

Head Neck Advanced Case #3

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
PATIENT IDENTIFICATION			
1	Medical Record #	999907	From record
2	Accession #	2007xxxxx	
3	Sequence #	00	No history other malignancies
4	Patient Name	Smithers, John	From record
5	Race 1	99	Race not documented
6	Spanish Origin	0	No mention of Hispanic origin
7	Sex	1	Male
CANCER IDENTIFICATION			
8	Class of Case	1	Dx and Tx at this facility
9	DATE 1st Contact	11/25/2007	Date admission for excision
10	DATE Initial Dx	11/25/2007	Diagnosed this admission
11	Primary Site	C001	Vermilion border, lower lip
12	Laterality	0	Not paired site
13	Histology	8070	Squamous cell CA
14	Behavior	2	In situ
15	Grade	9	Not documented
16	Diagnostic Confirmation	1	Path report
17	Ambiguous Terminology Dx	0	Definitive statement malignancy (path report)
18	Date of Conclusive Dx	88/88/8888	Dx made with definitive statement
19	Date of Multiple Tumors	00/00/0000	Single tumor
20	Mult Tumors Reported as 1 Prim	00	Single tumor
21	Multiplicity Counter	01	1 tumor only
STAGE OF DISEASE AT DIAGNOSIS			
22	DATE Surg Dx/Stage Procedure	00/00/0000	No biopsy/excision performed
23	Surg Dx/Stage Procedure Code	00	No biopsy/excision performed
24	Clinical T	is	Pathologic 'is' allowed in clinical T
25	Clinical N	0	PE Negative neck exam
26	Clinical M	0	PE Negative other mets
27	Clinical Stage Group	0	(pTis cN0 cM0) Clinical staging of in situ tumor allowed in AJCC rules
28	Clinical Stage Descriptor	0	No descriptors
29	Clinical Staged By	1	Managing physician
30	Pathologic T	is	Per path and MD staging report
31	Pathologic N	X	No LNs removed
32	Pathologic M	0	Clinical info
33	Pathologic Stage Group	99	No path staging
34	Pathologic Stage Descriptor	0	No descriptors
35	Pathologic Staged By	5	Registrar
36	SEER Summary Stage 2000	0	In situ
COLLABORATIVE STAGING			
37	CS Tumor Size	004	3-4 mm crusty lesion described on PE
38	CS Extension	00	In situ
39	CS Tumor Size/Ext Eval	3	Surgical resection
40	CS Lymph Nodes	00	Neg LN
41	CS Reg Nodes Eval	0	Clinical assessment
42	Regional Nodes Positive	98	No LNs removed
43	Regional Nodes Examined	00	No LNs removed
44	CS Mets at Dx	00	No mets
45	CS Mets Eval	0	Clinical assessment

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46	CS Site-Specific Factor 1	000	No LNs involved
47	CS Site-Specific Factor 2	888	Not applicable (No LN involvement)
48	CS Site-Specific Factor 3	000	No LNs involved
49	CS Site-Specific Factor 4	000	No LNs involved
50	CS Site-Specific Factor 5	000	No LNs involved
51	CS Site-Specific Factor 6	000	No LNs involved
FIRST COURSE OF TREATMENT (FCOT)			
52	DATE of FCOT	11/25/2007	Date of surgery
53	DATE 1st Surgical Procedure	11/25/2007	Date of surgery
54	DATE Most Definitive Surg Primary	11/25/2007	Date only surgery
55	Surg Procedure Primary Site	27	Excisional biopsy with path
56	Surg Margins Primary Site	0	Lesion extends up TO margin, not documented as involved
57	Scope Regional LN Surgery	0	No LN Surgery
58	Surg Procedure Other Site	0	No Other Surgery
59	DATE Surg Discharge	11/25/2007	Outpatient, discharge
60	Readmit Same Hosp w/in 30 Days	0	Patient not inpatient or surgery
61	Reason No Surg Primary Site	0	Surgery performed
62	DATE Radiation Started	00/00/0000	No RT done
63	DATE Radiation Ended	00/00/0000	No RT done
64	Location of Radiation Treatment	0	No RT done
65	Radiation Treatment Volume	00	No RT done
66	Regional Treatment Modality	00	No RT done
67	Regional Dose: cGy	00000	No RT done
68	Boost Treatment Modality	00	No RT done
69	Boost Dose: cGy	00000	No RT done
70	Number Treatments per Volume	00	No RT done
71	Radiation/Surgery Sequence	0	Only surgery, no sequence
72	Reason No Radiation	1	Not part of FCOT
73	DATE Systemic Therapy Started	00/00/0000	No systemic therapy
74	Chemotherapy Code	00	Not done
75	Hormone Code	00	Not done
76	Immunotherapy Code	00	Not done
77	Hematologic Trsplt & Endo Code	00	Not done
78	Systemic/Surgery Sequence	0	No systemic, no sequence
79	DATE Other Treatment Started	00/00/0000	Not done
80	Other Treatment Code	00	Not done
81	Palliative Treatment Code	00	Not done
RECURRENCE			
82	DATE 1st Recurrence	00/00/0000	No recurrence documented
83	Type 1st Recurrence	00	No recurrence documented
84	DATE Last Contact/Death	11/25/2007	Last date recorded
85	Vital Status	1	Alive
86	Cancer Status	1	No evidence disease
CASE ADMINISTRATION			
87	Is Case Complete?	Probably	Contact MD to see if any further procedures done for close margin on path report