INFORMATIONAL ABSTRACT

A Guide to Determining What Text to Include

LYMPHOMA

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:** Include the age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** This is a brief statement of the reason the patient sought medical care.
- **History:** Physician notes documenting patient's ECOG performance status if documented, family history of any cancer; tobacco type, frequency, amount; alcohol: frequency, amount; workplace exposure; relevant environmental factors or exposures.
- **Comorbid Conditions:** Chronic health problems, irritations, or infections. List of co-morbidities, particularly those that impact the cancer diagnosis or treatment decisions.
- **Physical Exam (PE):** Date of the exam and documentation of information pertinent to lymphoma, such as adenopathy in lymph node bearing areas, size of liver and spleen (organomegaly), and HIV status. Also note any B symptoms (such as night sweats, unexplained fever, unexplained weight loss, or other B symptoms) documented by the physician. The physician will document findings related to the lymphatic system in his patient evaluation. The lymphatic system includes lymph nodes and lymph vessels. It also includes other lymphatic organs such as tonsils, spleen, thymus and peyer patch (lymphoid tissue on the visceral surface of the small intestine). The physician will document any positive findings related to the lymphatic system in his patient evaluation.
- **Past Cancer Treatment:** Document all previous cancers, including date (Approximate date is acceptable) primary site, histology (if known) and treatment.

Do not include: Negative findings unrelated to lymphoma.

Example: 76-YO WM, non-smoker, presents with lower abdominal pain. PE: Cervical lymphadenopathy. No axillary, supraclavicular, or inguinal adenopathy. Neg for masses, tenderness, hepatomegaly, splenomegaly. Previous history of non-small cell lung cancer in 2003, 2 lesions treated with radiation. ECOG status 1. Family History: Mother-breast cancer. Grandfather: prostate cancer.

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X-RAYS/SCOPES/SCANS

Include:

- Date, identify imaging performed such as PET/CT, CT C/A/P including use of diagnostic contrast and pertinent findings.

Example: 7/13/25: CT 7.7 cm posterior mediastinal mass possibly associated with r inguinal adenopathy. No other areas of adenopathy suggestive of primary tumor source.
7/27/25: CT Neck soft tissue: Upper Right cervical lymphadenopathy with 6 cm mass in posterior mediastinum, favor systemic neoplastic process such as lymphoma or less likely metastasis.
8/21/25 PET: Right cervical, posterior mediastinal and right inguinal region lymph nodes are hypermetabolic with maximum SUV or 12.7. There are 5 separate hypermetabolic osseous lesions in T7, L4 and L5 Vertebral bodies.

- **LABS:** Complete Blood count with differential, LDH, comprehensive Metabolic Panel, Uric Acid.
- **SSDI's:** Document in text any of the factors that are required to complete SSDI Components. Note that lymphoma, lymphoma ocular adnexa and lymphoma CLL/SLL have separate schemas. Be sure to click the correct schema when determining which SSDI Data items to include.

Where to find information: History and Physical, Labs, and notes that include the Physician's evaluation, impression and plan.

DIAGNOSTIC PROCEDURES

Include:

- **Imaging:** Tissue Biopsy
  Imaging contributes key information about the primary tumor, involvement of lymph node chains and the involvement of distant sites or visceral organs.
- **Tumor Markers:** C-myc DNA Amplification, bcl-2 Oncogene Analysis, Beta-2M (B-2 Microglobulin), TDT (Terminal-Deoxynulceotidal Transferase), Ferritin),
- **Mediastinoscopy:** other endoscopies.
- **Biopsy:** Include date, name of procedure and brief description of the findings. Biopsy results are most commonly obtained from peripheral blood, bone marrow biopsy, lymph node Fine Needle Aspiration (FNA), core biopsy or excisional biopsy.
- **Findings:** Document immunophenotyping, and flow cytometry results that support the specific histologic diagnosis.

Example: 8/14/25: SP16-3549 Left iliac bone lesion core bx: Diffuse large B-cell lymphoma, immunophenotype CD20 & BCL6 positive. Ki-67 proliferation index 90%, FISH Panel interpretation-BCL6(3q27): Negative for rearrangement, Positive for BCL6 gain, 51%-MYC(8q24) Neg for Rearrangement, Positive for MYC gain, 56%-IgH/BCL2 t(14;18) (q32;q21): Negative for translocation; Positive for IgH(14q32) gain, 33%;Pos for BCL2(18q21) gain, 45%

- **Staging Laparotomy:** Evaluation of the contents of the abdomen to determine the extent of disease. This procedure is only done occasionally. A staging laparotomy includes abdominal exploration, wedge and needle biopsy of the liver, multiple lymph node biopsies, bone marrow biopsy and splenectomy. This is considered a diagnostic procedure, not surgical treatment and is required for pathological AJCC Staging. Since this procedure is no longer routinely performed, most lymphoma staging will be clinical stage only.

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SURGICAL PATHOLOGY

Include:

- Date of the procedure, Name of procedure, and Surgical Pathology results.

Where to find information: Surgical pathology report.

Example: 12/4/25: SP18-2697 Small Bowel Resection: high grade B-Cell malignant lymphoma NOS, involving small bowel mucosa with serosal adhesion, radial, proximal and distal margins neg. Closest margin 5 CM. 0+/1 mesenteric lymph node. 0+/12 pericolic lymph nodes. Immunophenotype CD10, CD20, BCL-2, & MYC Positive. EBV negative. Ki67/mib-1=95%. Fish panel results: BCL6 (3q27) negative for disruption. MYC (8q24) Negative for disruption. IgH-BCL2 (negative for t(14;18).

PRIMARY SITE

Include:

- Primary site and code

Example: Lymph Nodes, multiple regions (C778)

HISTOLOGY

Include:

- Histologic description and morphology code

Example: Diffuse Large B-Cell Lymphoma, NOS (9680/3)

TREATMENT

Include:

- **Surgery:** Include name and date of the procedure, physician who performed the procedure, facility where the procedure was performed, and findings. Surgery for extra-nodal lymphomas should be described according to surgical codes for that primary site. If surgery is not recommended, add that information to your note along with the name of the physician who made the recommendation.

Example: 12/14/25: Dr A. Anyone, Any Hospital: Laparoscopic assisted small bowel resection. Findings: small bowel stricture in the distal 1/3 of the ileum, resected as if it were a malignancy, but it could be inflammatory.

- **Radiation:** Include the start date and the end date of the radiation course, the name of the administering physician, the type of radiation, and facility where the radiation was administered. Include the

primary area of the body treated, including lymph node regions (receiving the largest dose of radiation). For each phase of radiation include the treatment modality, the planning technique, the dose per fraction, the total dose per phase and the number of fractions. The CoC and SEER have approved the use of CTR Guide to Coding Radiation Treatment to assist with accurate coding for radiation treatment.

- **Types of Radiation:** Limited radiation directed to a symptomatic area of the body. Mantle field radiation- Delivered to the neck, chest and mediastinum, and axilla. Mini-Mantle radiation delivered to the neck, axilla and upper chest. Total Body Irradiation (TBI)-low dose radiation delivered to all lymph chains and areas of advanced disease. Inverted Y-Radiation delivered to pelvic and para-aortic nodes.

Example: 4/5/25 – 4/18/25: Dr J Somebody, Any Hospital: Phase 1 External Beam Radiation; 18 MV Photon beam to T4-T7 Spine, 250 cGy delivered in 10 Fractions to a total dose of 2500 cGy.

- **Systemic Therapy (induction therapy):** Lymphoma patients are usually treated with a systemic drug cocktail, which may include a combination of chemotherapy drugs, immunotherapy drugs and/or hormone therapy drugs. Document each drug administered and code to the correct type of drug.

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Elements of systemic therapy include:

- **Chemotherapy:** Date started, name of the physician managing the therapy, and the chemotherapy drugs administered.
- **Immunotherapy:** Date started, name of the physician managing the therapy, and the immunotherapy drugs administered.
- **Hormone Therapy:** Date started, name of the physician managing the therapy, and the hormone drugs administered.

Note: this is one of the instances when Prednisone (or an equivalent) may be administered as part of the treatment, not just to manage the side effects of chemotherapy. Because prednisone is commonly used for symptom management for the different cancers, and also used as active treatment in specific circumstances, this drug is sometimes missed. Review the use of prednisone carefully, the physician notes will usually document the intent of the prednisone. Check with physician if necessary.

Other Therapy:

- **Stem Cell Transplant:** A small percentage of patients are receiving stem cell transplants as part of first course therapy. If so, document the high dose chemotherapy that follows the induction therapy, radiation (if administered), and the stem cell transplant as part of the first course of treatment.
- **Maintenance Therapy:** Beginning date of maintenance therapy when it is administered as part of first course treatment. It will be administered after the patient has responded well the first line therapy. The purpose of maintenance therapy is to keep the cancer in remission. Maintenance therapy may last for weeks, months or years.

Example: 8/9/25: Dr J. Smith, Any Hospital: R-CHOP regimen: Chemotherapy: Cyclophosphamide, Doxorubicin, Vincristine. Immunotherapy: Rituximab. Hormone Therapy: Prednisone.

12/28/25: Dr J Smith, Any Hospital: Good response to R-Chop therapy, cancer in remission. Maintenance therapy with reduced dose Rituximab initiated.

RESOURCES

NAACCR Standard Abbreviations for Registrars
NAACCR Data Standards & Data Dictionary Database (Formerly Volume II)

CTR Guide to Coding Radiation Treatment:
STORE 2024 Radiation Data Items
store-manual-2024.pdf

NCCN Evidence Based Treatment by Stage Guidelines:
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp
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

SEER Hematopoietic Project:
https://seer.cancer.gov/tools/heme/

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

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