Dec 2025

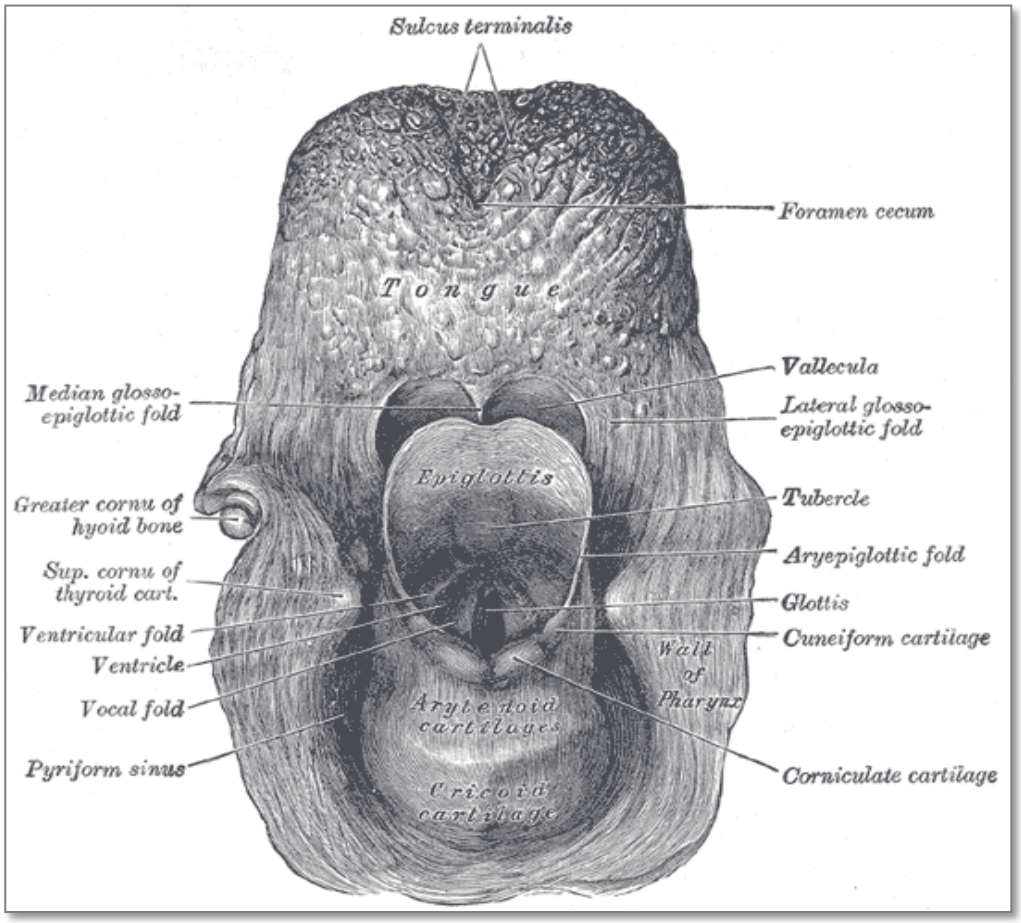
Missouri Cancer Registry and Research Center

Show-Me-Tips

Coding...Abstracting...Education...

Ed 25:04
Base of Tongue

Base of Tongue - Oropharynx



https://commons.wikimedia.org/wiki/File:Gray955.png

Base of Tongue

The base of the tongue refers to the **posterior one-third** of the tongue and is also called the **root**.

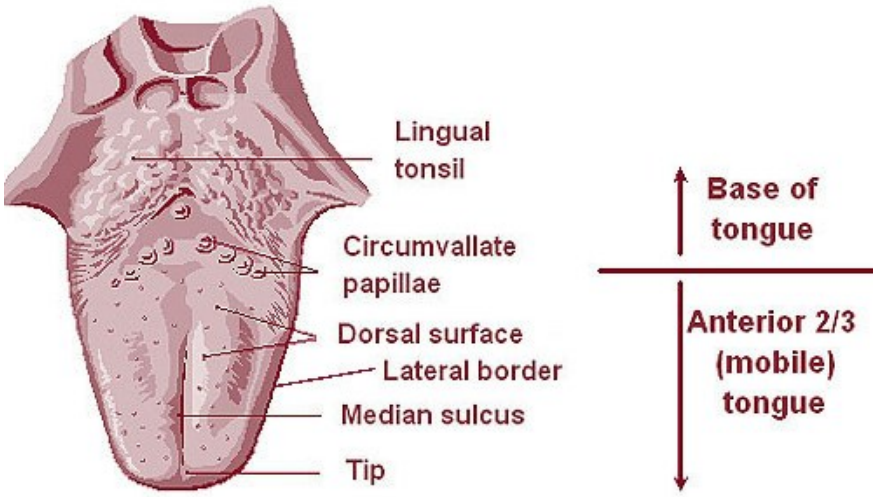
The base of the tongue is not visible when the mouth is open, and forms the anterior wall of the oropharynx. This section of the tongue is fixed by the firm attachment to the hyoid bone.

Embedded within the mucosal lining are the Lingual tonsils. (the bumps at the back of your tongue) They defend against pathogens entering the body.

Another feature is the Vallecula. The Vallecula is the valley between the lateral and medial glosso-epiglottic folds. It's a pouch-like depression that directs saliva during swallowing.

The lateral and medial glosso-epiglottic folds connect the base of the tongue to the epiglottis.

Base of tongue cancer diagnosis are likely to present with some regional node metastasis.



https://commons.wikimedia.org/wiki/File:Illu04_tongue.jpg

This project was supported in part by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Missouri Department of Health and Senior Services (DHSS) (NU58DP007130-04) and a Surveillance Contract between DHSS and the University of Missouri.

https://seer.cancer.gov/tools/solidtumor/

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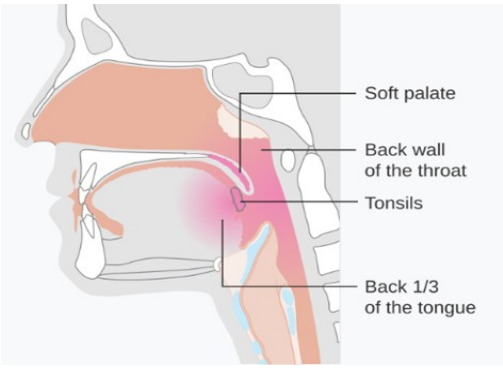
Oropharynx Subsites:

C01.9 Base of Tongue
C02.4 Lingual Tonsil
C05.1 Soft Palate
C05.2 Uvula
C09.0 Tonsillar Fossa
C09.1 Tonsillar Pillar



https://commons.wikimedia.org/wiki/File:Diagram_showing_the_parts_of_the_oropharynx_CRUK_332.svg

Priority Order for Identifying Primary Site When There is Conflicting Information

Note: Record primary site based on the most definitive indication of primary site in the medical documentation and use the priority order when there is conflicting info without a definitive statement.

1.Tumor Board
  A. Specialty
  B. General
2. 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
3. Scans
  A. CT
  B. MRI
  C. PET
4. Physician documentation. Use the documentation in the following priority order:
  A. Physician's reference in medical record to primary site from original pathology, cytology, or scan(s), any other documentation
  B. Physician's reference to primary site in the medical record

Coding Primary Site

Identifying the primary site is difficult because:

- Workups (PE scans, endoscopies, biopsies) each provide a unique view of the tumor, therefore the medical record often contains conflicting documentation on the primary site.
- The sites/organs are small and right next to each other. Tumors frequently extend into adjacent anatomic sites, or overlap multiple contiguous sites.

Terms that are NOT Equivalent or Equal

There are no casefinding implications.

- Component is not equivalent to subtype/type/variant Note: Component is only coded when the pathologist specifies the component as a second carcinoma
- **p16 positive is not equivalent to HPV positive (pre-2022)**
- **p16 negative is not equivalent to HPV negative (pre-2022)**
- Phenotype is not equivalent to subtype/type/variant
- Squamous cell carcinoma with prominent keratinization 8070 is not equivalent to keratinizing squamous cell carcinoma 8071
- Salivary gland adenocarcinoma 8140 is not equivalent to salivary duct carcinoma 8500

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HUMAN PAPILLOMAVIRUS

HPV Positive Oropharyngeal Cancer diagnosis is increasing and is considered a separate disease from HPV negative cancers. 90% of oropharyngeal cancer is p16+ positive. This disease occurs more often in younger and healthier patients and has a better prognosis than patients with p16– negative oropharyngeal cancers. P16+ positive patients also respond well to treatment, specifically focused on delivering the minimum treatment to receive a favorable outcome.

HPV 16/18

p16 & p18 are the most commonly detected tumor suppressor protein types

HPV NEGATIVE

Squamous cell carcinoma HPV-negative 8086*

Cases diagnosed prior to 1/1/2022:

Note: HPV-negative is not equivalent to HPVmediated (p16-). According to 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. HPV testing must be negative by viral detection tests in order to code histology as 8086.

Cases diagnosed 1/1/2022 forward:

Note: HPV mediated (p16-) test results can be used to assign code 8086.

HPV POSITIVE

Squamous cell carcinoma HPV-positive 8085*

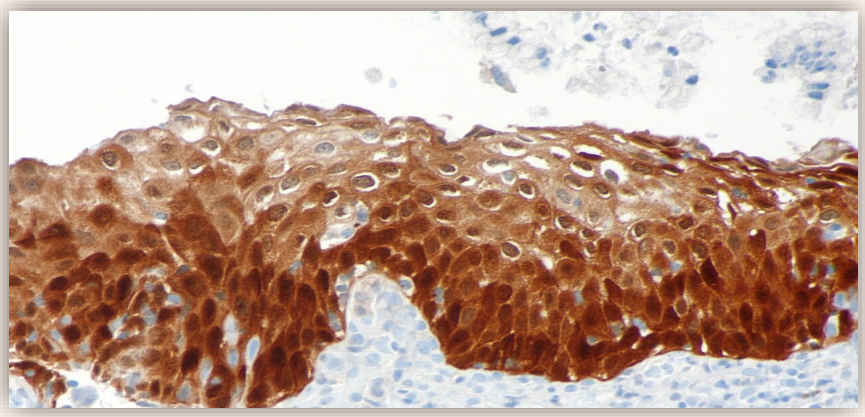
Cases diagnosed prior to 1/1/2022:

Note: HPV-positive is not equivalent to HPVmediated (p16+). According to 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. HPV testing must be positive by viral detection tests in order to code histology as 8085.

Cases diagnosed 1/1/2022 forward:

Note: HPV mediated (p16+) test results can be used to assign code 8085.

HIGH GRADE SQUAMOUS INTRAEPITHELIAL LESION SHOWING STRONG P16 STAINING



https://commons.wikimedia.org/wiki/File:High_grade_squamous_intraepithelial_lesion_-_2_-_p16_--_high_mag.jpg

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Table 5: Tumors of the Oropharynx, Base of Tongue, Tonsils, Adenoids

Specific or NOS Term and Code	Synonyms	Subtypes / Variants
Adenoid cystic carcinoma 8200		
Polymorphous adenocarcinoma 8525	Cribriform adenocarcinoma Polymorphous low-grade adenocarcinoma Terminal duct carcinoma	
Squamous cell carcinoma 8070 **Note 1:** Beginning 1/1/2022, keratinizing squamous cell carcinoma, HPV negative is coded 8086 for sites listed in Table 5 only. A diagnosis of keratinizing squamous cell carcinoma, NOS is coded 8071. **Note 2:** Beginning 1/1/2022, nonkeratinizing squamous cell carcinoma, HPV positive is coded 8085 for sites listed in Table 5 only. A diagnosis of non-keratinizing squamous cell carcinoma, NOS is coded 8072.	Conventional Squamous cell carcinoma NOS	Basaloid squamous cell carcinoma **8083** Keratinizing squamous cell carcinoma **8071 (see note 1)** Lymphoepithelial carcinoma **8082** Non-keratinizing squamous cell carcinoma **8072 (see note 2)** Papillary squamous cell carcinoma **8052** Squamous cell carcinoma HPV-negative **8086*** **Cases diagnosed prior to 1/1/2022:** **Note:** HPV-negative is not equivalent to HPVmediated (p16-). According to 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. HPV testing must be negative by viral detection tests in order to code histology as 8086. **Cases diagnosed 1/1/2022 forward:** **Note: HPV mediated (p16-) test results can be used to assign code 8086.** Squamous cell carcinoma HPV-positive **8085*** **Cases diagnosed prior to 1/1/2022:** **Note:** HPV-positive is not equivalent to HPVmediated (p16+). According to 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. HPV testing must be positive by viral detection tests in order to code histology as 8085. **Cases diagnosed 1/1/2022 forward:** **Note: HPV mediated (p16+) test results can be used to assign code 8085.** Squamous cell carcinoma, spindle cell **8074** Verrucous carcinoma/Carcinoma cuniculatum **8051**

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Head and Neck Multiple Primary Rules

Rule M3

Abstract multiple primaries when there are separate/non-contiguous tumors in any two of the following sites:

- Aortic body **C755** AND carotid body **C754**
- Glottis **C320** AND/OR supraglottis **C321** AND/OR subglottis **C322** AND/OR laryngeal cartilage **C323**
- Hard palate **C050** AND/OR soft palate **C051** AND/OR uvula **C052**
- Maxilla **C410** AND Mandible **C411**
- Maxillary sinus **C310** AND/OR ethmoid sinus **C311** AND/OR frontal sinus **C312** AND/OR sphenoid sinus **C313**
- Nasal cavity **C300** AND middle ear **C301**
- Postcricoid **C130** AND/OR hypopharyngeal aspect of aryepiglottic fold **C131** AND/OR posterior wall of hypopharynx **C132**
- Submandibular gland **C080** AND sublingual gland **C081**
- Upper gum **C030** AND lower gum **C031**
- Upper lip **C000** or **C003** AND lower lip **C001** or **C004**

Note 1: Use this rule only for multiple tumors.

Note 2: Timing is irrelevant.

Note 3: Histology is irrelevant.

Note 4: These primary sites differ at the fourth character of the site code CxxX.

Use this rule ONLY for the primary sites listed.

Rule M6

Abstract multiple primaries when the patient has a subsequent tumor after being clinically disease-free for greater than five years after the original diagnosis or last recurrence.

Note 1: Clinically disease-free means that there was no evidence of recurrence on follow-up.

- Scopes are WNL
- Scans are WNL

Note 2: When there is a recurrence less than or equal to five years of diagnosis, **the "clock" starts over**. The time interval is calculated from the date of last recurrence. In other words, the patient must have been disease-free for greater than five years from the date of the last recurrence.

Note 3: When it is unknown/not documented whether the patient had a recurrence, use date of diagnosis to compute the time interval.

Note 4: When the patient has more than one Head & Neck primary, it is often difficult to determine which primary recurred. Use the last date of recurrence for any tumor to calculate the time interval.

Note 5: The physician may state this is a recurrence meaning the patient had a previous head and neck tumor and now has another head and neck tumor. Follow the rules; **do not attempt to interpret the physician's statement.**

RULES THAT EXPLAIN WHEN TO USE TABLES:

M7-Abstract multiple primaries when separate/non-contiguous tumors are two or more different subtypes/variants in Column 3 of the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. **Timing is irrelevant**.

Note: The tumors may be subtypes/variants of the same or different NOS histologies.

- **Same NOS:** Alveolar rhabdomyosarcoma 8920/3 and embryonal rhabdomyosarcoma 8910/3 are both subtypes of rhabdomyosarcoma 8900/3 but are distinctly different histologies. Abstract multiple primaries.
- **Different NOS:** Colloid-type adenocarcinoma 8144 is a subtype of adenocarcinoma NOS 8140; Spindle cell squamous cell carcinoma 8074 is a subtype of squamous cell carcinoma 8070. They are distinctly different histologies. Abstract multiple primaries.

M8-Abstract multiple primaries when separate/non-contiguous tumors are on different rows in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. **Timing is irrelevant**.

Note: Each row in the table is a distinctly different histology.

M12-Abstract a single primary when separate/non-contiguous tumors in the same primary site are on the same row in the appropriate site table (Tables 1-9) in the Equivalent Terms and Definitions. **Timing is irrelevant**.

Note: The same row means the tumors are:

- The same histology (same four-digit ICD-O code) OR
- One is the preferred term (column 1) and the other is a synonym for the preferred term (column 2) OR
- A NOS (column 1/column 2) and the other is a subtype/variant of that NOS (column 3) OR
- A NOS histology in column 3 with an indented subtype/variant

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