

Advanced Abstracting Breast Cancer Case #02
Memorial General Hospital Cancer Registry Patient Abstract

FIELD #	FIELD NAME	CODE	DESCRIPTION	RATIONALE
PATIENT IDENTIFICATION				
1	Medical Record #	999902	Provided	Provided—pre-filled on the answer sheet to identify the case
2	Accession Year	2007	Provided	“
3	Sequence #	00	Provided	“
4	Last Name	Green	Provided	“
5	Race 1	01	Provided	“
6	Spanish Origin	0	Provided	“
7	Sex	2	Provided	“
CANCER IDENTIFICATION				
8	Class of Case	1	Dx and first-course tx	Patient was diagnosed and treated at the reporting facility & by staff physicians
9	DATE of 1st Contact	08/10/2007		Date of the bilat mammogram and ultrasound
10	DATE of Initial Dx	08/10/2007		Date of the mammo and ultrasound both of which state carcinoma
11	Primary Site	C509	Breast, NOS	Two lesions in different sub-sites, so site is breast, NOS
12	Laterality	2	Left	Several references to left breast, needle bx says right breast “mass” but no other indication of mass, bx or even suspicion of right breast, so “right” is wrong
13	Histology	8500	Infiltrating ductal carcinoma	Most representative specimen (mastectomy) shows only infiltr duct ca. Disregard DCIS in core biopsies.
14	Behavior Code	3	Invasive	Description of the histology in the path report says infiltrating
15	Grade	2	Grade 2	The MRM path report provides the Nottingham score of 6-7 and grade 2, which are both consistent for grade 2 (see conversion table, p.15, FORDS).
16	Diagnostic Confirmation	1	Histologic	Histological diagnosis per the path reports
STAGE OF DISEASE AT DIAGNOSIS				
17	DATE Surg Dx/Stage Procedure	08/11/2007		Core biopsy date was the diagnostic procedure date
18	Surg Dx/Stage Procedure Code	02	Incis bx of primary site	Core biopsy procedure
19	Clinical T	2	More than 2 cm but not more than 5 cm	Probable measurement discrepancies on original imaging documents. 12:00 tumor is 5.4 cm on U/S and 5.4 mm on mammo. Since the 33.3 mm tumor at 1-2 o'clock is described as the larger on the ultrasound, the 5.4 mm measurement must be correct. The largest clinical size therefore is 33.3 mm or (3.3 cm) tumor at 1-2:00. There is direct extension to the skin w/thickening that doesn't meet the criteria for T4. Tumor is cT2 based on size between 2 cm and 5 cm.

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20	Clinical N	1	Movable ipsilateral axillary lymph node(s)	Palpable nodes aren't mentioned until the OP report which mentions a hard lower axilla node and other hard nodes observed as surgical exploration proceeded. Palpable, moveable nodes are N1.
21	Clinical M	0	No distant extension or mets	Metastatic workup (chest X-ray and other) was negative prior to the start of treatment. Strict AJCC rules do not include imaging information obtained after the start of any treatment. Mastectomy was performed as a result of the clinician's observations that there was no clinical evidence of metastases.
22	Clinical Stage Group	2B	Stage IIB	AJCC Staged: T2, N1, M0 is stage 2B
23	Clinical Stage Descriptor	3	Multiple primary tumors in single site	Multiple tumors in a single primary site use the "m" suffix.
24	Clinical Staged By	5	Ca Registrar	The physicians did not provide a clinical stage.
25	Pathologic T	2	More than 2 cm but not more than 5 cm	The pathologist's final diagnosis said the largest size of the invasive component was 4 cm which is T2 (between 2 and 5 cm). The direct extension to the skin w/o dermal lymphatic involvement does not meet the criteria for T4.
26	Pathologic N	2a	Mets in 4-9 axillary lymph nodes	6 of 11 axillary nodes were positive. N2a (mets in 4 to 9 nodes). Size of mets is not mentioned, so they are assumed to be larger than micromets.
27	Pathologic M	X	Distant metastasis could not be determined	PET scan was done within timing limits following surgery. PET report describes a "suspicious" mediastinal node. The SUV is in the borderline range for malignant tissue, and the size of the lymph node is not abnormally enlarged. The managing physician (medical oncologist) struggles with the significance of the mediastinal node, calling it "possibly inflammatory" and "of uncertain etiology." He does not commit to distant metastases and opts to observe and treat it further. The mediastinal node, if positive, would be M1, but it's obvious the physicians don't want to call it malignant without further observation. The ambiguity makes MX the most appropriate.
28	Pathologic Stage Group	99	Not assessed	T2, N2a, MX is stage 99.
29	Pathologic Stage Descriptor	3	Multiple primary tumors in single site	Multiple tumors in a single primary site use the "m" suffix.
30	Pathologic Staged By	6	Registrar and any of the specified physicians	Staged by the radiation oncologist (managing physician), the pathologist and the registrar. The registrar provided the Stage Group.
31	Managing Physician's Assigned Stage	T2 N2a MX		Managing physician did not provide group stage, but did document T2 N2a MX

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32	SEER Summary Stage 2000	9	Unknown	Extension to skin is regional and the nodes are regional, making the tumor at least stage 4, but the question of the mediastinal node was not resolved. There is evidence the node is a mets, but not enough evidence to be diagnostic. So, the stage is unknown.
COLLABORATIVE STAGING				
33	CS Tumor Size	040	4 cm	The largest dimension of tumors was the pathological size of 4 cm described as 1.5 cm from nipple.
34	CS Extension	20	Skin infiltration of primary breast	Extension to the skin of the breast, including nipple is code 20
35	CS Tumor Size/Ext Eval	3	Pathological resection	The evaluation was pathological resection without neoadjuvant treatment (code 3)
36	CS Lymph Nodes	25	Movable axillary lymph node(s), ipsilateral, positive	6 positive moveable axillary lymph nodes
37	CS Reg Nodes Eval	3	Regional lymph nodes removed for examination (removal of at least 1 lymph node) without pre-surgical systemic treatment	The nodes were removed and examined w/o neoadjuvant therapy, so the code is pathologic 3
38	Regional Nodes Positive	06	Number of nodes positive	Path report said 6 axillary nodes were positive
39	Regional Nodes Examined	11	Number of nodes examined	Path report said 11 nodes were examined
40	CS Mets at Dx	99	Unknown	See rationale in #27. There was an extensive metastatic workup without mets being specifically diagnosed but one suspicious mediastinal node that could not be completely assessed. The oncologist on 9/29/2007 states "mediastinal lymph node of uncertain etiology."
41	CS Mets Eval	0	Evaluation based on physical examination, imaging examination, and/or other non-invasive clinical evidence.	The evaluation for mets was strictly clinical—all scans. Note that although the Mets at Dx field is coded as unknown, the methods of evaluation were known, so this field can be coded 0 rather than 9.
42	CS Site-Specific Factor 1	010	Elevated ERA	ER was positive as mentioned in the path report and other places.
43	CS Site-Specific Factor 2	010	Elevated PRA	PR was also positive.

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44	CS Site-Specific Factor 3	006	Number of positive axillary nodes	Number of positive axillary nodes was 6. All the positive nodes were axillary.
45	CS Site-Specific Factor 4	888	Not applicable; nodes not neg	SSF4 evaluates node negative patients, the case wasn't node-negative, so the code is 888.
46	CS Site-Specific Factor 5	888	Not applicable; nodes not neg	SSF5 evaluates node negative patients, the case wasn't node-negative, so the code is 888.
47	CS Site-Specific Factor 6	020	Invasive and in situ components present, size of invasive component stated and coded in CS Tumor Size	Asks if the tumor size includes a DCIS component. This is a pathological evaluation and the 4 cm size is an invasive component only.
FIRST COURSE OF TREATMENT (FCOT)				
48	DATE of FCOT	08/18/2007		First treatment was the modified radical mastectomy done on 08/18/2007.
49	DATE 1st Surgical Procedure	08/18/2007		The date of the modified radical mastectomy was 08/18/2007 on the op report.
50	DATE Most Definitive Surg Primary	08/18/2007		Date of the most definitive surgical resection was also the date of modified radical 08/18/2007.
51	Surg Procedure Primary Site	51	Mod rad mastect w/o removal of uninvolved contralat breast	Modified radical without removal of uninvolved contralateral breast
52	Surg Margins Primary Site	0	Negative	Per the path report, the margins were uninvolved
53	Scope Regional LN Surgery	5	4 or more nodes removed	6 regional nodes were removed
54	Surg Procedure Other Site	0	None	Removal of the small amount of pectoralis muscle is included in the MRM and doesn't count as surgery to a regional site, so no procedure was done to a regional/distant site.
55	DATE Surg Discharge	99999999		Date was not given. The appropriate code is 99999999.
56	Readmit Same Hosp w/in 30 Days	0	None	No unplanned readmission was mentioned in the progress notes.
57	Reason NO Surg Primary Site	0	Surgery done	Surgery to the primary was done.
58	DATE Radiation Started	88888888	Recommended	Radiation is planned when chemotherapy is finished so the date is entered as 88888888.
59	DATE Radiation Ended	88888888	Recommended	It hasn't happened yet but recommended so 88/88/8888 is appropriate.

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60	Location of Radiation Treatment	0	No radiation treatment	Assumption is that the Radiation Oncology Clinic was at the facility (code 1) but it could be argued that because the radiation oncologist calls it "his" clinic, that this was an OP clinic separate from the hospital (code 4). However, since the radiation had not yet been given, it would be code 0.
61	Radiation Treatment Volume	00	No radiation	Rad onc said the chest wall and scar would be treated but no XRT was given yet, so the code is 00
62	Regional Treatment Modality	00	Not done	No radiation was given yet so the code is 00
63	Regional Dose: cGy	00000	None	XRT not given yet so the code is 00000
64	Boost Treatment Modality	00	Not done	Not given, so code 00
65	Boost Dose: cGy	00000	None	00000 means none was given
66	Number Treatments per Volume	00	None	None is 00
67	Radiation/Surgery Sequence	0	No radiation	No radiation would make it code 0
68	Reason NO Radiation	8	Recommended	Code 8 for radiation is planned
69	DATE Systemic Therapy Started	10/02/2007	Given	Medical oncologist documented the patient had one cycle AC chemotherapy on 10/02/2007 and refused any more of that particular regimen. The date is still correct.
70	Chemotherapy Code	03	Multiple drugs	One cycle of AC before patient refused more Adria. She started getting TAC w/o the A (Taxotere and Cytoxan w/o Adria). The type of drugs did not change, so the TC chemo was not subsequent. Since they are regimens of more than one drug, the correct code is 03.
71	Hormone Code	88	Recommended	Planned for when XRT is almost completed. Code as 88 until actually given or not given, then update code.
72	Immunotherapy Code	00	None	None given (code 00)
73	Hematologic Trspl & Endo Code	00	None	None documented as given
74	Systemic/Surgery Sequence	3	Chemo post surgery	Chemotherapy was started after surgery, and hormones are planned even later (code 3).
75	DATE Other Treatment Started	00000000	None	Didn't receive so the date is 00000000
76	Other Treatment Code	0	None	None documented as given
77	Palliative Treatment Code	0	None	None given. The intent of the documented treatment was to cure or provide a long disease-free survival
RECURRENCE				
78	DATE 1st Recurrence	00000000	Provided	No recurrence so date is 00000000
79	Type 1st Recurrence	00	Provided	No recurrence is coded 00
FOLLOW-UP				
80	DATE Last Contact/Death	12/19/2007		Date of the medical oncology visit on 12/19/2007 for foot pain possibly related to chemo. Taxotere stopped.
81	Vital Status	1	Alive	Patient alive at the follow-up visit

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82	Cancer Status	9	Unknown	Code 9 unknown. The mediastinal node issue hadn't been resolved at the last contact date. Called possible mets at last contact.
83	Follow-up Source	2	Clinic visit	The follow-up information came from the patient's follow-up visit to the medical oncologist (physician's office), which is code 2.
84	Next Follow-up Source	2	Physician	Should be letters to the radiation oncologist and the medical oncologist who are continuing to treat and follow her.
CASE ADMINISTRATION				
85	Abstracted by		Abstractor code	Needed to manage the database and report to the state.
86	Date Abstracted	< 02/10/2008	Within six months of date of first contact	The case is required to be abstracted by this date, although some of the treatment has not been started. Strictly speaking, the abstractor should update the abstract when the additional information becomes available. For the exercise, all information available should be abstracted.
87	Is more surgery info needed to complete 1 st course therapy for abstract?	No		Surgery information is complete.
88	Is more radiation oncology info needed?	Yes		Radiation information is not complete. Suggest trying to get accurate dates and other details of treatment.
89	Is more systemic therapy info needed?	Yes		Hormone therapy is not complete. Suggest getting accurate dates
90	Is Case Complete?	Yes No		Abstract is technically complete but not very accurate for doing analyses either at the hospital or the central registry levels until the treatment info is complete.