Pharynx

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.
Fabulous Prizes

Guest Speaker
Wilson Apollo, Radiation Therapist and CTR
Agenda

Anatomy
Occult Tumors of Head and Neck
Solid Tumor Rules

Staging
- AJCC
- Summary Stage
- EOD
- SSDI

Radiation

Anatomy of the Pharynx

- Nasopharynx
- Oral cavity
- Hyoid bone
- Larynx
- Esophagus
- Trachea
- Nasal cavity

Pharynx

Oropharynx

Hypopharynx
Anatomy

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

HPV Testing

- P16 Overexpression
- Viral DNA by ISH test
- Viral DNA by PCR test
- ISH E6/E7 RNA test
- RT-PCR E6/E7 RNA test

Occult Tumors of Head and Neck
2018 Case Scenario

Patient presents with an enlarged cervical lymph node.
- The lymph node is excised and is positive for squamous cell carcinoma.
  - Metastatic deposit measured 7mm.
  - No extranodal extension
  - The tumor is **p16 negative** and **EBV negative**.

The managing physician performs an extensive exam and is **unable to find a primary tumor** or any additional metastasis.

Per the physicians notes the patient had an occult tumor of the head and neck.

The patient went on to have a lymph node dissection.
- 24 lymph nodes removed.
- No metastasis identified.

Determining Primary Site

Does the physician think the cancer arose in a head and neck site?
- If the physician gives multiple potential primary sites, then code primary site to C80.9.
- If the physician only gives head and neck sites as possible primary sites, then determine if the tumor is p16 or EBV positive.
**p16 and EBV Status**

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<th>Positive</th>
<th>Negative</th>
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<td>C10.9 Oropharynx</td>
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If primary site is assigned **C10.9 Oropharynx**

**Schema Discriminator 2**
- If p16 positive
  - AJCC Chapter 10: HPV-Mediated (p16+) Oropharyngeal Cancer
  - EOD and Summary Stage: Oropharynx HPV-Mediated (p16+)
- If p16 negative
  - AJCC Chapter 11: Oropharynx (p16-) and Hypopharynx
  - EOD Summary Stage: Oropharynx (p16-)
If primary site is assigned C11.9 Nasopharynx

AJCC chapter 9: Nasopharynx

C76.0 Ill-Defined Site of the Head and Neck

Schema Discriminator 1:
- 2-5
  - AJCC Chapter 6: Cervical Lymph Nodes and Unknown Primary Tumors of the Head and Neck
  - EOD and Summary Stage: Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck

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<tr>
<td>3</td>
<td>Unknown EBV, p16 negative in head and neck regional nodes</td>
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<td>4</td>
<td>Unknown EBV, p16 negative in head and neck regional nodes</td>
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<td>5</td>
<td>Negative for both EBV and p16 in head and neck regional nodes</td>
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</table>

If C76.0 discriminator does not apply:
- Positive p16 in head and neck regional nodes, EBV unknown or negative: Assign primary site C119
- Positive EBV in head and neck regional nodes, p16 positive, negative, or unknown: Assign primary site C119
2018 Case Scenario

Patient present with an enlarged cervical lymph node.
- The lymph node is excised and is positive for squamous cell carcinoma.
  - Metastatic deposit measured 7mm.
  - No extranodal extension
  - The tumor is p16 negative and EBV negative.

The managing physician performs an extensive exam and is unable to find a primary tumor or any additional metastasis.

Per the physicians notes the patient had an occult tumor of the head and neck.

The patient went on to have a lymph node dissection.
- 24 lymph nodes removed.
- No metastasis identified.

Staging Summary

- Primary site: C76.0
- p16 and EBV negative
- Occult tumor
- Positive cervical lymph node
- No additional metastasis
- Lymph node dissection
  - 00/24

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Staging Summary

- Primary site: C76.0
  - p16 and EBV negative
- Occult tumor
- Positive cervical lymph node
- No additional metastasis
- Lymph node dissection
  - 00/24

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Solid Tumor Rules

HEAD AND NECK
H1 Note 2

When the histology is not listed in Tables 2-10, use the ICD-O and all updates

1. 2018 ICD O 3 Coding Table
   https://www.naaccr.org/implementation-guidelines/#ICDO3

2. ICD O 3 Manual
New Histologies Coding Clarification

Squamous cell carcinoma HPV-negative 8086
Squamous cell carcinoma HPV-positive 8085
  ◦ Do not use a p16 test to code 8085 or 8086.
  ◦ HPV testing must be positive by viral detection tests in order to code histology as 8085.

Per the 2018 SEER Manual
  ◦ HPV-type 16 refers to virus type and is different from p16 overexpression (p16+).
  ◦ HPV status is determined by tests designed to detect viral DNA or RNA. Tests based on ISH, PCR, RT-PCR technologies detect the viral DNA or RNA; whereas, the test for p16 expression, a surrogate marker for HPV, is IHC.

Pop Quiz

What histology would be coded to the following:
  ◦ 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 report shows HPV positive for viral DNA by ISH test
    ◦ 8085 Squamous cell carcinoma, HPV positive
### Case Scenarios

#### SCENARIO 1

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<td>Histology Rule</td>
<td>H1-Single histology</td>
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#### SCENARIO 2

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<td>Pathological Grade</td>
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<td>Post Therapy Grade</td>
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### Staging

- **AJCC**
- **SUMMARY STAGE**
- **EOD**
- **SSDI**
AJCC

AJCC Chapters-Pharynx

Chapter 9- **Nasopharynx**

Chapter 10 HPV-Mediated (p16+) **oropharyngeal** chapter

Chapter 11 **Oropharynx** (p16-) and **hypopharynx**
Chapter 9 - Nasopharynx

Primarily treated with radiotherapy +/- chemotherapy without resection of primary.
- Pathological classification is largely irrelevant (AJCC Manual pg. 106).

T0 used only when patient is EBV positive.
Stage 4B is only assigned when patient has distant metastasis.

Chapter 10 – HPV mediated (p16+)
Oropharyngeal

New chapter
- Patients who are high risk HPV positive (p16+) oropharyngeal 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.
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.

Summary Stage & EOD
Summary Stage EOD

SUMMARY STAGE 2018

• Cervical Lymph Nodes And Unknown Primary Tumors Of Head And Neck
• Nasopharynx
• Oropharynx
• Hypopharynx

EOD

Cervical Lymph Nodes And Unknown Primary Hypopharynx
Oropharynx (p16-)
Oropharynx HPV-Mediated (p16+)
Nasopharynx

Schema Discriminator 1

C11.1

° Posterior wall of the nasopharynx
° SS2018 Nasopharynx
° Adenoid
° SS2018 Nasopharynx
° Pharyngeal tonsil
° SS2018 Oropharynx

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<td>2</td>
<td>Adenoid</td>
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<tr>
<td></td>
<td>Pharyngeal tonsil</td>
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<td>Primary Site is NOT C111, Discriminator is not necessary</td>
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</table>
Check the manual!

A tumor arising in the pyriform sinus and extending into postcricoid area.

Localised or Regional?

SSDI’s

Extranodal Extension H&N Clin
Extranodal Extension H&N Path
Lymph Nodes Size of Mets

SEER_SSF1: SEER Site-Specific Fact 1:

Human Papilloma Virus (HPV) Status
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.

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.
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 1.5 cm (15 mm) Level II lymph node, pathological examination shows Level II 1.3 cm (13 mm) metastatic deposit. Code 13.0.

◦ If the largest involved node is not examined pathologically, use the clinical node size

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.
Case Scenario 1-Staging Summary

Primary Tumor
- Tumor Size
  - Pre-treatment
    - 3cm
  - Post-surgery
    - No surgery of primary site
- Extension
  - Pre-Treatment
    - Confined to the pyriform sinus
  - Post Surgery
    - No surgery to primary site

Lymph Nodes
- Pre-treatment
  - Palpable, moveable level III lymphadenopathy.
  - Largest measured 2cm per CT
  - FNA of lymph node positive for CA
- Post Surgery
  - No lymph node dissection

Distant metastasis
- No indication of distant metastasis

Tumor Size

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<td>Tumor Size Pathological</td>
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<td>Tumor Size Summary</td>
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AJCC Staging

Which AJCC chapter do we use?
- Primary Site: C12.9
- Histology: 8070/3
- HPV Status: Negative

Chapter 11

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Summary Stage/EOD

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<td>EOD Mets</td>
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</table>

CLINICAL or PATHOLOGICAL
Metastasis in MULTIPLE ipsilateral nodes
No nodes larger than 6 cm in greatest dimension
Extranodal extension (ENE) negative or unknown
SSDI’s

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</table>

Scenario 1

Case Scenario 2-Staging Summary

**Primary Tumor**
- Tumor Size
  - Pre-treatment: 2.4cm
  - Post-surgery: 2.6cm
- Extension
  - Pre-Treatment:
    - Laryngoscopy-lesion arising in lateral wall of oropharynx extending to posterior tonsillar pillar.
  - Post Surgery:
    - Tumor of the right lateral wall of oropharynx extends into tonsillar pillar. No further extension

**Lymph Nodes**
- Pre-treatment
  - CT shows 2 retropharyngeal lymph nodes- most likely represent mets. Largest is 2.4cm. No indication of ENE.
- Post Surgery
  - 02/14 positive lymph nodes.
  - Largest metastatic focus 2.1cm
  - ENE present 0.3mm

**Distant metastasis**
- No indication of distant metastasis
Tumor Size

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Scenario 2

AJCC Staging

Which AJCC chapter do we use?
- Primary Site: C10.2
- Histology: 8070/3
- HPV Status: p16 Positive

Chapter 10

What would the stage be if the patient was p16 negative (see page 130)
**Summary Stage/EOD**

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<td>EOD Mets</td>
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500-Pathological evaluation only
Regional lymph node(s) involved

**SSDI’s**

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Questions?

The Role of Radiation Therapy in the Management of Pharyngeal Cancer

WILSON APOLLO, MS, CTR, RTT
Questions?

Fabulous Prize Winners
Coming UP…

Collecting Cancer Data: Breast
• 12/06/2018

Collecting Cancer Data: Testis
• 01/10/2019

CE Certificate Quiz/Survey

Phrase

Link
https://www.surveygizmo.com/s3/4656348/Pharynx-2018