# Q&A Collecting Cancer Data: Pharynx

Thursday, November 1, 2018

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Q: ­If P16+ are we to assume HPV type 16+? ­

A: ­Yes. P16 is used to detect HPV type 16+.­

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Q: ­HPV testing-for primary-known oropharyngeal cancers, must the HPV test be performed on the primary site, or can the test be performed on a metastatic site? Is this addressed in the AJCC manual, and if so, where? ­

A: HPV testing can be done on the primary or a metastatic site.

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Q: ­Please clarify, aside from coding the specific HPV positive or negative histologies are we not to assume HPV+ if P16+? I'm confused!­

A: ­If p16+, we can assume HPV+ for staging purpose only. For determining the histology, you cannot use p16+ overexpression. There must be documentation of HPV+ by ISH or other tests that Jim listed. ­For staging purposes, p16 test can be used to determine HPV 16 pos or neg. It should not be used to assign 8085 and 8086 histologies.­‑

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Q: ­Why is the Hx not 8085­

A: In order to code 8085/3 Squamous cell carcinoma HPV-positive either the final diagnosis in the path report has to state squamous cell carcinoma, HPV-Positive or the path report must state squamous cell carcinoma and a separate test designed to detect viral DNA or RNA must be done and show the tumor is positive for HPV type 16. The results of an p16 test cannot be used to code histology 8085 or 8086.

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Q: ­Donna Gress also did a webinar on AJCC 8th for head & neck. She also provided clarification about HPV & p16 and also what to do when there are conflicting test results.­

A: Thank you!

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Q: ­In 2018 Case Scenario can you explain why the pT value would be 0 and not X­

A: We had this clarified by AJCC. They feel that it appropriate to assign a pT0 if a lymph node dissection was completed.

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Q: ­If the head and neck primary overlaps sites, but it is stated "started" at a specific site, do we code that to where is started or overlapping?­

A: ­If it's stated where it started, code it to that site. See page 133 of the STORE manual. ­‑

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Q: ­The path from scenario 2 says moderately differentiated. So should grade be 2 or 3 from the biopsy? Jim said 9 then 3. Thanks!­

A: ­That slide will be revised to reflect grade 3. The correct code for both clinical and pathological grade for scenario 2 should be *C-Poorly Differentiated*.

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Q: ­So the grade will be assigned from the biopsy and not the resection?­

A: Pathological grade is the highest known grade from the primary site after the resection of the primary tumor. In our case the grade from the biopsy was higher than the grade from the resection. Therefore, pathological grade is based on the biopsy specimen.

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Q: ­How do you know a LN is ipsiliateral with an occult primary? slide 18­

A: My understanding is you consider the lymph nodes to be “ipsilateral” if they are all on one side. I think what they are trying to distinguish is if the lymph node metastasis is all on one side or if it is bilateral.

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Q: ­What would you use for clinical cN if they don't give you the size of the lymph nodes­

A: It depends on the site and classification. If the patient has a p16+ oropharyngeal primary, the size of the lymph node does not matter for pN. It does matter for cN and both cN and pN for p16- primaries. For these primaries I would assign an NX if the size of the lymph node was not given.

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Q: ­Slide 33, Schema Discriminator 1: Adenoid pointing to SS2018 Nasopharynx doesn’t seem to jibe with the table where adenoid and pharyngeal tonsil are grouped together as code 2 and you say pharyngeal tonsil points to SS2018 Oropharynx. Please clarify.­

A: This is only an issue with Summary Stage. The problem is that topography code C11.1 is used for posterior wall of the nasopharynx, adenoid, and pharyngeal tonsil. Posterior wall of the nasopharynx and adenoid are included in the summary stage chapter for Nasopharynx and pharyngeal tonsil. The computer doesn’t know what chapter to go to when C11.1 is assigned. Schema discriminator 1 is simply asking in which of these 3 subsites the primary arose. The computer uses that information to pull up the correct chapter codes.

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Q: ­Trying to determine planning technique to be a problem. In Mosaic, we can get a Summary of Radiation therapy. It shows site radiated/Start Date/End Date/#Fractions/Total Dose/Dose per Fraction, but it does not show the Planning Technique and the radiation ­

A: It could be that you do not have full access to Mosaic as a radiation therapist may have. The actual RT prescription is found in Mosaic. You may want to reach out to someone from the Rad Onc dept to walk you through the database.

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Q: ­oncologist are not documenting that either. So what are registrars are doing is reviewing the Notes in Mosaic and looking at the Dose precertification status, and if it states Complex we code 3D, sometimes it states 3D or IMRT. ­

A: It goes back to being able to gain access to the RT prescription that the radiation oncologist approves for the patient. I know it can be found in Mosaic. It may be a question of not having full access to the software or not knowing where to look for it.

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Q: ­Apollo mentioned the TomoTherapy system is at the minimum IMRT or more advanced techniques. Do other planning systems (Philips Pinnacle, Varian Eclipse, etc) also have certain types of techniques associated with them?­

A: Most other equipment can deliver a variety of treatment techniques. But the Tomotherapy unit can only deliver RT while it rotates, which means that at the very minimum we have to consider IMRT and then beyond that look for the type of fractionation that is used. If standard or hyperfractionation, then I would stay with IMRT. If hypofractionation with only a few fractions are prescribed, then I would code to SBRT(SART).

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Q: ­I feel we are grasping at straws here.. How far are we suppose to dig for this info? I feel like digging thru billing info is a little sketchy. There must be a better way.. As contractors, contacting the physician is not an option... HELP!­

A: I would insists on gaining access to the radiation oncology database (Mosaic or ARIA).

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Q: ­Wow.. the example on SIB was explained to well.. Apollo Wilson we appreciate you!!!­

A: You are welcome!

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Q: ­For Phase to draining LNs: if LNs are negative do we code 88 or 00­

A: If LNs negative, they would not be included in the irradiation field. Code to 00.

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Q: ­Thanks for all that you all do! If Wilson could do a presentation on navigating Mosaic.. WOW! Thanks again for all that you do and sorry for so many comments :) Thanks again!­

A: You are welcome.

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Q: ­Is there another code IMRT and hyperfraction?? Does hyperfractionation make a difference in coding like Hypofractionation does?­

A: Unfortunately, hyperfractionation schedules can be used with 3D conformal plans and with IMRT plans. It still leaves us with the task of trying to find the RT prescription to confirm which code to use.

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Q: ­Thanks so much Apollo. Makes some much more sense now!!­

A: ­You are welcome!­

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Q: Why is the number of total fractions carried across all phases instead of the number of fractions per boost in scenario 1?

A: SIB IMRT presents us with a very unique and complex scenario. Keep in mind that the regional dose (PTV) and PTV1 boost as well as PTV2 boost is being delivered every day for the duration of the treatment. So if the treatment consists of 35 fractions, each day a small part for each of the phases is being deposited within the patient.

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Q: Our radiation oncology manager showed us to go to the D and I to get the details we need to code these fields. I would suggest they meet with the corresponding manager/director at their facility

A: I agree with you. I think we all need to take the initiative to educate our facilities on the new RT items are now working with.