Q&A Session for Head & Neck 2023

January 12, 2023

#	Question	Answer
1.	Where did the chart lining up p16NEG and unknown EBV = C76.0 come from?	It is in the SSDI manual at the beginning of the h/n SSDIs. 00060: Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck chapter.
2.	Since LN size of mets is based on clinical sizing for case #1, should it be 37.0 based on the size on MRI?	The MRI described the 3.7cm possible LN metastasis as a "mass." It may have been more than 1 LN, so the size wasn't coded based on the MRI.
3.	Is there guidance on when chemo is radiosensitizing/radioprotectant (STORE & SEER both say not to code)? At my facility we rarely ever see physician statement that chemo is radiosensitizing in cases of concurrent chemoradiation. I have heard registrars say they got guidance from their pharmacy on what dosages are radiosensitizing. Is there a national standard? SEER manual points to PDQ & NCCN but not sure where to look in those.	The STORE manual (page 294) states: "If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer." If the physicians doesn't specify "radiosensitizer," Cancer Forum tells us: "Review the treatment plan…All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient." https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/radiation-data-items-

		aa/98226-radiosensitizer-chemo-according-to-store https://cancerbulletin.facs.org/forums/forum/fords-national-cancer-data-base/store/first-course-of-treatment-aa/systemic-chemo-hormone-endocrine-bio-modifers-aa/119929-class-of-case-when-radiosensitizing-agent-is-only-care-provided-at-our-facility Personally, I would code the chemotherapy unless it is clearly stated chemo is given as a radiosensitizer.
4.	The MRI LN size is 3.7 cm, which is larger than PET LN size of 2.8 cm, why not take to 3.7 cm LN size for LN size of mets?	The MRI described the 3.7cm possible LN metastasis as a "mass." It may have been more than 1 LN, so the size wasn't coded based on the MRI.
5.	Case #20 in v4 CTR guide to RXT is an unk H&N & Case #13 is H&N SIB - but phase 2 & 3 in that example only target LNs.	The CTR guide cases are excellent as a reference. There is a lot of variation among registries, regarding how their radiation oncology records document the treatment. Treatment summaries don't usually break the information down to phases. The best way to understand the radiation information at your facility, is to get assistance from someone in the radiation department.
6.	Similar to case #13 in CTR guide to RXT, when I see my facility RadOnc do SIB for H&N the phases also often target psite & different regional LN (involved LN, "high risk" LN, and/or "low risk" LN per MD) - have to check initial tx plan & multiple RadOnc notes for the specifics as not always delineated in the end of tx summary which may only list "PTV1, 2, 3 etc" (planned tx vol).	The CTR guide cases are excellent as a reference. There is a lot of variation among registries, regarding how their radiation oncology records document the treatment. Treatment summaries don't

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13.	Where did the chart lining up p16NEG and unknown EBV = C76.0 come from?	live answered
14.	That table was originally in AJCC lectures that I did on Head & Neck, you can see them on the AJCC website under the 8th edition lectures.	Thanks.
15.	The reason the doses are the same in the CTR guide and case #1 is because this is standard dosing for head and neck when you treat the lymph nodes. Phases 2 and 3 are to the lymph nodes only. Did you consult with the radiation department about the sites the radiation was going to?	Our radiation records do specify the sites of the treatment.
16.	For the radiation volume for Case 1, I would have thought the radiation volume would have been 02-Neck Lymph Node Regions?	Case 1 treatment volume is code 29 because of the definition in STORE.
17.	Could the primary site be oropharynx, NOS?	Not based on the table since it was p16- and the primary was not found/seen
18.	The higher dose is typically to the primary and the lesser doses are to the lymph nodes.	The cases we used reflect what actually was done.
19.	If you have access to the radiation prescription it will help you clarify what is being treated.	The cases we used reflect what actually was done.
20.	NCCN guidelines are a good source for information on RT with radiosensitizers.	The STORE manual (page 294) states: "If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer." If the physicians doesn't specify "radiosensitizer," Cancer Forum tells us: "Review the treatment plan…All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually

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21.	Also look at the interval that the chemo is given in relation to the radiation sessions	Good tip!
22.	Comment about why you cannot code the site to oropharynx, the AJCC physicians specifically set up chapter 6 for unknown primary site. the SSDI team & others made the decision to use C76 so that it matched with AJCC Chapter 6 unknown primary site since that is a code most registrars do not use	Thank you.
23.	NCCN Guidelines states: I believe the chemo for case 1 should not be coded because it was give as 60 mg. Based on published data, concurrent systemic therapy/RT most commonly uses conventional fractionation at 2.0 Gy per fraction to a typical dose of 70 Gy in 7 weeks with single agent cisplatin given every 3 weeks at 100 mg/m2 ; 2–3 cycles of chemotherapy are used depending on the radiation fractionation scheme (RTOG 0129) (Ang KK, et al. N Engl J Med 2010;363:24-35). When carboplatin and 5-FU are used, the recommended regimen is standard fractionation plus 3 cycles of chemotherapy (Bourhis J, et al. Lancet Oncol 2012;13:145-153). Other fraction sizes (eg, 1.8 Gy, conventional), multiagent chemotherapy, other dosing schedules of cisplatin, or altered fractionation with chemotherapy are efficacious, and there is no consensus on the optimal approach. In general, the use of concurrent systemic therapy/RT carries a high toxicity burden; altered fractionation or multiagent chemotherapy will likely further increase	The STORE manual (page 294) states: "If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer." If the physicians doesn't specify "radiosensitizer," Cancer Forum tells us: "Review the treatment plan…All therapies specified in the physician(s) treatment plan are a part of the first

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24.	Due to the change in STORE 2021 for scope Reg LN = 1, for case scenario #1 (2019 dx) and #2 (2022 dx), although the scope of reg LN is 1 for both cases, in scenario #1	From STORE, exclude Scope of Reg LN Surgery code 1: Record the date of the first surgical procedure of the types

	we consider it surgery for date 1st surg procedure & date 1st tx & for surg/rxt & surg/sys sequences BUT in scenario #2 we do NOT, is that correct?	coded as Surgical Procedure of Primary Site [1290], Scope of Regional Lymph Node Surgery [1292] (excluding code 1) or Surgical Procedure/Other Site [1294] performed at this or any facility
25.	If radiation therapy is incomplete at time of abstracting, should total dose be unknown, or should you record dose up to the time of abstracting?	In our registry we don't consider the case complete until we know all of the radiation. We use a User Defined field in our registry software that we call "revisit date," so we don't forget to finish putting the treatment into the abstract. Another registrar's option: We generally code it as 9's until the entire treatment is complete. Also you would need to wait until the end to code if it was discontinued early, etc.
26.	When and if they change Radiation reporting, they should have actual radiation oncologist involved in the process. The data is not consistent, if anything...standard setters should go back to the way radiation used to be coded. A lot simpler for anyone to code.	We'll see what happens in the future.
27.	Where is the SEER list of primary site codes, I don't recall every seeing it in the SEER manual?	If you mean the Head and Neck primary sites in slide# 10 of the presentation, that list was created by the presenter, based on looking at the ICD-O-3 site codes. The primary site for Glossotonsillar sulcus, was found on page 95 of the SEER Program Coding and Staging Manual 2023 that can be found here: SEER Program Coding and Staging Manual 2023 (cancer.gov)
28.	I just want to make sure I understood the comment about "fixed" lns. When there is a statement that lns are "fixed" are we to assume that this equals ENE+. I have read in AJCC that "matted" indicates ENE, but was not sure about "fixed"?	In the SSDI manual under clinical ENE it states, The terms 'fixed' or 'matted' are used to describe lymph nodes Other

		terms for ENE include: 'extra nodal spread', 'extracapsular extension', This is under note 5.
29.	http://www.cancerregistryeducation.org/Files/Org/f3f3d382a7a242549a9999654105a63b/site/Chemotherapy_Codes.pdf	Thank you!
30.	Just remember, while you can use HPV testing for the histology, you cannot use HPV testing to choose the correct AJCC staging chapter - that is only based on p16. For example if p16 is negative and HPV is positive, you would use the AJCC p16 negative chapter for oropharynx per the AJCC physicians	Thanks, I did learn a thing or two about p16 vs. HPV testing, in regard to the 8th Edition. However, Case#3 in this webinar is in fact p16 positive! I made an error while reading the case, and inadvertently missed the statement that results of the tonsillectomy were p16 positive. MEO
31.	In this particular case wouldn't the site be Tonsil? The Rad Onc Note may state "Oropharynx" but with the p16: Positive, more Specifically it seems that the site would be Tonsil with Lymph node involvement.	Case 2: Solid Tumor Rules, Priority Order for Identifying Primary Site When There is Conflicting Information, Tumor Board is the 1st priority. Tumor Board stated the primary site to be glossotonsillar sulcus.
32.	If you are using 2 cm to stage it wouldn't you change your c size to a 020?	Clinical tumor size was 2 cm, but path tumor size was 1 cm, so the tumor size summary is 010. The tumor size is the tumor size summary, which we use pathological if available. So, the 2 cm was used to clinically stage, but the tumor size summary would use the path size which was 1 cm.
33.	What was the clinical tumor size and the pathological tumor size for Case 3? Slide shows Tumor Size: 010	Clinical size, only mentioned in the operative report, 2cm. Pathological size code 010, up to 1cm.
34.	Some of you know I am a librarian, can't resist a research challenge. This is from Up To Date (subscription service so I can't send URL of entire entry)	I don't see a question or a link, here.
35.	Do y'all know that if you type in Cisplatin in the SEER Rx that H&N site is NOT listed as a primary site as FDA approved therapy?	Refer to NCCN and you'll see cisplatin in H&N regimens.

36.	"Cisplatin — Two main schedules of cisplatin administration are used clinically (bolus and weekly). For patients receiving cisplatin as a radiosensitizer, we suggest cisplatin 40 mg/m2 weekly rather than bolus cisplatin 100 mg/m2 every three weeks. In a randomized trial, weekly cisplatin as part of definitive chemoradiation had noninferior locoregional control (LRC) and was better tolerated compared with bolus cisplatin [24].	That is helpful background info! I wonder if there
37.	The efficacy of cisplatin is also dose dependent when given as a single agent concurrently with RT, and total doses >200 mg/m2 are more effective than lower doses, regardless of the schedule used [24-28]. Data from these and other studies also support the use of weekly cisplatin in all primary tumor sites (including oral cavity tumors) and other pathologic subtypes (eg, human papillomavirus [HPV] associated oropharyngeal tumors); the latter is discussed separately."	Thanks for the reference.
38.	Thank you for pointing out difference btw LN met deposit size versus pathological LN size. Found this post from Jennifer Ruhl that explains discrepancy btw CAP & AJCC & when we may code LN met deposit size vs LN size & how it may disagree w/ pathologist assigned N category: https://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018/85097-lymph-nodes-size-of-metastasis?p=98781#post98781	Thanks for the reference.
39.	This article has a helpful table showing systemic treatment regimens for H&N SCC including the radiosensitizer schedule described above (100 mg/m2 every three weeks - article predates Up to Date so doesn't include 40 mg/m2)https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6718707/	Thanks for the reference.
40.	Regional LN list is also in the SS2018 manual (page 40 if you are looking at the Oct 2022 version; the LN were updated to match AJCC as of 2018+)	Thanks for the reference.
41.	SEER surgery notes are SO helpful - are there any discussion among the standard setters to trim the surgery codes from STORE and just have it in the SEER manual? There are also discrepancies in instructions for same data items in STORE & SEER manual that causes confusion for registrars.	No such discussion has come to my attention.
42.	from AJCC Chapter 10 p16 Testing p16 immuno testing is mandatory to use this staging system for HPV-associated cancer. HPV by in situ hybridization (ISH) may be done as an alternative. If a case of oropharyngeal cancer does not have p16 or HPV by ISH, then the case is staged by the p16- negative system (Chapter 11).	Thanks, I did learn a thing or two about p16 vs. HPV testing, in regard to the 8th Edition. However, Case#3 in this webinar is in fact p16 positive! I made an error

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43.	For Case 1: Is it possible the radiation was given as a Simultaneous Integrated Boost? That would impact the radiation field codes, right?	If the XRT Had been given as an SIB, you are correct it would have been coded differently. In this case, we had access to all of the information and we know this was not given as an SIB.
44.	For case 1, if imaging is initially calling an enlarged node just a "mass" but it is determined by further workup to be a metastatic lymph node, why wouldn't you code the largest size stated on any imaging?	It wasn't certain that the mass on MRI was only a single LN. In fact the PET scan 2 days later described 2 LNS.
45.	Can we use per M.D. - T.S. is 2-2.5cm? This is not documented anywhere in the record to support the tumor size if this record is reviewed by a surveyor or if anyone else questions it.	It should be documented in the abstract, that the doctor gave the registrar that information.
46.	One of our registrars is asking a question about tumor board presentation and coding the primary site. They are wondering if the information from tumor board must be from prior to surgery, after surgery, or it does not matter when the patient is presented in the treatment cycle.	As we review the medical record, we should find the most definitive statements about the primary site. Remember, the Priority Order rule is for when there is conflicting information. For any H&N case, looking at the chart as a whole, the primary site may become more evident after Tumor Board took place. I don't believe there is any information related to if this must be before surgery.
47.	With the 2023 change to emphasize that a phase is actually a separate prescription, do you have any tips for how to identify a radiation prescription in the medical record? Often, we don't have access to radiation software, and we can't always count on the radiation summary to indicate what the prescription was.	I don't know how you'd be able to code the phases accurately if you don't have access to the radiation records.
48.	What is meant by the size of mets in the node? I have never seen this separate from the size of the LN	Some pathology reports will actually report the size of the mets in the node - in other words, the node itself may be 3

		cm, but the metastatic deposit inside it is only 1.5 cm. The SSDI calls for you to record the actual size of the node, not just the mets inside.
49.	Where did you say the EBV p16 chart was located?	It is in the SSDI manual at the beginning of the H/N data