



NPCR Education and Training Series (NETS)
Module 2: Abstracting for the Beginner
Part 3: How to Complete an Abstract

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National Program of Cancer Registries
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www.cdc.gov/cancer/npcr



This presentation is Part 3 of Abstracting for the Beginner. We will describe how to complete a cancer abstract when you have limited information.

ABSTRACT Plus

◆ Sections

- Demographic information
- Cancer identification
- Hospital-specific information
- Stage and prognostic factors
- First course of treatment
- Follow-up information
- Overrides
- State-requested items
- Confidential information

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ABSTRACT Plus is an abstracting tool used by abstractors and other individuals or groups who work with cancer data to summarize the medical record into an electronic report of cancer diagnosis and treatment. This free software was developed at CDC's Division of Cancer Prevention and Control in support of CDC's National Program of Cancer Registries (NPCR). All data items in national standard data sets, including text, are supported.

This is a quick preview of the ABSTRACT Plus software sections. Each section contains specific information about the patient and the tumor or cancer being reported. Examples used in this session are based on the NPCR required fields in the generic version of ABSTRACT Plus. It is important to note that each state central cancer registry (CCR) may require fields and/or sections in addition to what is being reviewed during this presentation of ABSTRACT Plus.

ABSTRACT Plus—Patient ID and Demographics

The screenshot displays the ABSTRACT Plus software interface. At the top, the title bar reads "ABSTRACT Plus" and the window title is "Unsaved *NEW* Abst. No. 1*". The menu bar includes "File", "Administration", "Utilities", "Reports", and "Help". Below the menu bar, there are several icons and a "Close Abstract" button. The main interface is divided into several sections:

- ABSTRACT SECTIONS:** A dropdown menu showing "CENTRLNAPCRV11".
- PATIENT ID:** A text field containing "CENTRLNAPCRV11".
- CONFIGURATION:** A dropdown menu showing "APDdefault - SEER2000 CStage calc only".
- Field List:** A table with two columns: "Field Title" and "Field Value". The "Field Title" column lists various demographic fields, including "LastName", "FirstName", "MiddleName", "MagName", "Alias", "SocSec", "DxNumAndSt", "DxSupp", "DxCity", "DxState", "DxCounty", "DxPostaCip", "Race1", "Race2", "Race3", "Race4", "Race5", "Hispanic", "BPCoDe", "BirthDate", "AgeDx", "Sex", "TxJusuaOcc", "TxJusuaInd", "DxSite", "PSite", "Lateral", "HistTypeCD03", "BehaviorCD03", "Grade", "DxConf", "TypeRepSite", "CSEx", "CSLymphNodes", "CSMetastDC", and "CSSSEF1". The "Field Value" column is currently empty.
- Name-Last:** A text field for the patient's last name.
- Current Value:** A text field for the current value of the selected field.
- Select New Value:** A button to select a new value.
- Erase Current Value:** A button to erase the current value.
- No Choice List for This Field:** A message indicating that there is no choice list for the selected field.
- Buttons:** "Ok", "Cancel", and "Field Context Help" (with a question mark icon).
- Text Fields:** A section with tabs for "Dx", "Rx", and "Misc". The "Dx" tab is selected, showing a list of diagnostic codes: "PE", "X-Ray / Scan", "Scopes", "Lab Tests", "OP", "Path", "Primary Site Title", "Histology Title", and "Staging".

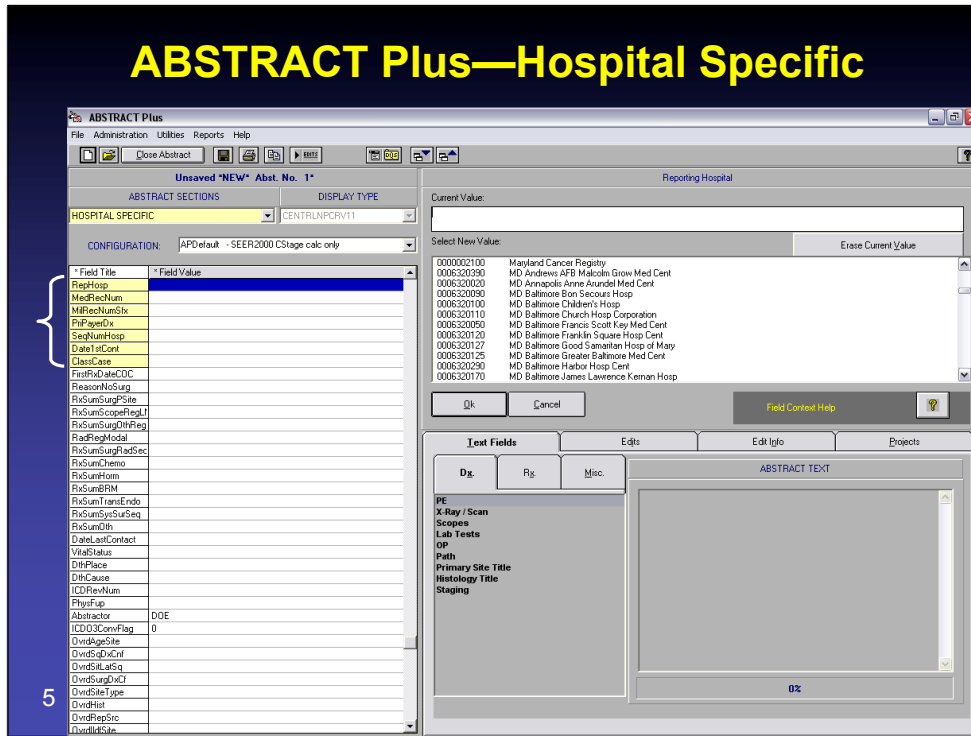
The first part of an abstract contains the demographic information on the patient. The patient's first and last name and any prefixes or suffixes that will help identify the patient should be included, such as Jr., Sr., or Fr. (Father). Also included are the patient's address at diagnosis, including street address (not a P.O. box), city, state, ZIP code, and county; Social Security number; race; and Spanish origin. Additional patient demographics are place of birth, date of birth, age (which is calculated), sex, and usual occupation and industry. The codes for each field are defined in the ABSTRACT Plus help screens as well as in the FORDS manual.

ABSTRACT Plus—Cancer ID and Stage

The screenshot displays the ABSTRACT Plus software interface. The window title is "ABSTRACT Plus" and the current form is "Unsaved NEW* Abst. No. 1*". The "ABSTRACT SECTIONS" dropdown is set to "CANCER IDENTIFICATION" and the "DISPLAY TYPE" is "CENTRLNPRV11". The "CONFIGURATION" is "APDdefault - SEER2000 CStage calc only". A list of fields is shown on the left, with "DxDate" selected. The "Current Value" field is empty. The "Text Fields" section includes "Dx", "Rx", and "Misc" tabs, with "Dx" selected. The "ABSTRACT TEXT" area is empty. A "4" is visible in the bottom left corner of the screenshot.

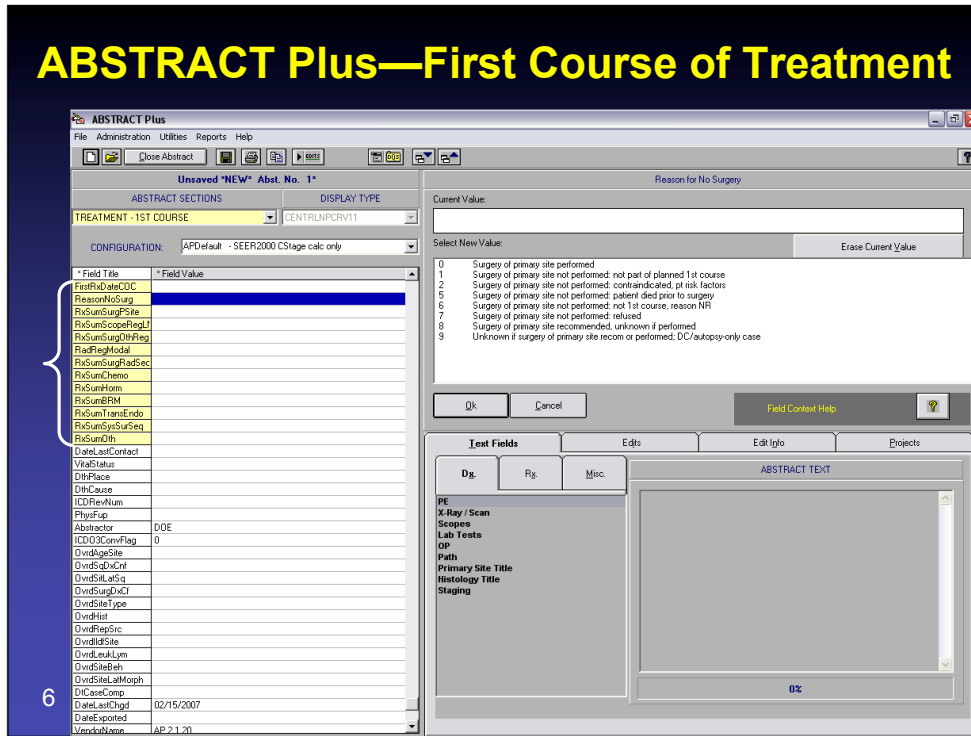
The second part of the abstract is cancer identification. The information recorded here includes the date of diagnosis, the primary site (ICD-O-3), the laterality of the tumor, the histology and behavior code (ICD-0-3), and the grade of the tumor. Diagnostic confirmation can also be recorded in this screen together with the type of reporting source. Again, the ABSTRACT Plus help screens or the FORDS manual can be used for appropriate codes and definitions.

ABSTRACT Plus—Hospital Specific



The hospital identification information includes the reporting facility identification number, medical record number, date of first contact, class of case, sequence number of this primary, and primary payer at diagnosis. With the exception of the facility identification number, each of these fields is specific to the patient and tumor being reported.

ABSTRACT Plus—First Course of Treatment



This section reports first course of treatment information. It includes any treatment planned and/or given to the patient at the time of initial diagnosis.

Treatment information should be noted in codes for each field *and* documented in text for support when available. This information is sometimes noted within text in the operative narrative or in the history and physical. For example, when the physician states that the patient received hormonal treatment prior to surgery or radiation to the prostate, it is recorded in the appropriate treatment field and in the text field.

ABSTRACT Plus—Follow-up/Recurrence/Death

The screenshot shows the ABSTRACT Plus software interface. The main window is titled 'Unsaved *NEW* Abst. No. 1*'. The 'ABSTRACT SECTIONS' dropdown is set to 'F-UP/RECURRENCE/DEATH'. The 'CONFIGURATION' is 'APDefault - SEER2000 C5stage calc only'. The 'DISPLAY TYPE' is 'CENTRLNCRV11'. The 'Vital Status' section is active, showing a 'Current Value' of '0 Dead' and a 'Select New Value' of '1 Alive'. The 'Field List' on the left includes fields such as 'DateLastContact', 'VitalStatus', 'DthPlace', 'DthCause', 'ICDRevNum', 'PhysUp', 'Abstractor', 'ICD93ComFlag', 'DvdAgeSite', 'DvdSdxCnt', 'DvdSillLeSq', 'DvdSungDxCl', 'DvdSiteType', 'DvdHist', 'DvdReopSic', 'DvdIdSite', 'DvdLeakLym', 'DvdSiteBeth', 'DvdSiteLaMorph', 'DCaseComp', 'DateLastChgd', 'DateReported', and 'VendorName'. A bracket on the left side of the field list highlights the 'DateLastContact' field. The 'ABSTRACT TEXT' area on the right contains a list of fields: 'PE', 'X-Ray / Scan', 'Scopes', 'Lab Tests', 'OP', 'Path', 'Primary Site Title', 'Histology Title', and 'Staging'.

The follow-up/recurrence/death section is where you record the latest information you have on the patient. Important elements are date of last contact, vital status, cancer status, and death information. For example, if the patient returns to your radiation therapy center for follow-up three months after his or her treatment, record the most recent date here, along with the tumor status information. If in that timespan the tumor has recurred, it would also be noted here. Remember to include the date of recurrence as well as the type.

If the patient dies during or after treatment, the death information, including date and place of death, plus cause of death if available, is also captured in this section.

ABSTRACT Plus—Overrides/Conversion/System

The screenshot shows the ABSTRACT Plus software interface. The title bar reads "ABSTRACT Plus" and the window title is "Unsaved 'NEW' Abst. No. 1". The menu bar includes "File", "Administration", "Utilities", "Reports", and "Help". The toolbar contains icons for "Close Abstract", "Print", "Save", "Cancel", and "Help".

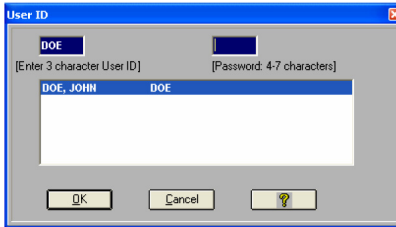
The main window is divided into several sections:

- ABSTRACT SECTIONS:** A dropdown menu showing "OVERRIDES/CONVERSION/SYSTEM ADMIN" and "DISPLAY TYPE" set to "CENTRALNCPORV1".
- CONFIGURATION:** A dropdown menu showing "APDefault - SEER2000 CStage calc only".
- Field List Table:** A table with two columns: "Field Title" and "Field Value". The "ICD-O-3 Conv Flag" field is highlighted in blue and has a value of "DOE".
- Current Value:** A text input field containing the value "0".
- Select New Value:** A dropdown menu with three options:
 - 0 Morphology not converted to ICD-O-3 (pre-2001 case)
 - 1 Morphology originally coded in ICD-O-3
 - 3 Morphology converted without review
- Buttons:** "OK", "Cancel", and "Erase Current Value".
- Text Fields Section:** A section with tabs for "Text Fields", "Edits", "Edit Info", and "Projects". It contains a list of fields: "PE", "X-Ray / Scan", "Scopes", "Lab Tests", "OP", "Path", "Primary Site Title", "Histology Title", and "Staging".

This section captures any overrides. Overrides are flags indicating that a discrepancy in the data has been checked out and verified. For instance, you may have a site and histology code combination that is questionable based on the site/histology compatibility edit. Review your pathology to verify that both site and histology are indeed correct, and code that you reviewed the information on this screen in the override site-type field.

There may be additional data fields and sections in other reporting facility cancer registry systems that are specific to state reporting. This information is used by the central cancer registry (CCR) to determine specifics about the cancer diagnosis being reported. For example, a CCR may require collection of information about the patient's smoking history or previous history of cancer. You can learn more about state-specific data fields by contacting your liaison person from the CCR.

ABSTRACT Plus



3. Type **guest** in the Password field. Notice that the system does not display the password, but displays asterisks instead. Passwords are not case sensitive.

Let's get started abstracting into the computer. Here is an example of the log on screen to access ABSTRACT Plus software. This log on information is specific to the reporter and should not be shared with anyone.

How to Complete an Abstract₁

- ◆ Abstracting a cancer diagnosis from
 - Pathology report only
 - Radiation oncology record
 - Surgical center or outpatient medical record
 - Inpatient medical record

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These are some sources that may contain a reportable cancer diagnosis. In the next several slides, we will use the ABSTRACT Plus software to create a “pathology report only” abstract of a rectal cancer, just as if we were in a pathology laboratory and want to report the case to the central cancer registry (CCR). Unfortunately, this is usually the record or document with the least amount of information available to the reporter, but reporting even “pathology report only” information is very important to assuring the completeness of data for the CCR.

Again, our examples are from the ABSTRACT Plus software. The screens or order of the data fields may differ in other cancer registry software, but the information collected and the coding systems used to complete an abstract are standardized.

How to Complete an Abstract₂

- ◆ Resource materials and Web sites
 - NPCR for Registry Plus Online Help
 - ◆ www.cdc.gov/cancer/npcr/tools/registryplus/rpoh.htm
 - Facility Oncology Registry Data Standards (FORDS)
 - Collaborative Staging Manual, current version
 - ◆ www.cancerstaging.org or www.ncra-usa.org
 - Multiple primary and histology coding rules
 - ◆ www.seer.cancer.gov/tools/mphrules/
 - SEER database on new drugs and regimens
 - ◆ www.seer.cancer.gov/seerrx for SEER Rx
 - *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)*

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Here are the resources you will need to complete an abstract, in addition to your state central cancer registry's data reporting manual. The materials can be downloaded or ordered from the Web sites provided. This software includes Registry Plus Online Help, which incorporates all these reference materials with the exception of SEER*Rx. Registry Plus Online Help is also available free from NPCR's Web site as a stand-alone product that can be used with any software.

Now it is time to complete an abstract.

How to Complete an Abstract₃

Pathology Department

Patient: Jane Doe Surgical No.: S-3364-2004

MR No.: 0001234 Proc. Date: 1/15/2004

Age/Sex : 80 F Received: 1/15/2004

Date of Birth: 1/1/1922

Clinical History: Rectal bleeding; possible metastatic rectal cancer

Gross Examination Specimen-labeled rectal biopsy. The specimen consists of tissue weighing 9 gm and measuring 1 cm × 1.2 cm.

Microscopic Examination The specimen consists of sections of rectum in which there is a moderately to poorly differentiated gland-forming neoplasm. Extent of invasion cannot be determined.

Final Diagnosis—Rectal biopsy showing moderately differentiated to poorly differentiated adenocarcinoma. Depth of invasion cannot be determined.

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Here is a pathology report of a cancer diagnosis. This is the only information you may have available for this patient. Even so, there is plenty of information to record on the abstract to report to the state central cancer registry.

Let's begin to work this information into the abstract.

How to Complete an Abstract₄

◆ Rectal Carcinoma

- Demographic information on pathology report is limited

- ◆ Name: Jane Doe

- Medical Record#: 0001234

- Sex: Female

- Date of Birth: 01/01/1922

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There is very little information available on the pathology report to complete all of the fields in the demographic information section of ABSTRACT Plus. However, we should enter whatever is available into the abstract. If no information is available, leave the field blank. Do not enter NA (for not applicable), dashes, or other marks in the field. The computer may enter a default value as you move past a data field.

Abstract of Rectal Cancer—Demographics

The screenshot shows the 'ABSTRACT Plus' software interface. The main window displays a list of demographic fields on the left and a data entry area on the right. The fields are as follows:

* Field Title	* Field Value
LastName	D O E
FirstName	J A N E
MiddleName	
MaidName	
Alia	
SocSec	999999999
DxHunkndSt	UNKNOWN
DxStg	
DxCity	UNKNOWN
DxState	ZZ
DxCountry	999
DxPostalZip	99999
Race1	99
Race2	99
Race3	99
Race4	99
Race5	99
Hispanic	9
BPCode	000
BirthDate	01/01/1922
AgeDx	082
Sex	2
TxUsualOcc	UNKNOWN
TxUsualInd	UNKNOWN
DxDate	01/15/2004
PSite	C209
Lateral	0
HistTypeCD03	8140
BehaviorCD03	3
Grade	3
DxCat	1
TypeRepSrc	1
CSEst	99
CSLymphNodes	99
CSMetast	99
CCSCat	888

The right side of the interface shows a 'Current Value' field and a 'Select New Value' dropdown menu. Below this is a 'Text Fields' section with a '76%' progress indicator. The 'ABSTRACT TEXT' field contains the following text:

3/22/02 Path only case. Records sent were based on 10/31/2003 admit c.o. rectal bleeding & metastatic rectal ca. No other info about original primary.

The information included here is specific to the facility and what it collects. Complete demographic information is not always available to the reporter. In the pathology-only case we are reviewing, the information is minimal. More information may be available about the patient if you work in a treatment facility.

Some of the information may be provided within the text of the medical record. For instance, if there is a history and physical report or a physician's admitting note, the physician might state that the patient is a Hispanic female or an African-American male. You can code the sex and race accordingly. The doctor or nurse may note that the patient was born in Puerto Rico and moved to your state in the last two years. The birthplace can then be coded to Puerto Rico. Occasionally, a patient's social history will state their occupation within the history and physical. For instance, it might say "patient is a retired accountant." The point is, you will find information pertaining to the demographic data items throughout the medical record, not just on the admissions or face sheet. It is important to use whatever information is available. In this case, the patient's last name is Doe, first name Jane. The Social Security number is unknown, so it is coded 999-99-9999. The patient's address at diagnosis is also unknown. Online help or the FORDS manual can be referred to for the appropriate codes for these fields. From the information on the pathology report, the patient's date of birth can be coded, the sex is female, and the occupation is unknown.

Remember to record information in the text fields to support your choice of codes on the abstract. For example, enter "white, non-Hispanic female" in the physical exam text box on the lower right of the screen. These words support your findings that the patient is coded 01/white, 00/non-Hispanic, and 02/female. Also report any information relative to the patient's physical signs, symptoms, and how the tumor was diagnosed on the physical examination screen. For our example case, the information about rectal bleeding that was noted on the "Clinical History" line of the pathology report is important for a diagnosis of a rectal carcinoma.

As you gain experience abstracting, you will not find it necessary to read the entire record word for word looking for information, such as multiple race codes or occupation. You will identify a pattern in the documentation that you regularly review.

Abstract of Rectal Cancer—Cancer ID, Stage

The screenshot shows the ABSTRACT Plus software interface. The main window is titled 'ABSTRACT Plus' and contains several sections:

- Abstract No. 1**: Shows 'CANCER IDENTIFICATION' set to 'CENTRLNPRV1' and 'Date Of Diagnosis' set to '01/15/2004'.
- Field List**: A table with two columns: '* Field Title' and '* Field Value'. The values are:

* Field Title	* Field Value
DxDate	01/15/2004
PSite	C209
Lateral	0
HistTypeICD03	8140
BehaviorICD03	3
Grade	3
DxCont	1
TypeRepSrc	1
CSExt	99
CSymphNodes	99
CSMetastX	99
CSSFT	888
CSSF3	888
DerivedSS2000	9
DerivedSS2000Pkg	1
CSVet1st	010300
CSVet2nd	010300
RepHosp	0006320310
MedRecNum	000001234
MIPRecNumSfx	
PrfAgeCv	99
SeqNumHosp	00
Date1stCont	01/15/2004
ClassCase	0
FirstFndJahCDC	00/00/0000
ReasonRtg	1
RxSumSugPSite	00
RxSumScopeRegL	0
RxSumSugDthPkg	0
RxRegModl	00
RxSumSugPatSec	0
RxSumChemo	00
RxSumHom	00
RxSumBRM	00
RxSumTransEndo	00
RxSumEndoCan	0
- ABSTRACT TEXT**: A large text area for entering the abstract text, currently showing 'None'.

When entering information in the text fields, it is important to be concise and use standard abbreviations when possible. You do not need to type the full pathology report or even full sentences. Just enter the pertinent information about the cell type and how far the tumor has spread. The *NAACCR Vol. II Data Standards and Data Dictionary* has a list of abbreviations in the appendices.

The information included in this section is specific to the cancer diagnosis. Record the date of diagnosis, which is the date found on the pathology report. In this case, it is 1/15/2004. The primary site is rectum. Look up the code for rectum in your ICD-O manual or the “PSite” pick list by pressing F4 in ABSTRACT Plus. The laterality is 0, not paired site. Those code choices are on the screen when you put your cursor on the Laterality field. The histology is 8140, adenocarcinoma, NOS and behavior code of /3, invasive. These codes are in ICD-O or the ABSTRACT Plus F4 pick list for “HistType ICD03”. The grade is 3, poorly differentiated. The diagnostic confirmation is code 1, positive histology, and the type of reporting source is code 1. The information is coded according to the FORDS and the ICD-O-3 manuals, both of which are in the Online Help.

In a medical record with more information, it is important as with the physical examination text, to record all of the information you have about imaging, such as X-rays and scans. Remember to include the date and type of imaging done along with the “impression” or diagnosis made by the radiologist. For our pathology-only case, you can record “none.” Do not leave the text field blank, as the quality control editor at the central registry may think you just passed over it.

Abstract of Rectal Cancer—Hospital ID

The screenshot shows the 'ABSTRACT Plus' software interface. The main window is titled 'Abstract No. 1' and 'Military Record No Suffix'. The 'HOSPITAL SPECIFIC' section is active, showing a list of fields and their values. The 'CONFIGURATION' is set to 'APD et al - SEER2000 CStage calc only'. The 'Field Title' and 'Field Value' columns are visible. The 'Text Fields' section is also visible, showing a list of fields and their values. The 'ABSTRACT TEXT' field is currently empty, with the value 'None' displayed. The '02' value is also visible in the bottom right corner of the text field area.

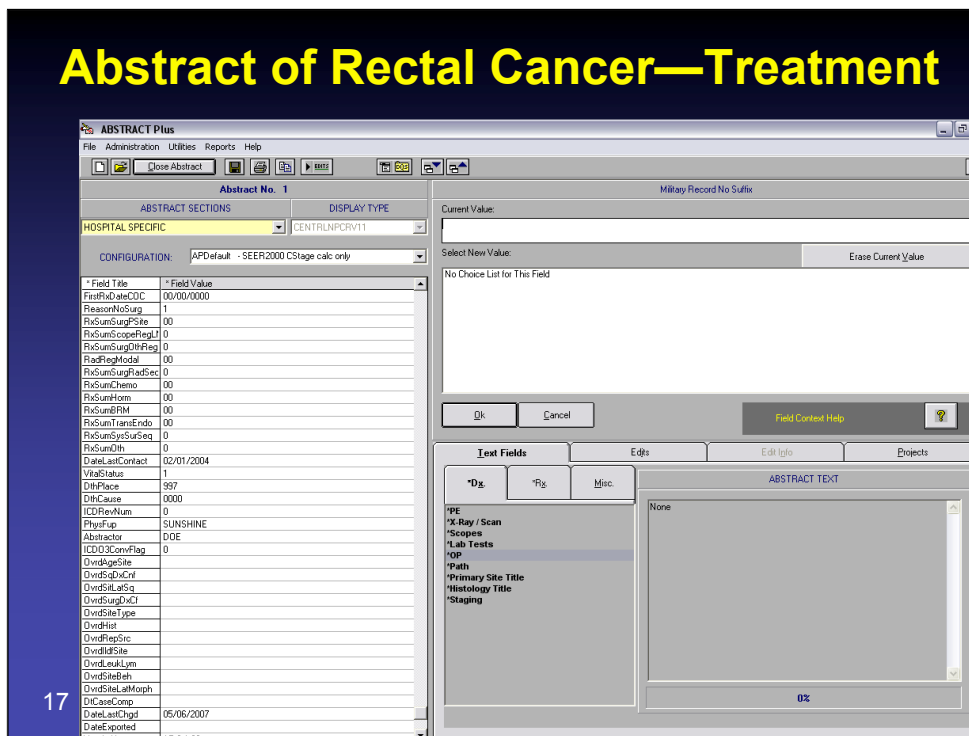
Field Title	Field Value
RegHosp	0006202710
MedRecNum	000001234
MRRecNumSix	
PIPayerDx	99
SeqNumHosp	00
DateFstCont	01/15/2004
ClassCase	0
FirstRxDateCOC	00/00/0000
ReasonNoSug	1
RxSunSurgSite	00
RxSunSurgPflg	0
RxSunSurgMdl	00
RxSunSurgFadSec	0
RxSunChemo	00
RxSunHorm	00
RxSunERM	00
RxSunTransEndo	00
RxSunSurgSeq	0
RxSunMth	0
DateFstContact	02/01/2004
VitaStatus	1
DthPlace	997
DthCause	0000
ICDRevNum	0
PhysFup	SUNSHINE
Abstractor	DOE
ICD03ConvFlag	0
DvndAgeSite	
DvndDvndCnl	
DvndStlStSc	
DvndSurgDxCl	
DvndSiteType	
DvndHist	
DvndFstSite	
DvndLstSite	

The hospital-specific information contains information about the facility reporting the case, such as the medical record number or account number. These are means of identifying the patient without using a name. Our example pathology report offers a MR# that can be recorded here. The facility identification number is noted here. Each facility has its own unique number recognized by the state or central cancer registry. The primary payer would be coded here, but in our case, it is unknown. The sequence number for this case is 00. This is the first time this patient has had a tumor reported, to our knowledge. Date of first contact is 1/15/2004, the date of the pathology report. Class of case is 0, tumor diagnosed at reporting facility, but all of first-course treatment performed elsewhere. Again, the online help or the FORDS manual can be used to find the appropriate codes and rules for these fields.

In the lower right of the abstract is the text for scopes. You can record here any information on endoscopy procedures performed. For example, this patient may have entered a surgical center for colonoscopy that resulted in this pathology report. That information would be entered as text under scopes. Again, for our pathology-only case, you can enter "none." Do not leave the text field blank.

You must also enter lab tests performed that pertain to the patient's cancer diagnosis. For instance, for a patient with prostate cancer, a PSA value would be recorded in text, under laboratory tests.

Abstract of Rectal Cancer—Treatment



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All treatment given to the patient at the time of the cancer diagnosis should be recorded if the information is available. Dates of treatment and types of treatment should be recorded if known. In this case, the treatment information is not available. In a surgical center, the surgery information would be recorded. In a radiation oncology center, the dates of treatment, treatment modality used, dose given, site treated, and so forth can all be coded and the text entered to support the codes.

Use the Online Help or FORDS manual to find the proper codes for any treatment provided. Each treatment modality has its own section with specific codes based on type of treatment and primary site.

Operative report findings must be recorded, if available. Record anything reported in the operative notes and/or procedures regarding normal or abnormal structures identified during the procedure in text. Include the date and type of procedure performed. If additional information is described about the tumor or spread of disease that may not be in the pathology report, you can note it under the operative findings.

Abstract of Rectal Cancer—Follow-up

The screenshot displays the 'ABSTRACT Plus' software interface. The main window is titled 'Abstract No. 1*' and 'Vital Status'. The interface is divided into several sections:

- ABSTRACT SECTIONS:** A dropdown menu showing 'FUP, RECURRENCE/DEATH' and 'DISPLAY TYPE' set to 'CENTRNLNCRV1'.
- CONFIGURATION:** A dropdown menu set to 'APDefault - SEER2000 CStage calc only'.
- Field List:** A table with columns 'Field Title' and 'Field Value'. The 'DateLastContact' field is highlighted in blue with a value of '02/01/2004'. Other fields include 'ReasonForSurg', 'RkSunSurgSite', 'RkSunScopeRegL', 'RkSunSurgDthReg', 'RadRegModal', 'RkSunSurgAsSec', 'RkSunChemo', 'RkSunHom', 'RkSunBRM', 'RkSunTransEndo', 'RkSunSurgSec', 'RkSunOth', 'DateLastContact', 'VitalStatus', 'DthPlace', 'DthCause', 'ICDRevNum', 'PhysFup', 'Abstractor', 'ICD10CancerFlag', 'DvrdgSite', 'DvrdgDxCrd', 'DvrdSiteSq', 'DvrdSurgD', 'DvrdSiteType', 'DvrdHist', 'DvrdRepSite', 'DvrdSite', 'DvrdLeuLym', 'DvrdSiteBeh', 'DvrdSiteMorph', 'DICaseComp', 'DateLastChgd', 'DateExported', and 'VendorName'.
- Vital Status:** A section with 'Current Value' set to 1 and a 'Select New Value' dropdown menu with options 0 (Dead) and 1 (Alive). Buttons for 'OK', 'Cancel', and 'Erase Current Value' are present.
- Text Fields:** A section with tabs for 'Text Fields', 'Edit', 'Edit Info', and 'Projects'. It contains a list of fields: '*Dx', '*Rx', 'Misc.', '*PE', '*X-Ray / Scan', '*Scopes', '*Lab Tests', '*OP', '*Path', '*Primary Site Title', '*Histology Title', and '*Staging'. A text area below contains the text: '01/15/2004 S3384-2004 Rectal BX: MD to PD adenocarcinoma.' Buttons for 'OK' and 'Field Context Help' are also visible.

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Follow-up screens are used to capture tumor information and vital status of the patient. In this case, the date of last contact is 2/1/2004. The date field can indicate a more recent date when the patient had another procedure or visit to the facility, even if that visit is unrelated to the diagnosis being reported or follow-up for the reported tumor. The date of last contact is the most recent date the patient was known to be alive. The vital status for the patient as of that date is code 1, alive. If the patient was deceased, you would code the screens accordingly. For further information about these fields, see Online Help or the FORDS manual.

One of the most important documents to capture information from is the pathology report. It is important to include the date and all text given in the final diagnosis as provided by the pathologist.

Abstract of Rectal Cancer—Overrides

The screenshot shows the ABSTRACT Plus software interface. The main window is titled 'Abstract No. 1*' and has a menu bar with 'File', 'Administration', 'Utilities', 'Reports', and 'Help'. Below the menu bar is a toolbar with various icons. The main window is divided into several sections:

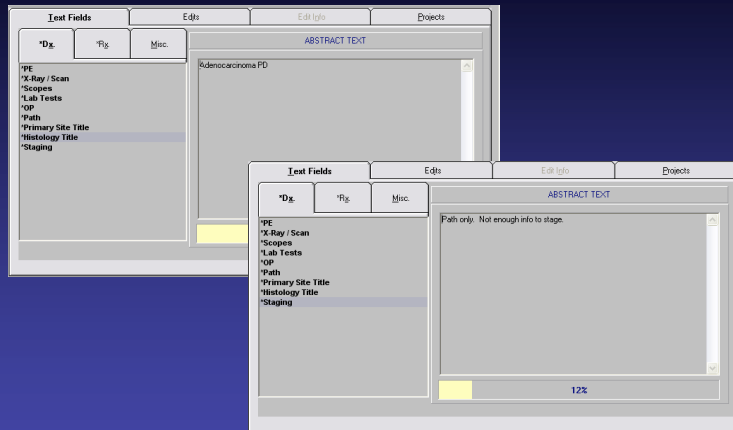
- ABSTRACT SECTIONS:** A dropdown menu showing 'OVER-RIDES/CONVERSION/SYSTEM ADMIN' and a 'DISPLAY TYPE' dropdown set to 'CENTRLNFCRV11'.
- CONFIGURATION:** A dropdown menu set to 'APDefault - SEER2000 CStage calc only'.
- Field List:** A table with two columns: 'Field Title' and 'Field Value'. The list includes fields like 'ReasonNoSurg', 'RGSumSurgFSite', 'RGSumScopeRegLI', 'RGSumSurgDthPtag', 'RGSumRegMstst', 'RGSumSurgRadSec', 'RGSumChemo', 'RGSumHorm', 'RGSumRM', 'RGSumTnuEndo', 'RGSumSysSuSeq', 'RGSumDth', 'DateLastContact', 'VitalStatus', 'DthPlace', 'DthCause', 'ICDRevNum', 'PhyFac', 'Abstractor', 'ICD10ConvFlag', 'OvrAgeSite', 'OvrSdxCnf', 'OvrSiteSc', 'OvrSurgDxC2', 'OvrSiteType', 'OvrHist', 'OvrRegSite', 'OvrDdSite', 'OvrLeukLym', 'OvrSiteBah', 'OvrSiteLabMorph', 'DthCause', 'DateLastChgd', 'DateExpted', and 'VendorName'.
- Overrides Section:** A panel titled 'Override Age/Site/Morph' with a 'Current Value' field and a 'Select New Value' dropdown. The dropdown is open, showing 'Not reviewed' and 'Reviewed'.
- Text Fields:** A panel with tabs for '*Dg*', '*Rg*', and 'Misc.'. The 'Misc.' tab is active, showing a list of fields: '*PE', '*X-Ray / Scan', '*Scopes', '*Lab Tests', '*OP', '*Path', '*Primary Site Title', '*History Title', and '*Staging'. The 'Primary Site Title' field is highlighted, and its value 'Rectum' is visible in the adjacent text field.

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The overrides sections give the reporter the opportunity to justify an unusual circumstance. In this case, there are no overrides. Remember there may be times that you will have to use this section to justify age/site, site/histology, or other discrepancies. You will know that you need to set an override when a message appears as you save and edit the case.

In the text field in the lower right, the Primary Site Title is highlighted. In this case, the primary site is the rectum. This information should also be provided in the text screen as seen here. In the pathology report under final diagnosis, the biopsy is of the rectum. In most circumstances, the site of the biopsy is the primary site of the tumor, but that is not always the case. In particular, be very careful with biopsies of the liver and lymph nodes as these are common metastatic sites for many primary cancers.

Abstract of Rectal Cancer—Text Fields



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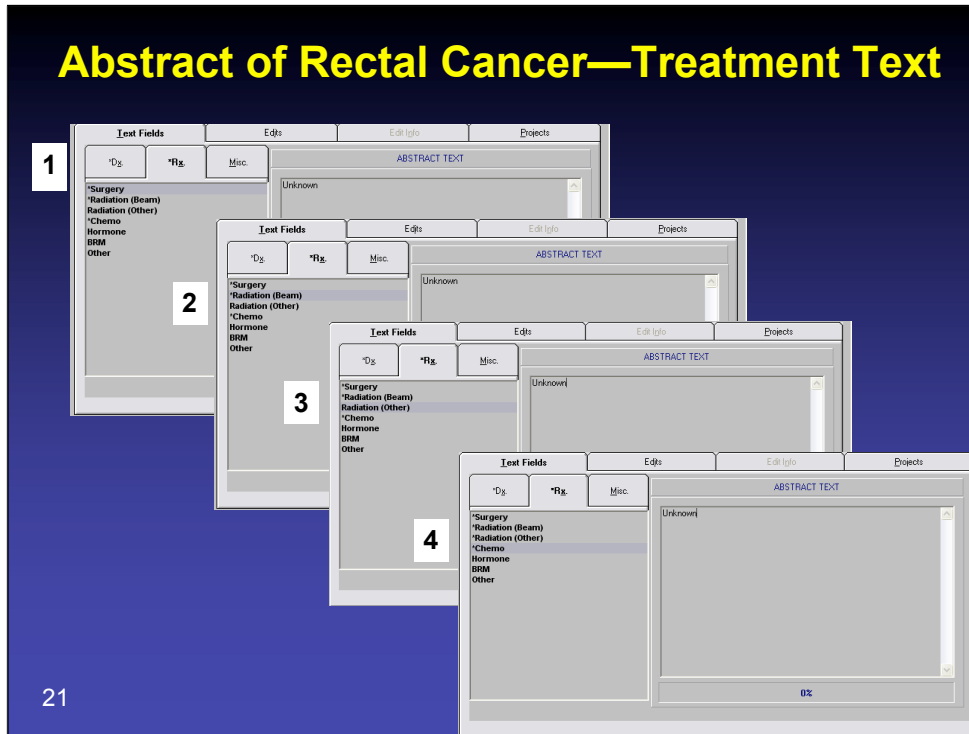


In the upper screen shot, the Histology Title is highlighted. The histology for this case is adenocarcinoma or code 8140. The behavior is 3/malignant and the grade or differentiation is poor or 3. The final complete histology code is 8140/33.

It is extremely important to support all coding with text. Each of these sections provide adequate space for text.

In the lower screen shot, Staging is highlighted. This is where text would be provided to support the stage or extent of disease. In our example pathology report, there is not enough information to provide codes for stage or extent of disease. The stage or extent of disease for our case is unknown. Remember to use your Collaborative Staging Manual when coding the extent of disease. You can find this manual at two Web sites, www.cancerstaging.org or www.ncra-usa.org. Part I of the manual will assist you with the general rules for coding the extent of disease for the primary site. Part II of the manual will provide you with the specific codes based on the extent of disease for each primary site.

Abstract of Rectal Cancer—Treatment Text



The treatment text fields are shown here. They correspond with the treatment code fields on the left side of the abstract.

In the first screen shot, Surgery is highlighted; all surgery text can be documented here. Include the type of surgical procedure performed, if known. For example, a rectal cancer case might have a low anterior resection or hemicolectomy. In our example, the pathology report was from a colonoscopy, which is not a treatment procedure, so we entered “unknown” for the type of surgical treatment.

In the second and third screen shots, specific types of radiation are highlighted, and all radiation text would be noted here. Remember that the text is to support the codes provided under the treatment section. Any additional information about radiation treatments given can be provided in text on this screen.

In the fourth screen shot, chemotherapy is highlighted. Note any chemotherapy agents or protocols on this screen, such as adriamycin and cytoxan.

The same type of comments should be added for Hormone, BRM, and Other Treatment, if any information on these is documented in the medical record.

Complete Abstract

◆ Abstract completed

- Save the document
- Check for edits/errors
- Confirm information
- Transmit data
- Log off the database

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Congratulations! You have completed an abstract.

While this is a pathology-only case and the information available is relatively limited, not all cancer reporting will be this limited. Include on the abstract any diagnostic and treatment information available to you.

Save your work. Check for edits or errors in coding. Be sure to confirm all of the codes and text prior to transmitting the case to the central cancer registry. It is extremely important for security purposes that you log off the database when you are finished abstracting. Remember that all of the information in the abstract is highly confidential.

This completes the third and final part of this presentation on cancer as a reportable disease. Thank you for your attention.