Abstracting Head & Neck: A CTR’s Perspective

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There are more than 70 primary sites in the head and neck!
- Primary sites often overlap, involving more than one site and the origin is often unknown
- Many sites are often called by different names
- Many times cancer often present in just lymph nodes of the head & neck without a known primary (assumed H&N Primary)
- Physicians may not provide a primary site, Registrars must rely on information available

Priority Order for Identifying Primary Site When There is Conflicting Information:
1. Tumor Board
2. Tissue/Pathology
3. Scans
4. Physicians Documentation
5. Use Table 1-9: single overlapping lesion
6. Overlapping Site Codes
7. NOS
c

Squamous Cell Carcinoma of H&N: HPV Positive vs HPV Negative
Diagnosed 1/1/2022 forward: p16 test results can be used to code HPV pos vs. neg!
- SCC HPV Pos (8085)
- SCC HPV Neg (8066)
If diagnosed pre-2022: Only use HPV status from ISH, PCR, RT-PCR tests (Detecting viral DNA and RNA HPV status)

Solid Tumor Rules: Head & Neck Table Index
Use to assist in assigning primary site when a single lesion overlaps two or more sites and no site of origin is confirmed
1. Find the two sites on the table index & identify which tables to review and have your histology code available!
2. Look for the histology code on each table: Histology on one primary site table and not on the other primary site table use the primary site containing the histology code!

Case Example: Conflicting Primary Site Information
A patient with an oral mass, biopsy reveals histology of invasive SCC HPV-negative, code 8086/3.
Physician #1: Impression of the primary site based on the imaging & exam is anterior two third of the tongue (C023) which is considered part of the oral cavity. Physician #2: Believes that the tumor is originating in the base of the tongue (C019) which is considered part of the oropharynx.
1. Use Table Index (Tables 1-9) when conflicting primary site
2. Table 4 includes the C023 site; Table 5 includes the C019 site
3. Table 4 histology list does not include 8086, Table 5 histology codes DOES include 8086
Per the solid tumor rules, code primary site to C019 base of tongue

Assigning Primary Site

No evidence of primary tumor in the Head & Neck?
- Level I-V lymph nodes positive for metastatic disease and its stated to be from Head & Neck origin, but no tumor is identified in the Head & Neck
- Imaging/scans, scopes, and other diagnostic procedures do not reveal a primary
- C760-Unknown Head & Neck primary: i.e., Right cervical level II lymph node biopsy confirmed metastatic squamous cell carcinoma. Pathologist states from head and neck origin. The patient does not return for any further diagnostic or staging workup and wished to start treatment. The Primary Oncologist does feel this is a Head & Neck primary
- If HPV Positive and no primary identified: Assign C109 Oropharynx NOS
- If EBV-Related and no primary identified: Assign C139 EBV-related
- If HPV or EBV Negative and no primary identified: Assign C760

AJCC Staging Criteria

Cervical Lymph Nodes with Unknown H&N Primary, Chapter 6
- Do not use this chapter if HPV-mediated (p16+)
- T category: Always T0! If you have anything else you are in the wrong chapter
- N category: Clinical vs. Pathologic N categories matter
- Check your AJCC manual for appropriate staging tables
- ENE (+) stage begins at N3
- Schema Discriminator (C76.0)
- Used to discriminate between head and neck tumors with unknown primary coded to C76
- Occult vs. Not Occult
- EBV or P16 positive/negative results (codes 2005-2006)
- Leave BLANK if not C760 primary

Solid Tumor Measurements
- Measured at diagnosis
- Per AJCC: Examples of gross ENE would be invasion of skin, infiltration of musculature or dense tethering to adjacent structures, OR cranial nerve, brachial plexus, or phrenic nerve invasion with dysfunction

The Truth Behind Coding “Extranodal Extension”

Clinical Staging: Clinical vs. Pathologic N categories are different!
- Definition: Extension of nodal mets through LN capsule into adjacent tissue
- There must be definitive presence of extranodal extension by physical exam that is supported by radiology.
- Radiology alone is insufficient to diagnose ENE
- Per AJCC: Examples of gross ENE would be invasion of skin, infiltration of musculature or dense tethering to adjacent structures, OR cranial nerve, brachial plexus, or phrenic nerve invasion with dysfunction

Pathologic Staging:
- Must be definitive extension of metastatic tumor microscopically
- Positive ENE=N3
- ENE positive increased the pN category by one FULL category

Example: Tonsillotomy and left neck dissection. The pathology describes a 4.8 cm lesion on left tonsilar pillar, squamous cell carcinoma, poorly differentiated, p16 (-). Lymph nodes 0/5 level 2A, 0/8 level 2B and 25/3 level 3. The largest lymph node mets is 4.5 cm with ENE 2 mm. There is no evidence of distant mets. pT3: Tumor is >4 cm
- pN3b: Mets to multiple ipsilateral nodes with any ENE(+)
- pM0: no clinical distant metastasis
- Pathological Stage Group IVB: Any T, N3 and M0

AJCC Staging Criteria

Understanding “Depth of Invasion” or “DOI”
- Cervical Cancer, Chapter 7 ONLY
- 2018+ diagnosis years and forward
- Measures the level of invasiveness of the cancer (regardless of the exophytic component)
- For every 5 mm of invasion, T category increases
- CTR’s do not determine DOI! Record only what is stated as “depth of invasion” on the chart report
- Uncertainty Rule Applies: If any doubt of depth of invasion, the clinician would assign the lower DOI category, not the CTR
- T category relies on both DOI and tumor size. Must both be used to assign T value

The Oral Cancer Chapter of AJCC 8th Edition for full details

Head & neck cases are difficult sites to abstract due to a combination of 3 elements; the lack of practice related to abstracting H&N cases and put this knowledge into action with a newfound confidence and understanding.

The purpose of this presentation is to simplify the most challenging elements of abstracting H&N cases and put this knowledge into action with a newfound confidence and understanding.