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NATIONAL CANCER INSTITUTE
SURVEILLANCE, EPIDEMIOLOGY AND END RESULTS (SEER) PROGRAM
BREEZE SESSION
January 12, 2007
Head and Neck Multiple Primary and Histology Coding Rules**

Slide 1

Hello, everyone. This is a Breeze Session to go over the Head and Neck Multiple Primary and Histology Coding Rules. My name is Peggy Adamo. And, we're going to start talking about the Terms and Definitions for Head and Neck.

Slide 2

One of the difficulties with Head and Neck sites is determining the primary site. So, for these sites—for the Head and Neck sites—we have included instructions in the Terms and Definitions for determining the primary site. And the first thing we want to point out to you is that you will not be coding the biopsy site many times as the primary site. You can't rely on the biopsy site as being the primary site. Head and Neck tumors often overlap and extend to contiguous sites so do not assume that the biopsy site is the primary site. They just biopsy whatever is easiest to get to usually. There could be one large tumor involving several sites with multiple biopsies in different sites. Surgeons often do multiple surgeries on Head and Neck sites to assess the margins and see if they're involved. This extensive resection adds to the difficulty of determining the primary site.

Slide 3

So, we have established some priority sources, an order of sources to use to determine the primary site. The highest priority source is a **Tumor Board**—a result of a Tumor Board meeting—either a *Specialty Tumor Board* or a *General Tumor Board*; If you have that documentation in the record, that is your first priority source for determining the primary site.

Slide 4

After that, if you don't have the Tumor Board information, the next priority would be the **staging physician's site assignment** either on an AJCC Staging Form or the **TNM statement** in the medical record. So those are the top two priority sources for determining the primary site.

If neither the Tumor Board nor the AJCC Staging are available, the third and fourth priorities are assigned based on whether the primary tumor was resected. Let's look at that.

Slide 5

If you have a total resection of the primary tumor, the margins could still be microscopically positive, and it doesn't mean that you have a total resection of

the primary site just the primary tumor. Then your first priority would be the **Operative Report** with the surgeon's statement or a **Final Diagnosis** on the path report. For example, if the patient has a tumor on the base of the tongue the entire tongue does not have to be resected. But the tumor has to be totally resected; no gross tumor at the margins.

Slide 6

If you do not have a resection, maybe just a biopsy, the priority order of sources would be first **endoscopy**; then the **radiation oncologist's** information followed by the **diagnosing physician's** information; followed by the **primary care physician's** information.

Slide 7

Then, if you don't have any of those go to something from **another physician**. If you have none of those, continue and take it from the **diagnostic imaging** and the last source here would be a **physician's statement based on clinical examination**. We think that this will be very helpful for one of the main problems with Head and Neck sites which is determining the primary site. It gives you, it gives us all some consistent ways to determine the primary site. So, hopefully, the data will be much more consistent and people will not be so confused about what to do; there'll be answers to your questions right here.

Slide 8

And continuing with that theme, we just listed here, in the Terms and Definitions for your help, these default site codes that apply to Head and Neck. And, these are to be used only when it is impossible to determine the point or organ of origin. And the three codes are C02.8, which is overlapping lesion of tongue; C08.8 overlapping lesion of major salivary glands; and C14.8 overlapping lesion of lip, oral cavity and pharynx.

Slide 9

Table 1 in the Terms and Definitions is a listing of the paired sites that apply to Head and Neck. These will come into play when you start looking at the rules. So, remember that this Table 1 is in the Terms and Definitions.

Slide 10

And Chart 1 is also in the Terms and Definitions. This Chart is used with the histology rules to code the most specific histologic term. It's basically a tree and it's arranged in descending order. Each branch is a histology group starting with the NOS terms or the group terms and descending down into the specific types for that group. As you follow the branch down in the chart on the tree the terms become more specific.

Slide 11

Here's the Chart that we're talking about, Chart 1. And if you start at the top you have the least specific histology descriptions in this top box: "Cancer/malignant

neoplasm and carcinoma,” [NOS] are your least specific terms. Then if you follow that down the next box says, “Undifferentiated carcinoma.” That’s a little bit more specific than what’s above it but not as specific as what’s below it. Continuing down one branch, let’s go over here to “Squamous cell carcinoma;” that’s going to be more specific than what’s above it—undifferentiated or cancer/malignant neoplasm, carcinoma. Then continuing down this branch, squamous cell carcinoma, if you go straight down into this big box at the bottom here, these are the most specific terms in that one branch. So least specific at the top; most specific at the bottom. Okay. That concludes what we have to point out from the Terms and Definitions.

Slide 12

I’m going to move into the Multiple Primary Rules now for Head and Neck. And, there are three modules in the Head and Neck Rules.

Slide 13

The first module is if you do not know whether you have a single or multiple tumors this is the module that you use. [Unknown if Single or Multiple Tumors] Examples of that situation are:

- if you are in a central registry you may get a path report of a biopsy followed by a hospital report of a resection. And you as a central registry may not know if this was a single tumor or multiple tumors.
- And for those of you in a hospital registry an example might be that you have an H&P documenting a biopsy in the physician’s office and the patient has another biopsy or a resection and you just don’t have enough information to confirm whether the patient has a single tumor or multiple tumors. You would use this module to determine the number of primaries.

Slide 14

This module consists of one rule and that rule is M1. And M1 says: “Is it impossible to determine if there is a single tumor or multiple tumors?” If the answer is, “Yes,” your decision is that you have a single primary. So this is a default rule. When you don’t know if you have a single or multiple tumors you default to a single primary. And the Notes warn you not to use this rule unless you’ve exhausted every source of information available to you. So you don’t use this rule as a first stop; this is your last stop really. Even though it’s the first rule it’s your last resort.

Slide 15

And, if this isn’t the case then you would go to the next module. The next module is for single tumors.

Slide 16

If your case is one tumor, you would go to this module to determine how many primaries there are. And, this module also consists of one rule and that rule is M2

and it says: “Is there a single tumor?” And if the answer is, “Yes,” your decision is that you have a single primary. So especially in Head and Neck this Note is applicable: “The tumor may overlap onto or extend into adjacent or contiguous sites or subsites.” But as long as it’s one tumor, no matter how big it is or how many sites are involved, it’s still a single primary.

Slide 17

If that’s not your situation then you would go to the Multiple Tumors Module. You would start with this module if you had a case with multiple tumors. This is where most of our rules are so let’s take a look at these.

Slide 18

The first rule in this module is M3. It says: “Are there tumors in both the left and right sides of a paired site?” And if the answer is, “Yes,” you have multiple primaries. Now, remember we looked at Table 1 in the Terms and Definitions? That is the Table where you discover whether you have a paired site or not. If the site that you are dealing with is listed in that Table, then for the purposes of these rules it’s a paired site. You have a tumor or tumors on the left and a tumor or tumors on the right of that site, multiple primaries. And remember not to go by the word “bilateral.” Bilateral is not a word we use with these rules to determine whether you have a single or multiple primaries. The only exception to this rule would be if there was a very clear statement from a physician that said that one side—the tumors on one side--were metastatic from the tumors in the other side. You would have to have a very clear statement of that to not apply this rule.

Slide 19

Okay. Let’s go on to M4. M4 says: “Are there tumors on the upper lip and the lower lip?” If the answer is, “Yes,” then you have multiple primaries. What this means is separate tumors: tumors on the upper lip and separate tumors on the lower lip. This is not something you’ve seen before. This is new to this set of rules. We’re not talking about one contiguous tumor that encompasses both the upper and lower lips. We’re talking about separate tumors. If that’s the case—tumors on the upper lip and tumors on the lower lip---it’s a multiple primary. This is an important rule to put here because you can see from looking at it that the site codes, the topography codes, are the same within the first three digits. So we want to make this a very plain rule to make these multiple primaries because normally you wouldn’t think to do that. It’s not something you’ve seen before.

Slide 20

The next rule, M5, is very similar but now we’re talking about the gum. “Are there tumors on the upper gum and the lower gum?” And, again, we’re talking about separate tumors on the upper and separate tumors on the lower, not one contiguous tumor that involves both. If the answer is, “Yes,” then you have multiple primaries. And, again, this rule was put in here specifically because the first three digits of the topography codes are the same so we want to make sure that this gets noted as a situation where you would have multiple primaries.

Slide 21

Okay. Moving on to the next rule, M6. “Are there tumors in the nasal cavity and the middle ear?” If the answer is “Yes” [then you have]—multiple primaries. This is again, another situation where the first three digits of the topography codes are the same so this rule points out that this situation—tumors in the nasal cavity and tumors in the middle ear—are multiple primaries. Previously these would have been abstracted as a single primary, but we’re making them multiple primaries this time around. So, here’s a special rule for you to go to when you have that situation.

Slide 22

Okay. Then the next rule is M7: “Are there tumors in sites with ICD-O-3 topography codes that are different at the second and/or third character?” This is the old three –digit site code rule and it comes after the rule about the lip, the rule about the gum and the rule about the middle ear and the nasal cavity. So you will have already used those rules if your case was one of those. You would not have gotten to this rule. So if you get to this rule and you have sites with topography codes that are different at the second or third character, it’s a multiple primary.

We have the Table from the previous rules in the Terms and Definitions, showing which sites were previously abstracted as a single primary. That Table is no longer in force but we provided it to you as a reference point for previous cases. You’ll find that in the Terms and Definitions. I believe it’s Table 2.

Slide 23

Okay. Moving on to M8: “Is there an invasive tumor following an in situ tumor more than 60 days after diagnosis?” If the answer is, “Yes,” you have multiple primaries. The reason we have this rule is so that the case will be counted as an incident or invasive case when incidence data are reported. And you are instructed to abstract this as multiple primaries even if the medical record or physician states it is recurrence or progression of disease. The reason for this is that we do not want survival graphs that show people dying of in situ disease. We are trying to avoid having the survival times that are affected by the time between an in situ and an invasive tumor. This is going to look very new to most people. SEER registries are probably familiar with it but for everyone else, this is something new.

Slide 24

The next rule is M9: “Are tumors diagnosed more than five years apart?” Five years is the timing rule for Head and Neck tumors. If the answer is, “Yes” [it’s] multiple primaries. If the tumors are more than five years apart, you have multiple primaries. This rule is going to help prevent any over-counting that might have occurred with recurrent in situ tumors. As you know, that’s very common in Head and Neck sites.

Slide 25

Okay. Moving on to M10. M10 looks complicated but it's not so bad. Let's look at it. This is what you might think of as the old NOS and a specific type rule but it's written out much more clearly and I think it will just be very helpful to everyone. The old one was a little bit harder to understand. This one is much clearer. So M10, the first block says: "Is there cancer/malignant neoplasm, NOS (8000) and another [tumor] is a specific histology?" If the answer is, "Yes," you have a single primary. The next block is similar. It says, "Is there carcinoma, NOS (8010) and another is a specific carcinoma?" If the answer is, "Yes," you have a single primary. The next block says, "Is there adenocarcinoma, NOS (8140) and another is a specific adenocarcinoma?" If the answer is, "Yes"—single primary. Following that we have, "Is there squamous cell carcinoma, NOS (8070) and another specific squamous cell carcinoma?" If the answer is, "Yes," you have a single primary. The next one is melanoma NOS and another specific melanoma; again, that would be a single primary. And, finally, sarcoma, NOS and another specific sarcoma would also be a single primary. So those are all your situations grouped sort of by cancer type/by histology with the NOS and the specific rule where if the tumors are NOS of carcinoma and then a specific carcinoma, etc. etc. you have a single primary. It's basically the same as the previous NOS rule, but it's laid out much better this time around, I think, easier to understand.

Slide 26

Following that we have M11: "Do the tumors have ICD-O-3 histology codes (histology codes now), that are different at the first, second or third number?" This should look pretty familiar to everyone. It's the old three-digit histology rule. If the answer is, "Yes," it's multiple primaries. It's not any different than it was before; the same information is presented in a slightly different format.

Slide 27

And the last multiple primary rule is M12 and it asks: "Does your case not meet any of the above criteria?" (that would be M1 through M11). If the answer is, "Yes," you have a case where none of the previous rules apply, you default to a single primary. This is so that we don't have to write several rules for everything we can possibly think of that might end up falling into this. We just write one rule, easy for everyone, single primary. But we do give you some examples down here at the bottom: three examples just to reassure you. However, we want to caution you not to use these examples to code your cases, not to determine your number of primaries looking at the examples. The examples are there to say, "Oh, yes. I get it. I'm in the right place. I did okay;" not to go directly to the examples and say, "Okay. That's my case. I'm going to code it here." Anyway, example one: you have multifocal tumors in the floor of the mouth. That's an example of a case that would fall through all of the eleven rules, end up here and be a single primary. Example two: an in situ and an invasive tumor diagnosed within 60 days. "Within 60 days" is an example--in situ and invasive-- that would fall through and become a single primary. And the last example is an in situ following an invasive tumor more than 60 days apart. It's more than 60 days but less than

the 5 years that we looked at before, is one that is also going to fall through here and become a single primary. So that's not so bad really for Head and Neck. I know. I was expecting a lot worse because Head and Neck sites can be really tricky. But that's it for the Multiple Primary Rules

Before I go on to the Histology Rules are there any questions? [No response] That's great. I think these will really help. When you get to use them you'll find them very user friendly.

Slide 28

Okay. Let's move on and look at the Histology Rules for Head and Neck. There are two modules within the histology rules and the first one is for single tumors.

Slide 29

If your case is a case of a single tumor this is where you would go to determine what histology code to assign.

Slide 30

And the first histology rule is H1 and it says: "Is there no pathology or cytology specimen or is the pathology/cytology report unavailable?" If the answer is, "Yes" you code the histology documented by the physician. So we have this rule for the hopefully unusual situation where you can't get a hold of the pathology report or there just isn't one. And the priority order for documents in this situation, the first thing you would look for, the highest priority would be:

- documentation in the medical record that refers to pathologic or cytologic findings

So if you've got a note there that says, "The pathology report says... carcinoma," that's what you want to go to. Failing that, you would use:

- a physician's reference to the type of cancer or histology in the medical record

So, if the physician says the person has squamous cell carcinoma, you could use that. If neither of those were available to you, you would use:

- reference of histology type from a CT, a PET or a MRI scan.

Note 2 says, "Yes, [we want you to] code that specific histology when you can, when it is documented." Go ahead and do that. If you can't get the specific histology from any of these sources, the third note tells you to go ahead and use 8000 which is cancer/malignant neoplasm, NOS or 8010 which is carcinoma, NOS if that's all the information you have -- nothing more specific is documented; you can go ahead and use those codes.

Slide 31

Okay. Let's go on to H2. "Is the specimen from a metastatic site?" meaning there is no pathology or cytology specimen from the primary site. If you only have a

specimen from the metastatic site, this rule allows you to code the histology from that metastatic site. The Note reminds you that the behavior code would be a /3 as opposed to a /6 which nobody would do, but we just want to make it very clear in the rules.

Okay. So, that's the second rule. These two rules, H1 and H2, cover situations where you don't have a pathology report or a specimen from your primary site.

Slide 32

Okay. H3 gets back to what we hope is more common where you do have that histology report. And, if that histology report mentions only one histologic type, if that's your case, then you code that histology. That's what this rule is saying, H3: "Is only one histologic type identified?" If there's only one type, then you code it; pretty straightforward. So examples of this would be the path report says "squamous cell carcinoma"—you code it; or "adenocarcinoma," you code it. We do have one caution, however. We say in this example: "Do not code 8072 (squamous cell carcinoma—non-keratinizing) unless the words "non-keratinizing" actually appear in the diagnosis. We found on some of our early testing that there were some instances where people would code it as "non-keratinizing" when there was no mention of whether it was "non" or "keratinizing." So we wanted to make sure that people knew not to assign 8072 unless the diagnosis actually has the words "non-keratinizing" in it. So, that's all that means.

Slide 33

And H4 follows: "Does the tumor have invasive and in situ components?" Remember, we're still in the single tumors module. If that tumor has in situ and invasive components and you are looking to code the histology, you code the histology of the invasive tumor. So here's an example to help you with this rule: The final diagnosis is keratinizing squamous cell carcinoma with areas of squamous cell carcinoma in situ. The invasive histologic type is keratinizing squamous cell carcinoma so that's what you would code in this situation. And, this is a change. If you are noting changes, this is one right here that you wouldn't have seen previously. We're emphasizing that even when the in situ portion is more specific you still code the invasive histology because the invasive histology is the one that's going to impact survival and treatment.

Slide 34

Okay. The next rule is H5. H5 says: "Are there multiple histologies within the same branch?" By "branch" we're talking about that Chart 1 that we looked at earlier in the Terms and Definitions. So, let's try that again: "Are there multiple histologies within the same branch such as:

- carcinoma/malignant neoplasm, NOS (8000) and a more specific histology? OR
- carcinoma, NOS (8000) and a more specific carcinoma? OR
- squamous cell carcinoma, NOS (8070) and a more specific squamous cell carcinoma? OR
- adenocarcinoma, NOS (8140) and a more specific adenocarcinoma? OR

- melanoma, NOS (8720) and a more specific melanoma? OR
- sarcoma, NOS (8800) and a more specific sarcoma?"

Any of those situations that are contained within the same branch in Chart 1 you would code the most specific histologic term using Chart 1. And, remember the most specific is going to be the one that's farthest down on the Chart starting at the top with the least specific working your way down to the bottom where they're more specific. So you want to code the most specific according to that Chart. And, our Notes tell you that "the specific histology for in situ tumors may be identified as pattern, architecture, type, subtype, predominantly, with features of, major, or with_____differentiation." The second Note says: "The specific histology for invasive tumors may be identified as type, subtype, predominantly, with features of, major, or with_____differentiation." The difference is that the words "pattern" and "architecture" can be used to identify a more specific type for in situ tumors but they do not apply for invasive tumors. The terms "pattern" and "architecture" do not apply to the invasive tumors. Okay? So if you move through this rule and it does not apply, you don't have a situation where you have two entities on the same branch, one's more specific than the other, you move down to the last rule in the single tumors module which is H6. And the last resort is to code the numerically higher ICD-O-3 histology code. If none of the previous rules apply, you would apply this one as a last resort. And that is the end of the single tumors module for coding histology for Head and Neck.

Slide 35

The next module is for "Multiple Tumors Abstracted as a Single Primary."

Slide 36

The first rule in that module is H7. This rule is very familiar to you. It's the same as the single tumor rule, which was H1: "Is there no pathology/cytology specimen or is the pathology/cytology report unavailable?" If the answer is, "Yes"—the same result—you code the histology documented by the physician. And the Notes here are exactly the same as they are for single tumors: the same priority order, etc. etc. No change. We put the rule here as well as in the Single Tumors [Module] so that each module could function independently; you wouldn't have to be jumping back and forth between modules. You could just pick the one that applied to your case and everything you need would be there.

Slide 37

So this rule H8, the next one, will look familiar as well because it is the same as the one that was in the Single Tumors Module. And it says: "Is the specimen from a metastatic site?" In other words, there's no pathology or cytology specimen from the primary site. If that is your situation you code the histology from the metastatic site and you assign the behavior code of /3. But hopefully, we have, most often we have, pathology/cytology reports so you would get at least to H9.

Slide 38

And H9 is the same again as the rule that's under the Single Tumors Module. It says: "Is only one histologic type identified?" If the answer is, "Yes," then you code that histology. And, again, these are situations where the diagnosis is, for example, "squamous cell carcinoma;" then you code "squamous cell carcinoma." The example is the same as it was previously, talking about, cautioning you not to use, not to code words that aren't actually in the diagnosis.

Slide 39

The next rule is H10. And this is similar to the rule that we just looked at in the Single Tumors Module. It has a slight twist here in the Multiple Tumors Module. Let's look at it. "Is one tumor in situ and the other invasive or are both tumors invasive?" If the answer is, "Yes," code the histology of the most invasive tumor. So that's a little bit different because we're talking about multiple tumors here. And in the Head and Neck Equivalent Terms and Definitions, we have a definition for "most invasive." If one tumor is in situ and one is invasive, you are going to code the histology from the invasive tumor. That's the same as the Single Tumor Module [H4]. But if both or all histologies are invasive, code the histology of the most invasive tumor. And, again, go to the Terms and Definitions and look up the definition for "most invasive" and it will tell you how to decide which one of your tumors is the most invasive. If you happen to have a situation where the tumors are equally invasive then you just continue on to the next rule.

Slide 40

That is H11. And H11 is the same as H5, which is the single tumor rule and it's again talking about Chart 1 and finding the most specific histology when you have multiple histologies on the same branch on Chart 1. You code the most specific. You start at the top with your terms and find them on the Chart and as long as they are all on the same branch the most specific one is going to be the one that's lower on the Chart. If that doesn't apply to your case, the last histology rule is H12.

And it's the default rule, the last resort rule. If none of the previous rules apply, you code the numerically higher ICD-O-3 histology code. This rule is last because it is the last resort. We want to try to use any of the previous rules that apply before relying on this old favorite.

So that concludes the Multiple Primary and Histology Rules for Head and Neck. We have time for some questions. Are there any?

Questions

Question 1

1. We had a question in regard to histology and pathology? [Okay] According to the General Rules the priority order to code histology is pathology

before cytology. Now, if you have a path report that is an NOS term such as carcinoma NOS, but the cytology of the same tumor is more specific such as a squamous cell carcinoma, do you follow the hierarchy and only code the carcinoma NOS?

Response to Question 1

Yes.

Okay. Thank you.

The General Rules apply to all sites unless there is a specific exception in the site-specific rules and we don't have that here.

Okay.

That was a good question. Anybody else?

Question 2

2. Peggy, I have a question about the five-year rule? Okay. So let's say a patient was diagnosed with a floor of mouth in 2005 and then comes in again in 2007. Does that mean you would not count the case in 2007?

Response to Question 2

You would look at the tumors that were present in 2007 that you didn't have in 2005 and you would apply the rules to those tumors that are in 2007. And if the rules tell you that you have a new primary then you would abstract the case and make that a new primary; otherwise you wouldn't. Does that help?

Question 3

3. That helps. Then also, I was just wondering, let's say the patient was diagnosed in 2002 and then had multiple recurrences right through to 2005 when does the clock start ticking: At the time of the original diagnosis or maybe at one of those recurrences?

Response to Question 3

At the time of the original diagnosis the clock starts ticking.

Question 4

4. Okay. So, let's say the person has a Head and Neck primary diagnosed in 2001 and then has multiple recurrences and then comes in, in 2007 and the same primary site has happened again. Do you count that as a new primary then?

Response to Question 4

Carol, do you have an opinion on that one?

Carol Johnson: Well, it's going to depend a lot, because you're giving a very gray matter case here. The fact is Head and Neck sites are rather small. So, a lot of them recur and recur with in situ because one of the reasons we did the five year rule—people were objecting a lot to getting all these primaries for Head and Neck. So, what I'm going to say to you is each time the patient recurs they usually treat it usually with radiation or surgery. If they truly recurred meaning that the tumor was gone and there was a new tumor in the same site with the same histology five years later, yes, you would code that as a new primary. But you've got to be careful because to be able to recur, or to have a new primary means you have to be cancer free.

Peggy, this is Steve. Could I add one more comment?

Absolutely.

Steve Peace: The five-year rule does not stand-alone. You can't just pluck the five-year rule out and use it independently. You still have to follow the sequence of the other rules and it's possible that you will have made a single vs. multiple primary decision before you get to the five-year rule depending on the location of the multiple tumors.

Carol Johnson: That's a good point. The sites, like I said, the sites are very small. So if it's in a different site, you're going to have a new primary, period. You're right, Steve.

Steve: Right. And you have the second or third character of the topography code rule **before** you have the five-year rule.

Carol: It has a different histology code.

Steve: It's just to point out: you still have to follow the sequence.

Peggy: Does that help with the question?

That helps. I'm just thinking of some cases where these people have a larynx primary and then they come in every couple of years and they pick away [excise pieces of it] at it or radiate it or whatever. So, probably that disease-free interval is probably what's not occurring.

Probably. Okay.

Have we any other questions?

Question 5

5. I have a question not about coding so much as about the manual itself. When we looked at our section of the manual for Head and Neck rules for the flowchart, it goes right from the M10 rule on page 88 to page 89 starting with H1. So, we're missing M11. Does anyone else see that?

Response to Question 5

We found that to be the case and I'm pretty sure that was updated on the Website. You might, if you download and print another set of Head and Neck flowcharts I think you'll find that corrected.

Okay. Thank you.

If you don't, let us know!

All right.

Carol Johnson: It was corrected in November.

Oh, okay.

Carol: I checked it out just recently.

Peggy: Great. That should be no problem now, I hope. Anybody else?

Question/Comment 6

6. I just printed out the Head and Neck rules this morning and those rules for M10 and M11 were there.

Response to Question/Comment 6

Oh, wonderful. Thank you for verifying that.

You're welcome.

We've got more time if there are other questions.

While there's a bit of a lull let me just mention before I forget that there will be ten cases, ten practice cases, for the Head and Neck. We will, our next Breeze session we'll go over those ten cases—go over the answers to those ten cases.

Question 7

7. When will those be posted?

Response to Question 7

When will the cases be posted? Is that the question?

Antoinette Percy-Laurry: They are posted now. But I'll send a link just in case you guys don't have the previous link. I'll go ahead and send the link again.

Thank you.

All right.

Question 8

8. What is the schedule for the next set of Breeze Sessions?

Response to Question 8

The schedule for the next set of Breeze Sessions? Has that been distributed? I don't think you did that yet?

Antoinette: Yes, I did. *Oh, you did do that.* I did that sometime in, I think, early December.

Peggy: Perhaps sending that out again might be worthwhile?

Antoinette: Okay. I'll do that.

Great.

We have quite a record number of people on today so it looks like it's going to be a banner year for these Breeze Sessions.

While we're all here together are there any other questions?

Well, that sounds pretty quiet so I'm going to assume there aren't any. But I know you'll let us know if you come up with any down the line.

Thank you all for joining us. This was a great session, lots of people. Happy New Year and take care.