Q&A Session for 2021: Larynx

April 1, 2021

#	Question	Answer
1.	Is there any data that shows any incidence with vaping?	They are starting to study it at research facilities.
2.	Do you have any helpful tips on deciding when to code C321 vs C101?	The solid tumor rules may be helpful. Otherwise, the ENT exam and/or operative notes should be helpful.
3.	Page 13 of slides: what is an example of a phenotype?	A phenotype is an observable characteristic. For humans, these characteristics include things like eye color, height, and hair color. Phenotypes result from the expression of genes. At the cellular level, phenotypes are identified using markers that look for the expression of certain genes (biomarkers). For head and neck cancers, CD44, CD133, and ALDH1 are the most extensively validated of the biomarkers, and are the ones with the most prognostic significance. For example, head and neck SCCs with high levels of CD44 (a surface receptor) are associated with metastasis and poor prognosis. The expression of CD44 can be identified using monoclonal antibodies.
4.	Can you please define the "most specific" histology if you have multiple subtypes or variants? Is it the highest numerical code?	We do not have a "code to the highest" histology coding rule. Per Rule M7, if you have 2 subtypes/variants in multiple tumors, you would have multiple primaries -- or a primary for EACH subtype in column 3. If you have a single tumor, that is an occasion when you would check SINQ or Ask A SEER Registrar.
5.	If the Staging presented by the PHY or PATH is correct do we enter the registrar's staging if the staging is incorrect?	We are encouraged to use accurate staging. If the physician/path staging was correct, we can use that. But if they do not follow the rules as outlined in the chapter, the registrar should stage accurately. You can note the physician/path stage in text fields.

6.	Do you have an example of (pg 42)? Grade pathological guidelines - 3. Code 9 when - No resection of primary tumor; clinical case only (except when (+) distant mets found during clin time frame) ?	If pM1 during the clinical stage timeframe, the clinical grade and clinical stage information may be used for pathological grade and staging even if the primary tumor is not excised. Here is an example from the CAnswer Forum: Prostate case is staged cT1c cN0 pM1 (based on microscopic proof of bone mets. Note 7 in the prostate schema instructs us to use the clinical grade when there has been no surgical resection of the primary site but there is positive proof of distant mets during the clinical time frame. The information from Note 7 is the exception to assigning code 9 for no resection of the primary tumor. If this case were cM0 or cM1, but there was no resection (for example, the patient elected for radiation therapy instead of surgery), the grade pathological would be coded to 9.
7.	Observation: Registrars need to notice WHEN the physician is staging the case and document in text. Sometimes the physician will state a stage prior to completion of the diagnostic workup.	That is correct. That is what is referred to as the working stage.
8.	"Question: 2 - If the grade is from a metastatic site during the clinical timeframe do you code the grade from the metastatic site in grade pathological? If there is a grade from both the primary site and the metastatic site do you prioritize the clinical grade from the primary site for grade pathological or take the higher of the grades from either the primary site or the metastatic site for grade pathological?"	The grade is coded from the **primary tumor**, regardless of which grade you are coding (clinical, pathological, post-therapy clinical, or post-therapy pathological). Do not record the grade from a metastatic site (regional or distant) during any timeframe. Note: there is an exception to this rule for breast cases when no primary tumor is identified (T0). See the Grade Manual for additional information.
9.	Do you code yc only if there is no surgery or do your code yc and yp?	Code yc grade when the patient has undergone neoadjuvant therapy, and a biopsy of the primary tumor is performed either prior to resection, or when there will be no resection. Code yp grade when the patient has

		undergone neoadjuvant therapy followed by resection that meets the resection criteria in the AJCC manual. If you have grades for both the yc and yp timeframes, you may code both, but only yp is required in that particular circumstance.
10.	Do you have to have a bx after neoadj treatment to determine the yc?	Yes, a biopsy must be performed after neoadjuvant therapy to assign yc. Grade is based on microscopic examination of the tissue.
11.	In the Head and Neck STR Table 3, HPV - 8086/3 & HPV + is not listed. When we have this histology described for larynx can we assign these codes? Also, is conventional SCC arising in the larynx 8070/3 ?	Please submit these questions to ASK a SEER Registrar, preferably with case examples. The CAP Protocol for Larynx lists "Squamous cell carcinoma, conventional (keratinizing)" as a histologic type.
12.	Can yc grade come from cytology?	If the cytology is from the primary tumor, yes. http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/87731-coding-urine-cytology-grade
13.	If you only have a yc grade, can you use that grade for the pathological grade? I just want to clarify … Patient has clinical grade from biopsy then neoadjuvant therapy followed by another biopsy so I have ycClinical Grade. Patient goes on to have resection and I now have ypGrade. If ypGrade is lower than ycGrade, do we use ycGrade? Thanks for your patience. I know you just went through this, but I got a little confused.	Grade post-therapy path "may include the grade from the post-therapy clinical workup (yc), as all information from the completion of neoadjuvant therapy (post-therapy clinical (yc)) through the surgical resection is used for post-therapy grade (yp)." (Grade Manual page 24) Therefore, if the yc grade is higher than the yp grade, assign the yc grade in the yp field.
14.	For Clinical N, are the sizes assigned based only on one of the nodes, or can it be the size of a conglomerate/mass of lymph nodes? For cN2b and cN3b?	"For some disease sites, the size of tumor metastasis within the regional lymph node is a criterion for the N category. If the size of the tumor in the regional nodal metastasis is unknown, the size of the involved lymph node may be used. The size of any mass, from a single node to a conglomerate mass of matted nodes, is used to

		determine the N category for some disease sites, such as head and neck." Amin, Mahul B.; Hess, Kenneth R.. AJCC Cancer Staging Manual, Eighth Edition (Page 39). American College of Surgeons. Kindle Edition.