Module 3: Abstracting

This module consists of seven units. Units 3.1-3.6 demonstrate that certain information is basic to any cancer registry abstract. Ideas for navigating through a medical record and locating pertinent information are provided. Unit 3.7 provides a list of ambiguous terms to be used when determining the reportability of a case.

After completing this module, cancer abstractors will be able to:

- Locate patient demographic information
- Locate diagnosing information
- Locate cancer information
- Locate extent of disease information
- Locate treatment information
- Be able to abstract pertinent information from a medical record
- Be able to provide summarized text documentation for the coding of diagnostic procedures, findings and treatment information
- Be able to recognize ambiguous terms considered as diagnostic of cancer, as well as, a list of terms not considered as cancer

Abstracting module was borrowed in part from note pages of a PowerPoint presentation The Art of Abstracting by Susan Van Loon, RN, CTR.

Module 3.1: Abstracting Hints

Each healthcare facility has its own procedures for organizing a medical record. However, medical records have certain characteristics in common. Usually, a record will be organized with the latest admission located at the front of the record. Most information includes patient identification, biographical information, medical history, physical exam, summary sheets and reports pertinent to the malignancy. Abstracting should be done from the actual reports in the record and not from the point of view of the attending physician.

A separate abstract is prepared for each unrelated malignancy.

It is acceptable to change data items such as primary site, histology, and stage, when information about the original diagnosis becomes more complete. If information has been added to the patient's medical record that was not available at initial diagnosis or at discharge, it is the practice to accept documentation about the case based on the latest or most complete information. The information must be supplementing the original diagnosis and not be based on changes as a result of tumor progression.

It is usually not beneficial to abstract a case immediately upon patient discharge from the healthcare facility; especially if cancer directed treatment has not been completed. Accepted practice allows that cases be abstracted within six months of the date of diagnosis. This offers the opportunity for all pertinent diagnostic and treatment information to be collected in the medical record.

Before abstracting cases, the cancer registrar should:

- Be well acquainted with medical terminology and anatomy and physiology
- Understand the composition and organization of the medical record
- Determine whether a case is reportable

Getting Started

Review the medical record for clues

- Face Sheet
- History & Physical (H&P)
- Imaging Reports
- Cytology Reports
- Pathology Reports
- Surgery Reports
- Consult Reports
- Discharge Summary

Note: *An abstract is a composite of information taken from multiple sources. Use as many of these reports as possible to obtain complete and accurate information. Unless no other reports are available, do not use the Discharge Summary as the sole source of information.*

Module 3.2: Face Sheet/History and Physical

Face Sheet

The face sheet contains pertinent patient information, such as:

- Name
  - Use the full name - avoid use of initials, if possible
  - Use a married woman's first name – do not use her husband's first name *Example: Mrs. Jane Smith not Mrs. John Smith*
- Social Security Number
- Date of birth:
  - Record month, day and year
- Age at initial diagnosis for the reported cancer
- Place of Birth:
  - Record state or country
- Race – *if not on the face sheet, it may be found in the H&P or Nurse's notes*
- Spanish/Hispanic Origin
- Gender
- Marital status
- Address:
  - Record the street, city and zip of current residence
  - Use the patient's residence, not the patient's billing address
- Occupation/Industry:
  - Use specific occupation/industry information, such as Carpenter/Construction
  - Do not record *RETIRED*.
  - If unknown, then record *UNKNOWN*.
- Hospital Medical Record Number

History & Physical (H&P)

The H&P contains:

- Findings relative to various body regions
- Important diagnostic statements
- Procedures planned for the patient such as, x-rays, scopes, lab tests, etc.
    - Record any pertinent information related to the malignancy.
      Example: Mass in left breast and palpable lymph node in left axilla.

Module 3.3: Imaging

X-rays/Scans/Scopes

Imaging reports contains:

- Pertinent findings about the primary tumor and metastatic sites
    - Record the date, type of x-ray, scan or scope.
    - Record all pertinent findings whether it is the primary site, extension or information about metastasis.
    - Be sure to read the whole report.
    - Be brief, highlight important information only.

- Most pertinent information can be found in the final assessment, the final impression, or the final diagnosis; however, some important information can be found in the body of the report.

  Examples:
  02/05/05 Ultrasound of abdomen-mass lesion, superior portion of the left kidney
  05/29/05 Chest x-ray negative for cancer
  09-01-05 Bronchoscopy – bronchogenic ca, tumor involving RUL
  10/3/05 Liver scan-abnormal. consistent with a central lesion, possible mets.

Module 3.4: Specimen Reports
Pathology/Bone Marrow/Cytology Reports/Laboratory Reports

Speciment Reports

Speciman reports contain:

- Pertinent findings with respect to the malignancy and metastatic sites.

Pathology Reports

Pathology reports contain very important information that may:

- Identify the primary site
- State the tumor size in the gross section or final diagnosis
- State structure and organ involvement
- State lymph node involvement

- State the extent to which the disease has spread
- State surgical margin involvement
- State Tumor Marker results
- Record the date and pathology number
- Record the name of the procedure performed
- Record the location of the primary site
- Record the size of the tumor
- Record the histologic (cell type) diagnosis, including grade (differentiation)
- Record the extent of disease within the primary site and beyond
- Record the number of lymph nodes removed and number of lymph nodes involved with the disease
- Record the tumor markers. For example: PSA levels for prostate cancer and CEA levels for colorectal cancer.

Bone Marrow Aspirations

- Record the date and report number
- Record the malignant diagnosis such as leukemia, metastasis, or any pertinent comment.
- It is not critical to abstract all of the actual lab values.

Cytology Reports

- Record the date and cytology number
- Record the results of brushings, washings, thoracentesis, and paracentesis with a cancer diagnosis.
  For example: 09-01-05 Fine Needle Aspirate (FNA) of pleural effusion returns as positive for malignant cells.

Module 3.5: Surgery and Other Treatment

Cancer directed treatment is any procedure that modifies, controls, removes, or destroys cancer tissue.

First course of treatment includes all methods of cancer directed therapy documented in the treatment plan and administered to the patient before disease progression or recurrence. Treatment may include multiple modalities. The time frame for first course of treatment may cover a long period of time e.g. a year or more. ***No therapy*** is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given.

Treatment Information

Treatment information may be located in:

- Surgical report
- Pathology report
- Radiation therapy records
- Progress notes
- Physician order sheets

- Medicine sheets
- Discharge notes

Surgery Reports

- Report the date of the surgery and name of the procedure.
- Report the primary site, tumor size, lymph node involvement and metastasis.
- Report the spread of disease on tissues that were not excised.

Note: *If there is conflicting information on the reports, please use the following hierarchy to determine the best information:*

- Pathologic information takes precedence over operative information
- Operative information takes precedence over information from imaging reports
- Information from imaging reports takes precedence over the physical exam.

  Example: If the imaging report states the tumor size is 3cm, but the pathology report states it is 2cm, then record tumor size as 2cm. If the physical exam states the tumor size as a 2cm lesion, but the imaging states it is 3cm, then record the tumor size as 3cm.

Other Treatment – Chemotherapy, Hormone therapy, Radiation therapy, Biological Response Modifiers (BRM), and Other therapy

- Report the dates
- Report all methods of therapy recorded in the treatment plan and administered to the patient

Module 3.6: One Last Step...Before Moving on to the Next Case

Perform visual editing:

- Check all dates
- Check demographic information
- Does the text support the primary site, laterality, histology and stage?
- Well summarized documentation aids in quality assurance activities
- Text documentation is required data for reporting to the Tennessee Cancer Registry.

Module 3.7: Ambiguous Terminology

Often times, the medical record clearly indicates the patient has cancer by using specific terms that are synonymous with cancer (i.e., carcinoma, adenocarcinoma, etc.). However, a diagnosis of cancer is not always clearly stated and ambiguous terminology may be used. Ambiguous terminology may appear in any source document, such as pathology report, radiology report, or from a clinical report.
An abstract must be submitted if any ambiguous term which is considered diagnostic of cancer is used (see the following list of ambiguous terms).

Ambiguous terms that are reportable

- Apparent(ly)
- Appears (effective with cases diagnosed 1/1/1998 and later)
- Comparable with (effective with cases diagnosed 1/1/1998 and later)
- Compatible with (effective with cases diagnosed 1/1/1998 and later)
- Consistent with
- Favor(s)
- Malignant appearing (effective with cases diagnosed 1/1/1998 and later)
- Most likely
- Presumed
- Probable
- Suspect(ed)
- Suspicious (for)**
- Typical (of)

Ambiguous terms that are NOT reportable
(Do not accession cases with a diagnosis based on only these terms)

- Cannot be ruled out
- Equivocal
- Possible
- Potentially malignant
- Questionable
- Rule(d) out
- Suggests
- Worrisome

***Exception:* If a cytology report indicates a specimen is "suspicious", do not interpret it as a diagnosis of cancer. Abstract the case only if a proven positive cytology, a positive pathology, other diagnostic methods, or the physician's clinical impression, support the cytology findings.

For example: A diagnosis of probable carcinoma of the colon would be considered diagnostic and the case would be reported.

A diagnosis of questionable carcinoma of the left breast would not be considered diagnostic and the case would not be reported

A possible carcinoma is not reportable.

Review for Module 3

To accurately abstract pertinent information from a medical record, a cancer registrar should be familiar with medical terminology and diagnostic procedures.

Most medical records contain patient identification information, biographical information, medical history, and physical examination.

Reports contained within a medical record include, but are not limited to: face sheet, imaging reports, cytology reports, pathology reports, surgery reports, consult reports, discharge summary.

Each healthcare facility has its own measures for organizing a medical record. Usually, a record will be organized with the latest admission located at the front of the record.

A separate abstract is generally prepared for each unrelated malignancy. Information may be added to the patient's medical record that was not available at initial diagnosis or at discharge.

It is usually not beneficial to abstract a case immediately upon discharge from the healthcare facility. Accepted practice allows for cases to be abstracted within six months of the date of diagnosis. This offers the opportunity for all pertinent diagnostic and treatment information to be collected in the medical record.