# Quiz 1

1. My software generates text that matches my codes for primary site, histology, and other key fields. Does this computer-generated text meet cancer registry requirements for text documentation?

*No. All the software will do is regurgitate the definition for the code entered. This field is used to identify and qualify the code entered and in some instances to provide more specific anatomic topography than ICD-O-3 topography codes support for sites like skin for melanoma.*

1. What is the recommended abbreviations reference to be used in the cancer registry?

*Latest Version* NAACCR Recommended Abbreviations for Abstractors (2016 is current version)

<https://www.naaccr.org/data-standards-data-dictionary/> - Appendix G

1. When the patient has a surgical resection as part of their cancer treatment – the only part of the text that is important is the pathology section, True or False? Explain.

*Surgical resection of the primary tumor plus or minus sentinel lymph node biopsy or regional lymph node dissection is a critical factor in assessing pathological staging for solid tumors. There are 4 standard required text fields used to provide documentation for different key variables of a surgical resection; NAACCR Item 2560 Text-DX Proc-Op, NAACCR Item 2570 (Text-DX-Proc-Path, and NAACCR Item 2600 (Text-Staging), and NAACCR Item 2610 (RX Text-Surgery).*

* *NAACCR Item 2560 (Text-DX Proc-Op) should convey information related to what the surgeon found when canvassing the surgical field and during the surgical procedure. Sometimes Operative Report findings are significant in that not all findings by observation include biopsy or resection of potentially involved tissue(s) or organ(s). Be sure to include dates even when only 1 procedure is performed and always when there are multiple procedures with multiple pathology reports for the same neoplasm.*
* *NAACCR Item 2570 (Text-DX-Proc-Path) should convey details from the surgical anatomic pathology report including date, accession number from path, tissue examined and final diagnosis. Comments, addenda and revisions often take priority over the original final diagnosis as they provide more specific information than the original report. Pathologic T and Pathologic N may be included on the report.*
* *NAACCR Item 2600 (Text-Staging) should not just repeat what you code in T, N, M fields or Stage Group field. It should include substantiation of what made you assign the T, N, M and Stage Group, Summary Stage, or other staging system that may apply. There is no need to repeat information from imaging or pathology – just summarize staging info.*
* *NAACCR Item 2610 (RX Text-Surgery) should provide a chronology of any surgical procedure performed whether biopsy, excision, resection or more. This is the field that needs to substantiate what you coded for Surgery of Primary Site, Scope of Regional Lymph Node Surgery and Surgery of Other Regional and/or Distant Sites. It should not include information from the operative report…only the procedures performed.*

1. Text documentation is only important for my state to do QC. True or **False**? Explain.

*Text documentation is relied upon heavily in a central cancer registry or state cancer registry. It is used when the hospital or the central registry conducts quality evaluations and is considered part of the coded abstract. Text is also used when the central registry, the hospital registry or other researchers need to look back at older abstracts to find bits of information that may be in the text but for which there are no coded fields. This is particularly important during periods of rapid or constant change as is the case in every cancer registry. Text is used as a written validation that coded data and uncoded information are valid, correct, complete, and timely. Text documentation is also used as part of reabstracting or data validation audits whether conducted by your state or by the CDC NPCR or NCI SEER Program. Text documentation may also be used by researchers when trying to identify unique characteristics for clinical research.*

1. What else is abstract text used for and who uses it?
   1. *Text is used in combination with Codes to build every Abstract*
   2. *Text is used to clarify the Continuum of Cancer Care for the patient – in English*
   3. *Text is used to identify missing information and miscoded information*
   4. *Not everything gets coded – state of technology outpaces cancer registry requirements*
   5. *Text provides supplemental information that is not coded within the coded values*
   6. *Text allows and assists the Central Cancer Registry during the process of Tumor Consolidation when the central registry brings abstracts (text and codes) together and creates a single ‘tumor record’ for each patient and each cancer. Text is used to validate information, verify chronology, identify location of treatment delivery, and much more.*

# Quiz 2

**Scenario 1**

A patient presents to your facility for imaging. The patient is found to have multiple nodules in the same lobe on imaging consistent with lung cancer

A CT of the chest showed a 3.5cm right upper lobe lesion consist with malignancy and two additional lesions in the right upper lobe measuring 1.4cm and the other less than a 1cm. The tumors were confined to the right upper lobe of the lung. No atelectasis was identified. No hilar or mediastinal lymphadenopathy. The patient did not have any biopsies done of the lung.

Per physician progress notes: The 3.5cm right upper lobe mass appears malignant. However, the two additional are more likely part of a benign process. The patient did not have any biopsies done of the lung.

The patient went on to have a right upper lobe lobectomy with chest wall resection and mediastinal lymph node dissection. Pathology revealed a 3.5cm right upper lobe squamous cell carcinoma and a 1.3cm acinar adenocarcinoma. The third nodule was benign. Thirteen lymph nodes were removed and were found to be negative.

Per the MP/H rules this is two primaries. Assign a stage to each primary.

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary 1** | | **Primary 2** | |
| Clin Stage | cT2a cN0 cM0 Stage 1B | Clin Stage | T N M Stage 99 |
| Path Stage | pT2a pN0 cM0 Stage 1B | Path Stage | pT1a pN0 cM0 Stage 1A |
| Summary Stage 1 Localized | | Summary Stage 1 Localized | |

1. A patient presents for an MRI of the head and is found to have a brain tumor. The radiologist states this is most likely a glioblastoma. The Table 56.3 in your AJCC Manual (pg 596) shows that glioblastomas are by definition a WHO Grade 4. How would you code Site Specific 1: World Health Organization (WHO) Grade Classification?
2. 030 Grade III
3. 040 Grade IV
4. **988 No histologic examination of primary site**
5. 999 Not documented in medical record; Unknown; WHO grade not stated
6. A patient presents for an MRI of the head and is found to have a brain tumor. The radiologist states this is most likely a glioblastoma. A biopsy of the brain tumor shows anaplastic astrocytoma. The Table 56.3 in your AJCC Manual (pg 596) shows that anaplastic astrocytoma by definition are WHO Grade 3 and glioblastomas are by definition a WHO Grade 4. How would you code Site Specific 1: World Health Organization (WHO) Grade Classification?
   1. **030 Grade III**
   2. 040 Grade IV
   3. 988 No histologic examination of primary site
   4. 999 Not documented in medical record; Unknown; WHO grade not stated