

INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not all inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE):** Date of the exam (may be an exam done in the doctor's office, which is included in the chart). Document the location of the tumor in the breast and its size. Document if the lymph nodes are palpable. Document any other findings pertaining to the breast cancer.
- **History:**
 - Personal history of any cancers
 - Obstetrical history
 - Use of hormone replacement therapy or birth control pills
 - Family history of breast, ovarian, and/or colon cancer
 - Family history of any other type of cancer
 - Smoking and alcohol history
 - List significant, relevant co-morbidities, particularly those that impact treatment decisions.

Genetics: List appropriate conditions as found in the patient's record or other information. If not applicable, state that. For example, list the results of BRCA testing (negative or positive). If no BRCA testing was done, note that as well.

Past Treatment: If applicable, include previous chemotherapy or radiation therapy.

Where to Find the Information: H&P, consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any relevant negative findings, such as if a bone scan, lymph nodes, and breast exam were negative.

Example: 58-year-old white Hispanic female w/ abnormal screening mammo. 8-13-14 3 cm mass in UOQ L breast. Axillary and SC LN not palpable. Rest of PE neg. She is G 2, P2. Postmenopausal. Never took BCP or HRT. No FH of CA.

X-RAYS/SCOPES/SCANS

Include:

- Screening mammogram
- Diagnostic mammogram (usually a follow-up exam after a suspicious mammogram)
- Breast ultrasound (often done at the same time as the diagnostic mammogram)
- MRI of the breasts
- Document the size of the lesion, the location of it, the status of the lymph nodes, and if there is more than one lesion.
- Other scans may be done if there is a suspicion of metastatic disease. They may include a bone scan and/or a PET/CT.
- Date of each x-ray/scan, in chronological order.

- Pertinent findings such as the size of the tumor and its location, the status of the lymph nodes, the location of metastatic disease.
- Radiologic findings done prior to admission to your facility.
- If there are no positive findings, it is acceptable to say negative.

Example: Prior to admission: PTA 7-15-14
Mammo 2 cm mas at 2:00 L breast. 7-18-14
Dx mammo 2 cm mass at 2:00 L breast w/
spiculated margins. L breast US Hypoechoic
17 mm mass at UOQ L breast. Axillary LN
neg. 7-30-14 MRI breasts. No other lesions
than 19 mm mass in UOQ L breast. R breast
neg. No LAD. 8-1-14 CXR neg.

LABS

Include:

- Estrogen receptor (ER) result.
- Progesterone receptor (PR) result.
- For invasive tumors: Human Epidermal Growth Factor 2 (HER2) result. HER2 can be done by IHC or ISH. Document which method was used.
- The HER2 copy number.
- The Ki67 result.

This information can be found in the Path Report. Most often these tests are done on the tissue obtained from the biopsy and are often listed as an addendum to the original report.

Example: 8-15-14 ER, PR pos. HER2 1.2 neg
per FISH. HER2 gene cell copy 2. Ki67 2%
low.

DIAGNOSTIC PROCEDURES

Include:

- **Biopsy:** Primary site or possibly a metastatic site including lymph nodes.
- **Findings:** List findings at definitive surgery. Often there will not be much in the OP Report, except the technique used. In that case, list what the surgeon removed, such as the tumor and sentinel lymph nodes or the entire breast with sentinel lymph nodes.

- **Reconstruction:** If the entire breast is removed (and sometimes the un-involved breast is also removed), there is often immediate reconstruction with a tissue expander or an implant. This information should be documented.

Example: 9-1-14 MRM: Removed entire L breast and sentinel LN. Followed by reconstruction w/ tissue expander. No significant findings.

PATHOLOGY

Include:

- Results of the biopsy of the primary site, lymph nodes, or other sites that might have been biopsied.
- Location of the tissue removed; the histology of the tumor, including the grade of the tumor; and the Bloom-Richardson or Nottingham score (if taken from the primary site); and lymphvascular invasion (LVI).
- Invasive tumor histology and the in situ, if any. If there is no in situ, that should be noted.
- Result of the definitive surgery to include the following.
- Size of the primary tumor.
- Size of another lesion, if any.
- Size of the in situ portion, if any.
- Number of lymph nodes removed and if they were sentinel nodes or non-sentinel nodes or both and how many were examined and how many were positive for tumor.

- Histology, including the grade of the tumor and the Bloom-Richardson or Nottingham score.

- Status of the margins: negative or positive. If positive, which margins are positive.
- Presence or absence of LVI.

Where to Find this Information: Path Report and the Synoptic Comment of the Path Report.

Potential for Recurrence: A further addendum may include tests done to determine the potential for recurrence. The most common test is Oncotype dx; the second most common is Mammo-print. If both are done, both results should be documented, but the Oncotype dx takes precedence when coding the SSF.

Example: 8-15-14 Bx L breast UOQ. Infiltrating ductal carcinoma (IDC) Gr 2. Nottingham score 6/9. No in situ ca. No LVI. 9-1-14 L breast TS 2.5 cm. Infiltrating ductal ca Gr 2. Nottingham score 7/9. DCIS meas 5 mm. No LVI. Margins neg. 0+/2 sentinel LN. Oncotype dx recurrence score 20.

PRIMARY SITE

Include:

- Exact location of the tumor, such as upper outer quadrant, lower inner quadrant, 12:00 and the laterality of the tumor.

Example: Breast left upper quadrant (C50.4).

HISTOLOGY

Include:

- Histology of the tumor and the grade. If the in situ portion has a higher grade than the invasive portion of the tumor, use the grade of the invasive portion.

Example: Infiltrating ductal carcinoma Gr 2 (8500/32).

TREATMENT

Include:

- **Surgery:** Date(s) of the definitive surgery (there might be more than one) for the primary site or surgery of a metastatic site, if that was first course treatment. List the location(s) of the surgery or surgeries.
- **Radiation:** The beginning and ending date of treatment. Location of treatment. The

number of cGy to what site (breast, breast and lymph nodes, chest wall, or chest wall and lymph nodes, following a simple or modified radical mastectomy). List the cGy given for the initial or regional dose and separate listing for any boost given. List the number of fractions and the days of treatment.

- **Type of Radiation:** External beam using what MV, electrons, proton beam, Intensity-Modulated Radiation Therapy (IMRT) often used with Image-Guided Radiation Therapy (IGRT), and intracavitary as for accelerated partial radiation using a catheter. Type of catheter used, such as SAVI.
- **Chemotherapy:** Beginning date. If known, include end date. Names of the drugs used, location where the drugs were administered (usually the medical oncologist office).
- **Hormone:** Beginning date of treatment and the hormone used. Location where the hormone was given (usually the medical oncologist office).
- **Clinical Trials:** Is the patient enrolled in any clinical trials? If so, include the name, trial numbers, and any other available details, including the date of enrollment.

General Notes: It may be necessary to contact the physician's office to get this treatment information. Also, if unsure of treatment expected, refer to the NCCN guidelines.

Example: 9-1-14 L simple mastectomy. Sentinel node biopsy at our facility.

Radiation: 9-15-14 to 10-31-14 5040 cGy to L chest wall w/ 6 MV photons w/ 1000 cGy boost to tumor bed w/ 18 MV photons (28 fx/47 days). (If the discharge summary does not include the number of elapsed days, go to www.timeanddate.com/date/duration.html.)

Chemotherapy: none

Hormone: 11-15-14 Arimidex w/ Dr. Oncologist

RESOURCES

Abbreviations – Use NAACCR Standard Abbreviations

<http://naaccr.org/Applications/ContentReader/?c=17>

Evidence-Based Treatment by Stage Guidelines

http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

The NCCN Guidelines are most frequently used for treatment and are also used for information on diagnostic workup.

Labs/Tests – NCI: Understanding Lab Tests/Test Values

<http://www.cancer.gov/cancertopics/factsheet/detection/laboratory-tests>

Multiple Primary & Histology Coding Rules

<http://seer.cancer.gov/tools/mphrules/>

NCI Physician's Data Query (PDQ)

<http://www.cancer.gov/cancertopics/pdq>

Site-Specific Surgery Codes: FORDS Appendix B

<https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual>

SEER Appendix C

<http://seer.cancer.gov/archive/manuals/2010/appendixc.html>

SEER RX Antineoplastic Drugs Database

www.cancer.gov/tools/seerrx

Treatment for Breast

www.cancer.gov/cancertopics/pdq/treatment/breast/HealthProfessional/