Cancer Reporting in California

Appendix T

Text Documentation Guidelines

California Cancer Reporting System Standards, Volume I: Abstracting and Coding Procedures

Twenty-Second Edition

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Appendix T: Text Documentation Guidelines

This appendix provides best-practices for recording information in text fields. In addition to the guidelines here, please see coding instructions for the data items within Volume 1.

Note: Text documentation guidelines for COVID-19 information are not included in this appendix and can be found on the SEER website under COVID-19-Abtraction Guidance.

General Guidelines:

- Document in text a summary of findings and information to independently support coded data elements.
    - This provides explanation and validates interpretations and coding are correct.
    - During Visual Editing and other QC reviews, when coded values differ from information provided by text documentation, precedence is given to text documentation.
- Text documentation should collectively record the sequence of events leading to the diagnosis and treatment of cancer and should:
    - Include pertinent patient demographic information.
    - Summarize patient presentation and diagnostic workup.
    - Record the type of cancer found.
    - Document extent of tumor spread.
    - Capture all 1st course treatment received.
    - Support the date of diagnosis.
- Abstractor verification of coded information.
    - Perform a Quality Control review of the abstract to confirm all data items are supported by text (see Quality Control).

Best Practices for Text Fields:

- Complete all text fields first before coding data items.
- Record ***pertinent*** cancer information only.
    - Avoid recording information not relevant to the case being reported, such as diagnostic tests/procedures for other medical conditions.
    - Document information for initial diagnostic workup and first course treatment only.

- Record dates for every procedure, diagnostic test, treatment, or significant event.

  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

- Include where the procedures, diagnostic test, treatment was performed when not at the reporting facility.
  - If exam occurred at another facility prior to admission, begin the exam findings with 'PTA'.
- Record text in a consistent, organized manner using ***standard*** medical abbreviations (per Volume I, Appendix I).
- 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. Record None, NR, or NA.
- Avoid using all capital/uppercase letters.
- Do not copy and paste/entire reports into text fields.

Text – Remarks

- Record:
  - The following demographic information.
    - This information may be entered in *either* Text – Remarks or Text – Physical Exam, but it is *preferred* to record it in Text – Remarks.
      - Age - when the patient is 100 years or older.
      - Race
      - Hispanic Origin

- Sex – when uncommon first name; name either male or female.
- Height, Weight
- Smoking information to support tobacco codes.
- Place of Birth - if it differs from race (White female born in India).

- History of previous primary malignancies and/or reportable benign/uncertain behavior CNS tumors, including diagnosis date and histology, if stated.
- Full name of Parent or guardian of a child whose case is being reported.
  - The parent's Occupation/Industry should be recorded in the Occupation and Industry text fields (see Volume 1).
- Include supplemental information which clarifies special circumstances that are not conveyed in the coded data items:
  - Patient lived outside of California at the time of diagnosis and moved here for treatment.
  - Patient was diagnosed in California but is referred to a physician or facility in another state for treatment.
- Record other pertinent information for which there is no designated data item.

  Examples:

  1. WF born in India; Ht: 5'6", Wt: 135lbs; TOB: never; PMH: 2012 R Breast CA, 2016 L upper arm melanoma.
  2. Mexican female, former 1 ppd x 8 yrs smoker, quit '72, physiology professor, h/o rt breast ca '07 and lt thigh melanoma '08.

Text – Physical Examination

- For ***Analytic*** cases, record:
  - Date of the first physical exam reported for the cancer at your facility.
  - Chief complaint/reason for the admission.
  - Brief statement of the patient's history of the cancer (if applicable) including admitting diagnosis/impression, any relevant treatment and staging information.

- Findings in the physical exam that are ***pertinent*** to the cancer:
  - *Primary site location (include laterality).*
  - *Tumor size/extension to surrounding tissue/structures.*
  - *Lymph Node status*
  - *Spread to distant sites*
- Physician impression: anything relevant which provides physician's impression to support the diagnosis, extent of disease, stage, or planned treatment.

- For ***Non-Analytic*** cases, record:
  - Date of admission to your facility.
  - Reason for the admission.
  - Patient's history of the cancer including all relevant staging information and 1st course treatment.
- Do not record planned diagnostic work-up.
- Do not record findings from exams that are recorded in other text fields on the abstract (X-Rays/Scans, Scopes, etc.).
- Record required patient demographics if not recorded in Text – Remarks.

Examples:

1. *Analytic Case*
   - 10/2/21 pt presented for US guided lt breast core bx due to susp findings on screening mammo. Palp mass noted in UOQ lt breast w/o palp ax LAD noted on exam.
2. *Non-Analytic Case*
   - 10/25/21 Mexican w/ h/o rt breast ca UOQ dx at unk hosp, s/p bilat mastectomy 3/2021 followed by chemo, c/o abd pain.

Text- X-Rays/Scans

- Record:
  - Date of exam(s) in chronological order.
  - Type of exam/body part examined (CT Chest; MRI Brain).
  - Where the exam was performed (if not at the reporting facility).
  - Pertinent findings, both positive and negative, that identify:

        - *Primary site location (include subsite/lobe/quadrant/laterality/whether it is multi-focal).*
        - *Tumor size/extension to surrounding tissue/structures.*
        - *Lymph Node status*
        - *Spread to distant sites*
        - *Capture any other clinical information needed to support site-specific data items).*
    - Diagnostic statement/impression of the radiologist or endoscopist.

      Examples:

      1. PTA 2/11/21 CT Abd/Pelv @ ABC Hosp: no tumor noted; 3/27/21 CT Chest: no E/O mets dz.
      2. 9/20/21 MMG and LT breast US: Susp 0.5 cm mass lt breast at 2 o'clock. Nonspecific Ax LNs. 10/8/21 L Breast MRI: 1.7 cm mass, 1-2 o'clock position, No LAD.
      3. 5/30/21 CT AP: 6cm wall thickening distal colon, peritoneal and pelvic LNs c/w susp for mets; neg for bone mets.

Text - Scopes

- Record:
    - Date of exam(s) in chronological order.
    - Type of exam/body part examined (laryngoscopies, colonoscopies, mediastinoscopies, other endoscopic procedures).
    - Where the exam was performed (if not at the reporting facility).
    - Pertinent findings, both positive and negative, that identify:
        - *Primary site location (include subsite/lobe/quadrant/laterality/whether it is multi-focal.)*
        - *Tumor size/extension to surrounding tissue/structures.*
        - *Lymph Node status*
        - *Spread to distant sites*
        - *Capture any other clinical information needed to support site-specific data items.*
    - Diagnostic statement/impression and/or stage of the endoscopist.

- Include mention of biopsies, washings, and other procedures performed during the examination. All results obtained from these procedures must be entered in the Text – Pathology field.

  Example:

  1. 1/18/21 EGD with bx: Tumor located in the distal esophagus extending into the gastric cardia for 2cm. Tumor invades through the muscularis propria and into the adventitia. Periesophageal LNs suspicious for mets. uT3N1 per endoscopist.
  2. PTA 4/2021 Colonoscopy @ Unk facility: @35cm nearly obst mass left colon, unk if bx taken.

Text - Laboratory Tests

- Text must support <u>every lab result and/or tumor marker that is used to code data items</u> on the abstract.
- Record:
  - Lab results pertinent to primary site being reported.
    - Pertinent labs prior to surgery or treatment.
    - Pertinent labs post OP for certain primary sites (e.g., Testis).
  - Date of test(s) in chronological order.
  - Name of test
  - Where the exam was performed (if not at the reporting facility).
  - Test Results
  - Normal test value/range and/or interpretation recorded in parenthesis.
  - If only the test result or interpretation is stated by the physician and there is no lab report in the chart, document results as per MD.

    Examples:

    1. Prostate primary:
       - 8/8/21 PSA: 25.5 (<4.0, elevated)
       - 8/8/21 PSA @ Outside facility ABC: 25.5 (elevated)
       - 8/8/21 PSA: 25.5 (elevated) per MD
    2. Breast primary:
       - 10/2/21 ER: 100%, strong, PR: 60-70%, weak to mod, Ki-67: 20-25%, HER2 IHC: 2+, equivalent on IHC; 11/25/19 Oncotype: 13

3. Colon primary:
    - 3/5/21 CEA: 2.3 (<3.9); MSI: present, per MD Notes

Text – Operative Findings

- Record pertinent observations of the surgeon (what is seen/felt/palpated) during surgical procedure.
- Include positive and negative results of diagnostic surgical procedures, such as biopsies, dilation, and curettage (D&C), and laparotomy, as well as definitive surgery findings.
- Findings may be listed in the formal operative report (heading labeled "operative findings"), within the body of the operative report, or in the "op notes" (progress notes).
- Do not report what the surgeon did (step by step procedure) or path findings.
- Record:
    - Date of procedure(s) in chronological order.
    - Type of procedure/body part(s) biopsied/resected/removed.
        - Provide enough information to support staging/diagnostic procedure and surgery codes.
    - Where the procedure was performed (if not at the reporting facility).
    - Pertinent findings, both positive and negative, that identify:
        - Primary site location (include subsite/lobe/quadrant/laterality/whether it is multi-focal).
        - Tumor size/extension to surrounding tissue/structures.
        - Lymph Node status
        - Spread to distant sites
        - Tumor tissue that was not/could not be removed.
        - Residual tumor status/size
        - Surgical Margins/Measurements
        - Record "technique only" if no findings are documented or NSF when there are no significant findings.

          Examples:

1. 10/2/21 Lt breast core bx at 2 o'clock: technique only; 11/1/21 Lt Breast segmental mast w/SLN bx: Palp, 1 cm centrally located mass w/bx clip at 2 o'clock, completely excised w/wide clinical margin. Additional marg taken circumferentially and passed off separately. 4 SLNS identified and removed.
2. 06/17/2021 Exp LAP resection of Lt sigmoid colon w/coloproctostomy w/partial resection of sm bowel w/ileo-colostomy. 35 cm mass; no liver mets palp; sm bowel involvement.

Text – Pathology Findings

- Includes all pertinent pathology/autopsy reports for procedures performed at your facility and any outside slide information that may be available.
- Record reports in chronological order as follows:
    - Date specimen collected.
    - Primary cancer site/tissue specimen source.
    - Clearly describe what is sampled/removed (FNA, Core Bx, organ resection).
    - Histology/Behavior/Grade
    - Tumor size (record greatest dimension only unless other dimensions are required to support codes).
    - Extent of disease within and beyond the primary site.
    - Lymphovascular Invasion status.
    - Status of Margins.
        - Including any site-specific margins such as CRM for colon.
    - Lymph node involvement stated as number of positive/number examined and name of lymph node chain if stated (6/12 AxLN)Other tissue/organs examined and findings.
    - TNM Staging by the pathologist.
    - Comments or reports from outside consultants (review of outside slides).
    - Addendums
    - Capture any other information needed to support site-specific data items

Examples:

1. 10/2/21 Lt breast bx at 2 o'clock: IDC w/micropapillary features, Grade II, BR 7, no LVI. 11/1/21 Lt breast: IDC w/micropapillary features, Grade II, BR 7, multifocal, 1.4 and 0.3cm, no LVI, neg margins, 0/5 +SLNS on IHC. pT1c (m) N0 (sn).
2. 7/5/2021 Rt Colon bx: PD Adenoca; 8/8/2021 Rt Colon: PD adenoca, 4cm, inv muscularis propria into fibroadipose tissue, LVI-, margins neg, CRM clear by >3cm, +10/20 pericolic LNs, Liver bx+ for mets, pT3 N2b, ROS confirms.

Text – Staging

- 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 Pos for bone mets.
    - Staging by MD's (other than the pathologist) or other info on who staged the case may be recorded here.

      Examples:

      1. Per Surgeon, pre-op clinical stage was T2N0M0 Stage 1.
      2. Per ROC report 5/1/16 TNM stage cT3cN1cM0 Stage 3 (Larynx).
      3. Clinical Stage per Registrar, Pathologic stage per Managing MD and Registrar.
      4. 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:

      Examples:

      1. Conflict between MD stage and Registrar documentation. Only partial/limited records available to Registrar – MD stage recorded.
      2. 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) Text Fields

Definitions and Guidelines – First Course of Treatment (Volume 1)

In addition to the text General Guidelines and Best Practices for Text Fields, the following instructions also apply to all the FCOT text fields:

- Record all cancer directed therapy administered as part of the FCOT.
- Include findings from 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.
- If it cannot be determined whether an intended therapy was performed, record that it was recommended but is not known if the procedure was administered.
    - For example, record "Radiation Therapy, recommended; unknown if given.
- If the MD has documented a treatment plan, but treatment has not yet been initiated, enter the "planned treatment" specifics in the respective treatment text field, including MD or facility where treatment will be delivered.
- If there is a delay in planned treatment and the treatment has not been initiated, enter the "planned treatment" specifics in the respective treatment text field and the reason for the delay.
- The following rules are to be followed to determine FCOT, and they are in the order of precedence:
    - 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.
    - If the patient is treated according to a facility's standards of practice, first course ends at the completion of the treatment.
    - FCOT includes all treatment received before disease progression or treatment failure.
    - 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.
    - 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.
    - 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.

- Treatment text fields should collectively support the data item RX Summary-Treatment Status. This data item is a summary of whether treatment was given, including an option that identifies active surveillance or watchful waiting.

Text – Surgery

Surgery of the Primary Site (Volume 1)

- Record:
  - Date and name of 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.

    Examples:

    1. 11/1/21 Lt segmental mastectomy w/SLN bx
    2. 4/1/21: Laparoscopic Sigmoid colectomy w/ Reg LND

Text – Radiation Therapy

Radiation Therapy – First Course of Treatment (Volume 1)

- Record information for **all** radiation therapy phases in the first Text – Radiation Therapy field.
  - Your software vendor may allow text to be entered for *each* phase, but only text from the *first* phase will be transmitted to the CCR and used during Visual Editing and other QC processes to validate coded values are correct.
- For each radiation phase, record in chronological order, the following information from the treatment summary to support the radiation data items:
  - Treatment start date
  - Primary Target Site/Treatment Volume, including radiation to draining lymph nodes
    - E.g. RUL Lung
  - Treatment modality
    - E.g. Ext Beam 6MV Photons or Intracavitary Brachytherapy, HDR
  - External Beam Planning Technique
    - E.g. IMRT, Stereotactic radiotherapy

- Dose per fraction
  - E.g. 266 cGy
- Number of Fractions
  - E.g. 16fx
- Total Dose
  - E.g Total 4256 cGy

Examples:

1. 12/30/21-1/21/22 Whole lt breast XRT, 3D-CRT, photons, 266 cGy x 16 fxs, 4256 cGy total
2. 1/22/21-1/25/22 Partial lt breast XRT, 3D-CRT, electrons, 250 cGy x 3 fxs, 750 cGy total

Systemic Therapy Text Fields

Text - Chemotherapy
Text - Hormone Therapy
Text - Immunotherapy

- Use SEER*Rx to determine if the agent is chemotherapy, hormonal therapy, immunotherapy, or an ancillary agent (non-cancer directed).
  - If a drug regimen is given to the patient, review each agent in SEER*Rx separately.
  - SEER*Rx indicates in the **Coding** section if the agent should be coded on the abstract. Only include information in text for agents that should be coded.
  - Read the remarks in SEER*Rx carefully, as some agents should be coded only in specific circumstances (e.g. Prednisone is only coded if part of a drug regimen).
- Record the following information in the appropriate text field (e.g. Chemotherapy agent recorded in Text-Chemotherapy).
  - Treatment start date
  - Agent(s)
  - Reason for no treatment if systemic therapy would be expected.
    - E.g. Patient co-morbidities
    - E.g. Patient refused recommended treatment

- Transplant/Endocrine Procedures should be recorded in Text-Immunotherapy since there is no corresponding text field for the Transplant/Endocrine data items. Record:
    - Date of transplant/procedure
    - Type of procedure. Provide enough information to justify the Transplant/Endocrine Procedure Code data item.
- Surgeries that are considered Endocrine therapy for the primary site should be recorded in Text – Hormonal Therapy (e.g. Bilateral Salpingo-Oophorectomy for Breast primary).

Examples:

- No chemo recommended:
    - Text - Chemotherapy: Per Dr. Smith chemo not rec based on low oncotype
- Letrozole started 11/26/21:
    - Text – Hormonal Therapy: 11/26/21 started Letrozole, planned x 5 yrs
- Cybor-D *regimen* started 09/01/21 for Multiple Myeloma:
    - Text – Chemotherapy: 9/1/21 Cytoxan, Velcade
    - Text – Hormonal Therapy: 9/1/21 Dexamethasone
        - Dexamethasone can be either an ancillary agent or a hormone. Per SEER*Rx, it is coded as hormonal therapy for multiple myeloma.

Text – Other Therapy

Other Therapy – First Course of Treatment

- Record information for definitive cancer-directed therapy that cannot be assigned to any other category.
- Record:
    - Date of therapy
    - Type of therapy. Provide enough information to justify the Other Therapy Code data item.

      Example: Optune treatment for Glioblastoma 10/1/21 - Optune is a treatment device that fights cancerous brain tumors using electrical energy fields. Text – Other Therapy: 10/1/21 Optune treatment

Text – Final Diagnosis

- Record the final diagnosis (FDX) as determined by a recognized medical practitioner as documented in the Discharge Summary or Progress Notes.
- Record the date of the notation and the final diagnosis, including stage if given. Include "per MD" or "per Dr XYZ" to indicate to regional registry staff that the diagnosis came from a medical professional and not from the abstractor.
- If there is no final diagnosis in the medical record, record NR; do not leave this data item blank.
    - Do not record the diagnosis as determined by the abstractor.
    - Do not repeat information that has already been recorded in Text-Pathology.

      Examples:

      1. cT1c N0 M0 Stage IA, pT1c (m) N0 (sn) M0 Stage IA, UOQ Lt Breast, IDC, Grade II per MD
      2. 10/15/21 Stage IIIB Rt Colon Cancer per Dr XYZ

Quality Control

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

1. Global view
    - Give the abstract a visual "once over" review.
    - Are any required fields blank?
    - Are all coded data elements supported and verified in text fields?
2. Case information validation
    - Is the class of case supported by the diagnostic and treatment information?
    - Has the correct CoC Accredited flag been selected? (If your software vendor requires this to be manually selected for each case).
3. Demographic information validation
    - Record any unusual situations in "Remarks"
    - City vs county
    - Name/ethnicity/race/birthplace/sex
4. Diagnostic evaluation data fields validation
    - Is date of diagnosis the earliest documented date? Is there a logical sequence of events from the date of diagnosis to treatment?
    - Is the diagnostic confirmation consistent with the clinical work-up and/or surgical procedures? Sequence number-are

other primaries documented in the history and physical exam text or Remarks field?

5. Cancer identification data fields validation
    - Verify primary site/sub-site text vs ICD-O-3 code.
    - Check primary site and laterality-is it a paired site?
    - Pathology-site/histology/behavior/grade/laterality
    - Is tumor size recorded in text?
6. Staging validation
    - Verify the correct Staging system(s) were used for the diagnosis year to assign stage or site specific factors.
    - 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
7. Treatment validation
    - Is there documentation of all first course treatment modalities?
    - Is date of earliest treatment recorded?
    - Is date of treatment after date of diagnosis?
8. Follow-up/outcome validation
    - Is date of last contact the same date or later than the latest treatment information?
    - Is disease status logical in relation to stage and treatment?
9. Exchange abstracts with a co-worker
    - Can you follow the sequence of events?
    - Can you easily assign codes to their text?