INFORMATIONAL ABSTRACT
A Guide to Determining What Text to Include

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient’s disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC)** Write a brief statement about why the patient sought medical care.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the melanoma, such as examination of moles and their appearance, noting color, size, and shape.
- **History:** Personal history of any cancer; family history of any cancer; smoking history: length of time, frequency, amount, type; alcohol: frequency, amount; exposures: workplace exposure and/or relevant environmental factors; significant, relevant co-morbidities, particularly those that impact treatment decisions.
- **Genetics:** List appropriate conditions as found in the patient’s record or other information. If not applicable, state that.
- **Past Treatment:** If applicable, include previous chemotherapy or radiation therapy.
- **Where to Find Information:** H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

**Example:** 55-year old white female noticed a mole on her right arm that was changing color, getting larger, itching and bleeding. This has been going on for the last month. She does not have any history of cancer in the family or cancer herself. She does not smoke and rarely drinks alcoholic beverages. She does work outside with a great deal of sun exposure. She is a gardener and is out of doors most of the day during the summer months.
MELANOMA

X-RAYS/SCOPES/SCANS
List names of all X-rays, scopes, and scans. Include dates and results.

Include:
• Imaging Reports: Chest x-ray, MRI, CT scan, PET scan (detect disease and/or metastatic spread).
• Scopes: Endoscopies, bronchoscopies (may be used to detect/confirm metastatic spread). Include name of test, date and results of test.

Example: 1/22/18 Chest x-ray showed an area quite suspicious for spread of disease in a patient with known melanoma of the right arm.

LABS
List names of all tests, dates and results.

Include:
• Lactate dehydrogenase (LDH): a blood test used to detect if the melanoma has spread to distant sites. A higher level than normal level may indicate that the cancer is harder to treat.
• Blood cell counts and blood chemistry done in advanced melanoma to see how well the bone marrow, liver and kidneys are working during treatment.

Diagnostic Procedures
For any of the diagnostic procedures, procedures that detect the cancer, but do not remove it, include the date, name of procedure, and a brief description of the findings.

Include: List names of all diagnostic procedures, dates, and summary of findings.

Testing for targeted treatments
Note: For further help with tests, values and what they mean, please consult the following website: http://www.cancer.gov/cancertopics/factsheet/detection/laboratory-tests

Example: 1/7/18 incisional biopsy of right arm mole.

PATHOLOGY
Include: Dates in chronological order; most recent to first.
• Cancer Cell Type
• Grade
• Size of the tumor (not the specimen size).
• Extent (extension) of primary tumor.
  (Usually found in the microscopic description on the pathology report).
• Lymph node involvement (or lack of it).
  (Number of lymph nodes examined and the number of lymph nodes positive for cancer).
• Evidence or indication of further spread of cancer.
• Breslow measurement (thickness or depth to which the cancer has grown).
• Ulceration noted.
• Mitotic count/rate (measurement of how quickly the cancer cells have divided or grown).
• Margins (are they clear of cancer; size of margin).

Example: 1/8/18 superficial spreading melanoma, Breslow thickness 1 mm, no ulceration, mitotic count: 0; margins are 1 cm and clear; lymph node involvement was monitored via lymphoscint.
### PRIMARY SITE

**Include:**
- Site where cancer started; for skin, state part of body where cancer is occurring as well as the laterality of the site.
  - Example: Right forearm skin

### HISTOLOGY

**Include:**
- Cancer cell type
  - Example: Superficial spreading Melanoma, C44.

### TREATMENT

**Include:**
- **Surgery:** Name of procedure, date, and pertinent findings notes by surgeon. Possibilities: excisional biopsy, electrocautery, fulguration, cryosurgery, polypectomy, laser excision, MOHS surgery, wide excision, re-excision; if lymph nodes involved, note lymph node dissection, regional lymphadenectomy. Code the procedure carefully based off pathologically stated margins, not operatively stated margins.
- **Chemotherapy:** Dates of beginning and ending of treatment, names of drugs, route of administration, note response if given. If any drugs were changed, note new drugs, why drugs were changed and when the new drug started.
- **Radiation:** Note beginning and ending dates of treatment, type of radiation, to what part of the body it was given and reaction if given. Note any boost doses, the dosage and where it was given and when it was started.
- **Immunotherapy:** (Drugs used to help boost the immune system). Note drugs given, the date they were started and finished, route of administration and response if given.
- **Targeted Therapy:** Dates, names and route of administration of these drugs and response to them if given.
- **Clinical Trials:** Include the name, trial # and any other available details including the date of enrollment.
- **Other:** Dates and names of any other treatment not fitting in the other categories.
  - Example: Surgery: 3/17/18 MOHS procedure –mole right arm
  - Immunotherapy: First dose of Ipilimumab was started on 3/25/18 given IV; last dose given 6/24/18, responded well to the treatment.
RESOURCES

Abbreviations: Use NAACCR Recommended Abbreviations for Abstractors (Appendix G)
http://datadictionary.naaccr.org/?c=17

The NCCN Guidelines are most frequently used for treatment and are also used for information on diagnostic workup.

NCI Physician’s Data Query (PDQ):
http://www.cancer.gov/cancertopics/pdq

For further information on specific types of drugs: Chemotherapy, targeted therapies and immunotherapies, please consult this website:
www.cancer.gov/cancertopics/pdq/treatment/melanoma/HealthProfessional/

Multiple Primary & Histology Coding Rules:
http://seer.cancer.gov/tools/mphrules/

Solid Tumor Rules:
https://seer.cancer.gov/tools/solidtumor/

NCI: Understanding Lab Tests/Test Values: http://www.cancer.gov/cancertopics/factsheet/detection/laboratory-tests

Site Specific Surgery Codes: STORE Manual, Appendix B:
https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals

SEER RX Antineoplastic Drugs Database:
http://seer.cancer.gov/tools/seerrx/