

**Advanced Abstracting Breast Cancer Case #04**  
**Memorial General Hospital Cancer Registry Patient Abstract**

FIELD #	FIELD NAME	CODE	DESCRIPTION	RATIONALE
<b>PATIENT IDENTIFICATION</b>				
1	Medical Record #	999904	Provided	Provided—pre-filled on the answer sheet to identify the case
2	Accession Year	2006	Provided	“
3	Sequence #	00	Provided	“
4	Last Name	Rosa	Provided	“
5	Race 1	01	White	Per race and ethnicity coding guidelines, "Mexican" is coded as white unless stated otherwise.
6	Spanish Origin	6	Mexican	Stated as Mexican under "Race" on face sheet
7	Sex	2	Provided	
<b>CANCER IDENTIFICATION</b>				
8	Class of Case	1	Dx and first-course tx	Patient was diagnosed and treated at the reporting facility and by staff physicians
9	DATE of 1st Contact	10/16/2006		Date of the mammo and ultrasound
10	DATE of Initial Dx	10/16/2006		Date of the mammo and ultrasound, both of which were diagnostic when they stated "highly suspicious for malignancy"
11	Primary Site	C501	Central portion of breast	Specifically at 12 o'clock position in retroareolar left breast without mention of areolar involvement, which translates to central breast.
12	Laterality	2	Left	Several references to left breast
13	Histology	8522	Infil duct and lobular	The core biopsy path diagnosed infiltr duct CA. The MRM path (most representative specimen) diagnosed mixed pleomorphic lobular and infiltr duct adenoca. Per Table 2, Breast Terms and Definitions, Multiple Primary and Histology Coding Rules, pleomorphic carcinoma is a specific type of duct Ca. Since we have a specific duct Ca, a duct Ca, NOS, and a lobular Ca in the same tumor, the tumor is a mixed lobular and duct Ca (8522).
14	Behavior Code	3	Invasive	Description of the histology in the path report said infiltrating
15	Grade	2	Grade 2	Path report said SBR grade 2/3, which using the BR conversion table in FORDS equates to grade 2.
16	Diagnostic Confirmation	1	Histologic	Histological diagnosis on the path report
<b>STAGE OF DISEASE AT DIAGNOSIS</b>				
17	DATE Surg Dx/Stage Procedure	10/16/2006		Ultrasound-guided core biopsy was the diagnostic procedure
18	Surg Dx/Stage Procedure Code	02	Incisional bx of primary site	Incisional core biopsy of the primary site
19	Clinical T	4b	Ulceration skin of breast/ separate lesions	History of present illness documented on the discharge summary for the MRM hospital stay mentioned ulceration and separate skin lesions (cT4b). The large size of the lesion doesn't contribute to the T stage.
20	Clinical N	1	Node involvement	OP report mentioned clinically positive axillary nodes (cN1).

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21	Clinical M	0	No distant metastasis	Documentation of the metastatic workup consisted only of a chest x-ray. However, her plan of treatment included only surgery and hormone therapy, which implies mets were not suspected (cM0).
22	Clinical Stage Group	3B		AJCC Staged: T4b N1 M0 is stage 3B.
23	Clinical Stage Descriptor	0	None	There were no special circumstances to indicate a prefix or suffix
24	Clinical Staged By	5	Cancer Registrar	Abstractor. No physician provided a clinical stage
25	Pathologic T	4b	Ulceration skin of breast/separate lesions	Pathologist's final diagnosis mentioned a 5.5 cm subareolar infiltrate tumor and multifocal involvement of the dermal skin which did not seem to be direct extension (pT4b). Ulceration of the skin and a 1 cm skin lesion were documented in the gross.
26	Pathologic N	1A	None	Only 1 of 25 axillary nodes was positive (pN1a).
27	Pathologic M	0	None	When the tumor and nodes are evaluated pathologically, a clinical M can be used for pathological staging (pM0).
28	Pathologic Stage Group	3B		AJCC Staged: T4B N1 M0 is stage 3B.
29	Pathologic Stage Descriptor	4	Classification during or after initial multi-modality therapy	The hormone Arimidex was started prior to the hospital admission or even possibly on the day of admission—date was not specifically given, but the intent was not neo-adjuvant therapy to downstage the tumor. The timing was so close to the day of surgery that the hormone would have had no effect on pathologic stage, but the y descriptor is also appropriate for concurrent therapy and should be used in this case.
30	Pathologic Staged By	5	Cancer Registrar	Pathologic stage was staged by the registrar. There was no pathologic or clinical stage documented by a physician.
31	Managing Physician's Assigned Stage	None		The managing physician did not stage the case; neither did the pathologist
32	SEER Summary Stage 2000	4	RE and RN	All the nodes mentioned were regional and the ulceration of the skin was regional extension, so the stage is regional by node involvement and direct extension, code 4.
<b>COLLABORATIVE STAGING</b>				
33	CS Tumor Size	055	5.5 cm	Largest tumor size, 5.5 cm, was provided on the MRM path report (055), the clinical sizes on the mammo and the ultrasound were both smaller. The 7 cm size mentioned on the discharge summary as being palpated on PE was not from the best source.
34	CS Extension	51	Ulcerated skin	Ulceration of the skin with satellite skin lesions

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35	CS Tumor Size/Ext Eval	6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.	Both the clinical and pathological evaluations would have provided the same CS extension code; however the hormone therapy creates an issue with preop treatment. The hormone might have been given a few days prior to the surgery but was apparently was not intended as preop "treatment". However, it probably was preop in regards to timing (CS code 6).
36	CS Lymph Nodes	25	Movable axillary lymph node(s), ipsilateral, positive	One positive node in moveable, ipsilateral axillary nodes, not identified as micromets
37	CS Reg Nodes Eval	6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.	Nodes were removed and pathologically examined after preop hormone therapy.
38	Regional Nodes Positive	01	Lymph nodes positive	Path report said 1 node was positive
39	Regional Nodes Examined	25	Lymph nodes examined	Path report said 25 nodes were examined
40	CS Mets at Dx	00	None	There was not an extensive metastatic workup documents but mets were not mentioned and treatment was consistent with loco-regional disease
41	CS Mets Eval	0	Clinical evaluation	The evaluation for mets was strictly clinical—all scans
42	CS Site-Specific Factor 1	010	Elevated ERA	ER was positive as mentioned in the core bx path report
43	CS Site-Specific Factor 2	010	Elevated PRA	PR was also positive
44	CS Site-Specific Factor 3	001	Number of Pos LN	Number of positive axillary nodes was 1. All the positive nodes were axillary.
45	CS Site-Specific Factor 4	888	Not applicable	Evaluates node negative patients, the case wasn't node-negative, so the code is 888
46	CS Site-Specific Factor 5	888	Not applicable	Targets node-negative patients, so this code is also 888
47	CS Site-Specific Factor 6	020	Clinical tumor size coded	Asks if the tumor size includes a DCIS component. This is a pathological evaluation. There was a small DCIS tumor component, but the tumor size represented only the invasive component (CS code 020).

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FIRST COURSE OF TREATMENT (FCOT)				
48	DATE of FCOT	10/26/2006		First treatment was the hormone therapy but date wasn't given; it started sometime between the biopsy date and the date of surgery, so a reasonable estimated is midway between the biopsy and MRM dates
49	DATE 1st Surgical Procedure	11/04/2006		Date of the modified radical mastectomy was 11/04/2006
50	DATE Most Definitive Surg Primary	11/04/2006		Date of the most definitive surgical resection was also the date of modified radical 11/04/2006
51	Surg Procedure Primary Site	51	Mod rad mastect w/o removal of uninvolved contralat breast	Modified radical without removal of uninvolved contralateral breast
52	Surg Margins Primary Site	0	Negative	Per the MRM path report, there was no residual tumor
53	Scope Regional LN Surgery	5	4 or more nodes removed	25 regional nodes were removed
54	Surg Procedure Other Site	0	None	No regional or distant sites were surgically removed
55	DATE Surg Discharge	11/08/2006		Documented at the top of the discharge summary
56	Readmit Same Hosp w/in 30 Days	0	None	No unplanned readmission was mentioned in the follow-up visit history of events. (This assumes case was abstracted more than 30 days after original discharge.)
57	Reason NO Surg Primary Site	0	Surgery done	Surgery to the primary was done
58	DATE Radiation Started	00000000	Not done	Radiation not done
59	DATE Radiation Ended	00000000	Not done	Radiation not done
60	Location of Radiation Treatment	0	No radiation treatment	Radiation not done
61	Radiation Treatment Volume	00	No radiation	Radiation not done
62	Regional Treatment Modality	00	Not done	Radiation not done
63	Regional Dose: cGy	00000	None	Radiation not done
64	Boost Treatment Modality	00	Not done	Radiation not done
65	Boost Dose: cGy	00000	None	Radiation not done
66	Number Treatments per Volume	00	None	Radiation not done
67	Radiation/Surgery Sequence	0	No radiation	Radiation not done
68	Reason NO Radiation	1	None	Radiation not done
69	DATE Systemic Therapy Started	10/26/2006		Used the same estimated date that was used for start of first course therapy (10/26/2006)
70	Chemotherapy Code	00	None	Not documented as given or planned
71	Hormone Code	01	Hormone therapy	Given Arimidex, a hormone
72	Immunotherapy Code	00	None	None documented as given
73	Hematologic Trspl & Endo Code	00	None	None documented as given

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74	Systemic/Surgery Sequence	4	Systemic therapy before/ after surgery	Hormones were given shortly before surgery and continued afterwards
75	DATE Other Treatment Started	00000000	None	Didn't receive so the date is 00000000.
76	Other Treatment Code	0	None	None documented as given
77	Palliative Treatment Code	0	None	None given. The intent of the documented treatment was to cure or provide a long disease-free survival
<b>RECURRENCE</b>				
78	DATE 1st Recurrence	00000000	Provided	No recurrence so date is 00000000
79	Type 1st Recurrence	00	Provided	No recurrence is coded 00
<b>FOLLOW-UP</b>				
80	DATE Last Contact/Death	11/08/2006		Date of discharge
81	Vital Status	1	Alive	Patient was alive at the follow-up visit
82	Cancer Status	1	No evidence of this tumor	The MRM left no residual cancer and no mets documented
83	Follow-up Source	0	Reported hospitalization	Follow-up information came from the initial hospital stay
84	Next Follow-up Source	1	Physician	Should be a letter to the doctor who is following
<b>CASE ADMINISTRATION</b>				
85	Abstracted by		Abstractor code	Needed to manage the database and report to the state
86	Date Abstracted	< 04/16/2007	Within six months of date of first contact	The case is required to be abstracted by this date. For the exercise, the information available should be abstracted.
87	Is more surgery info needed to complete 1 <sup>st</sup> course therapy for abstract?	<b>No</b>		Surgery information is complete.
88	Is more radiation oncology info needed?	<b>No</b>		Radiation information is complete because no radiation was done.
89	Is more systemic therapy info needed?	<b>No</b>		Hormone therapy is complete--patient continued on Arimidex.
90	Is Case Complete?	<b>Yes</b>		Abstract is technically complete.