Text Documentation Guidelines

General Instructions for Text Fields
- Complete all text data fields first.

- Record *pertinent* site-specific cancer information.
    - Information that describes/depicts the cancer being reported.
    - Positive and/or negative findings that validate the coded values for primary site, histology, extent of disease, treatment and outcome.

- Avoid recording information not relevant to the case being reported.

- Record a date for every procedure, diagnostic test, or significant event.
    - Recording vague dates **Volume I, III.3.3.2; III.3.3.3**
    - Enter an approximate date when exact date can't be determined.
    - At a minimum, a year of diagnosis is required for all analytic cases.
    - Use either a (/) or (-) to separate month, day and year.

        ✓ Acceptable formats for recording dates
mm/dd/yyyy	02/06/2013
mm/dd/yy	02/06/13
m/d/yyyy	2/6/2013
m/d/yy	2/6/13
m/dd/yy	2/06/13

        ✓ Unacceptable formats for recording dates
mdyyyy	262013
mmdyyyy	0262013
mmdyy	02613

- Record text in a consistent, organized manner using *standard* medical abbreviations (per Volume I, Appendix M.1 or M.2).

- Use phrases not complete sentences.

- Separate key phrases using either periods (.) or semi-colons (;).

- Do not leave a text field blank when information is missing from the medical record, or when there is no *pertinent* information. For example, you could record None, NR, or NA.

- Avoid using all capital/uppercase letters.

- Do not copy and paste entire reports into text fields.

General Instructions for Text Fields *continued:*

- ♦ Review the site-specific chapters in the current Summary Stage Manual, and the current AJCC TNM Staging Manual to identify **pertinent** text information to record in support of your coded staging values.

- ♦ Review the Collaborative Staging Manual V02.05 for notes specific to coding the required Site-Specific Factors (SSF) and include text which supports your coded values.

- ♦ *Note: During Visual Editing and other QC reviews, when coded values differ from information provided by text documentation, precedence is given to text documentation.*

Case Identification

- ♦ Sequence Number **Volume I, II.3.3**
  - o Record in the "Remarks" field text back-up any history of previous primary malignancies and/or reportable benign/uncertain behavior CNS tumors including histology and diagnosis date if stated.
  - o Malignancies
    00= one/only primary malignancy; 01=first of at least two primary malignancies
  - o Benign and Uncertain Behavior CNS Tumors, Reportable by Agreement
    Use 60 for one tumor/only
    Use 61 for the first of at least two tumors

- ♦ Class of Case **Volume I, III.3.5**
  - o Analytic cases (codes 00-22) are grouped according to the location of diagnosis and first course of treatment.
  - o Nonanalytic cases include codes 30-49 and 99. The CCR requires that specific nonanalytic cases be abstracted by the reporting facility.
    - ▪ For reporting requirements, please reference **Volume I, I.1.6**

Demographics Volume 1, III.2

- ♦ Demographic text back-up should be recorded in either the H&P or Remarks field.

- ♦ Record both the information and the source of the information.
  - o Race (White per face sheet)
  - o Spanish/Hispanic Origin (Cuban per Nurses Notes)
  - o Sex Uncommon first name; name either male or female; (First name Morgan- patient is female; First name Dale-patient is male; Foreign names)
  - o Place of birth if it differs from race (White female born in India)

Demographics *continued:*

- ♦ Occupation and Industry   **Volume 1, III.2.13.1**
  - o Guidelines: http://www.cdc.gov/niosh/docs/2011-173/
  - o The "Cancer Registrar's Guide to Collecting Industry and Occupation" is available for review or download in pdf format from link above.

History/Physical Exam

- ♦ ***Pertinent*** findings, both positive and negative that describe what the MD finds when examining the patient, body part, body system thought to be involved with cancer.

- ♦ Record:
  - o Admitting impression/admitting diagnosis if stated by examining physician.
  - o Date of the first physical exam reported for the cancer
  - o Primary site location (include laterality)
  - o Tumor size
  - o Extent of disease
    - ✓ Spread w/in the organ of origin
    - ✓ Spread to surrounding tissues/structures/lymph nodes
    - ✓ Spread to distant tissues/structures/lymph nodes

- ♦ Do not record findings from exams that will be recorded elsewhere on the abstract (Mammogram, CXR findings, etc.) or planned work-up.

- ♦ Indicate patient sex, race and age - unless recorded in remarks section.

X-rays/Scopes

- ♦ Record:
  - o Date of exam(s) in chronological order
  - o Type of exam/body part examined (CT Chest; MRI Brain)
  - o Pertinent findings, both positive and negative, that identify:
    - ▪ Primary site location (subsite/lobe/quadrant/laterality)
    - ▪ Tumor size
    - ▪ Extent of disease
      - ✓ Spread w/in the organ of origin
      - ✓ Spread to surrounding tissues/structures/lymph nodes
      - ✓ Spread to distant tissues/structures/lymph nodes
- ♦ Diagnostic statement/impression of the radiologist or endoscopist.

Lab Tests/Tumor Markers
- ♦ Record:
    - o Lab results relevant to primary site being reported
    - o Date test performed
    - o Name of test
    - o Test results
    - o Normal test <u>value</u> and/or <u>interpretation</u> and/or range recorded in parenthesis. If only the test result or interpretation is stated, document result/interpretation is per MD or NR

      Examples:
        - ✓ 8/8/12 PSA: 25.5 (< 4.0; high/abn; reference range (<2.5ng/ml))
        - ✓ 8/8/12 PSA 25 per MD
        - ✓ 8/8/12 PSA 25 NR
- ♦ Site Specific Factors:
    - o Text must be present to support the coded value.
    - o Supporting text should include information as to whether the test was performed at the facility or not.

      Example:
        - ✓ Primary Site is Endometrium (Corpus Uteri). For SSF 2 Peritoneal Wash, you must document Pelvic wash was not done in order to use code 998/test not done.

Operative Findings
- ♦ ***Pertinent*** observations of the surgeon (what is seen/felt/palpated) during the surgical procedure.

- ♦ Findings may be listed in the formal operative report (heading labeled "operative findings"), within the body of the operative report, or in the "op note" (progress notes).

- ♦ Do not record what the surgeon did (step by step procedure) or path findings.

- ♦ Record
    - o Date of procedure
    - o Location of tumor
    - o Tumor size
    - o Extent to which tumor has/has not spread beyond primary site
    - o Residual tumor tissue
    - o Tumor tissue that was not/could not be removed
    - o Record "Technique only" if no findings are documented

Pathology

- ♦ Includes all **pertinent** pathology/autopsy reports for procedures performed in your facility and any outside slide information that may be available.

- ♦ Path Report Data Items include:
  - o Path Report Facility
  - o Path Report Number
  - o Path Date Specimen Collected
  - o Path Report Type
  - o Record TNM staging information **per pathologist**.

- ♦ Record text information in the following order:
  - o Label first path report R1.
  - o Subsequent paths labeled R2, R3, etc.
  - o Date specimen collected
  - o Record primary cancer site/tissue specimen source
  - o Clearly describe what is sampled/removed (FNA, Core bx, organ resection)
  - o Histology/behavior/grade
  - o Extent of disease within and beyond the primary site
  - o Tumor size (only record the greatest dimension of the tumor unless depth is also required)
  - o Status of margins
    - o including any site specific margins such as CRM for colon
  - o Lymph node involvement stated as number positive/number examined and name of lymph node chain if stated (6+/12 AxLN)
  - o Other tissue/organs
  - o Comments or reports from outside consultants

    Example:
    - ✓ R1 8/8/2013
    - ✓ Rt Colon:
    - ✓ PD adenoca;
    - ✓ infilt muscularis propria into adj fibroadipose tissue;
    - ✓ 4.0cm;
    - ✓ Prox/Dist margs neg; CRM clear by >3cm
    - ✓ 10+/20 pericolic LNs;
    - ✓ Liver bx (+) for mets;
    - ✓ ROS confirms

    (R1 8/8/2013 Rt Colon: PD adenoca; infilt muscularis propria into adj fibroadipose tissue; 4.0cm; Prox/Dist margs neg, CRM clear by>3cm; 10+/20 pericolic LNs; Liver bx (+) for mets; ROS confirms)

Staging Text field   Volume 1, IV.1.7

♦ This separate text field for staging is used to document *additional* staging information **not** already entered in other text fields.

- Diagnostic workup (date/procedure/findings), or other information (outpatient progress notes/consults/treatment summaries) which provided information for assigning stage.
  Example:
  ✓ Per MD Oncology Note, completion staging workup 11/1/16 Bone Scan: Pos (+) for bone mets.

- Staging by MD's (other than the pathologist) or other info on who staged the case may be recorded here.
  Example:
  ✓ Per Surgeon, pre-op clinical stage was T2N0M0 Stage 1.
  ✓ Per ROC report 5/1/16 TNM stage cT3cN1cM0 Stage 3 (Larynx)
  ✓ Clinical Stage per Registrar, Pathologic stage per Managing MD and Registrar
  ✓ Clinical and Path stage per Tumor Board consensus.

- Staging conflicts: useful for times when QC of registry abstract is compared to the source medical record or to explain any circumstance where text documentation and TNM stage recorded may conflict:
  Example:
  ✓ Conflict between MD stage and Registrar documentation. Only partial/limited records available to Registrar - MD stage recorded.
  ✓ Conflict between MD staging and Registrar review of complete records- Registrar stage coded. MD stage was (document original MD stage).

First Course of Treatment (FCOT*) General Instructions
Volume I, VI.I

♦ Record all cancer directed therapy administered as part of the FCOT.

♦ Include any therapeutic procedure directed at cancer tissue, whether in a primary or metastatic site, whatever the mode of treatment, and regardless of the sequence and degree of completion of any component part.

♦ Obtain information about the entire FCOT from the medical record. If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known whether the procedure was administered.
- For example, record "Radiation therapy, recommended; unknown if given."

First Course of Treatment *continued*:

- ♦ The following rules are to be followed for FCOT, and they are in the order of precedence:
  - o If there is a documented, planned FCOT, first course treatment ends at the completion of this treatment, regardless of the duration of the treatment plan.
  - o If the patient is treated according to a facility's standards of practice, first course ends at the completion of the treatment.
  - o FCOT includes all treatment received before disease progression or treatment failure.
  - o When there is no documentation of a treatment plan or progression, recurrence or a treatment failure, FCOT ends one year after the date of diagnosis. Any treatment given after one year is second course therapy in the absence of a documented treatment plan or a standard of treatment.
  - o If a patient refuses all treatment modalities and does not change his/her mind within a reasonable time frame, or if the physician opts not to treat the patient, record that there was no treatment in the first course.
  - o If treatment is given for symptoms/disease progression after a period of "watchful waiting," this treatment is not considered part of first course; this would be considered subsequent treatment.
  - o The data item RX-Treatment Status was added to summarize the status of all treatment modalities. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

- ♦ If the MD has documented a treatment plan, but treatment has not yet been initiated, enter the "planned treatment" specifics (including MD or facility where treatment will be delivered).
  - o Code the applicable data fields for "Treatment recommended, unknown if given".

- ♦ For each treatment category, record NR if there was no treatment given.

  * *The abbreviation FCOT has been approved by NAACCR and will be added to Appendix G, publish date 2018. It is acceptable to use this abbreviation now in advance of the formal NAACCR publish date.*
  CCR Volume 1, Appendix M.1 and M.2 will also be updated.

General Instructions-Surgery
Volume I, VI.2

- ♦ When recording the name of the surgical procedure, be sure to review the operative report and verify the stated procedure(s) was performed.

- ♦ Avoid recording non-pertinent information such as incidental appendectomy.

General Instructions-Radiation Therapy
Volume I, VI.3

- ♦ Record from the treatment summary:
  - o Treatment start date
  - o Primary Target Site/Volume
    - ▪ *e.g. RUL Lung*
  - o Modality/Method (s) of delivery/treatment
    - ▪ *e.g. External beam 18MV Photons or Intracavitary Brachytherapy, LDR*
  - o Dose/energy/fractions
    - ▪ *e.g. 5400 cGy in 23 fractions.*
  - o Boost Modality/Method of delivery
    - ▪ *e.g. Boost to pelvic LNs with Brachytherapy Intracavitary LDR.*
  - o Radiation treatment sequence with surgery
    - ▪ *After surgery/before surgery/intraoperative radiation, etc.*
  - o Reason no radiation treatment
    - ▪ *Patient refused*

General Instructions-Systemic Therapy
Volume I, VI.4-VI.6

- ♦ USE SEER Rx* to distinguish chemotherapy agents from hormonal agents from immunotherapy agents or from ancillary (non-cancer directed) agents.
- ♦ Record
  - o Cancer-directed drug treatments
    - ▪ Treatment start date
    - ▪ Agent(s)
  - o Reason no treatment if systemic therapy would be expected

Remarks
Volume I, VIII

- ♦ Record
  - o Any pertinent information that is not captured elsewhere.
  - o Text to justify coded demographic data items or history of previous tumors if not recorded in the History/Physical Exam field.
  - o Confirm Sex in text documentation if sex was coded 3, 4, 5, or 6.
  - o TNM stage stated by Managing MD, or indicate who staged the case (Managing MD, Radiation Oncologist, Combo Registrar and MD) if not already recorded elsewhere such as Text-Staging field.

Remarks *continued:*
- o Include text verifying patient age when over 100
- o Height, Weight
- o Smoking info to support tobacco codes
- o Supplemental information, which cannot be coded numerically but may be useful to clarify special circumstances or situations.
  - ▪ Patient moved to live with family and will receive additional treatment in another state.

Final Diagnosis, Text Volume 1, VIII.2
- ♦ Record the final diagnosis (FDX) as determined by a recognized medical practitioner as documented in the Discharge Summary or Progress Note.

- ♦ Record the date of the notation and the final diagnosis, including stage if given.

- ♦ If there is no final diagnosis in the medical record, please state FDX: NR; do not leave this field blank.

- ♦ If the only information available is a pathology report, which has already been recorded, then document "No MD FDX reported" in the FDX field.

Quality Control

Perform procedures a day or so after abstract has been completed.

1. Global view
   - o Give the abstract a visual "once over" review
   - o Are any required fields blank?
   - o Are all coded data elements supported and verified in text fields?

2. Demographic information validation
   - o Record any unusual situations in "Remarks".
   - o City vs county
   - o Name/ethnicity/race/birthplace/sex

3. Diagnostic evaluation data fields validation
   - o Is date of diagnosis the earliest documented date?
   - o Is there a logical sequence of events from the date of diagnosis to treatment?
   - o Sequence number-are other primaries documented in the history and physical exam text or Remarks field?

Quality Control *continued:*

4. Cancer identification data fields validation
   o Verify primary site/sub-site text vs ICD-0-3 code
   o Check primary site and laterality-is it a paired site?
   o Pathology-site/histology/behavior/grade/laterality
   o Is tumor size recorded in text?

5. Staging validation
   o Verify the correct AJCC Site Chapter and/or Summary Stage schema and/or Collaborative Staging schema was used to assign stage or site specific factors.
   o Compare staging elements with pathology text or additional text fields if used, to be sure there is supporting documentation for all staging data including:
     ▪ Tumor size documentation
     ▪ Extent of disease documentation
     ▪ Regional lymph node status; number positive/number examined
     ▪ Involvement of other organs/tissues
     ▪ Metastasis, distant site(s) or distant LNs
     ▪ Site Specific Factors

6. Treatment validation
   o Is there documentation of all first course treatment modalities?
   o Is date of earliest treatment recorded?
   o Is date of treatment after date of diagnosis?

7. Follow-up/outcome validation
   o Is date of last contact the same date or later than the latest treatment information?
   o Is disease status logical in relation to stage and treatment?

8. Exchange abstracts with a co-worker
   o Can you follow the sequence of events?
   o Can you easily assign codes to their text?

♦ *Reminder: During Visual Editing and other QC reviews, when coded values differ from information provided by text documentation, precedence is given to text documentation.*