CDRI Cancer Data Registry of Idaho

Text Documentation Requirements

Text documentation is a summary of findings and information to independently support your coded data elements. Use text to tell the story of the patient's cancer journey. Text documentation is critical for:

- Providing an explanation and validating that your interpretations and coding are correct.
- Supplementing information not transmitted with coded values.

General Guidance:

- **Be concise:** We don't need the patient's entire life story, just the cancer story.
- **Use phrases, not complete sentences:** Use punctuation for clarity; separate phrases with periods (.) or semi-colons (;).
- **Use Standard medical abbreviations**: NAACCR approved abbreviations only. No non-standard or stylistic shorthand. When in doubt, type it out.
- **Copy & Paste:** If you choose to copy & paste, review copied information. Delete information not relevant to the cancer being reported.
- **Include "relevant-to-this person/cancer" information only:** Edit your text documentation. ***If the person has multiple primaries, separate the text relating to each primary being reported.***
- **Use mixed case letters:** Avoid using all uppercase/capital letters when recording text.
- **Do not leave text fields blank:** If information is missing or there is no relevant information to record, state "None," "NR" or "NA." This helps with quality review.
- **Document in chronological order:** Date(s) or estimated date(s) in chronological order: Include for every procedure, diagnostic test, treatment, or significant event.
- **Overflow text:** Text carried over from one text area to another should be limited. Edit your text to see what you can abbreviate or delete. Overflow text may be continued in an empty text field and marked with an asterisk (*) to indicate the connection with preceding text.
- **Review text to make sure all coded elements are documented.** This helps with quality review. If it isn't documented, it wasn't done.

Required components of the text for each exam/test/treatment:

- **Dates:** Include start and end dates where appropriate.
- **Location:** Whether at your facility or an outside facility.
- **Description of event**: Name of test, study, or treatment.
- **Detailed findings**: Positive and/or negative which validate the primary site, histology, extent of disease, treatment, and outcome. (required for each exam/test/treatment)
- **Physician interpretation of findings**: Anything relevant to this person or tumor which provides the physician's impression to support the diagnosis, extent of disease, cancer stage or planned treatment.
- **Treatment plans:** Include any documented treatment plans (systemic and/or radiation) – even if treatment has not been initiated.
- **Supplemental information which cannot be coded numerically and/or clarifies special circumstances.**
  - ***Example:*** *Patient moved to live with family. (EX: Dx in Idaho, moved to Arizona. Dx in Florida, moved to Idaho).*
  - ***Example:*** *Surgery delayed due to insurance.*
  - ***Example:*** *History of cancer (site/histology, date, residency at DX).*

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Text – Physical Exam H&P
NAACCR item #2520
Field Length=1000
	• Review the H&P, physician, nurse or consult notes.
	• Exam date, facility & physician
	• What lead to the diagnosis/reason pt presents to your facility, ex: pertinent symptoms, detected on screening, incidental finding, etc.
	• Exam findings, including tumor location, size, LN status, etc.
	  • *Prostate cases must include DRE information if no DRE state no DRE.*
	  • *Lymphoma cases must include B-symptoms if no B-SX none or unknown.*
	• **Active surveillance/watchful waiting: Include the date decision for active surveillance/watchful waiting was decided.**
	• Ht/Wt/Tobacco/Insurance
	• Age, sex, race, ethnicity, marital status, occupation at time of diagnosis
	• Hx of prior cancers incl type & dx date (if known)
	• Family HX of cancer/known genetic abnormalities.
	• If patient was not a resident of Idaho at diagnosis, please include where, when, and any treatment given at diagnosis in your text

***Example**: 04/10/2021 (Facility, Dr Phil) 74 y/o white non-Hispanic married male c/o trouble urinating and elevated PSA. No hx of previous cancers; Father pos for prostate ca. Occupation unknown. PE: DRE revealed LT prostatic nodule. LNS neg. HT: 72", WT: 220#; never tobacco; Blue Cross.*	
Text – X-rays/Scans NAACCR Item #2530 Field Length=1000	• Test date, facility & type of test (chronological order); DO NOT include physician ordering/performing the test. • Read the entire body of the report, not just the impression. Size and other valuable information may be in the body. • Size & locations of ***POSITIVE*** findings – **including tumor size(s); extent of disease, LN status & met sites.** • **Record any ambiguous terms exactly as stated.** • Only report findings related to tumor being abstracted. • Relevant negative findings to establish stage
***Example**: 02/17/2022 (Facility) CT C/A/P: 4 cm RUL lung mass, involves adjacent rib, rt hilar LNs pos. Diffuse liver mets.* ***Example**: 03/14/2021 (Facility) Mammogram: Rt breast w/1.5 cm mass at 12:00 position. Rt axillary LNs neg.*	

Text – Scopes
NAACCR Item #2540
Field Length=1000
	• Date, facility, and type of endoscopic exam performed (bronchoscopy, colonoscopy, EGD, etc)
	• Detailed findings to include:
	  • Tumor location
	  • Size or no size given/found
	  • Involvement/extent of tumor spread
	  • Clinical assessment
	  • Site & type of endoscopic bx(s) taken
	  • When no positive findings, state "negative"

***Example**: 05/20/2022: (Facility) Colonoscopy: Sigmoid stricture at 30cm. Nearly circumferential mass involving the posterior part of the sigmoid colon. Biopsy taken of mass at stricture.*	

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Text – Lab Tests NAACCR Item #2550 Field Length=1000	• Test date, facility, and type of test (chronological order) • Only record tests relevant to the cancer • **Record all test information collected as SSDIs** (ER/PR/Her2, Oncotype, PSA, KRAS, NRAS etc) • Test results w/normal value reference range; If normal values are unknown, state elevated or not (if known) • Lab tests for Hematopoietic sites to back up DX Confirmation code. • Genetics/Immunophenotyping (tests listed in the Heme/Lymph database)
Example: *02/17/2020 ER 95% +, PR 95% +, Her2 equivocal 2+; FISH neg, ratio 1.2, copy# 1.8; Ki-67: 10%; Oncotype 30*	
RX Text – Op NAACCR Item #2560 Field Length=1000	• Observations noted by the surgeon found in the op note. • Date(s) & facility procedure performed (chronological order) • Descriptions of all bx(s) and all other surgical procedures from which staging information was derived. • Size of tumor • Number of LNs removed • Documentation of residual tumor • Evidence of invasion of surrounding areas
Example: *06/12/2021 (Facility) CT guided bx, LT breast 10:00; no significant findings (NSF)* ***Example:*** *07/05/2021 (Facility, MD name) Lt breast lumpectomy w/LT axillary SLN bx; 3 LNs identified and removed.*	
Text – Pathology NAACCR Item #2570 Field Length=1000	• Date of specimen/resection & facility where specimen examined (chronological order) • Pathology Accession # • Type of bx/procedure • Site & tumor size • Histology & behavior – include all modifying adjectives as stated, i.e., predominantly; w/features of; w/foci of; w/ _____differentiation etc. • Grade • Extent of tumor spread • Final margins • Name of LNs (noted as excised & /or bxd) • Number LNs pos/#LNs examined • LVI/PNI • **Treatment effect (for cases when neoadjuvant TX given)** • **Record all path information collected as SSDIs.** • Record addendums and any relevant path comments including differential dxs considered and any ruled out or favored. • If slide sent for outside consultation; record consultation results; statement of "concur" if ordering pathology lab agrees
Example: *02/06/2022 (Facility, Path Accession#): Lt breast lumpectomy: Invasive ductal carcinoma, Nottigham 9/9, G3; LT UOQ, 1.5 cm; All margins neg; LVI neg; Lt axillary SLNs neg 0/3; no prior treatment recorded; pT1cpN0(sn)*	

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RT Text – Staging NAACCR Item #2600 Field Length=1000	• All AJCC Staging as appropriate (including yc & yp) • Remember to include (m), (f), (sn) suffixes when appropriate. • **EOD Tumor/Nodes/Mets** • Summary Stage • Who performed staging (ex MD or ODS)
Example: *AJCC clinical stage per ODS: cT_ (DRE not performed) cN0 cM0 (neg on imaging), Stage 99. Not path. EOD primary tumor: 300 (localized) EOD LNs: 000 (imaging neg) EOD mets: 000 (imaging neg) SS: 1 (localized per imaging)* ***Example:*** *Clinically staged by ODS: cT1c (12 mm imaging) cN0 (imaging neg), cM0 (imaging neg) G1, stage IA; path staged by ODS and pathologist: pT1c (15 mm) pN0(sn)(0/2 sln) cM0 (imaging neg) G2 stage IA. EOD T: 100, EOD N: 070 (0/2sln) EOD M: 00 (imaging neg), SS: 1*	
RX Text – Surgery NAACCR Item # 2610 Field Length=1000	• Read the entire operative report. • Review the body of the OP note for additional information. • Date(s) & facility of procedure(s) (chronological order) • Type(s) of surgical procedure(s) performed and approach, including excisional biopsies and surgery to other distant sites. • Lymph nodes removed • Regional tissues removed • Metastatic sites • Other treatment information (ex: planned procedure aborted).
Example: *04/25/2021 (Hospital, surgeon) Robotic-assisted radical prostatectomy w/bilateral pelvic LN dissection.* ***Example:*** *06/12/2022 (Hospital, surgeon) RUQ lumpectomy w/SLN bx*	
RX Text – Radiation Beam/Other NAACCR Item #2620/#2630 Field Length=1000	• Typically found in the treatment summary • Start/end dates, facility & physician • Site(s)treated including LNs treated • Modality & planning technique, number of fractions & dose per fraction • Total phase dose • Total number of phases • Course total dose • Other treatment information with dates (ex: not recommended, refused, stopped early and reason, unknown if given)
Example: *08/30/2021 - 10/15/2021 (Facility, MD) 6 MV photon IMRT to the LT temporal lobe for 4500cgy in 25 fxs (180 cGy/FX) followed by 6 MV photon IMRT boost for 1440 cGy IN 8 FXS (180 cGy/FX), total 5940 cGy in 33 FXS over 2 phases. RT completed as prescribed.* ***Example:*** *10/03/2021- 09/07/2021 (Facility, MD) Phase I: Prostate, pelvic LNs, photons, 3D, 25/180=4500 cGy. Phase II Prostate, no LNs, photons, IMRT, 19/200=3800. Total 8300 cGy. Completed as prescribed.*	

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RX Text – Chemo NAACCR #2640 Field Length=1000	• Start date, facility & physician (chronological order) • Name(s) of chemotherapy per SEER*Rx • Other treatment information with dates (ex: not recommended, refused, cycle incomplete, unknown if given) • If there is any reason for no treatment document this as well, include date. • **Neoadjuvant therapy treatment response**
Example: *02/15/2022 (Facility, MD) R-CHOP x 6 cycles* ***Example:*** *10/17/2021 (Facility, MD) Due to patient's Alzheimer's disease, not treatment given*	
RX Text – Hormone NAACCR #2650 Field Length=1000	• Start date, facility & physician (chronological order) • Include HRT given in combination with chemotherapy. • Name(s) of hormone per SEER*Rx • Other treatment information with dates (ex: not recommended, refused, cycle incomplete, unknown if given)
Example: *02/15/2022 (Facility, MD) R-CHOP x 6 cycles* ***Example:*** *09/13/2022 (Facility, MD) Tamoxifen x 10 years*	
RX Text – BRM/Immunotherapy NAACCR # 2660 Field Length=1000	• Start date, facility & physician (chronological order) • Include BRM/Immunotherapy given in combination with chemotherapy. • Name(s) of BRM/Immunotherapy per SEER*Rx • Other treatment information with dates (ex: not recommended, refused, cycle incomplete, unknown if given)
Example: *02/15/2022 (Facility, MD) R-CHOP x 6 cycles* ***Example****: 05/12/2021 (Facility, MD) Keytruda*	
RX Text – Other NAACCR #2670 Field Length=1000	• Treatment that cannot be defined as surgery, radiation, or systemic therapy. • Start date, facility & physician (chronological order) • Type of treatment given (ex: blinded clinical trial) • Other treatment information with dates (ex: not recommended, refused, cycle incomplete, unknown if given)
Example: *11/12/2021 (Facility, MD) Blinded clinical trial, treatment not specified* **Example:** *08/12/2022 (Facility, MD) Phlebotomy*	
RX Text – Remarks NAACCR #2680 Field Length=1000	• If not listed in physical exam can document ht/wt, race, ethnicity, marital status, occupation, family history, previous cancer diagnoses w/date & sequence number if available, social history, insurance information. • Solid Tumor Rules – Document the Primary site or Histology rules used to determine number of primaries. • If the patient is a non-resident of Idaho at the time of diagnosis, document where pt lived at that time. • Follow-up information (NED, recurrence info, etc)
Example: *04/24/2022 (Facility, MD) Pt NED* ***Example****: Per STR Breast MPH 7-multiple primary* ***Example****: 03/13/2022 (Facility, MD) Pt moved to Arizona during treatment to be near family.* ***Example:*** *Pt originally dx in Arizona. No other information regarding address at diagnosis.*	

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Text - Address	• These rules apply for address at diagnosis as well as current address. • Code the street address of usual residence as stated by the patient. • A post office box is not a reliable source to identify the residency at diagnosis. PO boxes do not provide accurate geographical information for analyzing cancer incidences. • If the patient has a PO Box address, record "unknown" in the street field and record the PO Box address in the Address – Supplemental field. • Residence at diagnosis: If patient was diagnosed outside of Idaho, but then moves to Idaho, please note in the "Remarks" section where the patient was originally diagnosed. This will be the address at diagnosis information, the current address should reflect their address since moving to Idaho.
Example: *Street: UNKNOWN* *Supplemental: PO BOX 589* *City: Somewhere* *State: ID* *Zip: 99999* ***Example (Pt not Idaho resident at diagnosis):*** *Street: If known, otherwise unknown* *City: If known, otherwise unknown* *State: State pt lived when diagnosed* *Zip: If know, otherwise unknown* *County: If known, otherwise unknown*	
Text – Usual Occupation/Industry NAACCR Field #310/#320	• Record patient's usual occupation (the kind of work performed during the majority of the patient's working life before/during diagnosis). • Record the primary type of activity carried on by the business/industry where the pt was employed during the majority of the patient's working life before/during diagnosis. • Be sure to distinguish among "manufacturing," "wholesale," "retail," and service components of an industry that performed more than one of these components. • Do not record retired; if occupation unknown prior to retirement record "unknown". • If no information available record "unknown"
Example: *High School Teacher* ***Example:*** *Education* ***Example:*** *Homemaker* ***Example:*** *Own Home*	