

LUNG

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 all 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. Often it is a persistent cough, which may be productive, hemoptysis, chest pain, or a combination of symptoms. It may be a routine chest x-ray that shows an abnormality.
- **Physical Examination (PE):** Date of the exam and documentation of information pertinent to the lung cancer, such as diminished breath sounds or palpable lymphadenopathy. If no significant physical findings, it is acceptable to say PE neg.
- **History:**
 - Personal history of any cancer
 - Family history of any cancer
 - Tobacco: type, frequency, amount
 - Alcohol: frequency, amount
 - Workplace exposures and/or relevant environmental factors, such as asbestos or radon and exposure to second-hand smoke.
- List 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 the Information: H&P consultations, ER physician notes, nursing notes, physician progress notes, discharge summary, admission notes.

Note on Negative Findings: Include any **relevant** negative findings, such as negative chest X-ray.

Example: 70-year-old Chinese male who presents with hemoptysis x 1 mo. 4-1-14 2 cm firm palpable LN in the L SC region. Lungs are clear to A&P

X-RAYS/SCOPES/SCANS

Include:

- X-rays and scans pertinent to the diagnosis of cancer and metastases, if any.
- Each exam dated and listed in chronological order, if possible.
- Most commonly these will include a chest x-ray and a CT of the chest.
- Other studies may be done to rule out metastases and may include a bone scan, an MRI of the brain, a CT of the abdomen and pelvis, a PET/CT.

- Endobronchial ultrasound (EBUS) to look for adenopathy. If negative, it might lead to a mediastinoscopy to determine resectability.

Example: 2-15-14 CXR 2 cm mass in LUL. 2-18-14 CT chest 2.5 cm mass in LUL extending to pleural surface. L hilar LAD. 1.5 cm mass in L SC region which may be nodal met. 3-1-14 B/S (bone scan) – neg. MRI brain neg. 3-15-14 PET/CT 3 cm hypermetabolic mass in LUL. FDG-avid mass in L SC region and FDG-avid L hilar LNs. Findings concerning for primary lung malignancy with nodal mets.

LABS

Include:

- There are no pertinent lab tests for lung cancer. There may be lab tests which indicate mets, such as elevated LDH.

DIAGNOSTIC PROCEDURES

Include:

- Procedures such as bronchoscopy to look for endobronchial lesions. Occasionally mediastinoscopy will be done to determine the possibility of resection of the primary.
- Information about a possible palpable lymph node that may have been biopsied first before biopsying a suspected primary site.

Example: 4-1-14 Bronchoscopy. Carina normal. No endobronchial lesions. 4-2-14 CT-guided bx L SC LN.

PATHOLOGY

Include:

- Results of biopsies and surgical resection, if any. List in chronological order. EGFR and ALK-/KRAS tests, if the histology is adenocarcinoma.

Example: 4-1-14 Bronch washings and brushings. Atypical cells suspicious for squamous cell carcinoma (SCC). 4-2-14 CT-guided bx L SC LN – met MD SCC c/w primary lung origin. 4-4-14 CT-guided bx LUL PD SCC.

PRIMARY SITE

Include:

- Primary site, including laterality.

Example: Lung Left Upper Lobe C34.1.

HISTOLOGY

Include:

- Histology of the primary site, including the morphology, the behavior, and the grade of the primary site. If there is no histology from the primary site, do not code the grade of a metastatic site.

Example: Squamous Cell Carcinoma PD 8070/33.

TREATMENT

Include:

- List all treatment given in chronological order.
- Date of surgical procedure, if surgery is done.
- Surgical approach, such as endoscopic, open, robotic. If a surgical resection, list the method of entering, such as thoracotomy or video-assisted thoroscopic surgery (VATS) and the findings. Include the location of the tumor, attachment or invasion of the pleura, the status of the lymph nodes. Document what was removed, such as the entire lobe and which lymph nodes, if any.

- Significant findings as dictated by the surgeon. If the surgeon does not give any significant findings, it is acceptable to say “no significant findings.”
- Is the patient enrolled in any clinical trials? If so, include the name, trial numbers, and any other available details, including the date of enrollment.

Example: 4-15/5-30-14 5040 cGy to L lung and regional lymph nodes and L SC region w/ 6 MV IMRT (28 fx/46 days). If the radiation discharge summary does not include the number of treatment days, go to www.timeanddate.com/date/duration/html. 6-2-14 Carboplatin, etoposide with Dr. Oncology.

RESOURCES

Abbreviations – Use NAACCR Standard Abbreviations

<http://naaccr.org/Applications/ContentReader/?c=17>

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.

Labs/Tests – NCI: Understanding Lab Tests/Test Values

<http://www.cancer.gov/cancertopics/factsheet/detection/laboratory-tests>

Multiple Primary & Histology Coding Rules

<http://seer.cancer.gov/tools/mphrules/>

NCI Physician’s Data Query (PDQ)

<http://www.cancer.gov/cancertopics/pdq>

Site-Specific Surgery Codes: FORDS Appendix B

<https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual>

SEER Appendix C

<http://seer.cancer.gov/archive/manuals/2010/appendixc.html>

SEER RX Antineoplastic Drugs Database

www.cancer.gov/tools/seerrx

Treatment for Lung

www.cancer.gov/cancertopics/pdq/treatment/lung/HealthProfessional/