

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

### PHYSICAL EXAM/HISTORY

#### Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care. Common complaints include throat irritation or pain, hoarseness or voice change, dysphagia.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to larynx cancer, such as palpable neck masses, or lymph nodes.
- **History:** Personal history of any cancer, family history of cancer; tobacco use: type, frequency, amount; alcohol: frequency, amount; depression; ECOG Performance Scale Status.  
List significant, relevant co-morbidities, particularly those that impact treatment decisions
- **Genetics:** List appropriate conditions as found in the patient's record or other information. If not applicable, state that.
- **Past Treatment:** Document any previous cancer related surgery, systemic therapy, radiation therapy or other cancer related therapy.
- **Other:** Note if tumor is clinically apparent or not apparent from clinician's exam.

**Where to Find Information:** H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

**Note on negative findings:** Include any **relevant** (coded) negative findings.

*Example: 65-year old white male presents with persistent cough, voice change and feeling like throat is closing off. Family history: father-prostate cancer, mother-breast cancer at 46. No hx of smoking or ETOH (alcohol); no submandibular, parotid or thyroid mass; no lymphadenopathy.*

## X-RAYS/SCOPES/SCANS

### Include:

Date of each imaging study performed, including those performed outside of your facility and/or prior to admission. Include pertinent findings from the studies, such as extent of disease and/or metastasis. Record negative findings from pertinent studies as well.

- **CT/MRI/PET CT Chest/Abd/Pelvis:** Detects extent of disease as well as determines if metastasis has occurred.

*Example: 9/15/25 General Medical Center CT-Neck: 2.8 cm mass involves epiglottis, limited extension to rt aryepiglottic fold and pre-epiglottic space. No suspicious evidence of mets.*

- **Imaging Tests:** Date of each imaging study performed, including those performed outside of your facility and/or prior to admission. Include pertinent findings from the studies, such as extent of disease and/or metastasis. Record only pertinent negative findings from studies such as extra-nodal extension seen on MRI or PET.

## LABS

### Include:

Type, date(s)

*Example: 10/17/25 HPV Test: P16*

## DIAGNOSTIC PROCEDURES

For any of the diagnostic procedures, procedures that detect the cancer, but do not remove it, include the date, name of procedure, and a brief description of the findings.

### Include:

- Laryngoscopy
- Endoscopy
- Esophagoscopy
- Bronchoscopy

*Example: 11/24/25 Laryngoscopy Ulcerated mass on RT epiglottis along laryngeal surface extending out to aryepiglottic fold*

## PATHOLOGY

### Include:

- **Biopsy Findings:** Most common is biopsy taken during endoscopic procedure.

### Necessary data needed:

- **Date of pathology report and pathology accession number:** List pathology reports in chronological order, most recent to first.
- **Histology Type:** Most commonly squamous cell carcinoma, but there are other several other histology's that may occur in laryngeal sites.
- **Grade:** Clinical, pathologic grade, post neoadjuvant grade as applicable. Site Specific Grade tables can be found in the AJCC Manual and the NAACCR Data Items. The recommended grading system is specified in the AJCC Chapter. The AJCC Chapter-specific grading systems (codes 1-5) take priority over the generic grade definitions (codes A-E, L, H, 9).

For Larynx, the following histologic grades apply:

- GX: Grade cannot be assessed
- G1: Well-differentiated
- G2: Moderately differentiated
- G3: Poorly differentiated apply according to AJCC
- **Size of tumor** (not specimen size): Note the number of tumor(s) found in the primary site.
- **Extent** (extension): of the primary tumor (how far the tumor has spread beyond the primary site). Pay attention to the limits of the larynx tissues as defined in the AJCC manual, AJCC T stage is based on the extent of tumor spread.
- **Lymph node involvement** (or lack of it): state number of nodes examined and number of nodes that are positive for cancer, broken down by the lymph node level where

lymph nodes were excised, size of lymph node mets, extra nodal tumor extension, ipsilateral, contralateral, bilateral lymph node involvement. Any evidence of further spread found in the pathology report.

- **Margins:** note any involvement of surgical margins.  
Perineural invasion; Lymphovascular invasion

*Example: 1/17/25 Memorial Hospital MH1645 RT supraglottis bx: inv PD SCC. P16  
2/8/17 Memorial Hospital MH17-1733 RT Hemi supraglottic resection: invasive SCC, PD, involves RT aryepiglottic fold & pre-neck level 3 LN dissection: 0+/4. LT neck level 2A LN dissection 0+/5. LT neck level 4 LN dissection 0+/3. epiglottic & pre-epiglottic space. Tumor Size 3.0 cm. Tumor invades cartilage. Susp for perineural invasion; LVI neg. RT neck level 4 LN dissection: 2+/7; RT neck level 2a 1+/8 with ENE RT.*

## PRIMARY SITE

### Include:

- **Primary Site:** where the cancer started.
- **AJCC Stage:** The primary site description in the AJCC 8th edition includes very specific descriptions of which tissues are and are not involved in the T Stage. For purposes of this stage classification, the larynx is divided into three main subsites and cT stage depends on visual inspection of the larynx and measurement of the size of the neck mass and assessment of additional tumors of the upper aerodigestive tract. pT Stage depends on complete resection of the primary site and pathological examination. PT stage does include all clinical evidence found prior to the surgical resection. The subsites of the glottis include:
  - **C32.0 Glottis:** suprahoid epiglottis, infrahyoid epiglottis, aryepiglottic folds, arytenoids, ventricular bands (false cords).
  - **C32.1 Supraglottis:** suprahoid epiglottis, infrahyoid epiglottis, aryepiglottic folds, arytenoids, ventricular bands (false cords)
  - **C32.2 Subglottis:** subglottis

- **Lymph Nodes:** The maximum size of the lymph node mass should be measured for cN stage. Regional lymph nodes should be described according to the level of the neck that is involved. Clear descriptions of the lymph node levels are included in AJCC, Chapter 5 Staging Head and Neck cancers. Unambiguous evidence of gross ENE (extra nodal extension) qualifies as ENE positive for clinical staging. pN Stage depends on regional lymph node dissection and pathological examination of the resected lymph nodes. All surgically resected lymph nodes should be examined for presence and extent of ENE.
- **Metastasis:** Distant spread is common only for patients who have bulky regional lymphadenopathy. Spread to the lungs is most common, skeletal or hepatic metastasis occur less often. Mediastinal lymph node metastases are considered distant metastasis, except level VII lymph nodes.

**Note:** No SSDIs for glottis, subglottic, supraglottic

## HISTOLOGY

### Include:

- The exact cell type of the cancer.  
*Example: Invasive Squamous Cell Carcinoma (8070/3)*
- **Site Specific Data Items and Grade:** Each subsite of the larynx has its own separate site-specific instructions. Be careful to choose the correct subsite.

- **AJCC Stage:** Read the general staging instructions before reading the site-specific chapters. AJCC Stage is Assigned according to the guidelines for each Primary site outlined in the AJCC Staging Manual.

- **Seer Summary Stage:** Read the general coding instructions before attempting to apply the Larynx site-specific Summary Stage to ensure correct coding. <https://seer.cancer.gov/tools/ssm/>. Larynx is

found in the Head and Neck Chapter of the Summary Stage Manual. Each subsite of the larynx has its own chapter in the Summary Stage Manual. Be sure to review the correct subsite.

## TREATMENT

### Include:

- **Surgery:** Record type of surgery performed, any lymph node dissection performed, any reconstructive surgery, any surgical findings noted by the surgeon. Possible surgeries for laryngeal cancer include:
  - Partial laryngectomy: removes part of the larynx
  - Total laryngectomy: removes the entire larynx
  - Hemilaryngectomy: removes only one side of the larynx
  - Thyroidectomy: removes the thyroid gland
  - Cordectomy: removes some or all of the vocal cords
  - Vocal cord stripping: removes the cancer cells from the surface of the vocal cords
  - Laser surgery: uses a laser to remove tumor from the surface of the larynx
  - Supraglottic laryngectomy: removes only the top portion of the larynx
  - Neck dissection: surgery to remove the lymph nodes in the neck where the cancer has spread
- **Radiation:** May be delivered before or after surgery. Lower stage tumors may receive radiation and/or surgery. Higher grade tumors may receive chemotherapy and radiation. Chemotherapy and radiation may sometimes be given concurrently or separately.
- **Dates:** Beginning and end dates of radiation treatment, type of radiation, to what part of body it was given, dosage and reaction to treatment (if noted); boost dosages.

*Example: Dose Phase 2 Dose per fraction*

- **Chemotherapy:** Systemic treatment may be given concurrently with radiation.
  - **Dates:** Beginning and end dates of chemotherapy, names of drugs, and route of administration; if available, response to treatment.
  - **Biologic therapy (immunotherapy):** most commonly the patient will be given chemotherapy. Only two immunotherapy drugs have been approved for treatment of laryngeal cancer and they are used to treat recurrences or progression of chemo resistant laryngeal cancers.
  - **Dates:** Beginning and end dates of therapy, names and routes of administration of drugs given (and response if noted).
  - **Clinical Trials:** Dates, name of trial, and number of trial.
- Note:** at the conclusion of a blinded trial, when you find out what the patient was actually treated with, you will go back and update the abstract with the actual treatment administered.
- **Other:** Any other treatment not fitting in the other categories.

*Example: Pt on clinical trial for laryngeal cancer, NCT03040999-A randomized phase III study of Pembrolizumab given Concomitantly with Chemoradiation and as maintenance therapy vs. Chemoradiation alone in subjects with locally advanced head and neck squamous cell carcinoma*

## RESOURCES

### RECOMMENDED ABBREVIATIONS FOR ABSTRACTORS

[NAACCR Data Standards & Data Dictionary Database \(Formerly Volume II\)](#)

#### Evidence Based Treatment by Stage Guidelines:

<https://www.nccn.org/guidelines/guidelines-process/about-nccn-clinical-practice-guidelines>

The NCCN Guidelines are most frequently used for treatment and are also used for information on diagnostic workup.

#### NCI Physician's Data Query (PDQ):

<http://www.cancer.gov/cancertopics/pdq>

#### 2024 Solid Tumor Rules:

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

#### 2024 SEER

[Appendix C: Site Specific Coding Modules - 2024 SEER Program Coding and Staging Manual](#)

#### NAACCR Site-Specific Data Items

<https://apps.naaccr.org/ssdi/list/>

#### Seer Summary Stage Manual:

<https://seer.cancer.gov/tools/ssm/>

#### Labs/Tests:

##### NCI: Understanding Lab Tests/Test Values:

<https://www.cancer.gov/about-cancer/diagnosis-staging/understanding-lab-tests-fact-sheet>

#### Site Specific Surgery Codes:

##### 2024 STORE Manual, Appendix A:

[store-manual-2024.pdf](#)

#### Specific Types of Treatment:

<https://www.cancer.gov/types/head-and-neck/hp>

#### Systemic Treatment:

##### Chemotherapy/Immunotherapy/Other

#### SEER RX Antineoplastic Drugs Database.

<https://seer.cancer.gov/tools/seerrx/>

#### Radiation Coding:

[https://www.facs.org/media/fr0phnbd/case-studies-for-coding-radiation-treatment-v4-0-20220519064258\\_496407.pdf](https://www.facs.org/media/fr0phnbd/case-studies-for-coding-radiation-treatment-v4-0-20220519064258_496407.pdf)