Q: I have seen glossotonsillar sulcus as a site. Would that be coded to C14.0?

A: That is a good question. I would code it as oropharynx nos (C10.9). It is located just below the palatine tonsil between tonsil and the tongue. I sent this question to SEER for Clarification.

Q: Please clarify the .8 overlapping site codes. These must be overlapping contiguous sites, right? If multiple subsites are involved but they are not contiguous, NOS code .9 is correct, right?

A: You are correct. Multiple subsites must be involved.

Q: Occasionally we see cancer arising in ectopic thyroid tissue found in the oropharynx. Should the primary site be thyroid C73.9?

A: That is a great question. We have sent it to SEER for Clarification

Q: Maybe it's rare, but when would code 999 be appropriate for SSF3-6 lymph nodes?

A: If CS Lymph Nodes is coded as 999 (unknown), then SSF3-6 would be coded as 999.

Q: If you have a measurement of a "nodal mass" in a path report versus an individual lymph node measurement, which would take priority in SSF1? It seems coding the larger size of the nodal mass would capture the highest extent of disease.

A: Code the largest size of the individual lymph node.

Q: This question has to do with the Pop Quiz on page 19. The Answer 150 is based on a CAnswer Forum question and answer and will be added to revised schema. This revision will not be available until when? Using manual would be code 310. What is expected in interim?

A: The general instructions for coding CS Extension state that a code for T_ with no other information on extension only be used when the only information about the extension of the primary tumor is the T category. In the pop quiz question, there is specific information indicating that the primary tumor is confined to one subsite, the tonsil, even though it is not listed in the code description. The CTAP team recommended to the mapping team that tonsil be added to the description; however, I don’t know if or when that will happen. In the meantime, if the primary is the tonsil and the malignant tumor is confined to the tonsil, assign code 150.

Q: For Case 2, can we use the HPV that was used on the tonsil tissue?
A: For case 2 the patient has two primaries. One primary was of the tonsil and another of the true vocal cord. The tonsil was biopsied and an HPV test was done that was negative (000). There is no indication that tissue from the larynx was tested for HPV. Code 998 (not done) or 999 (unknown) would be appropriate for SSF 10 for the laryngeal primary.

Q: Wouldn't the statement of "matted" nodes in path report indicate macroscopic extranodal extension?

A: There is a statement of matted nodes on the path report, but it does not indicate if the matting was identified macroscopically or microscopically. We chose code 040 (Regional lymph node(s) involved pathologically, extracapsular extension pathologically, unknown if microscopic or macroscopic) for that reason instead of code 030 (Regional lymph node(s) involved pathologically MACROSCOPIC extracapsular extension pathologically).

Q: For Case 2, 1st primary, would SSF4 be 101 for the retropharyngeal nodes on CT (assumed not resected)?

A: Hmm. I am not comfortable with that because the CT scan generically says probably malignancy but that terminology is not associated with the specific nodes. Then the retropharyngeal nodes are not resected. I am most comfortable not coding it. However, you make a good point.

Q: How do the terms comprehensive and selective neck dissections translate into radical or modified radical neck dissection?

A: Please see the sites below for comparison comprehensive and radical neck dissections.
http://emedicine.medscape.com/article/849834-overview

Q: Define berry picking.

A: Berry picking is when the surgeon only removes specific lymph nodes. During a neck dissection (selective or comprehensive) the surgeon also removes nodal tissue as well as some of the surrounding soft tissue in the anatomically defined compartments.

Q: How should involvement of a positive hypoglossal lymph node be coded?

A: I would assume a hypoglossal lymph node is located somewhere along the hypoglossal nerve (the 12th cranial nerve that leads to the tongue). Without further information I think you would have to treat this
as a regional lymph node, NOS, for a pharyngeal primary. This lymph node would not be reflected in SSF’s 3-6.

Q: Please address using C76.0 vs. C14.8 (or even C80.9) for unknown ENT primaries. If you have a tumor that overlaps oral cavity, pharynx or larynx, it doesn’t really fit into a correct AJCC chapter 3, 4, 5 or CS staging.

A: There is a note in the ICD-O-3 manual on page 48 under code C14.8 stating that “neoplasms of the lip, oral cavity and pharynx whose point of origin cannot be assigned to any one of the categories C00 to C14.2.” All of the standard setters agree on this. See http://seer.cancer.gov/registrars/data-collection.html. I’ve sent this question to SEER for clarification. Specifically I asked them what to do if you have a single primary involving both the laryngeal aspect of the aryepiglottic fold (C32.1) and the pharyngeal aspect of the aryepiglottic fold (C13.1).

Q: When a physician stages as N3, but all we have for size is a description of a "LN MASS" 7cm (probably multiple nodes)...is it still logical/legitimate to code 7cm as the LN size so that we can derive N3 (per MD stage)?

Often our physicians’ stage the nodes based on PE (for instance, if the CT said the largest tumor is 1.8cm) but they palpate a 4cm node, they would stage using the PE. We always try to derive what they stage...so wouldn’t it be ok to use PE if MD uses it?

A: This question has been sent for clarification.

Q: Quiz Q5...if the patient had had neoadjuvant treatment would we code 993 for CS Tumor Size (to capture the pre-treatment size)?

A: Yes.

Q: In case scenario 2, tonsil primary, for SSF 1 what about using 045 from specimen M on the path report? See AJCC 7th Ed. page 25 and CS Manual, Part I, Section 1, page 46, 4d.

A: 4.5 cm is the measurement of the matted mass that included multiple nodes, not the measurement of the largest node.

Q: "Possibly" is considered diagnostic for lymph nodes? On Case 1 you included level 3.

A: I would not include level III based only on possible level III from physical exam, but treatment summary documents that level III nodes were involved prior to treatment.

Q: In Case Scenario 2, tonsil primary, for SSF 9 what about using 030? Specimen M sates the nodes form a matted mass. Matting is a gross/macroscopic description.
A: Yes, matted is a gross description but the statement of extranodal tumor invasion is separate from
the statement of matting and without more information I don't know that the statement of extranodal
tumor invasion is from macroscopic information.

Q: In Case Scenario 2, glottic primary, the HPV test was not from the glottic primary. Would 999 be a
better code to use?

A: 998 or 999 would be appropriate codes.