Washington State Department of Health

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Washington State Cancer Registry Text Requirements

Nearly all coded items in the abstract need text support. Text documentation is used for general quality control, visual editing, re-abstracting studies, special research projects and consolidation by the central cancer registry. Proper text documentation allows for the review and correction of abstracts without access to the patient's actual medical record. Text from the original abstract is also used to audit the central cancer registry's consolidation practices by our standard setters.

Each abstract takes a significant amount of time and effort to produce. We are all striving for consistent, accurate data. Your text validates the codes selected in your abstract and is vital to resolving discrepancies between multiple facilities who may have submitted an abstract on the same patient.

General Instructions:

- Data fields that must have text verification include patient race, age, sex and other demographics (marital status, insurance, and vital status/death information), primary site, histology, extent of disease, treatment, and any other positive/negative findings that validate the primary site, histology, extentof disease and treatment.
- The few data fields that do not need text support include date of birth, social security number, next of kin, NPI or facility numbers, phone numbers, patient address information, and medical record number.
- Please document the use of all edit overrides on unique primary site and histology combinations and provide clarification to validate unusual or difficult coding situations. Edits test the logic behind the coding rules, and overrides allow for unique case data to pass through these logical checks – overrides are double-checked at various times by the central cancer registry to avoid override abuse. This documentation is simply "Per SINQ" or "Per CAnswer Forum" or "per Tumor Board" this is correct primary site/histology.
- If information is missing or workup was not done, or a required data item is not available, please use **N/A, unknown or none.** Blanks are not acceptable values.
- Keep text concise. Avoid including irrelevant information. Use NAACCR approved abbreviations where possible (http://datadictionary.naaccr.org/?c=17).
- For full explanations and instructions for each field, please refer to the current NAACCR Data Standards and Data Dictionary: https://www.naaccr.org/data-standards-data-dictionary.

Abstract Text Requirements:

These requirements are intended to establish the *minimum* text guidelines for submitting abstracts to the central cancer registry. Your facility may require additional documentation of information relevant to the diagnosis, treatment and other aspects of the patient's cancer.

Rationales list the main data items that should be validated within these fields. If your facility requires an item indicated in a different field, e.g, Text--PE versus Text--Remarks, it is fine.

Text--Place of Diagnosis NAACCR Item #2690 Length 60	**Instructions:** Document the facility, physician office, city, state or country where the diagnosis was made. If the diagnosis was made at a small clinic or family practice, do not abbreviate the name of the practice unless it exceeds allowable space within the text box; please indicate "Cascade Family Medical Clinic" versus "CFMC."
	Rationale: If your facility is not the diagnosing facility, this is used to validate where the diagnosis was made and provides rationale for NAACCR data item #610, Class of Case. If the patient is involved in a research study, researchers will know where the medical record can be obtained.
	Example(s): UW, Seattle, WA. Harvey Smith, MD
Text--Primary Site Title NAACCR Item #2580 Length 100	**Instructions:** Document the primary site including applicable subsite along with laterality in this field.
	Rationale: Validates coded values of primary site (#400) and laterality (#410).
	Example(s): Right Breast @ 10:00 *or* Right Breast, UOQ
Text--Histology NAACCR Item #2590 Length 100	**Instructions:** Document the histology, grade and the behavior of the tumor.
	Rationale: Validates that text agrees with coded values for histology (#522), grade (#440) and behavior (#430).
	Example(s): Squamous Cell Carcinoma, G2 *or* Adenocarcinoma, Gleason 6 *or* DCIS, high grade *or* Melanoma in situ

Text--Dx Proc-Lab Tests NAACCR Item #2550 Length 1000	**Instructions:** Document cancer-specific tumor markers and dates of applicable lab results other than cytology or histopathology and/or studies done to confirm the presence of metastatic disease.
	Rationale: This field validates the coding for site specific factors, special studies, some staging items and validates information used to assign more specific histology types. If the diagnosis was made clinically, it is used to confirm clinical diagnosis.
	Example(s): Breast: 1/1/17: ER+/PR+, HER-2 neg (Score 0) on IHC 1/10/17: HER-2 by FISH neg, ratio: 1.7 *or* **Prostate:**1/1/17 PSA 10 ng/mL (elevated) *or* **Liver:** 1/17/2017 Bilirubin 2.0 mg/dL, INR<2.0, AFP 1000 ng/mL (pre-tx), 3/17/2017 AFP 200 ng/mL (post tx). 2/10/17: Ascites neg.
Text--Path NAACCR Item #2570 Length 1000	**Instructions:** Use this field to pull pertinent information from pathology reports. This includes specimen collection dates, path report numbers, procedures, tissue specimens, and any language that describes primary site, histology, laterality, behavior, grade, extent of disease, tumor size, margins, or status of lymph nodes.
	Rationale: Validates the coding of Primary Site (#400), Date of Diagnosis (#390), Histology (#522), Grade (#440), Behavior (#523), Diagnostic Confirmation (#490), extent of disease-related fields, values selected for site-specific factors, and surgical procedure and treatment fields. Validates staging information such as Pathologic Size (#754) and/or Tumor Size Summary (#756), lymph node involvement and metastasis.
	Example(s): 1/1/17 [*Facility Name/Doctor Name*] (PS-14-5687) Ascending Colon Mass Bx: Invasive mod diff adenoca w/ mucinous and signet ring cell features; 1/15/17 [*Facility Name/Doctor Name*] (SUR- 17-10587) Hemicolectomy: Sigmoid Colon, 8.0 cm, LVI: absent, Perineural Invasion: Neg, Margins (-), circumferential or radial 2.0 cm from proximal margins, LNs +2/5, +Liver Bx c/w mets, Omentum: neg. for malignancy *or* PTA 1/1/17 [*Facility/Doctor Name*] (Path N/A): Ascending colon bx performed, per referral notes mod diff adenoca found in sigmoid colon.

Text--PE NAACCR Item #2520 Length 1000	**<u>Instructions</u>:** Document the history, physical examination and clinical presentation information including any symptoms that led to workup and evaluation for cancer. This includes date of exam, age, sex, race, clinical tumor size, tumor location, palpability of lymph nodes, positive and negative clinical findings.
	<u>Rationale</u>: Validates Date of Diagnosis (#390), Class of Case (#610), Diagnostic Confirmation (#490), clinical staging information, Race (#160 - #164), Sex (#220), Spanish/Hispanic ethnicity (#190), and site-specific factors.
	<u>Example(s)</u>: 1/1/17 51 YOWF, ref to med onc, [*Doctor Name*] for consult for recent dx of cancer of the RLL Lung. Pt originally presented to ER for severe cough, imaging found nodule Rt Lung, Bx +adenoca, presents now for tx of cancer; PE: Gen: obese female, HEENT**(-)** No LNs palp**;** Lungs: Bilat crackles, Abd: Neg, NT, ND, GU: neg, Skin: NL
Text--Remarks NAACCR Item #2680 Length 1000	**<u>Instructions</u>:** Document pertinent information not indicated in other text fields. Includes smoking history, family and personal history of cancer, comorbidities/complications not documented in PE, place of birth, date of death/vital status and justification of over-ride flags.
	<u>Rationale</u>: Used to verify coded information that is not contained in any other text field. Use to validate decisions for sequencing and/or multiple primaries versus recurrence if not indicated elsewhere.
	<u>Example(s)</u>: Medicare+ private supplement. Married. Former smoking hx, quit 1984, 1ppd x10yrs, no ETOH hx, med rec states Ashkanzi Jewish decent, no fh ca, +personal hx of breast ca in 2010 s/p bilat mastectomy, reconstruction +chemo & rad. Per rule M5 new primary, tumor arose from breast tissue within the reconstruction. Ref SINQ 20120062 *or* Death Certificate Only, Autopsy only; *and/or* Patient record states "born in the Midwest" (*justifies place of birth coded to USA*). Referred to hospice 5/1/17, deceased 5/20/17.

Text--OP NAACCR Item #2560 Length 1000	**Instructions**: Document the date of surgical procedures or biopsies; include the location of tumor and what specimen was resected or biopsied. Document tumor size if provided, and note if there was residual tumor or no evidence of disease. If a surgery was aborted give a brief explanation. Document all pertinent findings that provide information for staging.
	Rationale: Validates RX Summ--Dx/Stg Proc (#1350), Surg Primary Site (#1290), Reason for No Surg (#1340) and staging decisions.
	Example(s): 1/1/17 Right Hemicolectomy, LN dissection, and Omentum Bx**:** Ascending colon, 8.0 cm mass removed, 5 peri-colonic LNs removed, bx in OP+ for adenoca, No evidence of residual tumor, margins clear. *or* 1/1/17 Laproscopic-assisted colectomy: Aborted, numerous suspicious liver lesions id'd on abdomen inspection. Surg not indicated.
Text--Scope NAACCR Item #2540 Length 1000	**Instructions**: Document the date and location of where the study occurred. If you do not have facility name, use the doctor's name. Document all endoscopic examinations and findings that provide information for staging and treatment.
	Rationale: Validates RX Summ--Dx/Stg Proc (#1350), Surg Primary Site (#1290), staging decisions, Laterality (#410), Primary Site (#400), Diagnostic Confirmation (#490), Histology (#522).
	Example(s): 1/1/17 [*Doctor Name*] Colonoscopy**:** Fungating ulcerated mass in terminal ilium, 2.0 cm, extends to margins, polyp near mass resected; 1/1/17 [*Doctor Name*] EUS w/FNA: 3.0 cm colon mass found 42 cm from anal verge, unable to complete FNA due to circumference of tumor; 1/1/17 [*Facility Name/Dr. Name*] Bronchoscopy w/FNA: in RLL, 2.5 cm mass found c/w malignancy, FNA performed.
Text--Imaging NAACCR Item #2530 Length 1000	**Instructions:** Document date, facility, imaging test performed and any pertinent results, findings and impressions.
	Rationale: Validates Date of Diagnosis (#390), clinical stage-related fields, Tumor Size Summary (#756), extent of disease-related fields, and Diagnostic Confirmation (#490).
	Example(s): 1/1/17 [*Facility Name*] CT A/P: Two pancreatic masses, one 2.5 cm arising in head of pancreas and second 2.3 cm arising in junction of head and body of pancreas; rec MR Abd; 1/10/17 MRI ABD: Progressive pancreatic duct dilatation, suggesting intraductal papillary mucinous tumor of pancreas, solid component arising in head of pancreas, susp for malignancy.

Text--Staging NAACCR Item #2600 Length 1000	**Instructions:** Document the date, doctor's name and clinical and/or pathologic staging information and the source of the staging information. Include registrar staging information.
	Rationale: Validates summary stage, clinical and pathologic T, N, M fields (#940, #950, #960, #880, #890, and #900) clinical evaluation and pathologic evaluation fields, documents registrar staging and stage group decisions.
	Example(s): 1/1/17 per Tumor Board [*Doctor Name*] Clinical Stage I cT1 cN0 cM0, Path Stage I pT1 pN0 cM0 *or* 1/1/17 Staged on colonoscopy [*Doctor Name*]: Clinical Stage 1 cT1 cN0 cM0/No path performed *and/or* per registrar cTx cN0 cM0 Stg Grp 99, tumor not assessed, no +LNs/Mets per imaging.
Text--Surgery NAACCR Item #2610 Length 1000	**Instructions:** List the surgical procedures performed and the dates.
	Rationale: Validates Date First Course RX (#1270), Date of Diagnosis, RX--Summ Surg Prim Site (#1290), Rx--Date Surg (#1200), RX SUMM--Surg/Rad Seq (#1380), Reason No Surgery (#1340).
	Example(s): 1/1/17 Right Hemicolectomy, LN dissection; 1/11/17 Omentum Biopsy
Text--Radiation NAACCR Item #2620 Length 1000	**Instructions:** Document start and end date, facility, regional and boost modalities, regional and boost sites, treatment volume and total fractions. If the sequence of surgery and radiation is not apparent from dates, indicate sequence.
	Rationale: Validates Date First Course RX (#1270), Reason for No Radiation (#1430), Rx Date Radiation (#1210), RX SUMM--Surg/Rad Seq (#1380), RAD—Regional Rx Modality (#1570).
	Example(s): 1/4/17-3/13/17 [*Facility/Doctor Name*]: 5,040 cGy to pelvis in 28 fx w/ 6 mV photons; 1,000 cGy total boost in 200 cGy x5 fx to tumor bed XRT modality unk. *or* Radiation tx given after surgery but tx summary not avail and dates unk.

Text--Chemo NAACCR Item #2640 Length 1000	**Instructions:** Document start date, facility or doctor's name and chemotherapy agents or regimen. If treatment was discontinued or not completed, state.
	Rationale: Validates RX Date Systemic (#3230), RX Date Chemo (#1220), RX Summ-Systemic/Surg Seq (#1380) and/or Date First Course RX (#1270).
	Example(s): 1/2/17 [*Treatment Ctr*], Carboplatin+Taxol, discontinued due to adverse reaction/side effects and progression of disease. 2/4 cycles completed. *or* 1/1/17 [*Doctor Name*]: Recommended Carboplatin+Taxol, pt refused *or* Referred to [*Outside Cancer Facility*], unknown if chemo recommended or performed.
Text--Hormone NAACCR Item #2650 Length 1000	**Instructions:** Document date started, facility or doctor name, and drug used.
	Rationale: Validates RX Date Systemic (#3230), RX Date Hormone (#1230), RX Summ--Systemic/Surg Seq (#1380), Date First Course RX (#1270).
	Example(s): 1/1/17 [*Facility/Doctor Name*]: Levothyroxin
Text--BRM NAACCR Item #2660 Length 1000	**Instructions:** Document start date, facility or doctor name and immunotherapy agents.
	Rationale: Date First Course RX (#1270), RX Summ--BRM (#1410), RX Summ--Transplnt/Endocrine (#3250), RX Date BRM (#1240), RX Date Systemic (#3230).
	Example(s): 1/1/17 [*Facility Name*]: Herceptin *or* 1/1/17 [*Facility Name*]: Bone marrow transplant, donor cells
Text--Other NAACCR Item #2670 Length 1000	**Instructions:** Document treatment of tumor being reported with treatment that cannot be defined as surgery, radiation or systemic therapy. This includes clinical trials and palliative care for pain control or mets.
	Rationale: RX--Summ Other (#1420), RX Date Other (#1250), Date First Course RX (#1270).
	Example(s): 1/1/17 [*Treatment Facility*]: Clinical Trial #POS5 given to pt. *or* 1/1/17 [*Doctor Name*]: Palliative consult for rad to spinal mets.

Additional Text Fields:

Text--Usual Occupation NAACCR Item #310 Length 100	**Instructions:** Document the patient's Usual Occupation. This should describe what type of work the patient performed while he/she was employed, even if the patient is now retired.
	Rationale: Required to identify occupational groups in which cancer screening or prevention activities may be useful and to identify work-related health hazards. Required for central registry occupation and industry NIOSH coding.
	Example: Asbestos Factory Worker
Text--Usual Industry NAACCR Item #320 Length 100	**Instructions:** Document the patient's Usual Industry as it relates to the Usual Occupation (#310) of the patient.
	Rationale: Required to identify industrial groups in which cancer screening or prevention activities may be useful and to identify work-related health hazards. Required for central registry occupation and industry NIOSH coding.
	Example(s): Manufacturing

References:

Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 16, 20th ed. North American Association of Central Cancer Registries. http://www.naaccr.org/StagndardsandRegistryOperations/VolumeII.aspx

Fritz, April. The Cancer Registry CASEbook. 2nd ed. Vol. II. Reno: A.Fritz and Associates, 2008.