**Q&A Session**

**Collecting Cancer Data: Larynx and Thyroid**

**May 7, 2015**

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Q: ­With the N-category, can you simply code N2 or should you assign an N2a, N2b, or N2c?­

A: ­Yes. The subcategories don't change the stage. This isn't always the case, but it is for laryngeal primaries.­

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Q: ­Please describe again where the ventricles are located?­

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A: ­The ventricles are the laryngeal sinuses and located near the ventricular bands (false cords).­

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Q: ­Mucosal melanomas would be coded under what primary site? ­

A: ­A mucosal melanoma of the larynx would be assigned the topography code of the larynx sub-site of origin.­

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Q: ­If the histology code for the primary site does not fall into the code ranges listed in the AJCC manual, can we use AJCC to stage?­

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A: ­No, you cannot. However, it is recommended to check CS histology inclusion table AJCC 7th Ed. for the included histologies. It is more up-to-date than the AJCC Manual. ­

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Q: ­Going back to AJCC staging of the T category for C32.8 and C32.9, could you please explain the difference (if any) between the epi center vs. the bulk of tumor?­

A: The location of tumor bulk is the sub-site in which the majority of the tumor is located for overlapping or NOS tumors. Epicenter is the midpoint.

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Q: ­In case scenario #1, I don't have the date of treatment. Erbitux from 2013 should be coded to BRM, but for this case I assigned a chemo code for the oncology note. Is it correct?­

A: Effective with diagnosis January 1, 2013 and forward, cetuximab (Erbitux) is to be coded as BRM/immunotherapy per SEER\*Rx. For cases diagnosed prior to January 1, 2013, code this drug as chemotherapy. Case scenario 1 did not include a year of diagnosis. However, because we are presenting in 2015, we are using 2015 rules. We should have included a year in the case scenario to avoid confusion.

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Q: ­Re pop quiz path stage; since the MD chose NOT to examine lymph nodes my understanding is NX is used/valid (rather than blank), and the pM should be the cM0 for: pT1b pNx cM0 Stage 99. Please clarify.­

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A: ­The pM would be blank, but you use the cM0 with the pT and pN to determine pathologic stage group. The pN has caused great confusion. We sent a question to the CAnswer Forum, and the response was your understanding. If resection of the primary site meets the pathologic stage criteria and is performed, if lymph nodes were not removed, N category would be pNX, not blank.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/56581-x-and-blank>

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Q: When the surgeon removes the larynx in a total laryngectomy, do they sew down the epiglottis? ­

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A: *According to the Head & Neck Cancer Guide site:* ­“For a total laryngectomy, the incision is placed in the central neck, extending quite far to the side in order to perform neck dissections on both sides. This will allow exposure to remove the voice box along with the lymph nodes in the neck, if required. As part of this surgery, one or both lobes of your thyroid gland will be removed. Your surgeon might send frozen section margins after the voice box is removed to confirm no cancer cells are left behind. The closure will then be performed and will include creation of a laryngostome. A laryngostome involves sewing the top part of the trachea directly to the skin. This makes you a “neck breather” because there is no longer a connection from your mouth/nose down into your ­lungs. However, your mouth does remain connected to your throat and esophagus down into your stomach to allow you to eat.”

A: I looked for an answer to my question. The pharyngeal space is closed permanently separating your mouth and nose from your trachea. There is a good drawing here. <http://www.headandneckcancerguide.org/adults/cancer-diagnosis-treatments/surgery>

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Q: ­In case scenario #1 there is pre-epiglottic space involved. What is the difference between CS Extension code 520, paraglottic space, and code 650, pre-epiglottic tissues? Is there a difference between space and tissues?­

A: ­I think the difference is that paraglottic is around the glottis while pre-epiglottis is before the epiglottis.­

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Q: In larynx case #1, would the thyroid be considered as adjacent site and the surgery code 42?­

A: This question has been submitted to the CAnswer Forum. You can follow it at <http://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/fords/first-course-of-treatment/surgery/56731-total-laryngectomy-and-right-hemithyroidectomy>

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Q: ­In larynx case #2, could the CS extension code be 110 since the biopsy of the ventricle was negative for malignancy?­

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A: ­I think 300 is the better code because in the CT scan they say again that there is ventricle infiltration. More likely they missed the tumor in the biopsy.­

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Q: ­Isn't it true that this usually occurs with the combination of alcohol & smoking­?

A: ­Yes it is true that the combination of tobacco and alcohol use is a significant risk factor for laryngeal carcinoma. Synergy!­

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Q: ­For the thyroid pop quiz, do you include the "s" for single tumor in the T category?­

A: ­Yes. However, not all software includes a place for descriptors. I don't think most central registries collect descriptors in AJCC stage.­

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Q: ­In order to clinically stage thyroid carcinoma in a patient that presents with a thyroid mass or nodules on imaging, it must by microscopically confirmed in order to use the imaging findings to clinically stage correct?­

A: ­That's how I read the clinical staging requirements.

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Q: ­If no biopsy is done and the patient presents with a mass or nodules and cancer is confirmed on surgery, can it be clinically staged?­

A: ­We sent the question to CAnswer Forum and received the following response.

*Q: In the rules for clinical staging for thyroid it is stated that the diagnosis of thyroid cancer must be confirmed by needle biopsy or open biopsy of the tumor. If a patient presents with a measurable mass in the thyroid but no biopsy is done, can a clinical stage be assigned? In our example the patient went on to have surgery that confirmed malignancy.*

*A: Without a biopsy confirming cancer, the patient cannot be assigned a clinical stage. Especially since the staging is so dependent on the histology, without knowing the type of cancer you cannot assign stage.*

*This was verified with an AJCC expert panel member.*

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/education-developed-by-partner-organizations/naaccr-webinars/56673-clinical-stage-thryroid-no-bx>

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Q: ­In reporting a patient with thyroid cancer that had a total thyroidectomy, I often see no record of hormones. Wouldn't the patient have to be on hormone replacement therapy for the rest of their life?­

A: I would assume so, but you cannot code hormone treatment as being done unless you have documentation.

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Q: ­For sequence of systemic treatment before and after, if patient had synthroid prior to surgery, I know we code treatment date as diagnosis date. I guess it be correct to code systemic treatment before surgery. Would this be considered neoadjuvant? ­

A: It would not be considered neoadjuvant treatment. There is an interesting post at <http://cancerbulletin.facs.org/forums/forum/collaborative-stage/larynx-and-trachea/thyroid/6108-synthroid-after-diagnosis-but-before-treatment>

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