

Colorectal Advanced Case #1 Answer Sheet

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
PATIENT IDENTIFICATION			
1	Medical Record #	123456	From record
2	Accession #	2007xxxxx	
3	Sequence #	00	No history other malignancies
4	Patient Name	Corona, John	From record
5	Race 1	01	White; Consult 2/8/07
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	02/10/2007	Date of colonoscopy w/biopsy; first date the cancer was identified. Per FORDS pg. 87--only use the date of admission if pt admitted with a cancer diagnosis. See I&R 22762.
10	DATE Initial Dx	02/10/2007	Colonoscopy w/biopsy
11	Primary Site	C187	Sigmoid colon
12	Laterality	0	Not paired organ site
13	Histology	8261	Biopsy pathology mentions villous adenoma. New histology rules state to use histo 8261 when there is a diagnosis of adenocarcinoma and there is reference to pre-existing polyps. This is an adenocarcinoma in a villous adenoma.
14	Behavior	3	Malignant, primary site
15	Grade	3	Path report states moderately to poorly differentiated. Use the higher grade, poorly differentiated.
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	02/10/2007	Biopsy
23	Surg Dx/Stage Procedure Code	02	Biopsy
24	Clinical T	X	Not enough info to stage clinically. Depth of tumor not known.
25	Clinical N	X	Not enough info
26	Clinical M	X	Not enough info
27	Clinical Stage Group	99	(TXNXMX)
28	Clinical Stage Descriptor	0	No descriptors
29	Clinical Staged By	5	Registrar
30	Pathologic T	4	Tumor stated to invade through the muscularis propria to involve the serosa and pericolic fat. The bladder excision also showed the bladder to be involved with adenocarcinoma by contiguous extension. Pathologist coded T4. Tumor directly invades other organs or structures.
31	Pathologic N	1	2/20 LNs positive. Pelvic LN mentioned in path report is distant node.
32	Pathologic M	0	None
33	Pathologic Stage Group	3B	(T4N1M0)
34	Pathologic Stage Descriptor	0	No descriptors
35	Pathologic Staged By	6	Registrar and pathologist. Registrar provided M0 and stage grouping. The pathologist provided the T4 N1.
36	SEER Summary Stage 2000	4	Reg direct extension and Reg LNs
COLLABORATIVE STAGING			
37	CS Tumor Size	075	Path report states tumor 7.5 x 6.5 x 1.7 cm
38	CS Extension	75	Extension to bladder per Path

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39	CS Tumor Size/Ext Eval	3	Path report
40	CS Lymph Nodes	10	Path report reads 2/20 positive pericolic LNs
41	CS Reg Nodes Eval	3	Path report
42	Regional Nodes Positive	02	02 LNs positive per path report
43	Regional Nodes Examined	20	20 LNs examined per path report
44	CS Mets at Dx	00	CT scan nor surg notes mentioned mets
45	CS Mets Eval	0	Clinical findings
46	CS Site-Specific Factor 1	010	CEA 13.6 – considered positive/elevated
47	CS Site-Specific Factor 2	888	Not applicable
48	CS Site-Specific Factor 3	888	Not applicable
49	CS Site-Specific Factor 4	888	Not applicable
50	CS Site-Specific Factor 5	888	Not applicable
51	CS Site-Specific Factor 6	888	Not applicable

FIRST COURSE OF TREATMENT (FCOT)

52	DATE of FCOT	02/11/2007	Segmental resection
53	DATE 1st Surgical Procedure	02/11/2007	Segmental resection
54	DATE Most Definitive Surg Prim	02/11/2007	Segmental resection
55	Surg Procedure Primary Site	32	Segmental resection w/excision part of bladder Path report indicated proximal and distal margins negative but radial margin positive.
56	Surg Margins Primary Site	2	≥ 04 regional LNs removed
57	Scope Regional LN Surgery	5	Subtotal cystectomy
58	Surg Procedure Other Site	2	Discharge
59	DATE Surg Discharge	02/25/2007	No readmission to hospital. Chemotherapy outpatient visit per progress note 3/1/07; pg 146 FORDS
60	Readmit Same Hosp w/in 30 Days	0	Surgery done
61	Reason NO Surg Primary Site	0	Not done
62	DATE Radiation Started	00/00/0000	Not done
63	DATE Radiation Ended	00/00/0000	Not done
64	Location of Radiation Treatment	0	Not done
65	Radiation Treatment Volume	00	Not done
66	Regional Treatment Modality	00	Not done
67	Regional Dose: cGy	00000	Not done
68	Boost Treatment Modality	00	Not done
69	Boost Dose: cGy	00000	Not done
70	Number Treatments per Volume	00	None
71	Radiation/Surgery Sequence	0	Only surgery done
72	Reason NO Radiation	1	Not part of FCOT
73	DATE Systemic Therapy Started	03/01/2007	FOLFOX therapy per progress Note page 17 of 18
74	Chemotherapy Code	03	Multiple agents
75	Hormone Code	00	Not done
76	Immunotherapy Code	00	Not done
77	Hematologic Trspl & Endo Code	00	Not done
78	Systemic/Surgery Sequence	3	Chemo given after surgery
79	DATE Other Treatment Started	00/00/0000	No other treatment
80	Other Treatment Code	0	Not done
81	Palliative Treatment Code	0	Not done

RECURRENCE

82	DATE 1st Recurrence	00/00/0000	No recurrence documented
83	Type 1st Recurrence	70	positive radial margins at time of surgery
84	DATE Last Contact/Death	10/05/2007	Follow-up visit
85	Vital Status	1	Pt alive
86	Cancer Status	2	Not documented as NED

CASE ADMINISTRATION

87	Is Case Complete?	Yes	
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