Q&A Session for Larynx and Base of Tongue

October 3, 2024

#	Question	Answer
1.	Patient diagnosed with laryngeal sq. Cell ca in 2019. Treated with radiation. Routine f/up in 2024 patients were negative for recurrent laryngeal squamous cell ca. In 2024 pt found to have a lump on the left side of neck. Initially treated with antibiotics but no response. Presented to the hospital for further evaluation. FNA of neck lump was positive for p16 sq cell ca. Physicians debated on recurrence vs. new primary. abstracted new primary per Solid tumor rule M6. Is this correct? Also, no other area involved with cancer. Isolated cervical LN positive.	I don't think M6 would apply since the new disease is occurring in a lymph node. I would go with the physician statement on this one.
2.	Often, I have path reports stating patchy P16, does not state POS or NEG.	Per the post below, "patchy" would be considered negative. https://cancerbulletin.facs.org/forums/node/141909#post142693 https://cancerbulletin.facs.org/forums/node/154974
3.	LN Size: our pathologists for LND give largest mets deposit w/in the ln. Would this be considered applicable for this data item?	I found a post that says it is ok to use the size of the largest deposit to code LN Size. https://cancerbulletin.facs.org/forums/node/85097 Per the CAP Protocol: "Measurement of the metastatic focus in the lymph nodes is based on the largest metastatic deposit size, which may include matted or fused lymph nodes.+ This indicates that for pathological, you want to record the actual metastatic deposit.
4.	LN size when using clinical size is there a "pecking" order - physical exam vs imaging? Thanks.	There are several posts on the forum stating imaging takes priority over a physical exam. Below is the most recent. https://cancerbulletin.facs.org/forums/node/156835

5.	Just confirming, "posterior wall of nasopharynx" - C11.1 should use Table 2 and not Table 5? Schema Disc 1 will be '1' and Scheme Disc 2 should be 9 or should it be BLANK if p16 status is unknown?	Yes, Posterior Wall of Nasopharynx you would use Table 2 but only when told to in the rules, Scheme Disc 2 should be black.
6.	For primary site priority order, just looking for clarification, what category does the surgeons statement of what he/she found during a procedure fall into? Surgeon states tumor arising from___.	According to SEER, the surgeon statement takes precedence over the pathology report. Tissue/pathology from tumor resection or biopsy A. Operative report B. Addendum and/or comments on tissue/pathology report C. Final diagnosis on issue/pathology report D. CAP protocol/summary
7.	What would site(s)/histology(ies) be for the following: Hx of right maxillary SCC (seq 01) in 2019 S/P RT hemi maxillectomy w/ipsilateral neck dissection. Pt then had multiple BXs consistent w/oral leukoplakia. Now with two BXs as follows: Direct laryngoscopy, right posterior cheek incisional punch BX, Omniguide CO2 laser was next used for palliative ablation of the verrucous lesion. OP FINDINGS: Proliferative verrucous leukoplakia extending from right mandibular alveolus to right floor of tongue to right ventrolateral tongue and right posterior cheek. No lesion notable on posterior pharynx, epiglottis, or vocal cords. PATH: Labelled "cheek/oral lesion", right; biopsy: verrucous squamous proliferation suspicious for verrucous carcinoma. 4/18/24 Left Mandible alveolus, incisional punch BX to depth of mandible at most severe site of mass. PATH: well diff invasive squamous cell carcinoma, keratinizing type. P16-. Also of note, patient refused any formal treatment and agreed only to palliative laser treatment as above until 8/2024	I'm leaning towards C06.1. There is a statement that the tumor extends *from* the right mandibular alveolus to right floor of tongue to right ventrolateral tongue and right posterior cheek. Note: The registrar that submitted the question said she went with I was thinking C06.8, 8071/3
8.	For STR rule M6 (5-year timing rule), do you use the date patient became disease free or the date or diagnosis to calculate 5 years?	Use the date of diagnosis
9.	When cisplatin is referred to as radiosensitizing or as a chemosensitizer (given in low dosage with xrt) STORE says we don't code as chemotherapy, the issue is the notes don't always use the	The statement you are referring to has been removed from STORE 2025 (see the STORE 2025 Summary of Changes). I assume that means for cases diagnosed 2025 and later, you

	term radiosensitizing or chemosensitizer, but sometimes the notes do - so the data is fragmented depending on case by case if the sensitizing term(s) were used. I don't like having some cases coded with Cisplatin chemo code and some cases not coded with Cisplatin chemo code, does anyone have any input into this issue? thanks!	no longer have to differentiate between chemotherapy given in a low dose as a chemosensitizer and chemotherapy given at a standard dose that also acts as a chemosensitizer. For cases diagnosed prior to 2025 I would code chemotherapy unless there is a specific statement from the physician indicating the chemotherapy is being given at a low enough dose that it is only being used as a chemosensitizer.
10.	Can you address the use of Bolus/No Bolus? Does this affect our coding?	Bolus is tissue equivalent material that is used to bring the absorbed dose closer to the surface. Rad onc may want to ensure that more superficial LNs are adequately irradiated. The use of bolus does not alter our coding in any way. The same plan is used on treatments with bolus or without bolus.
11.	I have seen a few of our radiation oncologists noting in their treatment summary the total dose to 4006.3, it was a planned 4005 cgy. Do we code these to 4006? If it was 4006.7, do we round up? This is not something I have come across until more recently.	As per STORE manual instructions on page 257, round to the nearest cGy.
12.	Maybe radiosensitizing instructions is changing? I noticed Per STORE 2025 Summary of changes for chemotherapy: "Removed: 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."	It looks like you are correct. If the instruction is no longer in the STORE manual, then for cases diagnosed 2025 and later we would not differentiate between low dose and standard dose chemotherapies that make the tumor more sensitive to chemotherapy.
13.	SEER 2025 is still the same though: "When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. See SEER*Rx. Do not code as chemotherapy. Review the radiation-oncology progress notes for information about radiosensitizing chemotherapy. Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizer."	We have notified SEER that there is a discrepancy. Hopefully, we can get this resolved before the start of 2025.

14.	Why does HPV Molecular Testing not qualify to determine the schema?	The AJCC physician determined that is the only test that should be used to distinguish chapter 10 from chapter 11 cases. The rule is based on their criteria.
15.	Our facility runs IHC only on HPV 16. How do we code this?	I would send that question to AJCC. The current rules state you should code schema discriminator 2 to 9. This would require you to stage the case using Chapter 11. I would ask if it is better to leave the stage information blank if the physician is assigning stage based on chapter 10, to record the physician stage, or to restage the case based on chapter 11.
16.	We see a lot of "HPV positive by ISH" without any more detail. For 2024 cases, if there is NOT a p16 test, then I assume we should assign SEER SSF1 to code 71 and for 2023 and earlier cases we would assign code 8?	We have sent this question to Ask a SEER Registrar. Issue number is 41764
17.	A patient has surgery with removal of a regional sentinel lymph node. The path report gross describes a 1.6 cm lymph node and the final diagnosis indicates the node is positive but does not give a size. Can you use the gross description to code the lymph node size SSDI?	Yes
18.	For priority order for determining the primary site, if there is more than one tumor board available, and the primary site is not the same on them, is it reasonable to use the most recent one to assign primary site, assuming that is the documentation where they had the most information (i.e. after surgery vs before surgery)?	I haven't seen any specific rules concerning this situation. Personally, I would use my professional judgement. If the physicians have more information at the second tumor board, I would go with that one.
19.	This question is not related to Solid Tumor Rules. So probably another Jim question. But in Case Scenario 2 in Angela's presentation, how would you code SEER SSF1? We don't know if this was DNA testing by ISH (code 21) vs RNA test by ISH (code 41).	Because a specific test was not documented, we think it would be coded to 71. We've sent the question to SEER for clarification.
20.	Should we be coding the fractions where a bolus is used as a separate phase even if the energy and the technique are the same?	See question #10. Disregard use of bolus when coding RT treatments.

21.	Do patient risk factors (GERD, smoking, alcohol consumption) affect whether XRT or surgery is chosen as the treatment option?	Not at all. But patients are encouraged to quit smoking/drinking as these factors can affect the effectiveness of the treatment.
22.	Please clarify how you would code the total dose for the radiation when the patient receives more than one boost. We see confusion and people adding all radiation phase doses together.	I will need additional information to be able to provide a useful response.
23.	SIB they add all the doses together and code 25000cGY?	That is incorrect. When SIB is used, code the highest delivered (PTV) dose as the total dose. See example #13 in the STORE manual.
24.	'@Wilson, you mentioned the need to protect the patient's eyes from the radiation during treatment. What about requiring a vision assessment from an Ophthalmologist to get a baseline on their vision and optic nerve prior to the start of treatment? Thank you for all of your wonderful trainings.	While we must consider the dose tolerance of all organs at risk, the eye is rarely within the tumor volume when treating a H&N cancer. The concern for exceeding the tolerance to the eye is present when treating for retinoblastoma.
25.	Since we did not go through the case scenarios, I am wondering if we can get the answers. Also, in the Q&A document can you answer how "conglomeration" of LNs on case #3 in the imaging is interpreted. Is conglomeration a synonym for "matted" LNs? Or do we just ignore that.	We will send out the case scenarios with answers. I will be sure to cover those two topics!