CDRI Cancer Data Registry of Idaho	Text Documentation Accurate. Concise. Standardized	April 2026 *Version 2.0*

Text Documentation Requirements

General Guidance

- **Be Concise:** Focus solely on the cancer story, not the patient's entire life history.
- **Use Phrases:** Avoid complete sentences. Use periods (.) or semicolons (;) to separate phrases for clarity.
- **Standard Abbreviations:** Use **NAACCR-approved** abbreviations only. Avoid stylistic shorthand; when in doubt, type it out.
- **Review Copy/Paste:** If copying/pasting, delete information not relevant to the cancer being reported.
- **Relevant Information Only:** Edit documentation to include only "relevant-to-this-cancer" details. For multiple primaries, separate the text for each primary reported.
- **Mixed Case:** Use both uppercase and lowercase letters; **avoid all caps.**
- **No Blank Fields:** If information is missing, state **"None," "NR," or "NA"** for quality review.
- **Chronological Order:** List every procedure, test, and treatment by date (or estimated date) in chronological order.
- **Manage Overflow:** Limit text carried between fields by editing for brevity. If necessary, continue in an empty field marked with an asterisk (*) to show the connection.
- **Validate Coded Elements:** Ensure all coded data is supported by the text. **If it isn't documented, it wasn't done.**

Required Components (Per Exam/Test/Treatment)

- **Dates:** Include both start and end dates where applicable.
- **Location:** Specify if the event occurred at your facility or an outside facility.
- **Description of Event:** Provide the specific name of the test, study, or treatment.
- **Detailed Findings:** Record findings that validate primary site, histology, EOD, treatment, and outcome.
- **Physician Interpretation:** Include the physician's impression to support diagnosis, stage, or planned treatment.
- **Treatment Plans:** Document all planned systemic or radiation therapies, even if not yet initiated.
- **Supplemental Information:** Note non-numerical data or special circumstances (e.g., insurance delays, history of prior cancers, or moving states).

Text – Physical Exam H&P (NAACCR Item: #2520)

- **Sources:** Review H&P, physician, nurse, or consult notes.
- **Core Info:** Exam date, facility, physician, and reason for visit (symptoms/screening).
- **Exam Findings:** Tumor location, size, and LN status.
    - **Prostate:** Must include DRE (if not done, state "No DRE").
    - **Lymphoma:** Must include B-symptoms (if none, state "None" or "Unknown").
    - **Active Surveillance:** Include the date the decision for surveillance/watchful waiting was made.
- **Patient Factors:** HT/WT, tobacco, insurance, age, sex, race, ethnicity, marital status, and occupation at DX.
- **History:** Prior cancers (type/date) and family history of cancer/genetic abnormalities.
- **Residency:** If not an Idaho resident at DX, include where/when they were diagnosed and any treatment given there.

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)

- **Logistics:** Test date, facility, and type (chronological). Do **not** include the ordering physician.
- **Review:** Read the entire report body, not just the impression.
- **Positive Findings:** Include tumor size, EOD, LN status, and metastatic sites.
- **Precision:** Record ambiguous terms exactly as stated. Only report findings related to the specific tumor being abstracted.
- **Staging:** Include relevant negative findings required 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.

Text – Scopes (NAACCR Item: #2540)

- **Logistics:** Date, facility, and type of endoscopic exam (bronchoscopy, colonoscopy, EGD, etc.).
- **Findings:** Tumor location, size, involvement/extent of spread, and clinical assessment.
- **Procedures:** Note site and type of any endoscopic biopsies taken. If no 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.

Text – Lab Tests (NAACCR Item: #2550)

- **Relevance:** Only record tests relevant to cancer (chronological order).
- **SSDIs:** Record all SSDI info (ER/PR/Her2, Oncotype, PSA, KRAS, NRAS, etc.).
- **Results:** Include values with normal reference ranges; if unknown, state "elevated" or "not elevated."
- **Heme/Lymph:** Include labs/genetics/immunophenotyping to support DX Confirmation codes.

Example: 02/17/2020 ER 95% +, PR 95% +, Her2 equivocal 2+; FISH neg; Ki-67: 10%; Oncotype 30

RX Text – Op (NAACCR Item: #2560)

- **Logistics:** Date(s) and facility of procedures (chronological).
- **Findings:** Surgeon's observations, descriptions of biopsies, and surgical procedures used for staging.
- **Tumor Stats:** Tumor size, number of LNs removed, residual tumor, and evidence of invasion.

Example: 07/05/2021 (Facility, MD name) Lt breast lumpectomy w/LT axillary SLN bx; tumor found in the UOQ, 3 LNs removed.

Text – Pathology (NAACCR Item: #2570)

- **Identifiers:** Specimen date, facility, and Pathology Accession #.
- **Tumor Details:** Procedure type, site, size, Grade, LVI/PNI, and extent of spread.
- **Histology:** Include all modifying adjectives (predominantly, w/features of, etc.).
- **Nodes/Margins:** Final margins, Name of LNs, and count (Number pos/Number examined).
- **Comments:** Treatment effect (neoadjuvant), SSDI info, and outside consult results; outside consults take priority over in-house pathology.

Example: 02/06/2022 (Facility, Path Accession #: Lt breast lumpectomy: Invasive ductal carcinoma, Nottingham 9/9, G3; LT UOQ, 1.5 cm; All margins neg; LVI neg; Lt axillary SLNs neg 0/3; pT1cpN0(sn)

RT Text – Staging (NAACCR Item: #2600)

- **AJCC Staging:** Include all appropriate staging (yc/yp) and suffixes (m, f, sn).
- **Summary:** Document EOD Tumor/Nodes/Mets and Summary Stage.
- **Personnel:** Note who performed staging (MD or ODS).

Example: Clinically staged by ODS: cT1c (12 mm imaging) cN0, cM0 G1, stage IA; path staged by ODS/Path: pT1c (15 mm) pN0(sn) (0/2 sln) cM0 G2 stage IA. EOD T: 100, EOD N: 070, EOD M: 00, SS: 1

RX Text – Surgery (NAACCR Item: #2610)

- **Details:** Date(s), facility, procedure type, and approach (e.g., Robotic).
- **Removal:** Document LNs, regional tissues, or metastatic sites removed. Note if procedures were aborted.

Example: 04/25/2021 (Hospital, surgeon) Robotic-assisted radical prostatectomy w/bilateral pelvic LN dissection.

RX Text – Radiation Beam/Other (NAACCR Item: #2620 / #2630)

- **Logistics:** Start/end dates, facility, and MD.
- **Target:** Site(s) treated and specific lymph nodes.
- **Dosage:** Modality, planning, fractions, dose/fraction, phases, and total course dose.
- **Status:** Document if refused, stopped early (include reason), or not recommended.

Example: 08/30/2021 - 10/15/2021 (Facility, MD) 6 MV photon IMRT to the LT temporal lobe for 4500 cGy 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.

RX Text – Chemo (NAACCR Item: #2640)

- **Agents:** Name(s) of chemotherapy per **SEER*Rx**.
- **Status:** Document start date, facility, and MD. Note if not recommended, refused, or incomplete.
- **Neoadjuvant:** Include 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, no treatment given

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RX Text – Hormone (NAACCR Item: #2650 | Field Length: 1000)

- **Agents:** Name(s) of hormone per **SEER*Rx**.
- **Details:** Include HRT given in combination with chemotherapy. Note if refused/not recommended.

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 Item: #2660 | Field Length: 1000)

- **Agents:** Name(s) of BRM/Immunotherapy per **SEER*Rx**.
- **Details:** Include combinations with chemotherapy. Note if refused/not recommended.

Example: 02/15/2022 (Facility, MD) R-CHOP x 6 cycles

Example: 05/12/2021 (Facility, MD) Keytruda.

RX Text – Other (NAACCR Item: #2670)

- **Definition:** Treatments not defined as surgery, radiation, or systemic (e.g., clinical trials, phlebotomy).

Example: 11/12/2021 (Facility, MD) Blinded clinical trial, treatment not specified.

Example: 08/12/2022 (Facility, MD) Phlebotomy

RX Text – Remarks (NAACCR Item: #2680)

- **History:** HT/WT, race, ethnicity, marital status, occupation, and family/social history (if not in PE).
- **Rules:** Document Solid Tumor Rules used (Primary Site or Histology rules).
- **Follow-up:** Include NED or recurrence information.

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.

Text – Address

- **Coding PO Boxes:** Record **"UNKNOWN"** in the Street field. Record the PO Box in the **Address – Supplemental** field.
- **Residency:** Code street address of usual residence. If the patient was diagnosed out-of-state and then patient moves to Idaho, please note in the "Remarks" section where the patient was originally diagnosed. This will be the address at diagnosis.

Example:
Street: UNKNOWN
Supplemental: PO BOX 589
City: Somewhere
State: ID
Zip: 99999
County: 999

Example (Pt not Idaho resident at diagnosis):
Street: If known, otherwise "unknown"
Supplemental: If known, otherwise "unknown"
City: If known, otherwise "unknown"
State: State pt lived when diagnosed
Zip: If known, otherwise "unknown"
County: If known, otherwise "unknown"

Text – Usual Occupation/Industry (NAACCR Item: #310 / #320)

- **Occupation:** Kind of work performed for most of the working life. **Do not record "retired."**
- **Industry:** Primary type of activity of the business (e.g., manufacturing vs. retail).

Example: High School Teacher | **Industry:** Secondary Education

Example: Homemaker | **Industry:** Own home

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Text Documentation: Quick Reference Guide

The "Golden Rules" of Text

- **Concise & Clinical:** Focus only on the cancer story. Use phrases, not sentences.
- **Standardized:** Use **NAACCR-approved** abbreviations. If unsure, type it out.
- **Case Sensitive:** Use mixed case (Upper/Lower). **Avoid all caps.**
- **Chronological:** List all events (tests, RX, staging) by date order.
- **Justify Codes:** Text must support every numerical value. *No documentation = Not done.*

H&P / Physical Exam

- **Core:** Date, Facility, MD, and Reason for Presentation (Symptoms/Screening).
- **Site Specifics: Prostate** must include DRE; **Lymphoma** must include B-Symptoms.
- **Social:** Age, Sex, Race, HT/WT, Tobacco, Insurance, and **Usual Occupation** (not "retired").
- **History:** Prior cancers (type/date), family history, and genetic markers.

X-Rays, Scans & Scopes

- **The "Body" Rule:** Read the full report, not just the impression. Record size/location from the body.
- **Findings:** Positive findings (Size, EOD, Nodes, Mets) and relevant negatives for staging.
- **Scopes:** Type (e.g., Colonoscopy), findings, and specific biopsy sites.
- **Ambiguous Terms:** Record terms (e.g., "suggestive of") exactly as written.

Lab Tests

- **Identifiers:** Date lab drawn, facility
- **SSDIs:** Record all markers (PSA, ER/PR/Her2, Oncotype, KRAS, BRAF, etc.)
- **Results:** Include numerical values and normal reference ranges.
- **Heme/Lymph:** Document genetics and immunophenotyping to support DX code.

Pathology

- **Identifiers:** Date, Facility, and Accession Number.
- **The Specimen:** Procedure type, Histology (with all adjectives), Grade, and LVI/PNI.
- **Nodes & Margins:** Final margin status; LN names and count (Positive/Examined).
- **Consults:** Results of outside slides and whether the primary lab concurs.

Surgery & Operative

- **The Procedure:** Date, Facility, MD, and **Approach** (e.g., Robotic, Open, Lap).
- **Findings:** Surgeon's notes on residual tumor, invasion of organs, and nodes removed.

Radiation & Systemic Therapy

- **Radiation:** Start/End dates, Facility, MD, Modality, Fractions, and Total Dose.
- **Systemic (Chemo/Horm/BRM):** Start date, MD, and **SEER*Rx** verified agents.
- **Deviations:** Document if RX was refused, not recommended, or stopped early with the reason.

Remarks & Residency

- **Rules:** Note **Solid Tumor Rules** (STR) used for multiple primaries.
- **Residency:** If non-Idaho resident at DX, state where they lived.
- **Address:** If PO Box only, Street = **UNKNOWN**; PO Box goes in **Supplemental**.
- **Follow-up:** Most recent status (NED or recurrence details).