Base of Tongue/ Head and Neck 2019

2019-2020 NAACCR WEBINAR SERIES

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Q&A

Please submit all questions concerning the webinar content through the Q&A panel.

If you have participants watching this webinar at your site, please collect their names and emails.

We will be distributing a Q&A document in about one week. This document will fully answer questions asked during the webinar and will contain any corrections that we may discover after the webinar.

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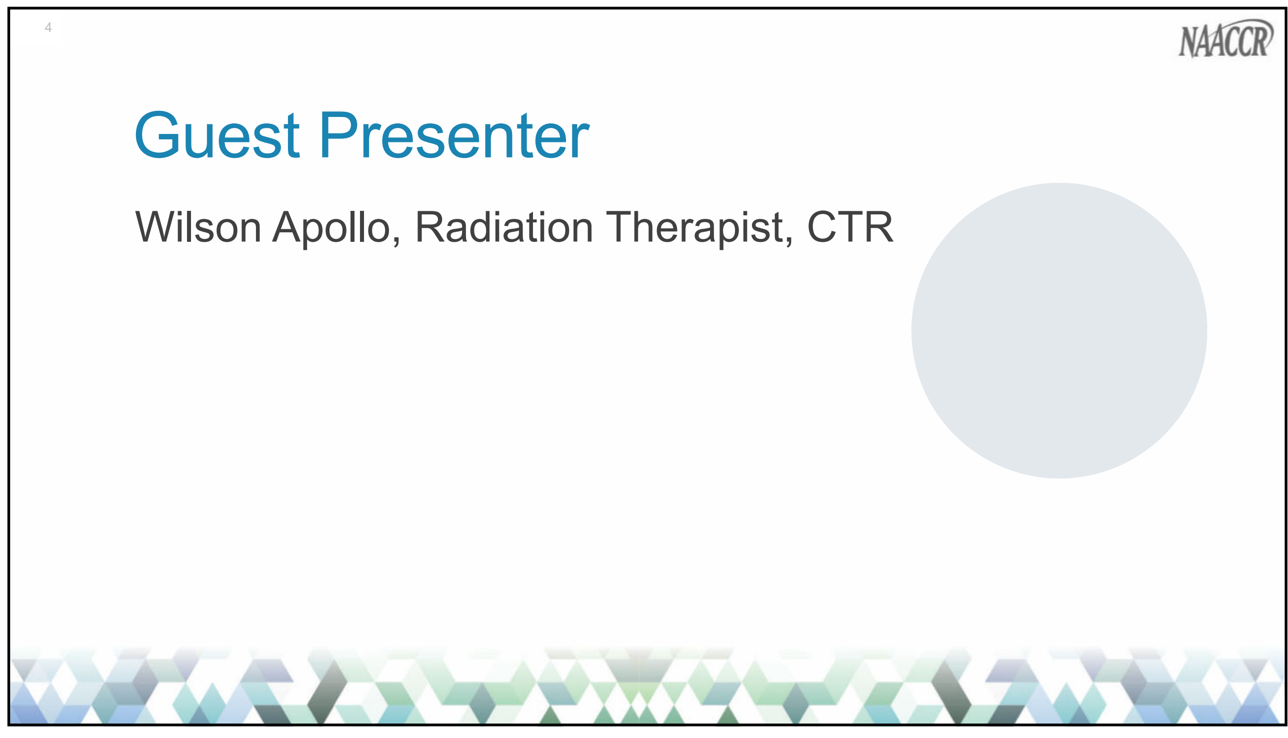
Fabulous Prizes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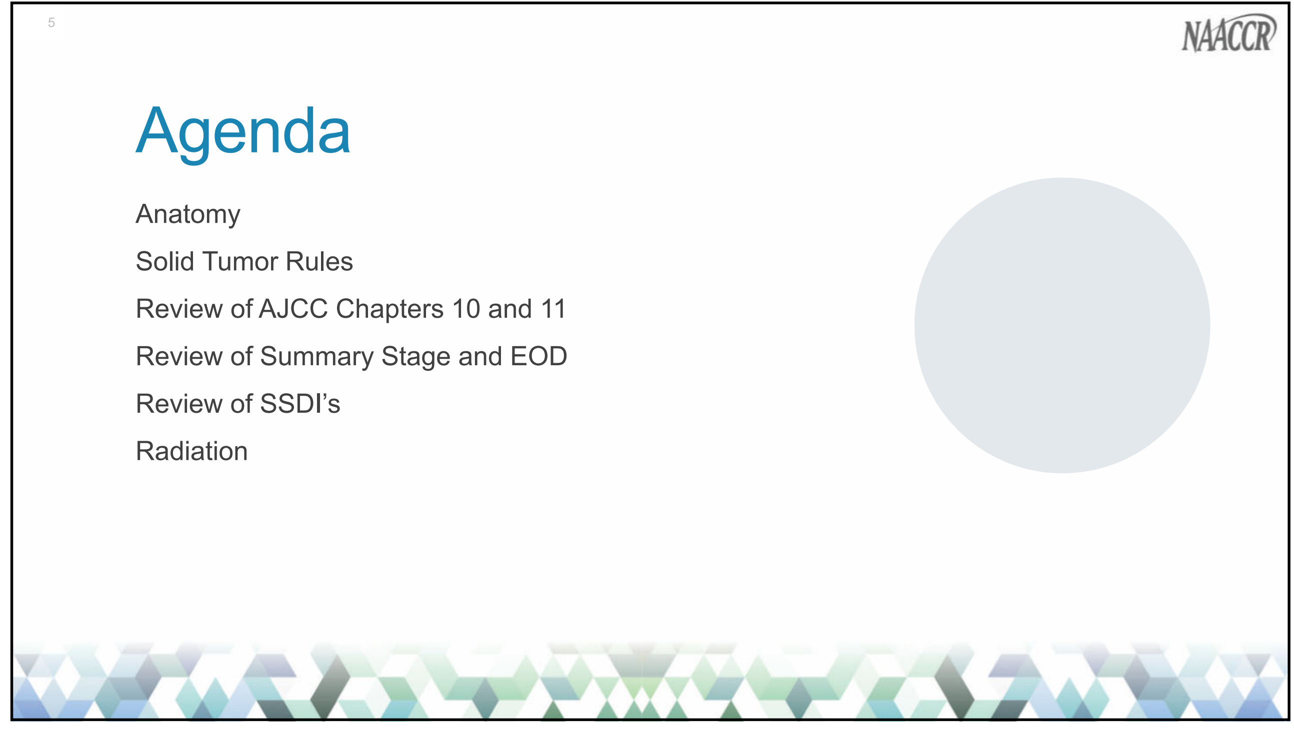
Guest Presenter
Wilson Apollo, Radiation Therapist, CTR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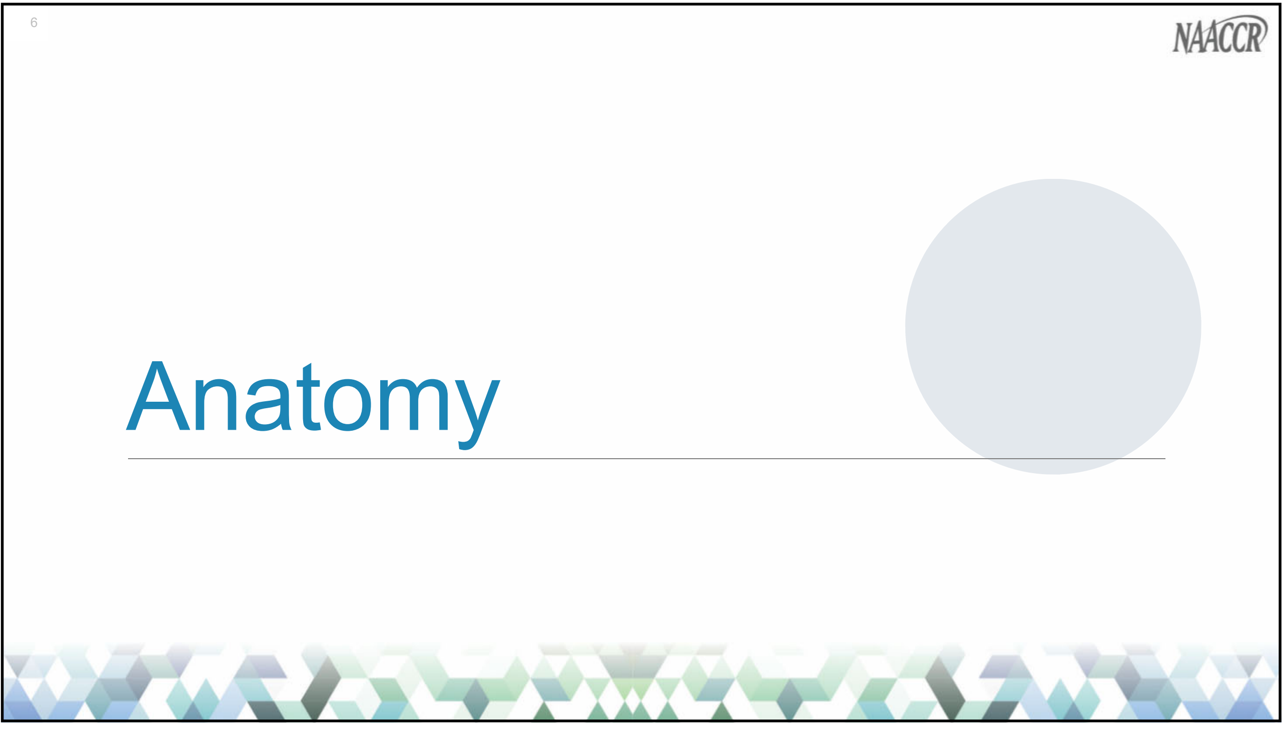
Agenda
Anatomy
Solid Tumor Rules
Review of AJCC Chapters 10 and 11
Review of Summary Stage and EOD
Review of SSDI's
Radiation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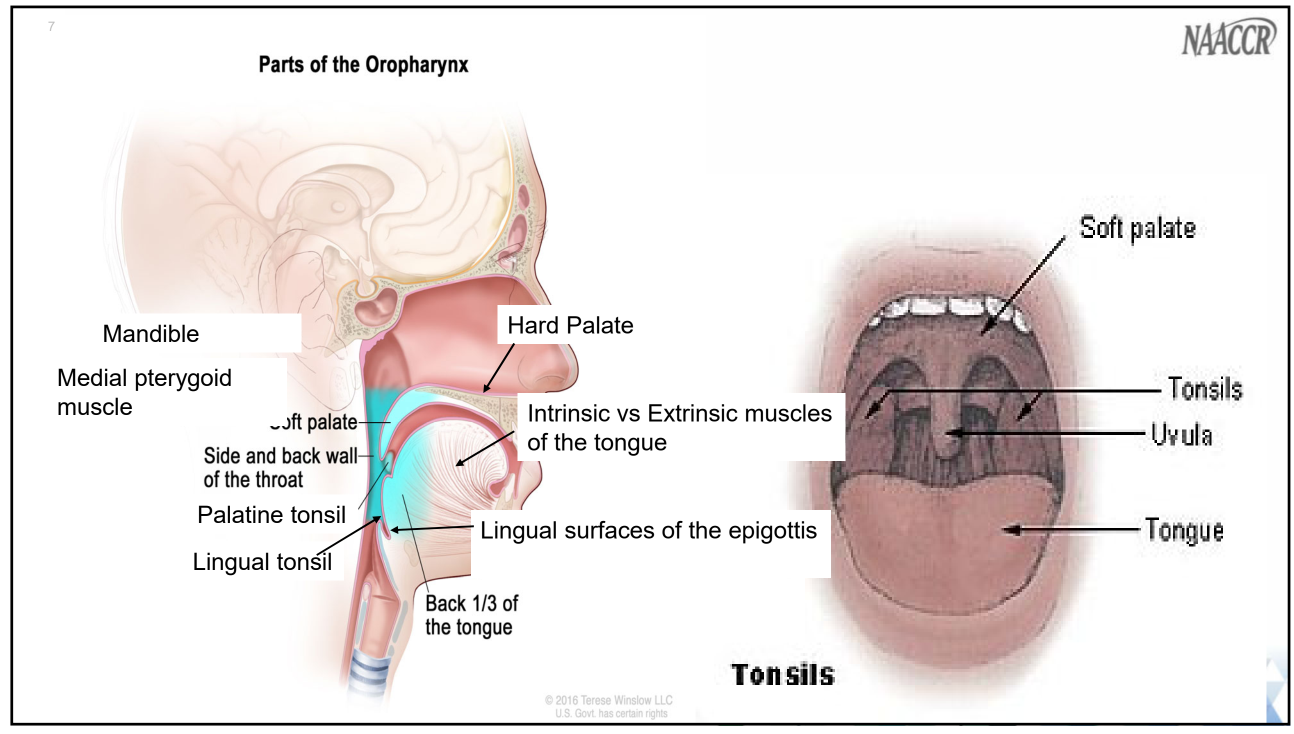
Anatomy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Parts of the Oropharynx
Mandible
Medial pterygoid muscle
Hard Palate
Intrinsic vs Extrinsic muscles of the tongue
Side and back wall of the throat
Palatine tonsil
Lingual tonsil
Lingual surfaces of the epigottis
Back 1/3 of the tongue
Soft palate
Tonsils
Uvula
Tongue
Tonsils
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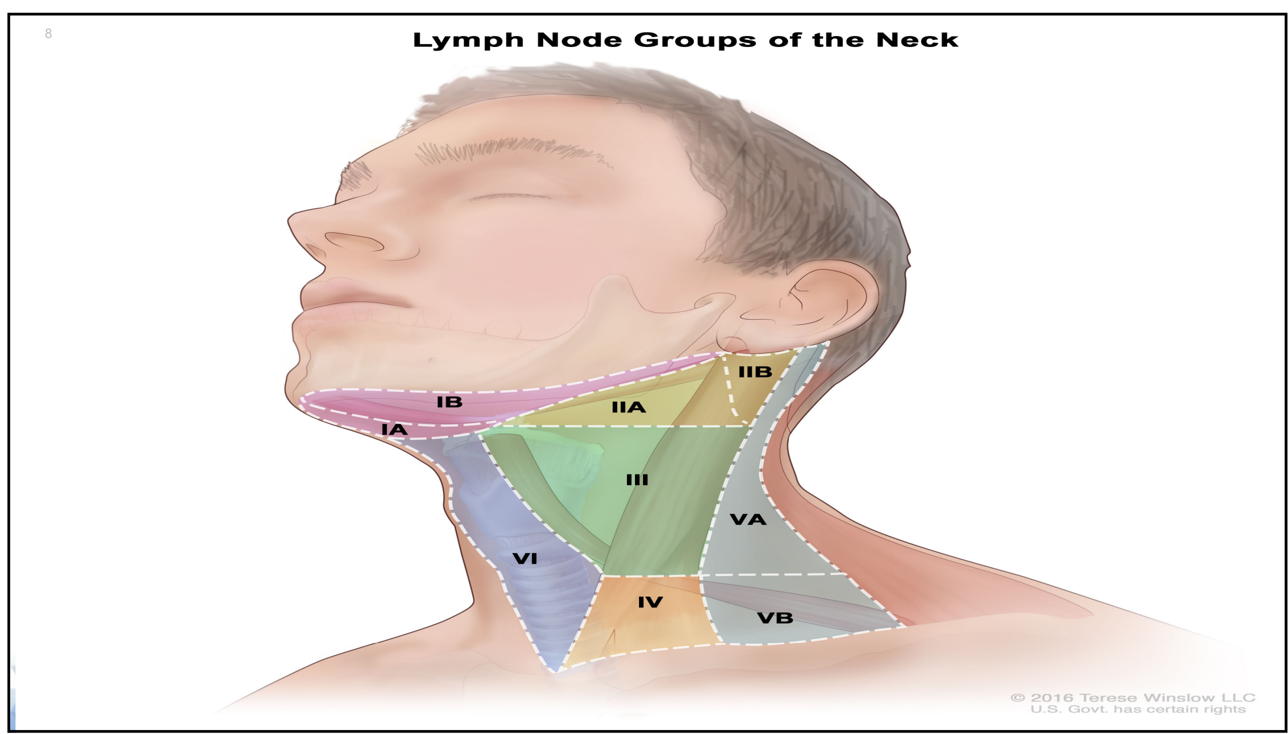
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Lymph Node Groups of the Neck
IA
IB
IIA
IIB
III
IV
VA
VB
VI
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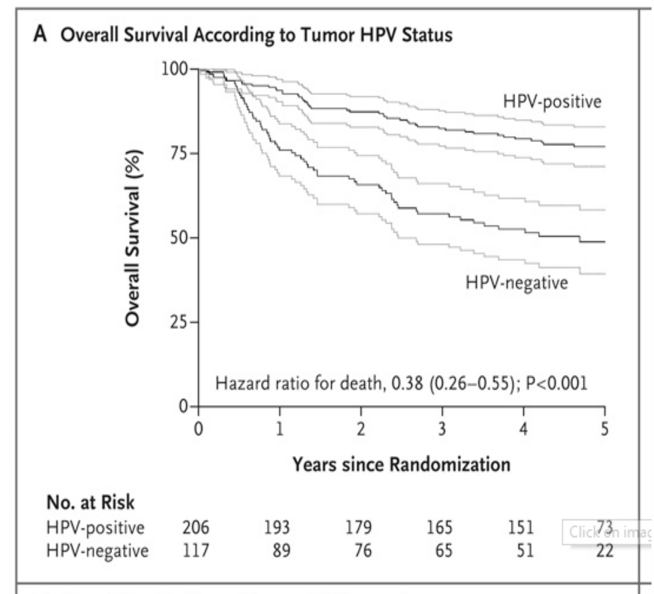
HPV

Patients with high risk HPV oropharyngeal primaries, have a much better prognosis than those that do not have high risk HPV.



Ang KK et al. N Engl J Med 2010;363:24-35

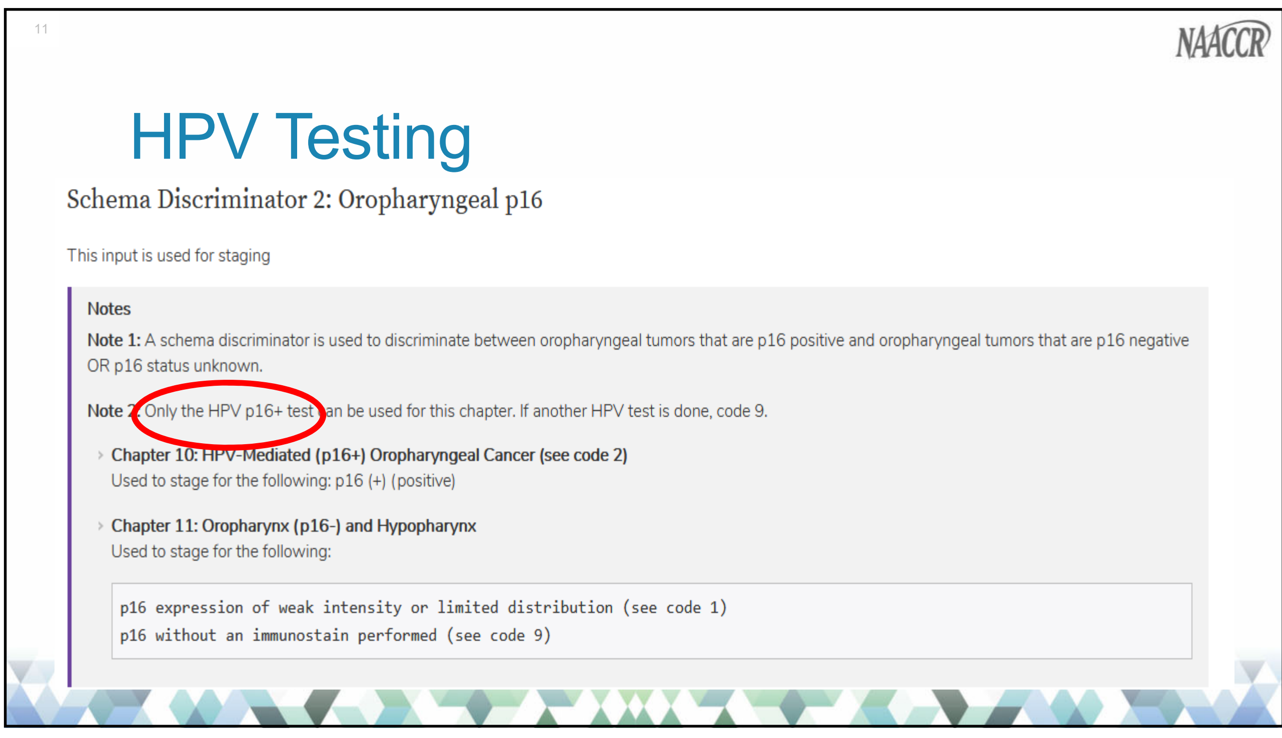
HPV Testing

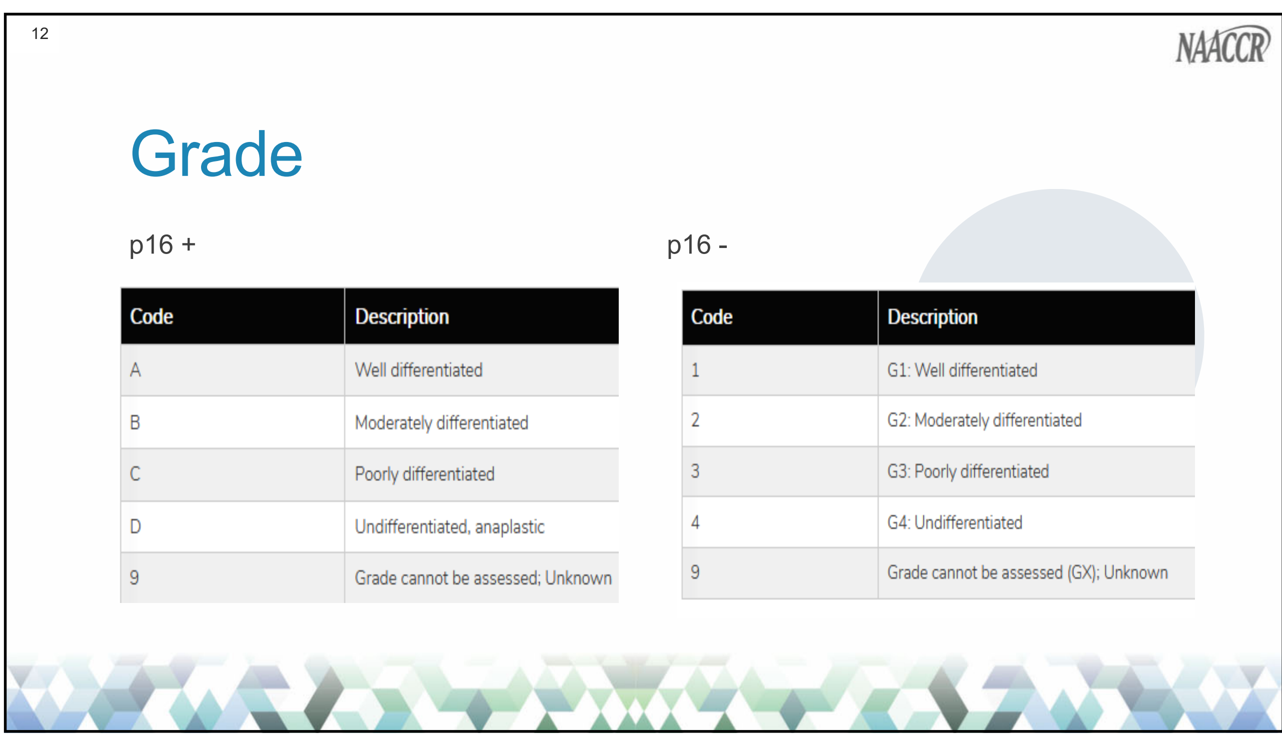
P16 Overexpression

- P16 is a tumor suppressor protein that is often overexpressed in tissue that is positive for HPV 16 positive
- The test doesn't actually identify the virus, but tumor cells with an overexpression of p16 are typically positive for HPV 16.
- p16 is the standard used for AJCC staging to distinguish HPV mediated

The following tests identify the actual HPV virus

- Viral DNA by ISH test
- Viral DNA by PCR test
- ISH E6/E7 RNA test
- RT-PCR E6/E7 RNA test





Code	Description
A	Well differentiated
B	Moderately differentiated
C	Poorly differentiated
D	Undifferentiated, anaplastic
9	Grade cannot be assessed; Unknown

Code	Description
1	G1: Well differentiated
2	G2: Moderately differentiated
3	G3: Poorly differentiated
4	G4: Undifferentiated
9	Grade cannot be assessed (GX); Unknown

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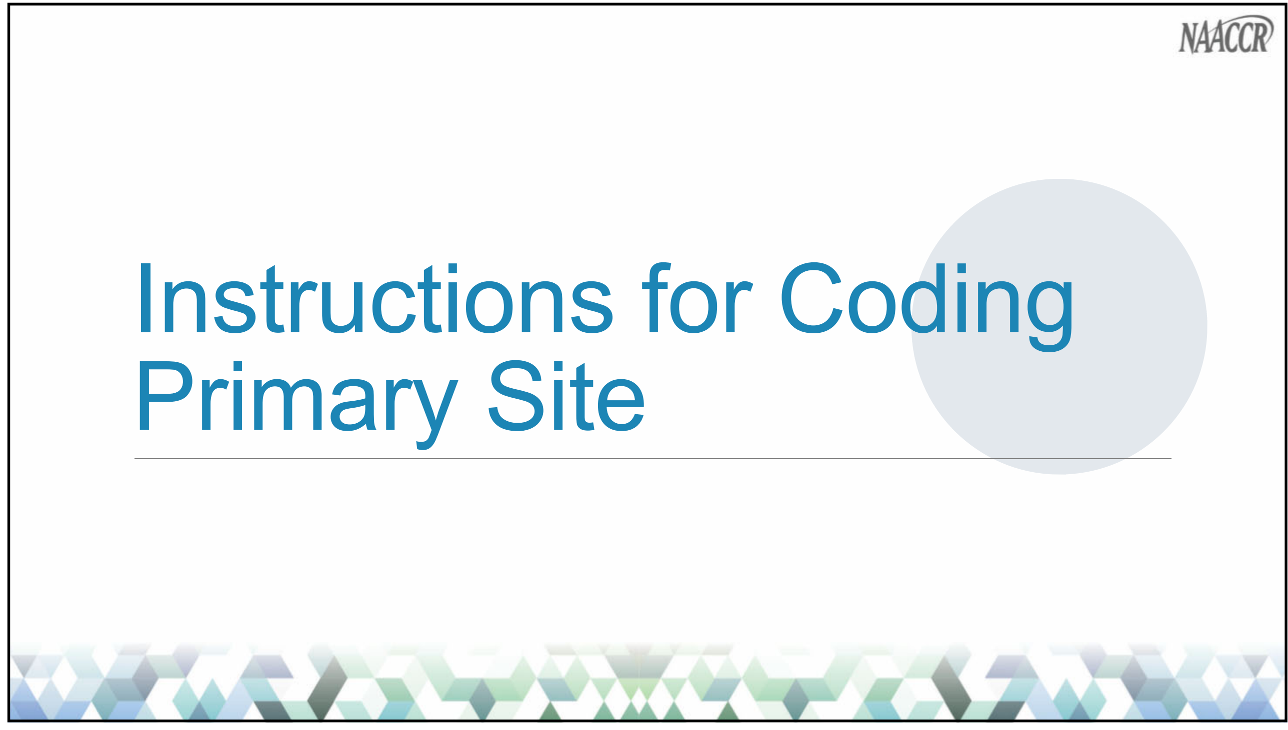
Head and Neck
SOLID TUMOR RULES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Instructions for Coding Primary Site

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Priority Order for Identifying Primary Site

1. **Tumor Board**
   A. Specialty
   B. General
2. **Tissue/pathology** from tumor resection or biopsy
   A. Operative report
   B. Addendum and/or comments on tissue/pathology report
   C. Final diagnosis on tissue/pathology report
   D. CAP protocol/summary

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Priority Order for Identifying Primary Site Cont'd

3. **Scans**
   A. CT
   B. MRI
   C. PET

4. **Physician documentation**. Use the documentation in the following priority order:
   A. Physician's reference in medical record to primary site from **original pathology, cytology, or scan(s)**
   B. Physician's **reference** to primary site in the medical record

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Priority Order for Identifying Primary Site Cont'd

5. Use **Tables 1-9** to assist in assigning primary site when a **SINGLE** lesion overlaps two or more sites.

   A. Go to the appropriate table for each involved site (use the hyperlinked index below).

   B. Compare the histology diagnosis to the histologies in the table for each of the involved sites.

   C. When the histology diagnosis is listed for only one primary site (only listed in one table), code that primary site.

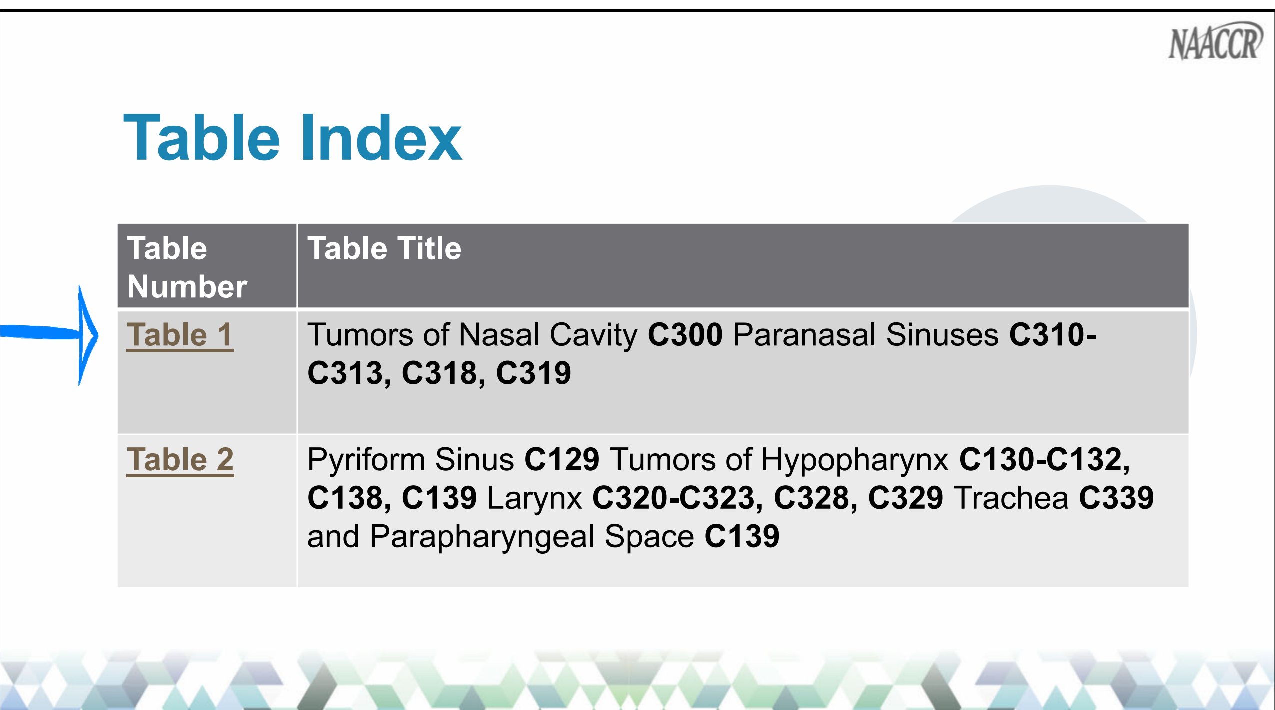

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Table Index

Table Number	Table Title
Table 1	Tumors of Nasal Cavity **C300** Paranasal Sinuses **C310-C313, C318, C319**
Table 2	Pyriform Sinus **C129** Tumors of Hypopharynx **C130-C132, C138, C139** Larynx **C320-C323, C328, C329** Trachea **C339** and Parapharyngeal Space **C139**

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Table 4 and 5

Mobile Tongue:
- **C020** Dorsal surface of tongue NOS
- **C021** Border of tongue
- **C022** Ventral surface of tongue NOS
- **C023** Anterior 2/3 of tongue NOS
- **C024** Lingual tonsil
- **C028** Overlapping lesion of tongue
- **C029** Tongue NOS

Note: C019 Base of tongue is included in Table 5

Oropharynx:
- **C100** Vallecula
- **C101** Anterior surface of epiglottis
- **C102** Lateral wall of oropharynx; lateral wall of nasopharynx
- **C103** Posterior wall of oropharynx; posterior wall of nasopharynx
- **C104** Brachial cleft
- **C108** Overlapping lesion of oropharynx; junctional region of oropharynx
- **C109** Oropharynx NOS; mesopharynx NOS; fauces NOS. Use this code only when the subsite has not been identified a subsite as the origin of the lesion.
  - ***Note:*** Code overlapping lesion of oropharynx; junctional region of oropharynx **C108** when a single tumor overlaps subsites of the oropharynx. For example, a single lesion which overlaps the vallecular and the anterior surface of the epiglottis.
- **C019** Base of tongue
- **Tonsils:**
- **C090** Tonsillar fossa
- **C091** Tonsillar pillar
- **C098** Overlapping lesion of tonsil
- **C099** Tonsil NOS
- **C111** Adenoids/pharyngeal tonsil (does not include posterior wall of nasopharynx)

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Table 5

The following histologies are listed in Table 5, but not in table 4
- Keratinizing squamous cell carcinoma 8071
- Non-keratinizing squamous cell carcinoma 8072
- Squamous cell carcinoma HPV-negative 8086*
- Squamous cell carcinoma HPV-positive 8085*

A patient has a squamous cell carcinoma HPV positive (8085/3) overlapping the base of the tongue (C01.9) and anterior portion of the tongue (C02.3).
Primary site would be base of tongue (C01.9) based on rule 5.

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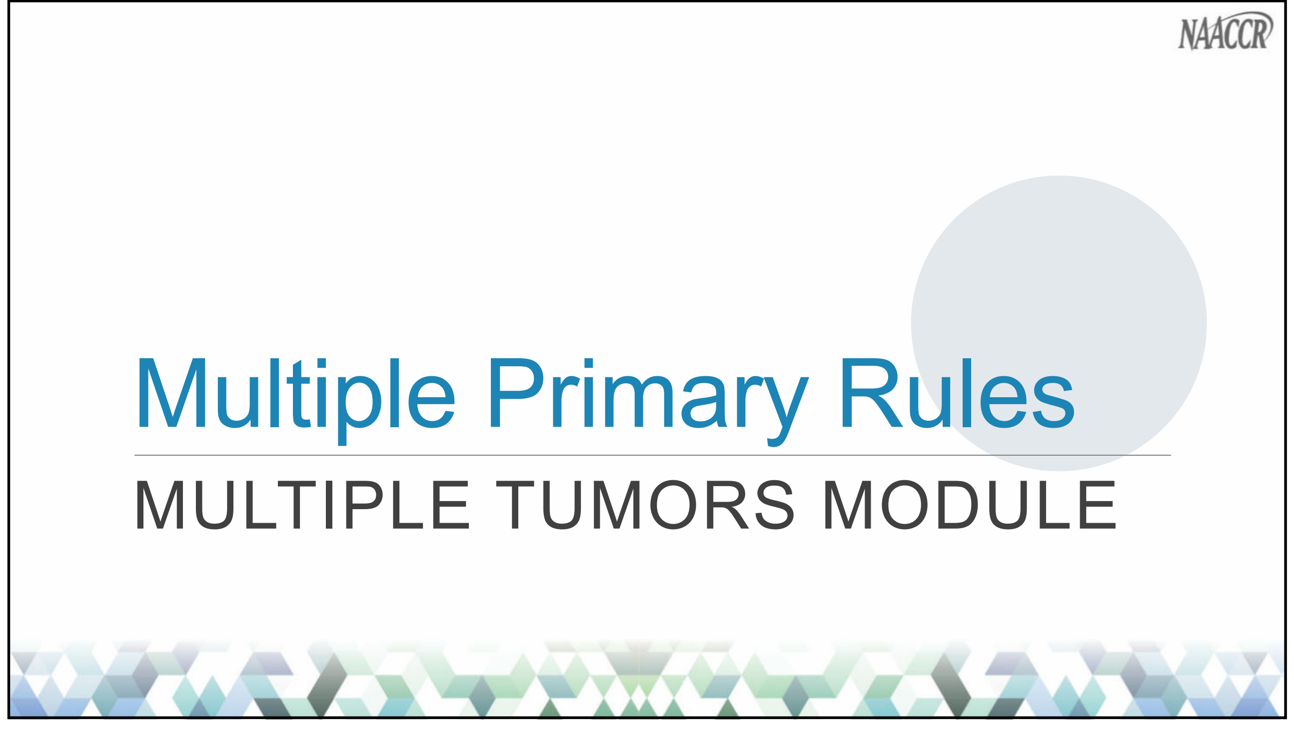
Priority Order for Identifying Primary Site Cont'd

6. When the primary site cannot be determined using previous instructions, code as follows for an overlapping lesion
   A. **C028** Overlapping lesion of tongue (See **Table 4** for subsites of the tongue)
   B. **C088** Overlapping lesion of major salivary glands (See **Table 6** for specific salivary glands)
   C. **C148** Overlapping lesion of lip, oral cavity and pharynx

Note: Codes and terms for overlapping lesions C__.8 are **not** included in the **tables**

Priority Order for Identifying Primary Site Cont'd

7. Code to the NOS region
   A. **C069** Mouth NOS (See **Table 4** for mouth subsites)
   B. **C089** Major Salivary Gland NOS (See **Table 6** for specific salivary glands)
   C. **C099** Tonsil NOS (See **Table 5** for tonsil subsites)
   D. **C109** Oropharynx NOS (See **Table 5** for oropharynx subsites)
   E. **C119** Nasopharynx NOS (See **Table 2** for nasopharynx subsites)
   F. **C139** Hypopharynx NOS (See **Table 3** for hypopharynx subsites)
   G. **C140** Pharynx NOS
   Note: Pharynx NOS includes the oropharynx, nasopharynx, and hypopharynx.
   H. **C760 Head, face, or neck NOS (organs involved unknown/not documented)**
   Note: This code is used in circumstances such as biopsy of lymph node and no information about primary site
   - Patient lost to follow-up; no further information available
   - Patient/family declined further work-up or treatment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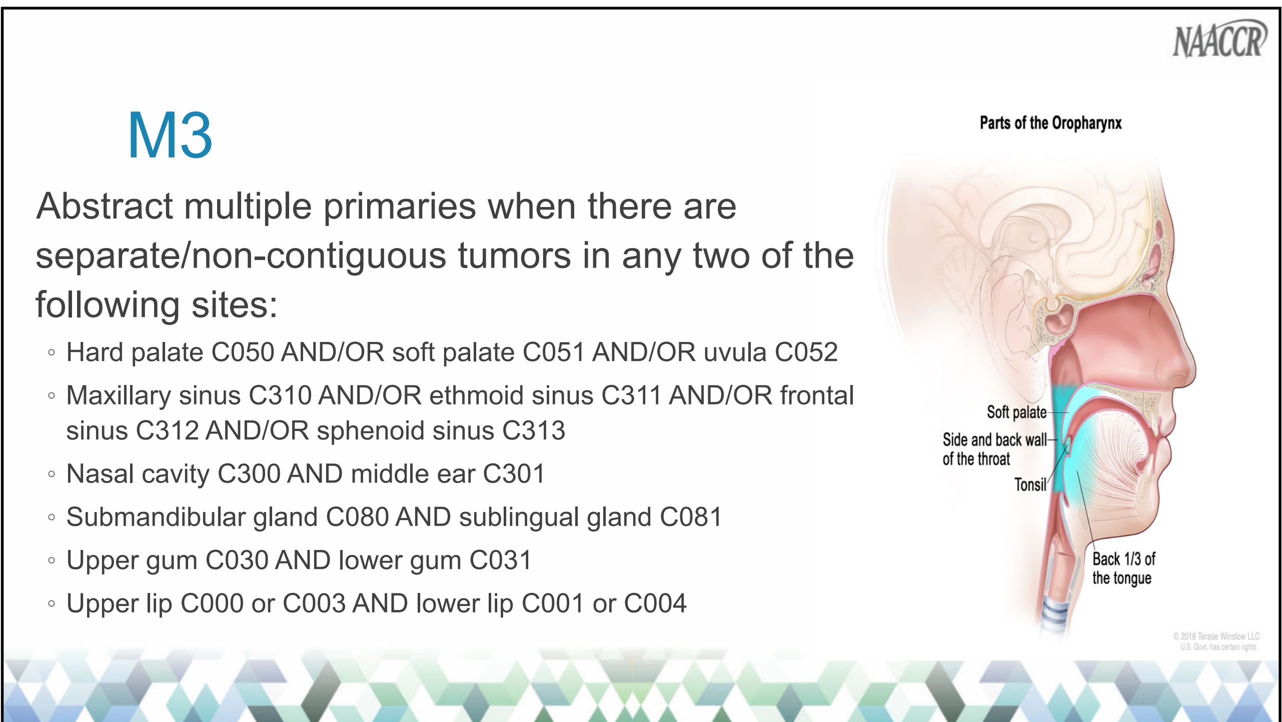
Multiple Primary Rules
MULTIPLE TUMORS MODULE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M3
Abstract multiple primaries when there are separate/non-contiguous tumors in any two of the following sites:
◦ Hard palate C050 AND/OR soft palate C051 AND/OR uvula C052
◦ Maxillary sinus C310 AND/OR ethmoid sinus C311 AND/OR frontal sinus C312 AND/OR sphenoid sinus C313
◦ Nasal cavity C300 AND middle ear C301
◦ Submandibular gland C080 AND sublingual gland C081
◦ Upper gum C030 AND lower gum C031
◦ Upper lip C000 or C003 AND lower lip C001 or C004
Parts of the Oropharynx
Soft palate
Side and back wall of the throat
Tonsil
Back 1/3 of the tongue

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M4

Abstract multiple primaries when separate/non-contiguous tumors are present in sites with ICD-O site codes that differ at the second CXxx, and/or third characters CxXx.

Note 1: Use this rule only for multiple tumors.

Note 2: Timing is irrelevant.

Note 3: Histology is irrelevant.

Example:

- Squamous cell carcinoma of the hard palate C05.0 and a squamous cell carcinoma of the base of the tongue C01.9 are multiple primaries per rule M4.

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M5

Abstract multiple primaries when there are separate/non-contiguous tumors on both the right side and the left side of a paired site.

- *Note 1:* See Table 10 for a list of paired sites.
- *Note 2:* Use this rule only for multiple tumors.
- *Note 3:* Timing is irrelevant.
- *Note 4:* Histology is irrelevant.

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M6

Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than **five years** after the original diagnosis or last recurrence.

Note 1: Clinically disease-free means that there was no evidence of recurrence on follow-up.

- Scopes are NED
- Scans are NED
- Biomarkers are NED

Subtype and Row Rules

M7

- Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. Timing is irrelevant.

M8

- Abstract multiple primaries when separate/non-contiguous tumors are on different rows in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. Timing is irrelevant.

M12

- Abstract a single primary when separate/non-contiguous tumors in the same primary site are on the same row in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. Timing is irrelevant.

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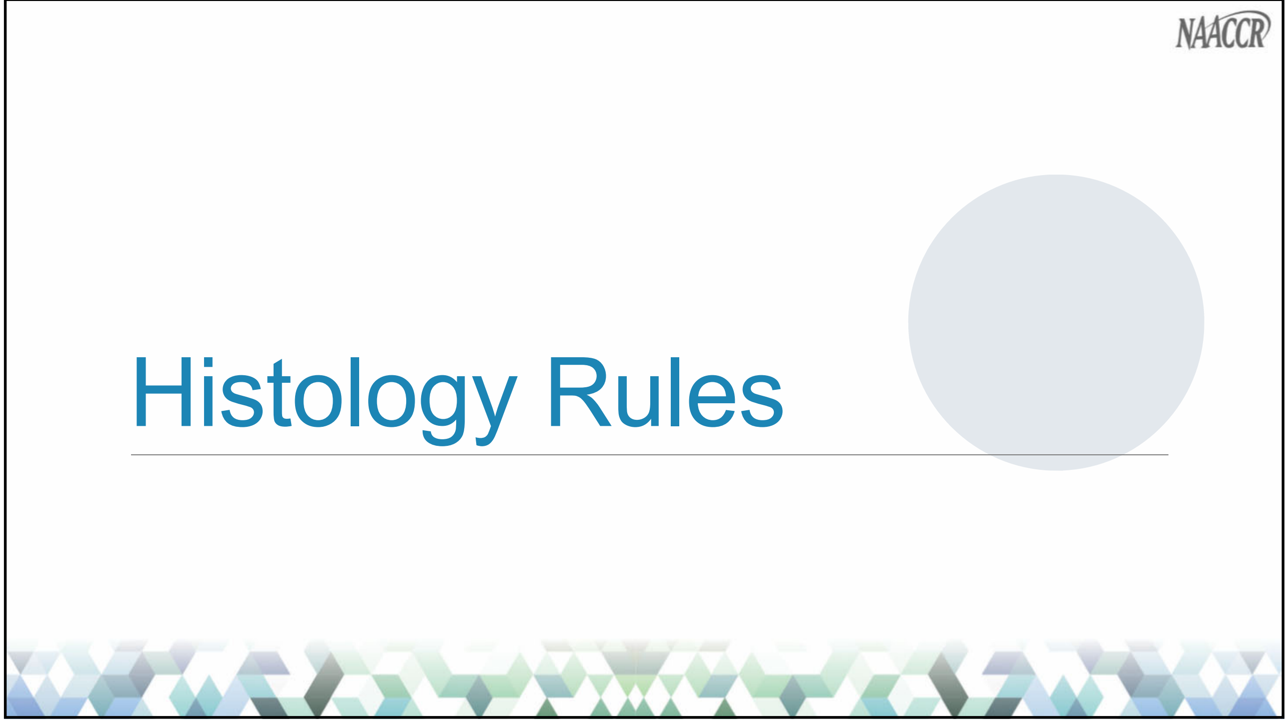
Table 5

Specific or NOS Term and Code	Synonyms	Subtypes/Variants
Polymorphous adenocarcinoma 8525	• Cribriform adenocarcinoma • Polymorphous low-grade adenocarcinoma • Terminal duct carcinoma	
Squamous cell carcinoma 8070		• Keratinizing squamous cell carcinoma 8071 • Non-keratinizing squamous cell carcinoma 8072 • Squamous cell carcinoma HPV-negative 8086* • Squamous cell carcinoma HPV-positive 8085*



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8070 vs 8085/8086

Must have a statement of “Squamous cell carcinoma HPV-positive” or “Squamous cell carcinoma HPV-negative”

Or

Results from an HPV viral detection tests to use codes 8085 or 8086
- Do not use a p16 test to code 8085 or 8086.

Histology	Code
Squamous Cell Carcinoma	8070
Squamous cell carcinoma HPV-positive	8085
Squamous cell carcinoma HPV-negative	8086

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Examples

Final diagnosis from path report is “squamous cell carcinoma”. Separate report shows tumor is p16+
- **8070 Squamous cell carcinoma**

Final diagnosis is “squamous cell carcinoma, HPV positive”
- **8085 Squamous cell carcinoma, HPV positive**

Final diagnosis is “squamous cell carcinoma”. A separate viral DNA by ISH test report shows the sample is negative for high risk HPV
- **8086 Squamous cell carcinoma, HPV negative**

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Source Documentation

This is a hierarchical list of source documentation when coding histology.

Code the most specific histology from either resection or biopsy.

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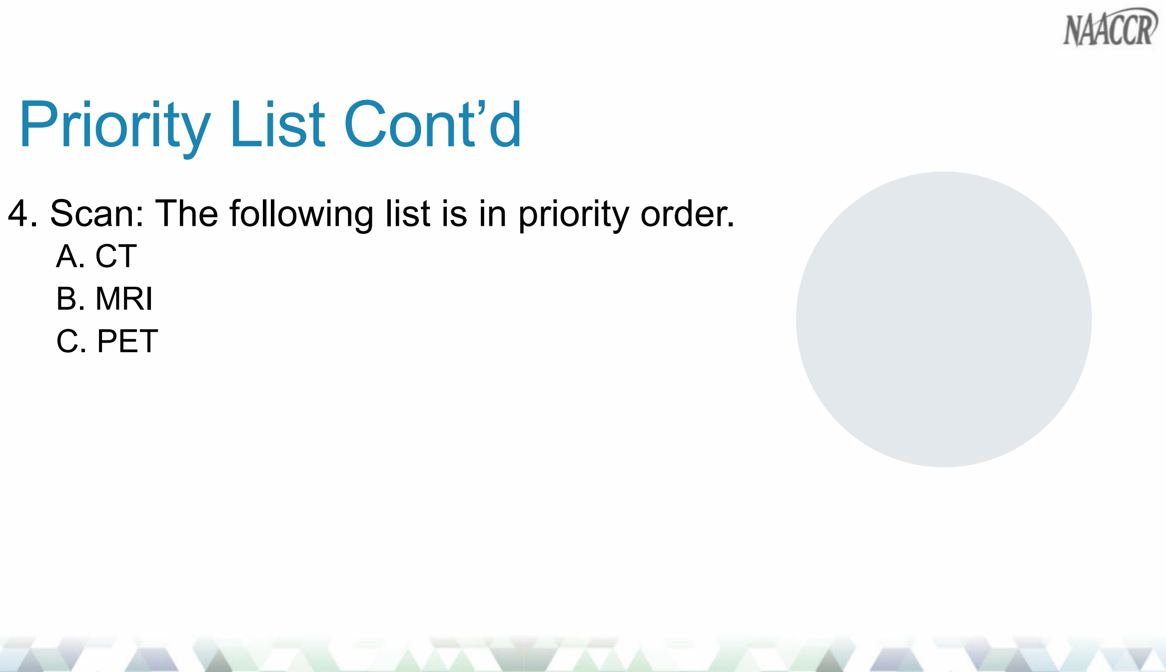
Priority List with #1 Having Highest Priority

1. Tissue or pathology report from biopsy or resection of primary site (in priority order)
   A. Addendum(s) and/or comment(s)
   B. Final diagnosis
   C. CAP protocol (check list)
2. Cytology of primary site (fine needle aspirate (FNA))
3. Tissue/pathology from a metastatic site



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Priority List Cont'd

5. Code the histology documented by the physician when none of the above are available. Use the documentation in the following priority order:
   - A. Tumor Board
   - B. Documentation in the medical record that refers to original pathology, cytology, or scan(s)
   - C. Physician's reference to type of cancer (histology) in the medical record

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Histology Rules Single Tumor Module

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Histology Codes

H1-H3-Single Tumor
- H1-Code the histology when only one histology is present.
- H2-Code the invasive histology when in situ and invasive histologies are present in the same tumor.
- H3-Code the subtype/variant when there is a NOS and a single subtype/variant of that NOS

H4-H6
- H4-Code the histology when only one histologic type is identified for all tumors
- H5-Code the invasive histology when one of the following criteria are met:
  - All tumors have both invasive and in situ elements OR
  - One or more tumors are invasive and one or more tumors are in situ
- H6-Code the subtype/variant when all tumors are a NOS and a single subtype/variant of that NOS

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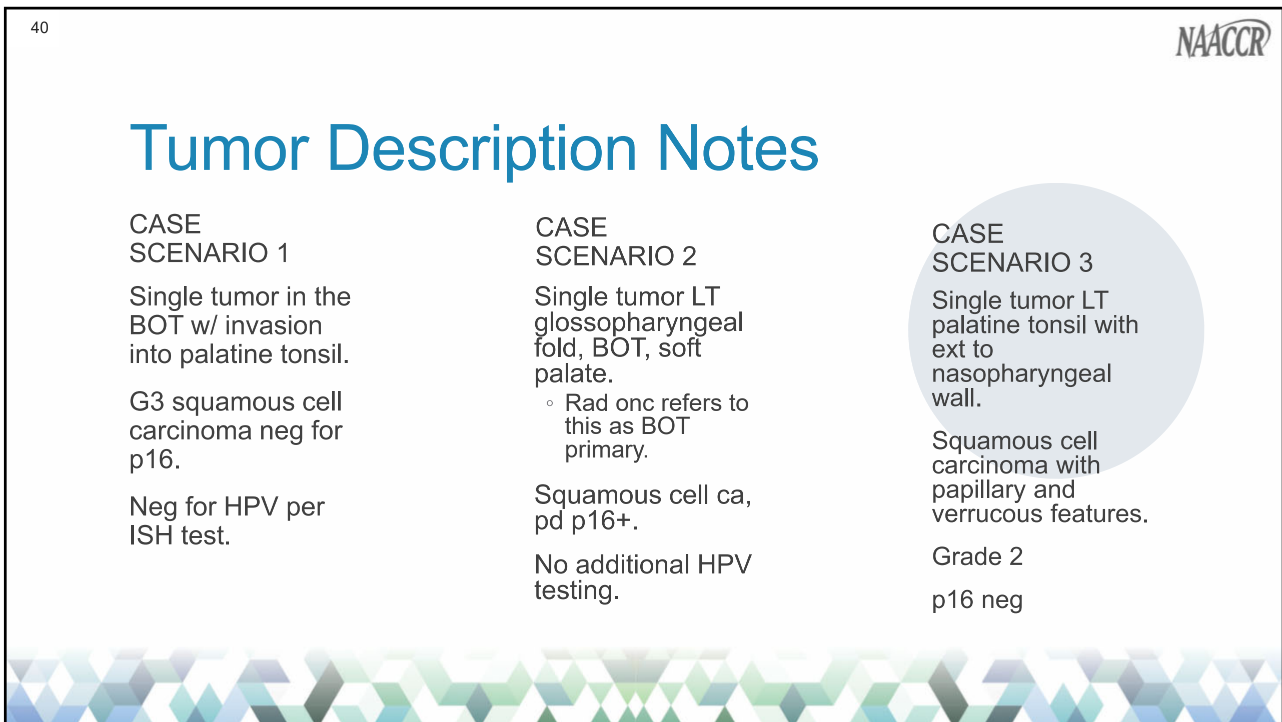
Review of Case Scenarios
CASE SCENARIOS 1-3 TUMOR DESCRIPTORS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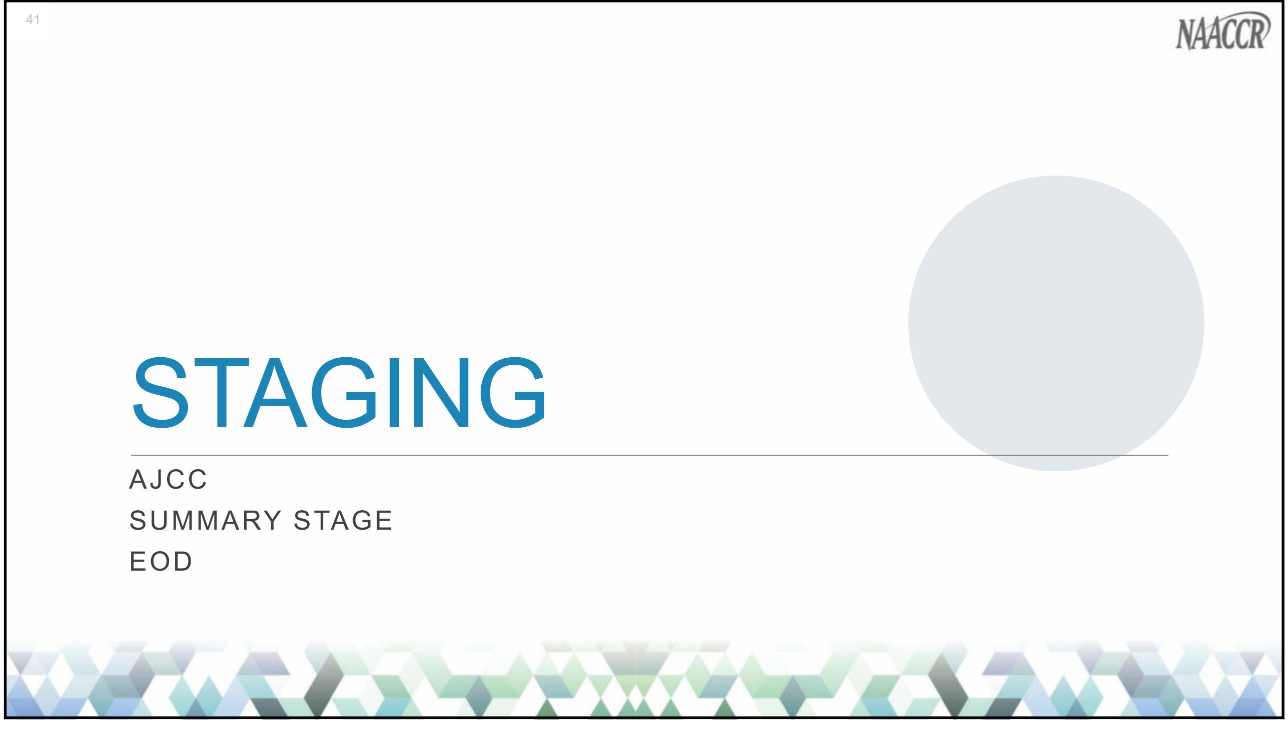
Tumor Description Notes
CASE SCENARIO 1
Single tumor in the BOT w/ invasion into palatine tonsil.
G3 squamous cell carcinoma neg for p16.
Neg for HPV per ISH test.
CASE SCENARIO 2
Single tumor LT glossopharyngeal fold, BOT, soft palate.
Rad onc refers to this as BOT primary.
Squamous cell ca, pd p16+.
No additional HPV testing.
CASE SCENARIO 3
Single tumor LT palatine tonsil with ext to nasopharyngeal wall.
Squamous cell carcinoma with papillary and verrucous features.
Grade 2
p16 neg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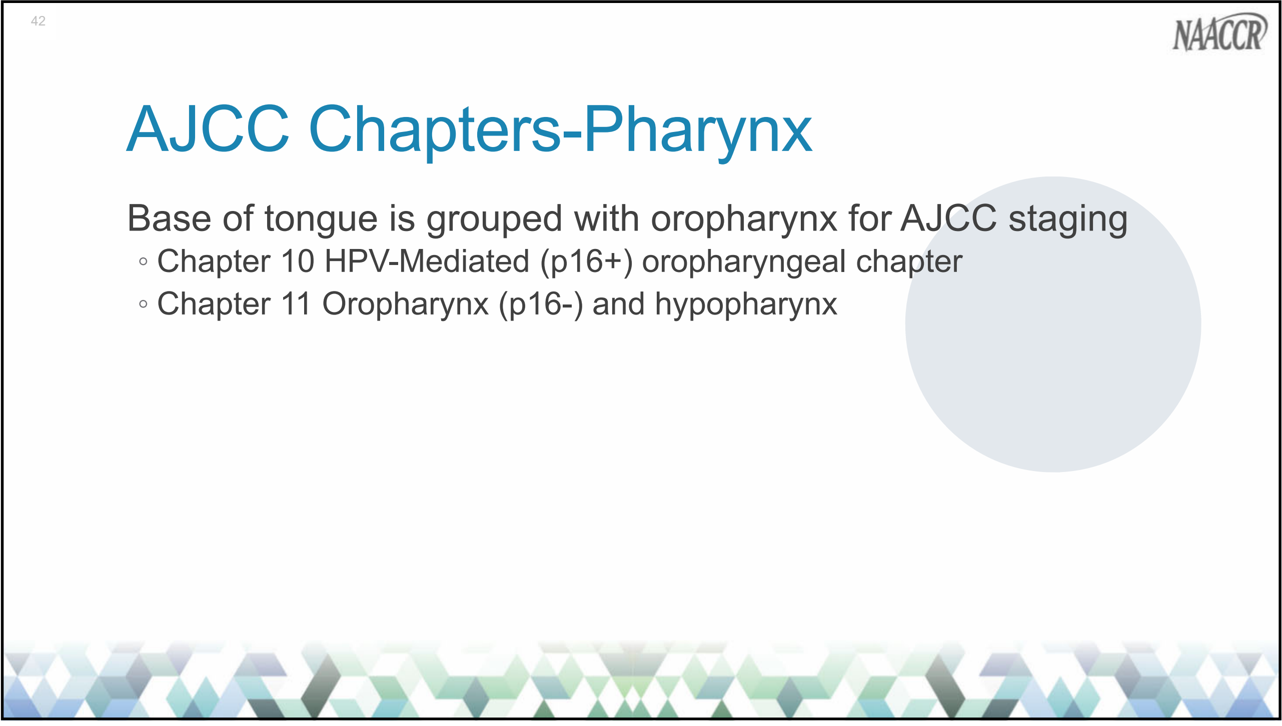
STAGING
AJCC
SUMMARY STAGE
EOD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AJCC Chapters-Pharynx
Base of tongue is grouped with oropharynx for AJCC staging
◦ Chapter 10 HPV-Mediated (p16+) oropharyngeal chapter
◦ Chapter 11 Oropharynx (p16-) and hypopharynx

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Chapter 10 – HPV mediated (p16+) oropharyngeal

New chapter

- Patients with high risk HPV oropharyngeal primaries have a significantly better prognosis than those that are HPV negative (p16-).

Clinical N values and Pathological N values are different.

Clinical Stage and Pathological Stage are different.

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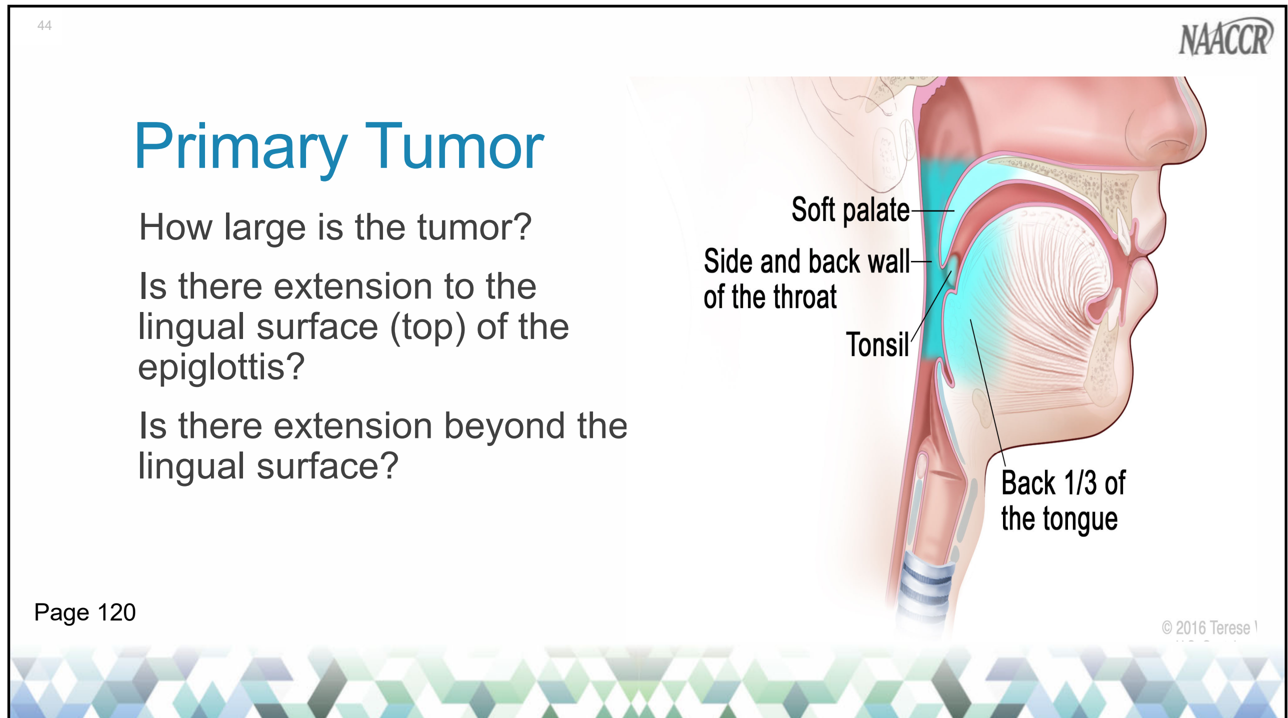

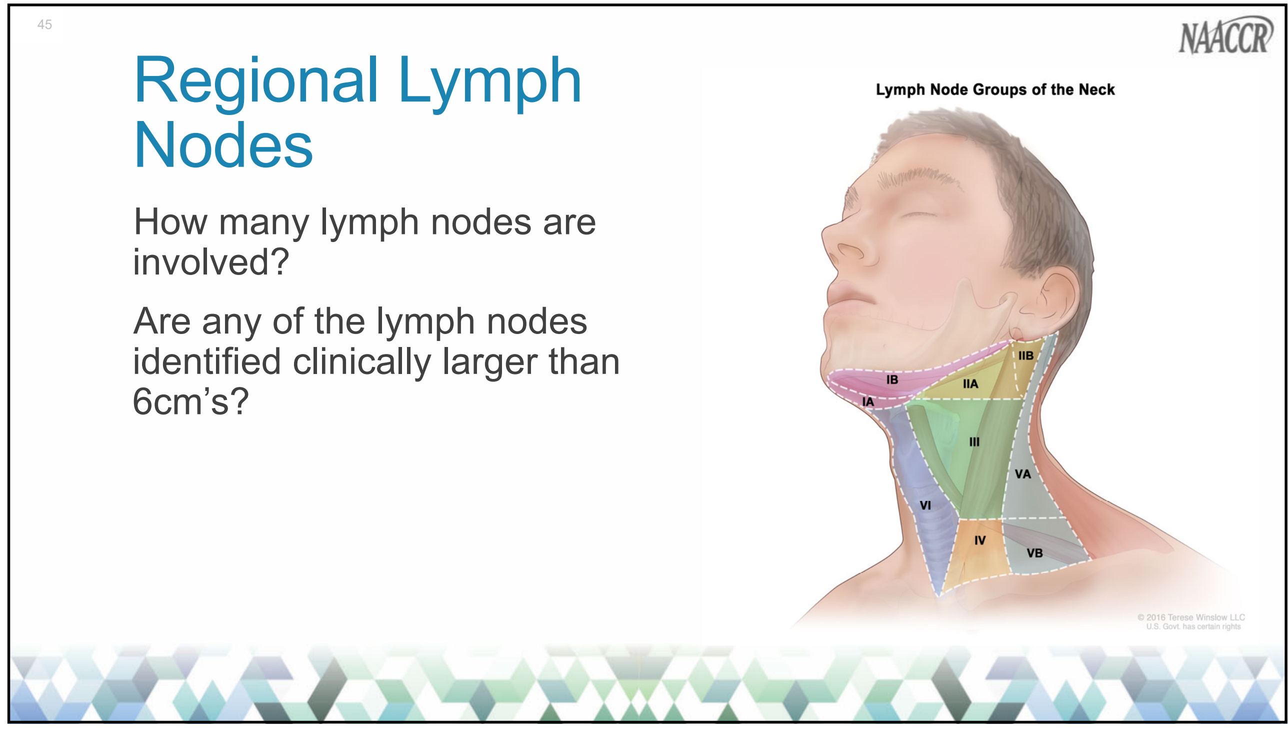
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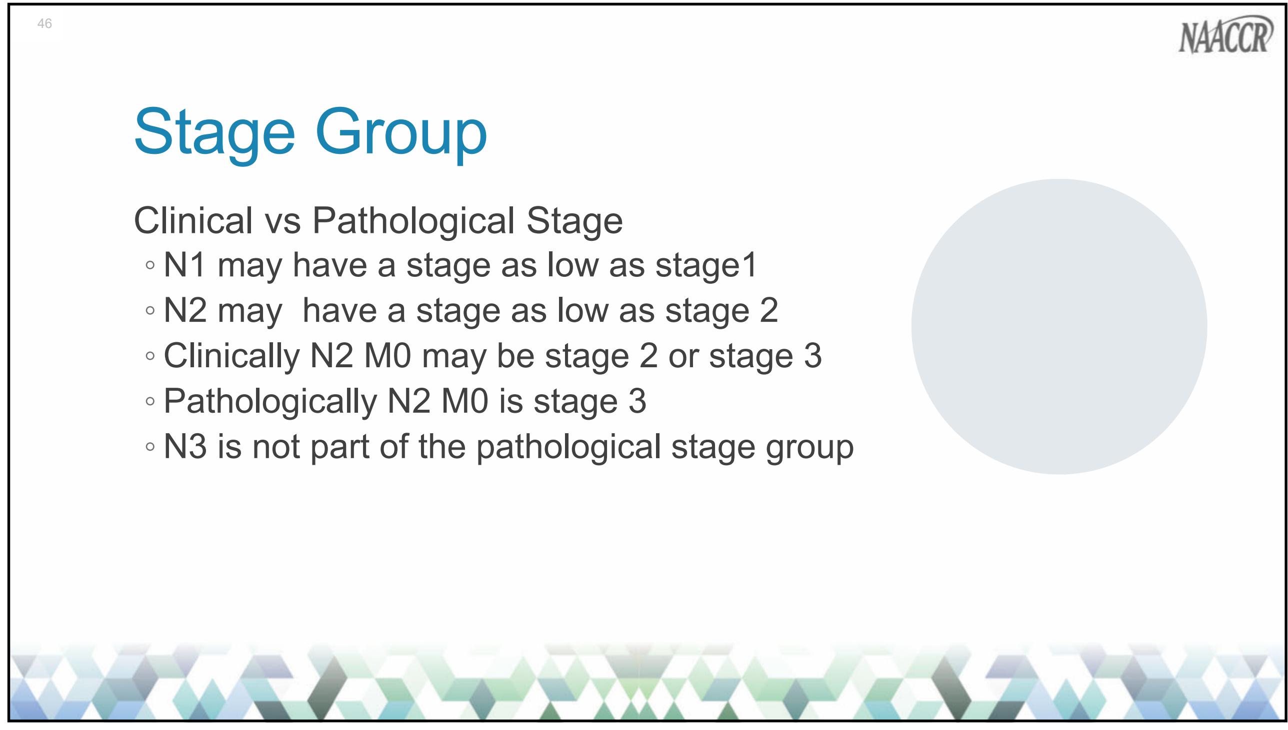
Regional Lymph Nodes
How many lymph nodes are involved?
Are any of the lymph nodes identified clinically larger than 6cm's?
Lymph Node Groups of the Neck
IB
IIA
IIB
IA
III
VA
VI
IV
VB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Stage Group
Clinical vs Pathological Stage
◦ N1 may have a stage as low as stage1
◦ N2 may have a stage as low as stage 2
◦ Clinically N2 M0 may be stage 2 or stage 3
◦ Pathologically N2 M0 is stage 3
◦ N3 is not part of the pathological stage group

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Chapter 11: Oropharynx (p16-) and Hypopharynx

T0 is not a valid value for this chapter

T values are different for oropharynx and hypopharynx

N categories are different for clinical N and pathological N

- ENE + is N3b for cN
- ENE + may be N2a or N3b for pN

If neck dissection is completed, a stage group may be assigned even if the primary tumor is not resected.

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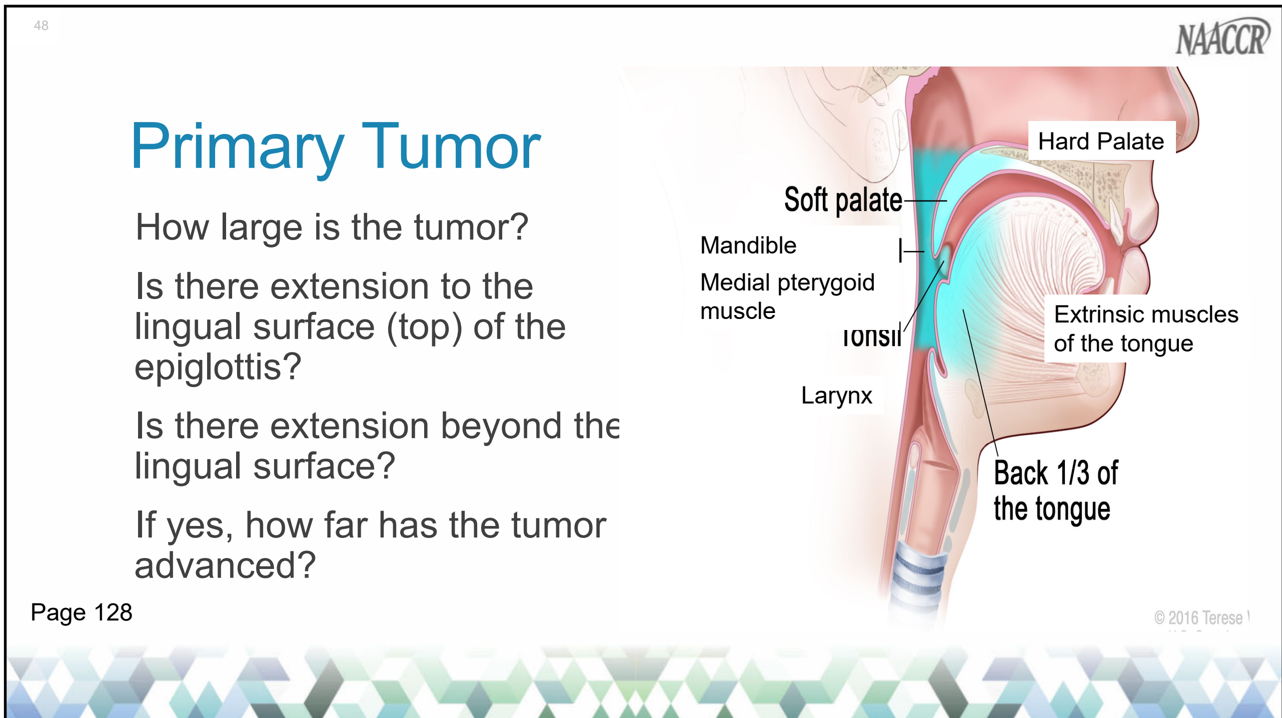

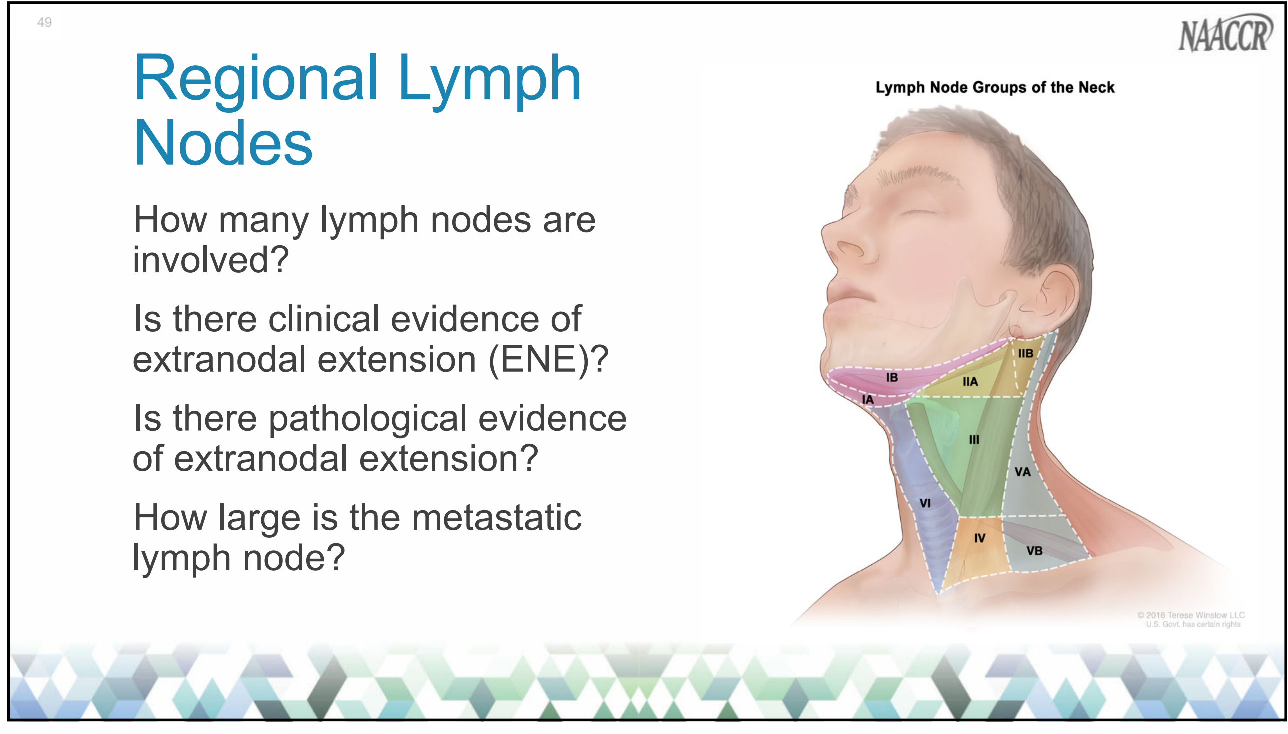
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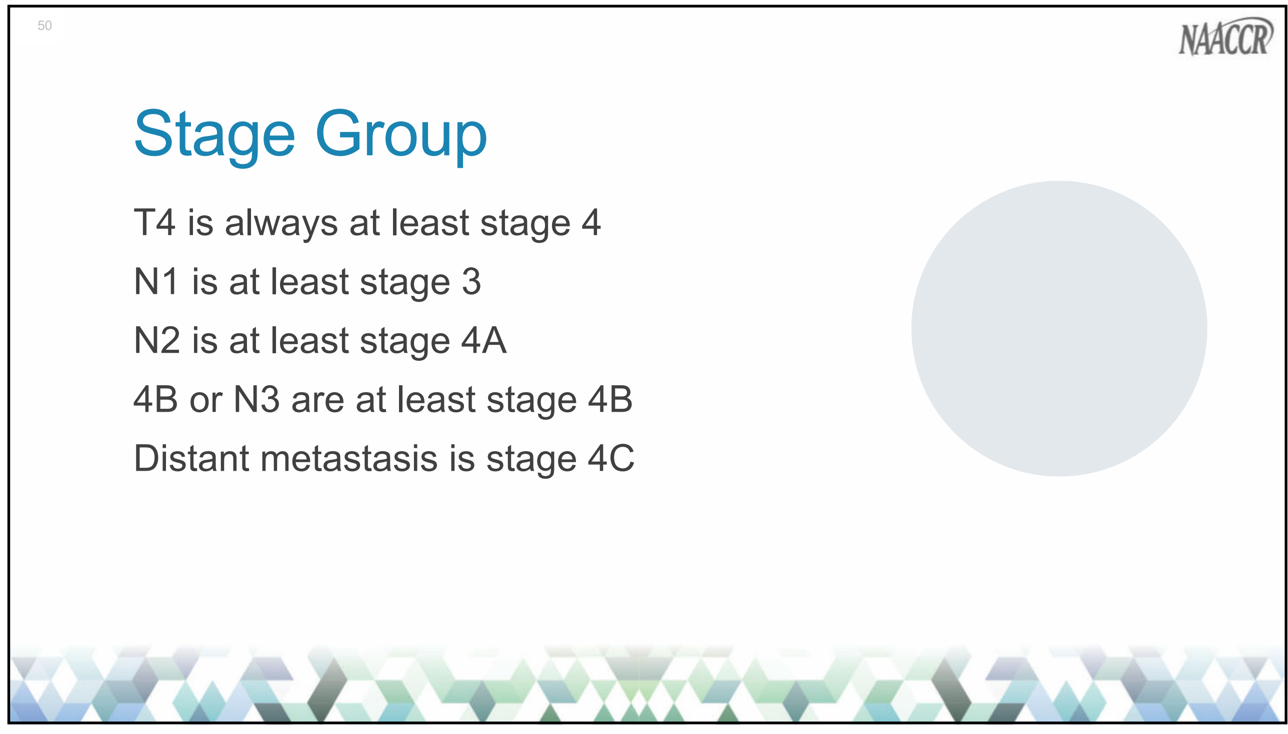
Regional Lymph Nodes
How many lymph nodes are involved?
Is there clinical evidence of extranodal extension (ENE)?
Is there pathological evidence of extranodal extension?
How large is the metastatic lymph node?
Lymph Node Groups of the Neck
IA
IB
IIA
IIB
III
IV
VA
VB
VI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Stage Group
T4 is always at least stage 4
N1 is at least stage 3
N2 is at least stage 4A
4B or N3 are at least stage 4B
Distant metastasis is stage 4C

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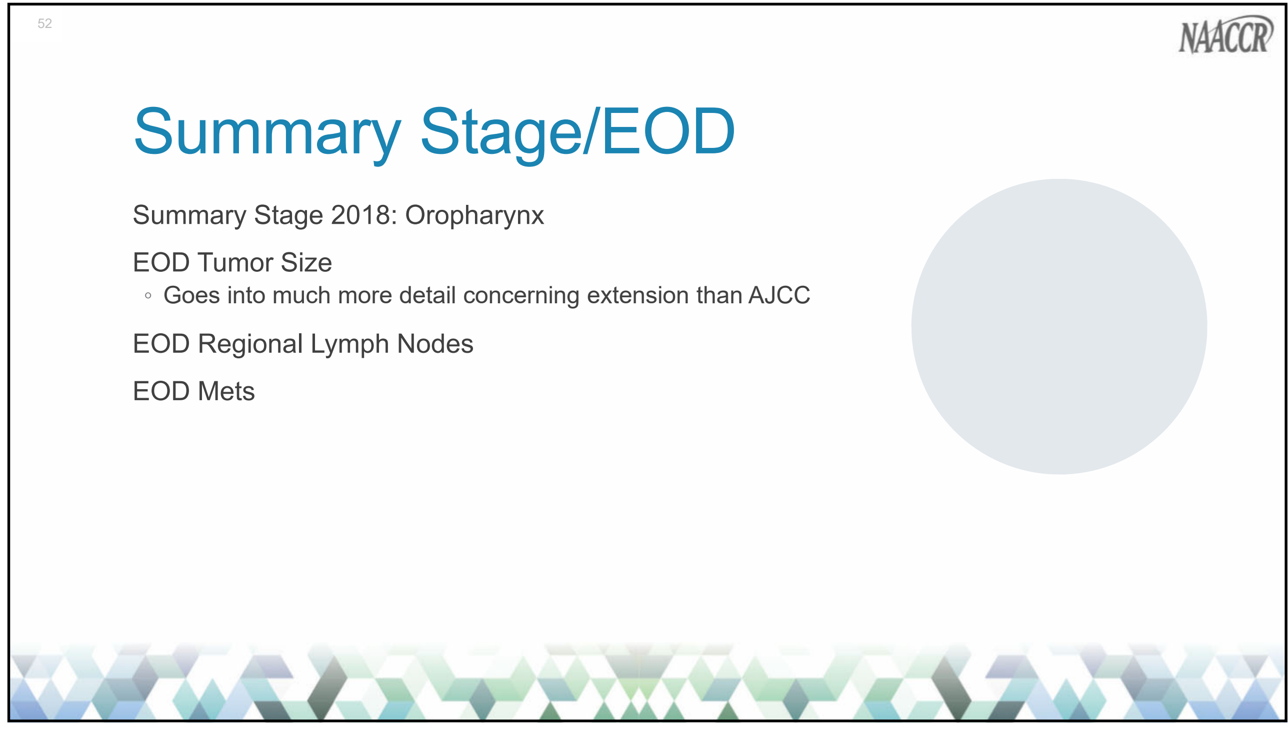
Summary Stage & EOD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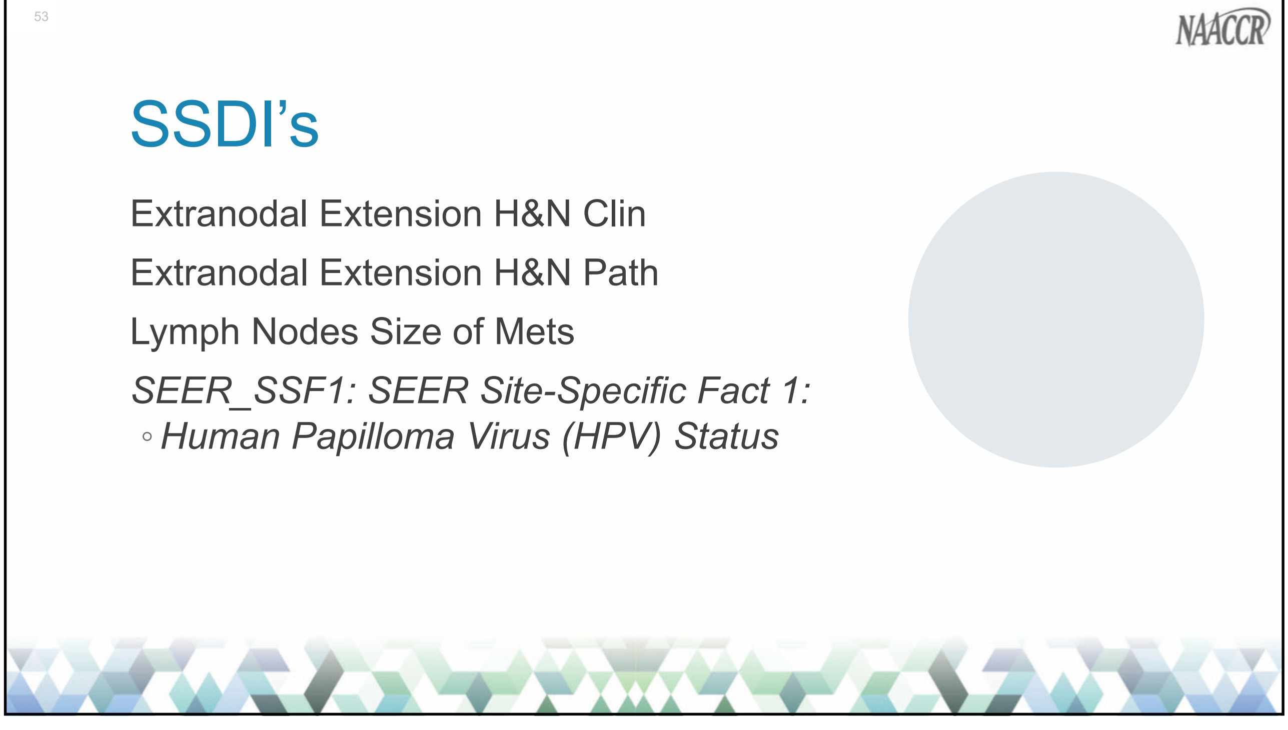
Summary Stage/EOD
Summary Stage 2018: Oropharynx
EOD Tumor Size
◦ Goes into much more detail concerning extension than AJCC
EOD Regional Lymph Nodes
EOD Mets



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Extranodal Extension H&N Clinical

- **Imaging alone is not enough to determine or exclude ENE.**
  - Code 0 when lymph nodes are determined to be positive and physical examination does not indicate any signs of extranodal extension.
  - Clinical ENE is described in the AJCC 8th edition as "Unambiguous evidence of gross ENE on clinical examination
    - (e.g., invasion of skin, infiltration of musculature, tethering to adjacent structures, or cranial nerve, brachial plexus, sympathetic trunk, or phrenic nerve invasion with dysfunction)“
  - The terms 'fixed' or 'matted' are used to describe lymph nodes.

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Extranodal Extension H&N Pathological

Code the status of ENE assessed on histopathologic examination of surgically resected involved regional lymph node(s).

- Do not code ENE from a lymph node biopsy (FNA, core, incisional, excisional, sentinel).
- Do not code ENE for any distant lymph node

Definitions of ENE subtypes and rules:

- Microscopic ENE [ENE (mi)] is defined as less than or equal to 2 mm.
- Major ENE [ENE (ma)] is defined as greater than 2 mm.
- Both ENE (mi) and ENE (ma) qualify as ENE (+) for definition of pN.

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Lymph Nodes Size of Metastasis

Record the size of the largest metastatic lymph node

- If the same involved node (or same level) is examined both clinically and pathologically, record the size of the node from the pathology report, even if it is smaller.
  - Example: Clinical evaluation shows 2.0cm (20 mm) Level III lymph node, pathological examination shows Level III 1.7 cm (17 mm) **metastatic deposit**. Code 17.0.
- If the largest involved node is not examined pathologically, use the clinical node size

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SEER_SSF1: SEER Site-Specific Fact 1: Human Papilloma Virus (HPV) Status

Required for SEER Registries only

- There are several methods for determination of HPV status. The most frequently used test is IHC for p16 expression which is surrogate marker for HPV infection.
  - **Do not record the results of IHC p16 expression in this field.**
  - The rest of the tests (based on ISH, PCR, RT-PCR technologies) detect the viral DNA or RNA.
  - **This data item is only for HPV status determined by tests designed to detect viral DNA or RNA.**
  - **Leave this field blank if tests not done.**

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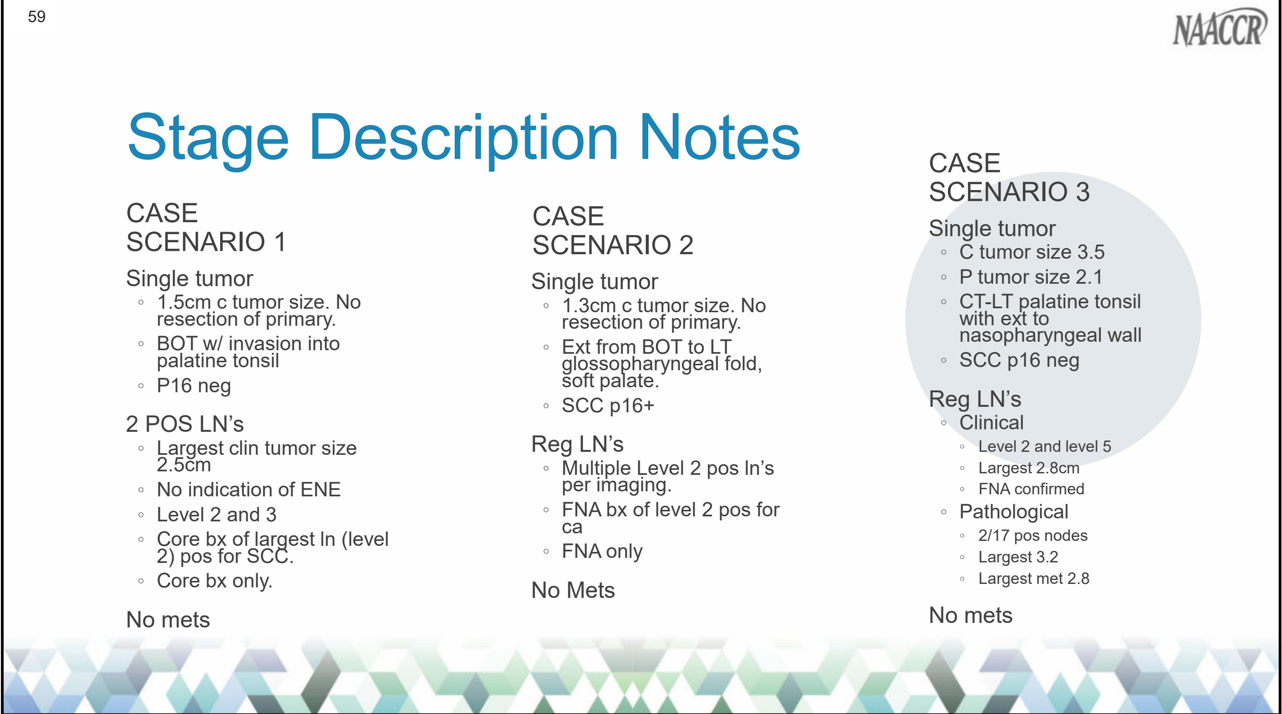
Review of Case Scenarios

CASE SCENARIOS 1-3 STAGE AND SSDI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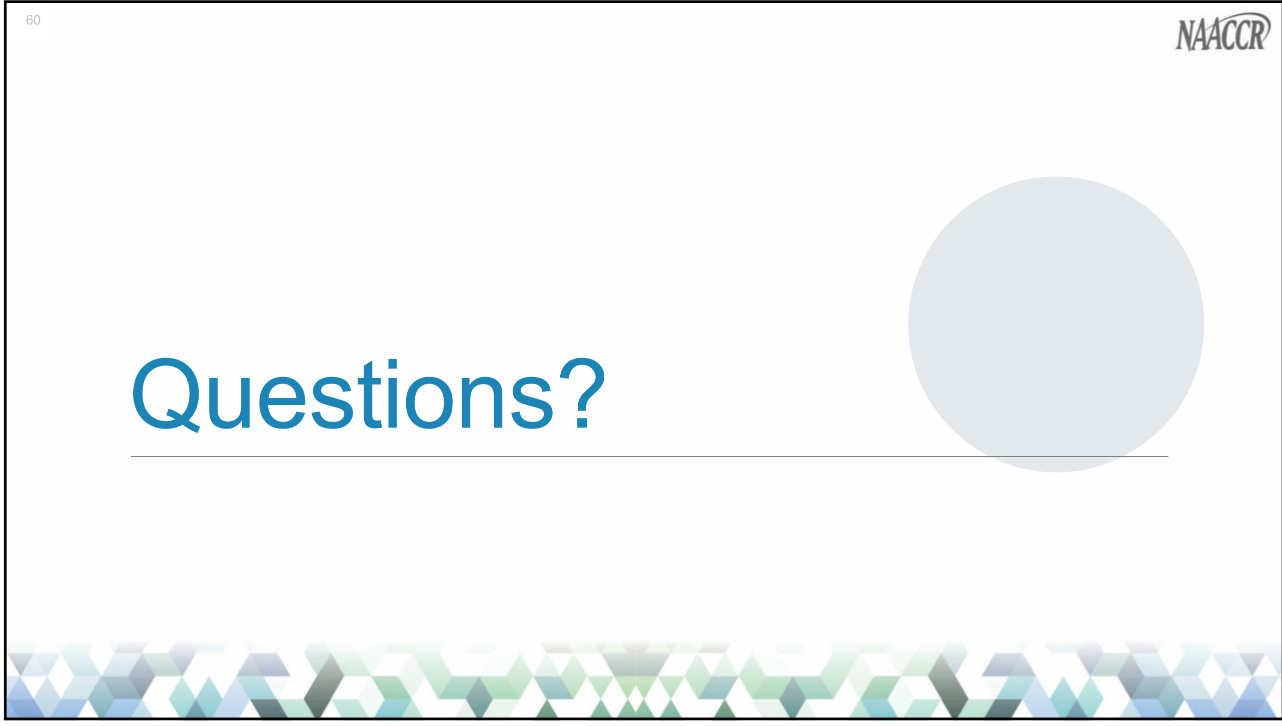
Stage Description Notes
CASE SCENARIO 1
Single tumor
1.5cm c tumor size. No resection of primary.
BOT w/ invasion into palatine tonsil
P16 neg
2 POS LN's
Largest clin tumor size 2.5cm
No indication of ENE
Level 2 and 3
Core bx of largest ln (level 2) pos for SCC.
Core bx only.
No mets
CASE SCENARIO 2
Single tumor
1.3cm c tumor size. No resection of primary.
Ext from BOT to LT glossopharyngeal fold, soft palate.
SCC p16+
Reg LN's
Multiple Level 2 pos ln's per imaging.
FNA bx of level 2 pos for ca
FNA only
No Mets
CASE SCENARIO 3
Single tumor
C tumor size 3.5
P tumor size 2.1
CT-LT palatine tonsil with ext to nasopharyngeal wall
SCC p16 neg
Reg LN's
Clinical
Level 2 and level 5
Largest 2.8cm
FNA confirmed
Pathological
2/17 pos nodes
Largest 3.2
Largest met 2.8
No mets


60
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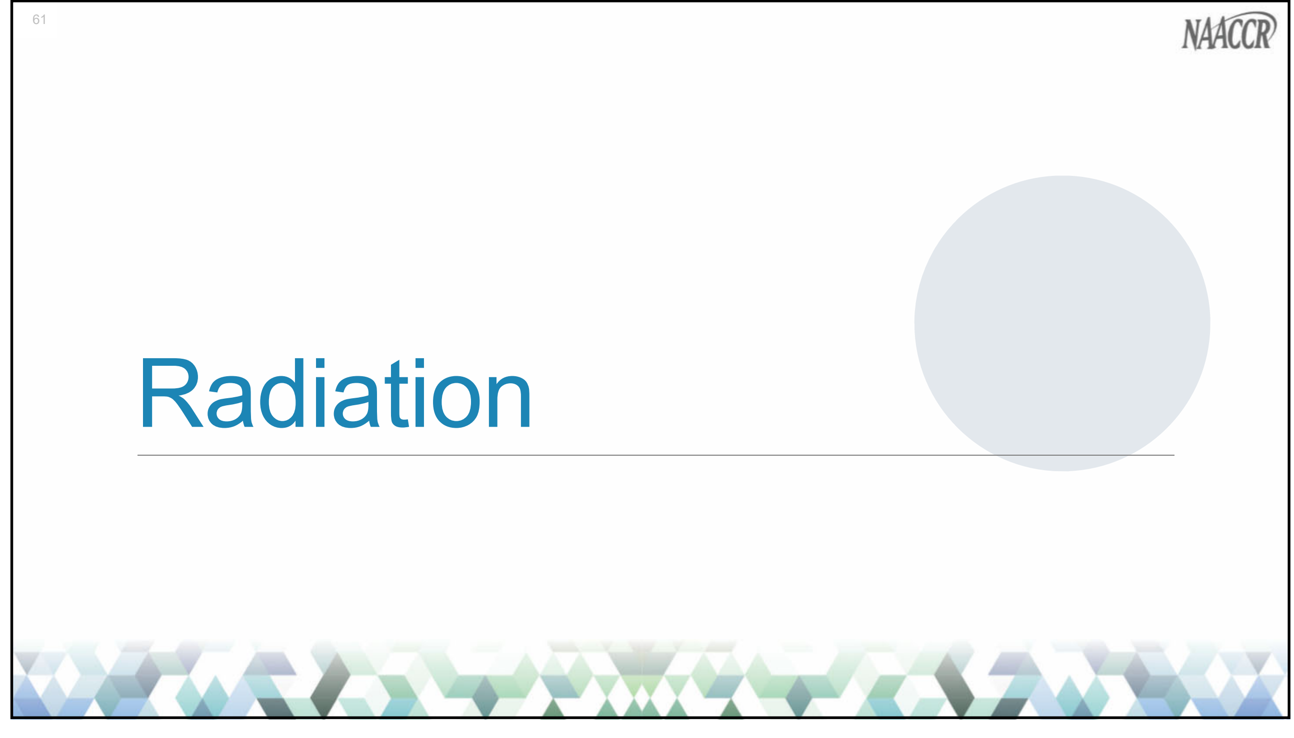
Questions?


61
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Radiation

62
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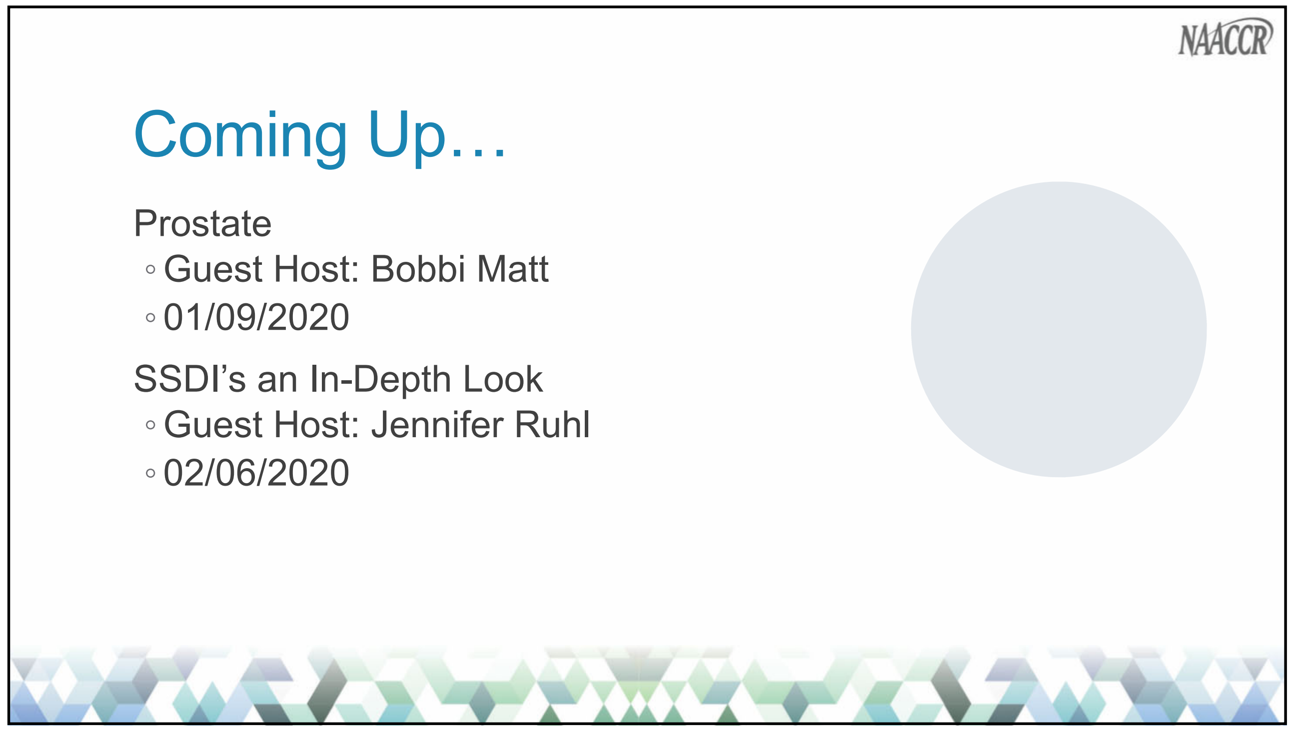
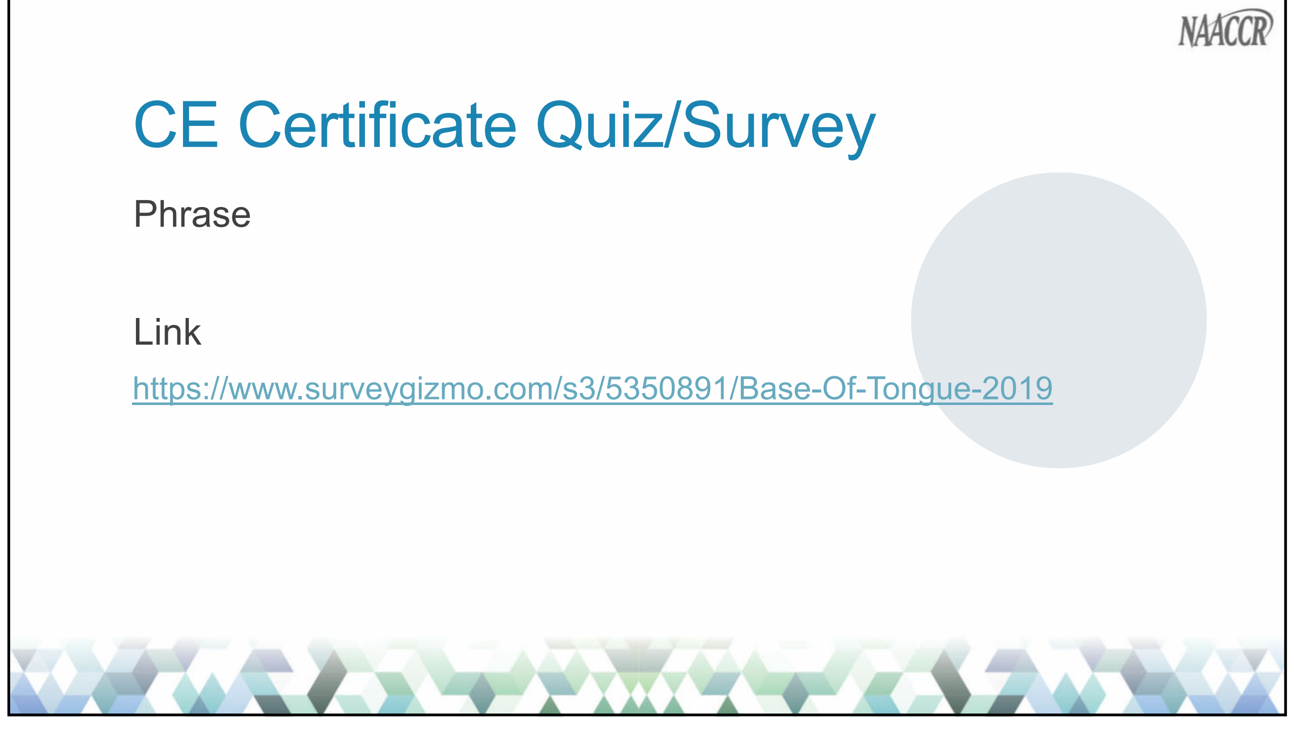
Fabulous Prizes


NAACCR
Coming Up…
Prostate
Guest Host: Bobbi Matt
01/09/2020
SSDI's an In-Depth Look
Guest Host: Jennifer Ruhl
02/06/2020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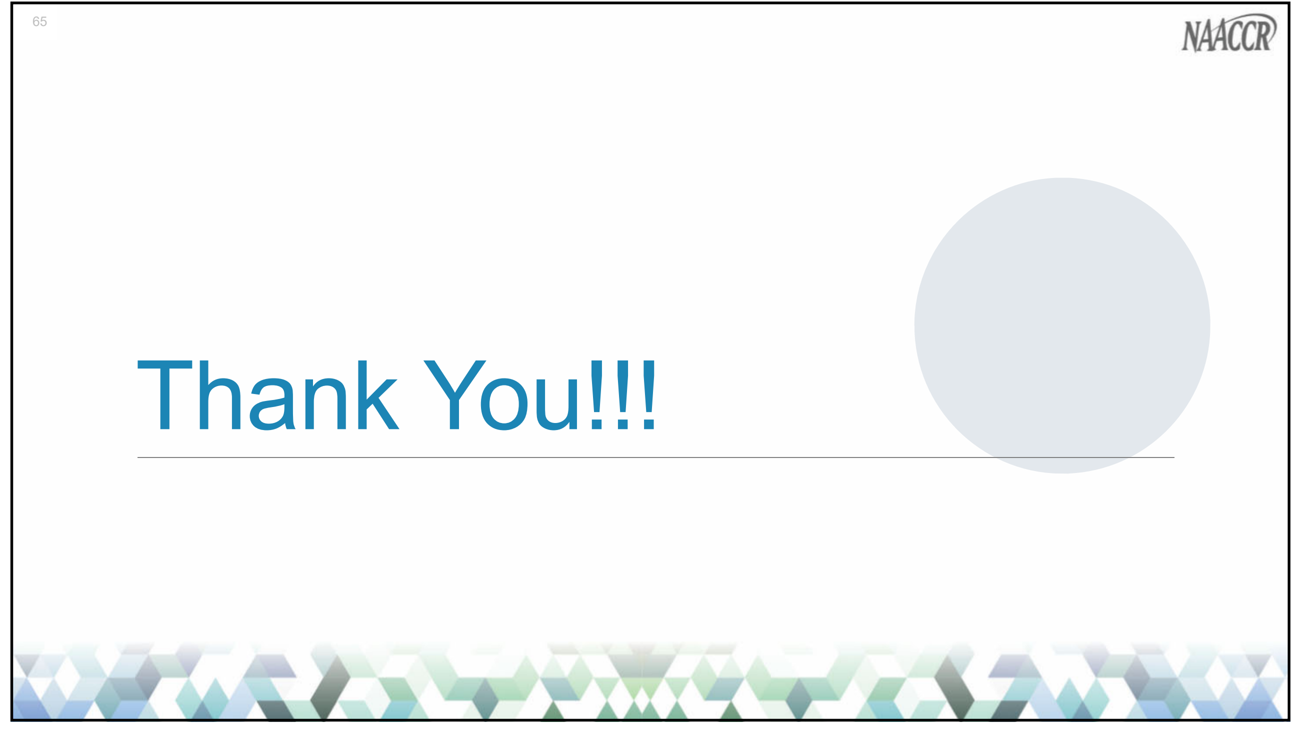
CE Certificate Quiz/Survey
Phrase
Link
https://www.surveygizmo.com/s3/5350891/Base-Of-Tongue-2019


65
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Thank You!!!