code of C009. SINQ 20051049 and SINQ 20150020

Q6. When a physician documents that this is a “recurrence” of an oral malignancy (as well as other primaries as well) but the MP/H states that there is a 5 year rule making it a new primary, does the physician statement override the MP/H rules?

A6. According to the MP/H general instructions/terms (p. 10) the term recurrence has two meanings: 1The reappearance of disease that was thought to be cured or inactive (in remission). Recurrent cancer starts from cancer cells that were not removed or destroyed by the original therapy. 2 A new occurrence of cancer arising from cells that have nothing to do with the earlier (first) cancer. A new or another occurrence, incidence, episode, or report of the same disease (cancer) in a general sense – a new occurrence of cancer. With this being said we should determine the number of primaries to be abstracted according to the MP/H rules and not just the physician statement of “recurrence”.

Q7. If C148 (overlapping lesion lip, oral cavity, and pharynx) is to be used for unknown head and neck primaries then when would we use code C760 (ill-defined head & neck)?

A7. Use ill-defined sites when it is modified by a prefix (peri-, para-, etc.) according to the ICD-O-3 Rule B, p. 25, or when the physician cannot identify the primary site (SEER Coding Manual 2016, p. 80). The code C148 is more specific than the ill-defined site code, C760, when it comes to unknown head and neck primaries.

Q8. On Quiz 1, question 6, if only a biopsy is performed why was the answer Tumor Board (B)? According to the MP/H Terms and Definitions #4 p. 18, Endoscopy is listed as first documentation to use.

A8. Yes, endoscopy is first if the only information you have is from a biopsy only and none of the other options are available then you would take the information from endoscopy. However, in the answer options for this question tumor board was an option which means that you have that information available to you. No matter if it is a biopsy only and you have a primary site from Tumor Board then you use that information over the other. Only if you don’t have tumor board information nor staging physician’s site assignment do you move to priorities #3 and #4.

Q9. ­Are these webinars on staging good for the 4 credits needed for the NCRA requirement for certification?­

A9. Yes. All of the NAACCR webinars related to abstracting are eligible for 3 Category A CE’s.

Q10. In the example you gave for a T0 metastasis was found but a primary tumor was not identified. Wouldn’t this be an unknown primary and therefore not stagable by AJCC?

A10. The example was a little confusing. Here is a more specific example. A patient is found to have a mass in the neck. A biopsy is positive for metastatic squamous cell carcinoma. The physician thinks the primary site is most likely the floor of the mouth even though inspection of the floor of the mouth is negative for a tumor. Since the physician thinks the primary site is floor of the mouth but evaluation fails to reveal the primary tumor, we could assign primary site as floor of mouth and cT would be a cT0.

Q11.Can we use the term “encased” for extension”

A11. A lip and oral cavity primary that is “encasing” the internal carotid is coded as a T4b. I would not take that to mean that the term “encased” always can be used to determine extension. You have to look at the context of how it is being used and determine if the physician believes the structure being “encased” is involved.

Q12. In the rules for classification for pathologic staging (pg 32), it states “Complete resection of the primary site and/or regional node dissection….allows the use of the designation for pT and/or pN, respectively.” What does “and/or” indicate? Do we follow the standard rules?

A12. we posted this question to the CAnswer forum. You can see it at <http://cancerbulletin.facs.org/forums/node/71147>

­Q13. Is pTX, pN1, cM0, pStage 99 valid for path staging elements in a scenario where the primary tumor wasn't removed but I have a + excisional bx proof of N1, which isn't the highest N category? ­

A13. See the link above. A biopsy of a single node would not be enough for a pN1 if the primary tumor was not removed.

Q14: ­On quiz 2 primary 2 could you use a pTis in the clinical staging of the floor of mouth primary since they did an excision of the lesion, would they have done an excision if they didn't suspect cancer?­

A14: They did a core biopsy of the floor of the mouth lesion and it did not come back as cancer. There was nothing documented that indicated the physician thought it was cancer. Therefore, the clinical stage would be cT blank, cN blank, cM blank, stage 99.

If the biopsy had come back negative but the physician thought it was cancer, the clinical stage would be cTX cNX cM0 stage 99. You could not assign a pTis to the cT data item since you didn’t have a biopsy confirming in situ.