

**Canadian Provincial & Territorial Cancer Registries**

**TNM Training**

**2018-19**

**Questions and Answers**

*Using AJCC TNM 8th edition*

*Version 8*

***General Guidelines***

1. Is there any resource for asking questions in Canada in order to follow CCR staging guidelines?

**Answer:** At this time, any AJCC TNM 8th edition questions should be submitted to CAnswer Forum and it is recommended, if possible, that the questions and responses be shared within your PTCR to continue the education process on TNM staging. In addition, other educational opportunities could be accessed including the NAACCR Cancer Registry and Surveillance webinars, SEER educate, and NCRA sessions.

1. Can you provide examples of when it is okay to leave T, N and/or M blank?

**Answer**:

* The most common situation when all 3 categories of T, N, **and** M are left blank is when the criteria for classification is not met.
	+ An example that doesn’t meet the criteria for Clinical classification is when an incidental prostate primary is found upon cystoprostatectomy for a bladder primary, the clinical T, N, and M categories are left blank and the clinical stage group is assigned “99” for unknown.
	+ An example that doesn’t meet the criteria for Pathological classification is many lung cases that are only diagnosed clinically and there is no surgery of the primary site, no biopsy of the highest T and highest N, or no microscopic proof of distant metastasis. For these clinical lung cases, the pathological T, N, and M are left blank and the pathological stage group is assigned “99” for unknown.
* One or more of T, N, or M are left blank when the criteria for classification are met but the information for the category is not known to the registrar:
	+ A more common example of this is if a prostate primary is diagnosed and workup, including CT and bone scan, are negative BUT the registrar does not have any information regarding the digital rectal examination (DRE). The clinical T would be left blank, N0, M0 for clinical stage group “99” (unknown) unless the grade group is 5 which would then allow clinical stage group to be assigned 3C.
1. If mets are proven microscopically during diagnostic workup, how is the clinical M category assigned?

**Answer:** Remember that for the clinical categories, the T and N can ONLY be cT\_ and cN; however, the M can be a cM0, cM1 or a pM1 (pM0 does not exist). If a potential metastatic site is proven positive microscopically, it is assigned a pM1 even if also confirmed clinically on physical exam and/or imaging as it is more important to know that the metastatic site was confirmed microscopically during the clinical work-up.

1. If mets are documented during the diagnostic workup (cM1) but, at the time of first course primary tumour resection, the mets are biopsied/resected and found negative, what is the pathological M category?

**Answer**: The pathological M category would then be assigned cM0 (remember, pM0 does not exist). For this situation, the microscopic exam of the “suspected” metastatic site has disproven that it is truly metastatic. However, this does not change the clinical M category which would remain as cM1.

1. Can we code suspicious lymphovascular invasion (LVI) as positive?

**Answer:** No, the guidelines have not changed and suspicious lymphovascular invasion (without any further determination of negativity/positivity) is coded to 9 (unknown).

1. Could you clarify the use of autopsy information in staging when treatment is given and not given?

**Answer:**

* An incidental finding of malignancy on autopsy is not captured in any of clinical, pathological or post therapy TNM fields. This is a separate classification of autopsy TNM (aTNM) and there is currently no way to capture this information. Leave the clinical, pathological and post therapy T, N, and M fields blank and assign “99” (unknown) in the clinical and pathological stage group fields.
* If a patient is diagnosed and dies before/without any treatment, autopsy findings are included in the clinical stage fields (similar to exploratory surgery findings) provided it’s within 4 months of diagnosis and before any progression.
* If a patient is diagnosed and dies after systemic and/or radiation therapy, autopsy findings are not included.
* If a patient is diagnosed and dies after surgery to the primary site, autopsy findings are included as part of the pathological stage if within the pathological timeframe.

The question on how autopsy findings can be used in staging was asked in preparation for the CPAC TNM 8th Edition Training and can be found with the following link:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/80291-autopsy-for-8th-edition>

1. For a case that meets both clinical and pathological criteria by microscopic proof of a metastatic site, we would assign cT\_ cN\_ pM1 Stage Group 4 in both the clinical and pathological fields. However, if a regional lymph node is also proven positive during the clinical work-up, is this a cN for clinical staging and pN for pathological staging?

**Answer:** No, remember that in order to have a pN there has to be a pT based on a primary tumour resection. This question was also verified in CAnswer Forum:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/83262-pm1-used-for-clinical-and-pathological-stage-iv-and-suffixes>

1. The Post Therapy M category remains the same as assigned during the clinical stage prior to neoadjuvant treatment; however, what was the exception, and could you provide an example?

**Answer:** The exception is when the clinical M category is cM0, but a distant metastasis is discovered upon resection of the primary tumour after neoadjuvant therapy, the Post Therapy M category is assigned as pM1 (not cM0).The example is provided in the following CAnswer Forum link:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/gynecologic-sites-chapters-33-39/82316-periumbilical-mets-found-during-surgery-for-ovarian-cancer>

1. It was stated that if the only information documented is a stage group then we can enter it in the stage group field; however, does this apply to other types of stages such as the Children’s Oncology Group (COG) staging for Wilms tumour?

**Answer:** If the only information to assign staging is a stage group, it must be an applicable AJCC stage in which AJCC staging is defined. For your example of Wilms tumor, AJCC does not define staging for these; therefore, AJCC staging is not applicable and the Clinical and Pathological T, N, M and Stage Group fields are assigned code 88.

1. Both Clinical classification and Pathological classification have a time frame of 4 months from diagnosis (or prior to progression). Does the Post Therapy classification have any timing guideline?

**Answer:** No, there is no set time-frame in terms of “months” for Post Therapy. The AJCC general guidelines for Post Therapy classification states “the time frame should be such that the post neoadjuvant therapy surgery and staging occur within a period that accommodates disease-specific circumstances, as outlined in the specific chapters and in relevant guidelines” (such as National Compressive Cancer Network {NCCN} and American Society of Clinical Oncology {ASCO} guidelines).

1. If a case is initially thought to be a certain primary but then discovered to be a different primary upon surgical resection, is the clinical stage left blank or can it be assigned based on the discovery of the true primary?

**Answer**: Based on the CAnswer Forum link below, clinical stage is re-assigned based on the discovery of the true primary keeping in mind that only documentation prior to the initiation of treatment (the surgery) can be used.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging/head-and-neck-chapters-3-9/77968-clinical-stage?_=1551304832944>

1. If a patient delays surgery such as initially refusing and then changing his/her mind and surgery occurs several months later, can pathological stage still be assigned?

**Answer:** The time frame for pathological stage classification includes the statement “through completion of definitive first course surgery if that surgery occurs later than 4 months after diagnosis and has not progressed.” Therefore, if you are considering the surgery to be first course treatment and the malignancy has not clearly progressed, then pathological stage may be assigned.

1. Can “enlarged” lymph nodes or “lymphadenopathy” be interpreted as involved lymph nodes and used to assign the clinical N category?

**Answer**: Without a stated N category (i.e. N1/N2, etc.) or further description from the clinician as to whether he/she feels the enlarged lymph nodes or lymphadenopathy is due to metastasis within the node(s), then these terms alone should not be interpreted as involvement. If possible, consult the clinician to determine the appropriate N category. If a clinician cannot be consulted, review the record including how the patient was treated and if the patient was treated as those the lymph nodes were involved, assign the N category as being involved.

1. For the N suffix, if an FNA/core biopsy or sentinel node procedure was performed during the clinical time frame we would assign an “(f)” for “(sn)” for the clinical N suffix. However, if a lymph node dissection is performed during resection of the primary tumour, what do we assign for the pN suffix?

**Answer:** The pathological N suffix would be left blank.

1. If an FNA/core biopsy is performed confirming one N category but imaging confirms a higher N category, is the N suffix “(f)” still applied?

**Answer**: Yes, the “(f)” simply indicates regional nodes were assessed during the particular time frame and do not need to prove the highest N. This is confirmed with the following CAnswer Forum link:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/principles-of-ca-staging-and-general-info-chapters-1-4/principles-of-cancer-staging-chapter-1/85689-fna-of-n2-node-n3-node-positive-on-pet-scan-assign-f-suffix>

1. During the N suffix discussion, an example was provided in which the clinical N category and suffix were used in the pathological stage. Could the example be included in the Q & A document?

**Answer**: Absolutely! First, the general guideline is that if a lymph node is assessed microscopically during the clinical time frame, it may also be used for the pathological stage if the primary tumour has been resected and no lymph nodes are assessed.

E*xample*: Ductal carcinoma of the breast in which a sentinel lymph node biopsy was performed indicating only 1 axillary lymph node positive [assigned cN1 in the clinical N category and (sn) in the clinical N suffix field]. A subsequent segmental breast resection is performed without further lymph node surgery. The initial sentinel node procedure can be used to complete the pathological N category as pN1a and the pathological N suffix is assigned (sn). Remember that pathological stage includes all clinical stage information along with the pathological information (operative report and pathological specimen) and you can only assign a pN if there is a pT.

1. During the breast presentation, an example was provided where the clinical N was a higher N category than what was assessed from removing nodes during resection and the higher N was used for the pN. Does this apply to all sites?

Answer: Yes, this guideline applies to all sites. The example provided was a breast case in which the ipsilateral supraclavicular node was involved on imaging/physical exam (cN3c) but upon resection of the breast, only axillary lymph nodes were removed and some were positive. This is assigned **pN3c** for the pathological N category based on microscopic confirmation of at least one regional lymph node AND the pathological classification definition “**all clinical stage information, supplemented/modified by the operative findings and pathological evaluation of the resected specimens**”. A resource confirming this information can be found on the AJCC Education page for Registrars with the following link:

<https://cancerstaging.org/CSE/Registrar/Documents/Lesson%2024.pdf>

1. What if grade is documented using terms not listed in the grade table for that site?

**Answer**: It is recommended to review the entire new Grade Manual for cases diagnosed 2018 and forward. Pages 32-33 include a table of other terms that can be used to assign grade **ONLY** as follows:

* *Only use the table when the appropriate grade table for a cancer uses the generic categories with alphabetic codes A-D, OR for a cancer site which includes codes A-D for when the priority grade system was not used/documented*
* *Do not use the table for a cancer that uses the generic categories but assigns numeric codes*
* *Do not use the table to code any priority AJCC recommended grade system terms.*
1. For a general grade such as a four-grade system with codes 1-4, how would you assign a grade when it is documented as grade 2-3?

**Answer:** Code the highest and assign grade 3.

1. Clinical and Pathologic Tumour Size description reads “This data item records the size of a **solid** primary tumour….”; therefore, are these fields left blank for hematopoietic cases or are they assigned 999?

**Answer:** For hematopoietic primaries, assign tumour size as 999

1. Does immunotherapy prior to surgical resection of the primary meet the criteria for Post Therapy Staging?

**Answer:** Yes, systemic therapies including chemotherapy and immunotherapy or radiation therapy prior to first course surgical resection of the primary meet the criteria for Post Therapy Staging. However, as indicated in the presentation materials, hormone therapy does not qualify as neoadjuvant treatment outside of a clinical trial.

1. Under Post Therapy stage classification, it was stated that not all medication is neoadjuvant treatment, i.e. days/weeks of hormone therapy for prostate cancer; however, does this also apply to the grade data item?

**Answer**: Yes, the Clinical grade data item must be recorded before any treatment including “neoadjuvant” treatment and the Pathological grade data item must be recorded from a primary tumour that has been surgically resected and for which no “neoadjuvant” therapy was administered. For both data items, if the medication is not considered neoadjuvant therapy (such as the example of Lupron for a few days/weeks prior to prostatectomy) then the grade may be assigned. However, if the medication IS considered neoadjuvant therapy (such as hormone therapy that is part of a clinical trial for prostate cancer), then the grade may not be assigned.

***Breast***

1. What if the biomarkers (ER, PR, and HER2) are performed on both biopsy and resection and are different?

**Answer (REVISED in version 7):** In practice, the biomarkers are usually only performed on the biopsy and can be used for both the clinical staging and pathological staging. Also, if the biomarkers are only performed on the primary tumour resection, it has been confirmed that those biomarkers can be used for both the clinical staging and pathological staging. For the scenario in which biomarkers are performed on both the biopsy and on the resection specimens and are found to be different, the CAnswer Forum query below indicates a specific scenario in which the biomarkers performed on the biopsy are used for clinical staging and the biomarkers performed on the resection are used for the pathological staging. However, because cases vary amongst the combinations of ER, PR, and HER2 results, the timing of those results (clinical vs. pathological), and even multiple tumours having different results, there isn’t a simple guideline to follow and it is recommended you submit your specific scenarios to CAnswer Forum.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/breast-chapter-48/breast-chapter-48-aa/82745-her-2-equivocal-on-biopsy-specimen-her-2-positive-on-segmental-mastectomy-specimen>

1. For Tis do you include the (DCIS) and (Paget)?

**Answer:** Yes, if a case is only ductal carcinoma in situ, then it is cTis(DCIS) and/or pTis(DCIS) as applicable for the case. If a case is only Paget disease, then it is cTis(Paget) and/or pTis(Paget) as applicable for the case. If a case is Paget disease with underlying DCIS, the DCIS has priority and assigned cTis(DCIS) and/or pTis(DCIS) as applicable for the case.

1. If the pathology of a biopsy, indicates grade 3 and does not indicate which grading system, can you assume its Nottingham?

**Answer:** If the pathology report includes a description of the features that comprise Nottingham grade including tubule formation, nuclear pleomorphism, and mitosis rate, then code as Nottingham grade 1-3. In addition, if you are able to consult the pathologist or central pathology lab to confirm if the numeric value is a Nottingham grade then code as Nottingham grade.

***Colorectal***

1. For a colorectal primary with distant lymph node mets, would multiple nodes in the same region or chain be assigned M1a (one region/chain = one site/organ) or M1b (multiple nodes = 2 or more sites/organs even if in same region/chain)?

**Answer**: As per the AJCC manual for colorectal chapter 20, multiple mets within only one organ, even if the organ is paired, is still M1a. Therefore, I would consider multiple lymph nodes in the same region/chain to still be assigned M1a but multiple lymph node regions/chains to be assigned M1b.

1. If more than one CEA is performed, the guidelines state to use the highest. However, is there a timing rule of how far back a lab test can still be used for coding this data item?

**Answer**: It is recommended to read all the general rules at the beginning of the SSDI manual which includes a section on recording lab tests. The default is to record a lab test no earlier than approximately 3 months prior to diagnosis. Basically, during the diagnostic workup for the colon primary.

***Prostate***

1. If there is no digital rectal examination (DRE) and only clinical mets, can a prostate case be staged clinically since DRE is needed to meet the criteria of clinical staging?

**Answer:** Yes, provided that a diagnosis of malignancy has been provided. Remember that the DRE is needed for the clinical T category, but that imaging can be used to determine the clinical N and clinical M categories. If a metastatic site was confirmed on imaging but there was no DRE, the clinical T would be left blank (not T0 or TX as the registrar does not have information on the DRE) but the clinical M is assigned cM1 (subcategory as applicable) for clinical stage group 4B.

1. If there is only an elevated PSA and positive needle core biopsy but no DRE information, can we assign cT1c?

**Answer:** No, without the DRE information and just an elevated PSA and positive needle core biopsy, the clinical T, N, and M categories would be left blank and clinical stage group would be assigned “99” (unknown). Remember that the clinical T category is based on the DRE information and, without that information, the clinical T cannot be assigned by the registrar. Since there is no other work-up information such as CT or bone scan, then the clinical N and M would also be blank as the registrar does not have any information to assign those categories.

This was confirmed after the training session on CAnswer Forum:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/male-genital-organs-chapters-57-59/prostate-chapter-58/85679-psa-and-biopsy-but-no-dre-info>

1. If there is no DRE but a referral or consult indicates, for example, cT1c, can we assign this cT1c into the clinical T category?

**Answer**: In general, yes. However, if you can determine that the stated T category is from imaging or biopsy it should not be used, and the clinical T category should be left blank.

1. If a DRE is stated to be “abnormal”, can this be used to assign cT2 (palpable/apparent)?

**Answer**: An “abnormal” DRE alone shouldn’t be assumed to be cT2. Abnormal could also imply enlargement/BPH for example. Terms such as “abnormal” or “hard” need to be used in context with what the clinician states. For example, if the clinician then assigns a T1 or indicates an “incidental finding” after biopsy, these terms are not considered apparent for that case. If the clinician assigns a T2 or further describes the DRE findings as being suspicious/due to a prostate tumour, then he considers it palpable/apparent. However, if it cannot be determined from reading all the documentation whether the term indicates an inapparent or apparent tumour AND consultation with the clinician is not possible, the cT category is left blank as the physician knows what the term means but you, the registrar, do not have the documentation to know what the term means.

1. If there is no DRE information documented but a TURP is being done for urinary retention or BPH, can we assign a cT1a or cT1b or do we need the DRE?

**Answer:** The *official* answer from AJCC is that it would be highly unusual for a clinician to perform a TURP without performing a DRE but, without the DRE, you would leave the clinical T category blank. However, it is my opinion to assign these to cT1a/cT1b (as incidental findings) since the documentation of urinary retention or BPH is all they are finding from performing a DRE – especially since AJCC indicates it would be highly unusual to perform a TURP without performing a DRE.

1. The prostate chapter specifically indicates the clinical T category is assigned based on the DRE findings and imaging is not to be used; however, nothing is documented as to whether or not findings on cystoscopy can be used for clinical T. If cystoscopy finds a prostate tumour that invades the bladder, can a cT4 be assigned?

**Answer**: It has been confirmed with AJCC that cystoscopy findings should *not* be used to assign the clinical T category; again, only DRE findings are used for the clinical T information.

1. It was stated that the clinical T should reflect the DRE findings only; however, the clarification on slide 5 of the CPAC TNM Training prostate presentation, implies that a positive rectal biopsy can be assigned cT4. Please clarify further.

**Answer**: The clarification on slide 5 was to make the point that in order to meet pathological stage criteria, a biopsy of the highest T **and** biopsy of the highest N is required. The AJCC manual is misleading in that it indicates a biopsy of the highest T (such as biopsy of the rectum) can be assigned pT4, which may be true BUT it doesn’t complete the general guideline that confirmation of the highest T and highest N is required to meet pathological criteria. If only a biopsy of the rectum is performed, the DRE information is still required to confirm the clinician could palpate the tumour extending into the rectum. This was followed up after the training session with the following CAnswer Forum link:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/male-genital-organs-chapters-57-59/prostate-chapter-58/77637-pt4-question>

1. For the prostate M category, if there are distant lymph nodes confirmed microscopically and bone mets only confirmed on imaging, would this be assigned pM1c since M1b is only defined as bone mets? Also, is this assigned pM1c based on the note under the prostate M table that reads “When more than one site of metastasis is present, the most advanced category is used. M1c is most advanced.”?

**Answer**: No, this would be assigned pM1b. M1c is only used when there are metastases other than distant lymph nodes and bone. This has been confirmed with the following CAnswer Forum query:

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/male-genital-organs-chapters-57-59/prostate-chapter-58/86022-clinical-staging-with-pm1>

***LUNG***

1. For adenocarcinoma is situ (AIS), does the case need to document the entire description of “adenocarcinoma with pure lepidic pattern” and be ≤ 3 cm in size in order to assign Tis?

**Answer**: Based on the CAnswer Forum link below and Note C of the Lung Cap Protocol, it’s my understanding that if a case is simply described as “adenocarcinoma in situ”, you may assign Tis for the case. The pathologist and/or clinician need to know what is required for a diagnosis of adenocarcinoma in situ.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/thorax-chapters-35-37/lung-chapter-36/81567-clinical-staging-for-ais>

1. Could you include the information discussed regarding occult lung carcinoma and the recommended AJCC pages for separate tumour nodules in the Q & A document?

**Answer:** Absolutely, here is the relevant information:

* Occult carcinoma, assigned TX N0 M0, is defined as a tumour proven by the presence of malignant cells in sputum or bronchial washings but NOT visualized by imaging or bronchoscopy AND without nodal or distant metastatic involvement. Of note, Donna Gress from AJCC has discussed that in order to use TX for the definition “primary tumour cannot be assessed”, there should be nodal (N1-N3) and/or distant metastatic involvement (M1).
* Separate Tumour Nodules: It was recommended to review pages 438-440 of the 3rd printing of AJCC 8th edition including Tables 36.3 through 36.6. These pages describe the 4 types of disease patterns of multiple lung tumours and how each should be assigned stage.

The AJCC Education site for registrars is a helpful resource. The above information is included in the Disease Sites Webinar Materials for Lung with the 7th edition (slides 14-15) and are still applicable for the AJCC 8th edition.

<https://cancerstaging.org/CSE/Registrar/Documents/Disease%20Site%20-%20lung.pdf>

***CERVIX***

1. In the AJCC 8th edition manual for cervix uteri, Figure 52.1 is an illustration of the regional lymph nodes for the cervix and shows inguinal nodes, but inguinal nodes are not in the list of regional nodes after the illustration. Are inguinal nodes regional or distant for cervix uteri?

**Answer**: Inguinal nodes are distant nodes for cervix uteri as confirmed with AJCC.

1. When a diagnosis of either HSIL, CIN3, or carcinoma in situ is confirmed by biopsy, does this meet the criteria to assign clinical stage?

**Answer:** No, AJCC Chapter 52 for cervix is meant for *invasive* primaries; therefore, having a diagnosis of HSIL, CIN3, or carcinoma in situ does not meet the criteria for clinical stage for *invasive* cervical carcinoma. If a patient with HSIL, CIN3, or carcinoma in situ proceeds to an excision that then determines invasive carcinoma, the clinical stage would be T blank, N blank, M blank, stage group 99 and the pathological stage would be assigned with the appropriate information from the excision along with any prior diagnostic work-up.

***CORPUS UTERI***

1. This is not a staging question but for the new ICD-O-3 term “Atypical hyperplasia/Endometrioid intraepithelial neoplasm (8380/2)”, if only atypical hyperplasia is indicated on the pathology report, is this a synonymous term that is reportable?

**Answer:** According to SEER, atypical hyperplasia without the term endometrioid intraepithelial neoplasm is not a reportable condition. This is also not reported to the Canadian Cancer Registry.

***Ovary***

1. With the words “histologically confirmed” in the description for N1, do the lymph nodes have to be microscopically confirmed in order to assign N1, N1a or N1b?

**Answer:** There actually is a CAnswer Forum question (see below) posted regarding this issue and the response is basically “no”. The note regarding “histologically confirmed” is for pN. You may still assign cN based on imaging for clinical stage.It is recommended to cross off “histologically confirmed” as it isn’t any different than most other schemas.

<http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition/female-reproductive-organs-chapters-49-56/ovary-fallopian-tube-and-primary-peritoneal-carcinoma-chapter-55/84393-n1-positive-retroperitoneal-lymph-nodes-only-histologically-confirmed>

***Head & Neck***

1. When a head and neck primary site unknown lymph node case is p16 positive, the guidelines indicate to code this to ICD-O-3 topography C10.9 and stage with p16 positive oropharynx chapter. However, the pathological stage criteria for AJCC chapter 10 (p16 positive oropharynx) requires a primary tumour resection, therefore would these cases ever meet pathological stage criteria?

**Answer:**

For this scenario, you can use the general guideline on page 19 AJCC manual under Pathological Classification which states, “If there is no evidence of a primary tumour or the site of the primary tumour is unknown, staging may be based on the clinical suspicion of the primary tumour with the tumour categorized as T0.“ in order for the scenario to meet pathological stage criteria. The guideline for meeting pathological stage criteria for p16 positive oropharynx requiring a primary tumour resection is truly only when a primary tumour exists.

1. Could the topography guidelines described in the Head & Neck presentation be incorporated into the Head & Neck 2018 Solid Tumor Rules?

**Answer:** An inquiry was submitted to SEER with the following response: “The Head & Neck site tables were developed at the request of registrars to ASSIST with determining primary site particularly for overlapping tumors and to help determine multiple primaries. It is not required or mandatory that registrars use these tables. Additional tables list the most common histology types that occur in a particular site group which may help with determining primary site. We will not add either TNM or SSDI information into the solid tumor rules as neither AJCC nor SSDI determine histology type or number of primaries.”