**Q&A Session for Base of Tongue 2019**

December 6, 2019

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| Question | Answer |
| Is it possible for a patient to be HPV+ but p16-? or vice versa? | Yes |
| The histology example that states A separate viral DNA by ISH test report shows the sample is "negative" for high risk HPV" Code 8085 Squam cell ca, HPV positive. The negative should read positive? | That is correct! 8086 would be the correct code to use if an ISH fails to identify HPV on a tumor specimen (8085 was typo on the slide). 8085 would be used if the ISH test was positive. |
| Histology on case #1 - You can use histology from lymph node. The rules state from primary site only. | Yes. The HPV status may come from the primary tumor or a metastatic site (regional or distant). |
| For Case # 2 could you use the staging given by the radiation oncologist? | The radiation oncologist assigned a cN2, but the information in the record only justified a cN1. Ideally, you would want to reconcile the stage with the radiation oncologist. Find out why they coded the case N2. You don't know if you are missing info or if the oncologist is using the wrong chapter or maybe using AJCC 7th edition. Chapter 11 or 7th would get you an N2. I would not enter the N2 into the registry without knowing why it was coded N2. |
| The p16 was done on the lymph node so do we always use any specimen? | That is correct. p16 can be based on primary tumor or metastatic tissue (Regional Nodes or distant mets). |
| Can you please clarify why EOD Regional LNs for case #2 is coded 300 and not 500? There was a positive FNA of a level II LN. | The FNA was performed during the clinical time frame. Therefore, code 300 would be used. |
| Why are Phase 2 and 3 coded to 22? | Good catch! While in a number of cases, all PTVs do include the primary tumor site, there is insufficient information provided to code the primary irradiated site to 22. In this case, failing any confirmation to the contrary, the best course of action is to code phase II and phase II radiation primary treatment volume to 01-Neck lymph node regions.  Radiation to draining lymph nodes should be coded to 88 for phase I and phase II. |
| There is some question between SEER & AJCC on what terms to use for the HPV+/- histologies, could you please explain in detail? | I’m not aware of a conflict between SEER and AJCC concerning terms used to indicate +/= HPV results. I do know that AJCC distinguishes which cases should be staged with chapter 10 and 11 on the p16 test. However, the p16 test cannot be used to code histology per the Solid Tumor Rules. |
| When they do an FNA of a regional LN without a resection of the primary site, is that considered clinical or pathological for the EOD LNS? We have looked through the general rules as well as the site specific rules and have found nothing that clarifies this. | I contacted Jennifer Ruhl from SEER and she passed along that if the FNA was collected during the clinical time frame, it would be considered clinical. |
| Shouldn't the grade be 9 for case scenario 1 because the grade is from a lymph node? There was no grade in the primary site biopsy. | Yes. You cannot code grade from a metastatic site. |
| Table 10.1 page #114 Synonyms for HPV-Mediated Oropharyngeal Cancer: HPV Positive. p16 Positive. Non-Keratinizing. Just curious why then p16 positive would not be sufficient for using Code #8085/3? | I contacted the chair of the Solid Tumor WG and she said that rule came directly from one of the Head and Neck Blue Books. |
| Should the LNS size of mets be coded 25.0 since 2.5 cm = 25 mm? | Yes! It should a 2.5cm lymph node would be coded 25.0. |
| Shouldn't we be tagging the AJCC N suffix on these case scenarios? | Yes! The should all have an (f) in the cN suffix field. |
| Shouldn't the site specific factor for case scenario 2 be p16+? Coded to 1. | SEER\_SSF1: SEER Site-Specific Fact 1 is left blank unless one of the test that identify the HPV virus directly. If all that is done is a p16 test, the field is blank. P16 results cannot be used to code this field. P16 results are coded in schema discriminator 2. |
| In scenario 3: CT states clinical tumor size as 3cm. Since priority order for identifying the primary site states CT before MRI, would we use the CT to assign tumor size rather than the MRI of 3.5cm? | Those directions were for assigning primary site and assigning histology. I'm not aware of a priority for different types of imaging when assigning primary site. |
| What's the difference between target volume and target site? | Consider the following common scenarios:   1. Patient is irradiated to the whole RT breast using the breast tangents technique to 50 Gy, followed by a photon boost of 14 Gy to the lumpectomy cavity. In this scenario, the target volume for the whole breast clearly is different to that of the target volume to the lumpectomy cavity, the latter being a much smaller volume. Nevertheless, both phases are targeting the same primary site, namely the right breast. The only difference lies in the extent of the target volume. 2. In this scenario, patient presents with a left lung primary metastatic to the L-spine at time of diagnosis. Since the lung mass is impacting on quality of life and the L-spine mets is symptomatic and debilitating, the medical team decided to treat both, the primary site (Left lung) and the metastatic site (L-spine). These are clearly two distinctive anatomical organs/sites.   Target volume refers to irradiated volume within the same site. Target site refers to distinctive anatomical organs/sites. |
| Under the RTx resources, the link is no longer correct, it has changed. | Try the link below,  [<https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards/Practice-Parameters-by-Subspecialty>](https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards/Practice-Parameters-by-Subspecialty)  Then scroll down for the links on radiation therapy and radiation oncology sources. |
| Does there need to be a suffix on Case Scenario 3 for the pN for regional LN dissection? | Yes! |