California Cancer Registry

"Q"-Tips

Quality Tips - Education - Abstracting - Coding

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Recording Information in Text Fields

General Guidelines

1. **Document in text a summary of findings and information to independently support your coded data elements.**
   - **This provides explanation and validation your interpretations and coding are correct.**

2. **Record the sequence of events leading to the dx/rx of cancer.**
   - **Describe the patient** (demographics, occupation, industry, any previous cancers).
   - **Summarize patient presentation and diagnostic workup** (physical exam, lab work, imaging, biopsy, pathology).
     - Do not cut and paste entire reports into text fields.
   - **Record the type of cancer found** (histology, behavior, grade).
   - **Document extent of tumor spread** (stage at diagnosis).
   - **Capture all treatment received for this tumor** (surgery, chemotherapy, radiation therapy, etc.).

3. **Include the following components when recording text:**
   - **Date(s) or estimated date(s):** Include for every procedure, diagnostic test, treatment or significant event.
   - **Description of event**: Name of test, study, or treatment at your facility, as well as facility and MD associated with tests or treatment if they occurred elsewhere prior to admit, if information is known.
   - **Detailed findings**: Positive and/or negative which validate the primary site, histology, extent of disease, treatment and outcome.
   - **Physician interpretation of findings**: Anything relevant to this person or tumor which provides the physician's impression to support the diagnosis, extent of disease, cancer stage or planned treatment.
     - Include any documented MD treatment plan - even if treatment has not yet been initiated.
   - **Standard medical abbreviations**: Reference Volume Appendix M.1 or M.2. When in doubt, write it out.
   - **Upper & lower case letters:** Avoid using all uppercase/capital letters when recording text.
   - **Phrases not complete sentences & include punctuation;** separate phrases with periods (.) or semi-colons (;).
   - **Supplemental information which cannot be coded numerically which clarifies special circumstances.**
     - Patient moved to live with family and will receive additional treatment in another city or state.
     - Patient surgery delayed due to insurance authorization and scheduling.
     - Patient delayed planned treatment for several months to care for an ill spouse.
   - **No blank text fields:** When information is missing from the medical record, or there is no pertinent information to record, include documentation such as "None", "NR" or "NA".

4. **Verify coded information:** Simple concise statements can verify many data elements. The example below verifies patient race, sex, ethnicity, age, primary site, laterality, case sequence, and TNM clinical "N" category.
   - ***7/10/16: 72-YO white non-Hispanic male. CC: Enlarging 6mm round dark lesion left forearm; here for exc bx. PE: Otherwise neg; no palpable suspicious LNs. Hx prostate ca Dx 2005 s/p prostatectomy currently NED.***

5. **Data Elements which do not require supporting text: DOB, MR#, SS#, Comorbidities & Secondary diagnoses.**

6. **For additional details, please reference the companion document "Text Documentation Guidelines" on the CCR website: http://www.ccral.org → Registrar Education and Training → Q-Tips and CCR Knowledge Series.**