



INSTRUCTIONS FOR MEDICAL RECORD ABSTRACT

Hardcopy Submissions of Information on Reportable Tumors TUMORS OF THE SKIN

February 2014

**PLEASE DO NOT EMAIL ANY CONFIDENTIAL
PATIENT INFORMATION**

MARYLAND CANCER REGISTRY

Instructions for Hard Copy Medical Record Abstracts

The Maryland Cancer Registry (MCR) of the Department of Health and Mental Hygiene contracts with Westat, Inc. to collect Medical Record Abstracts on tumors reportable by Maryland law (Health-General, Article §18-203, and 18-204) and Code of Maryland Regulations 10.14.01. For more information on reporting and reportable invasive, in situ tumors, and benign tumors, see http://phpa.dhmh.maryland.gov/cancer/SitePages/mcr_reporter.aspx.

The hardcopy abstract format allows a reporter to write the required information directly onto the Medical Record Abstract form. Please **attach a copy of the pathology or laboratory report** corresponding to the tumor being reported to the Medical Record Abstract and submit each Abstract to Westat, Inc. by fax or by mail:

**Mail or Fax report to:
Westat, Inc., Maryland Cancer Registry
1500 Research Boulevard, TB 150F,
Rockville, MD 20850-3195
Fax: 240-314-2377**

Questions? Call 1-888-662-0016 or 301-315-5990

DO NOT REPORT THESE TUMORS TO THE MCR:

The following tumors are not reportable:

Skin primary (C440-C449) with any of the following histologies:

Malignant neoplasm (8000-8005) not otherwise specified
Epithelial carcinoma (8010-8046)
Papillary and Squamous cell carcinoma (8050-8084)
Basal cell carcinoma (8090-8110)

INSTRUCTIONS FOR EACH FIELD

REPORTER IDENTIFICATION

FACILITY NAME: Enter the full name of your facility.

ABTRACTOR INITIALS: Enter the initials of the person reporting the case.

FACILITY ID #: Enter your 10 digit facility identification number as assigned by the Maryland Cancer Registry. If unknown or your facility does not have one, leave blank.

PHYSICIANS NPI#: Enter your physician's NPI number. If unknown, leave blank.

MEDICAL RECORD or RECORD IDENTIFICATION NUMBER: Enter the medical record number or record identification number assigned by your facility. Leave blank if this does not apply.

PATIENT IDENTIFICATION

PATIENT NAME: Enter patient name, Last Name, First Name, MI

SOC SEC #: XXX-XX-XXXX

DATE OF BIRTH: YYYY/MM/DD

PATIENT RESIDENTIAL ADDRESS: Enter the patient's residential address at the time of diagnosis

PATIENT RESIDENTIAL ADDRESS: If additional space is needed for patient address, enter here.

CITY/STATE/ZIP: Enter City/State (2 digit format)/ Zip Code (5 digit format)

COUNTY: Enter name of the county of residence at the time of diagnosis if known, otherwise leave blank.

PATIENT DEMOGRAPHICS

GENDER (check one): Male Female Other

PLACE (Country) OF BIRTH (if known): Enter the patient's Country or U.S. State of birth if known. If not known, record as Unknown.

RACE: Check the appropriate code or codes to describe race, such as: White, Black, Native American, Asian (give country of origin, if known, for example, China, Japan, Asian Indian, Pakistani), Pacific Islander (give country of origin, if known, e.g., Tahiti, Samoa, Fiji), Other, or Unknown. If Multi-racial, please check/list as many boxes that may apply.

SPANISH/HISPANIC ORIGIN: If this information is available, please document as Hispanic, Latino, Non-Hispanic or Unknown, etc. If this is not documented, record as Unknown. Please specify country of origin if known, otherwise, leave country of origin blank.

OCCUPATION: Please enter the information about the patient's usual occupation, also known as usual type of job or work. Do not record "Retired". If the information is not available or is unknown, check the box marked UNKNOWN.

DIAGNOSIS/TUMOR INFORMATION

DATE OF INITIAL DIAGNOSIS: YYYY/MM/DD Date of initial diagnosis by a recognized medical practitioner for the tumor being reported.

SITE OF TUMOR: Only the Skin sites are listed. Use C44.9 Skin, NOS (Not Otherwise Specified) if you cannot determine the exact site on the body or it is not specified on the pathology report. This is the anatomic site (on the body) where the tumor being reported was found.

CODE	DESCRIPTION
C44.0	Skin of lip, NOS, Upper/lower
C44.1	Eyelid, Upper/lower
C44.2	External Ear - Auricle, Ear lobe, Ear Canal, Skin of Ear, NOS.
C44.3	Skin of other and unspecified parts of face Cheek, chin, face, forehead, jaw, nose, temple, eyebrow.
C44.4	Skin of scalp and neck Skin of head, NOS, neck, scalp, cervical region, supraclavicular region.
C44.5	Skin of trunk Abdomen, abdominal wall, anus, under arm, back, breast, buttocks Chest, chest wall, flank, groin, perineum, thoracic wall, thorax, trunk, Umbilicus, gluteal region, infraclavicular region, inguinal region, Sacrococcygeal region, scapular region (shoulder blade only), perianal.
C44.6	Skin of upper limb and shoulder Antecubital space, arm, elbow, finger, forearm, hand, palm, shoulder, Thumb, upper limb, wrist, finger nail, palmar skin.
C44.7	Skin of lower limb and hip Ankle, calf, foot, heel, hip, knee, leg, lower limb, popliteal space, thigh, Toe, plantar skin, sole of foot, toe nail.
C44.8	Overlapping lesion of skin If the site of origin overlaps any of the above listed areas, use this category.
C44.9	Skin, NOS [<i>Excludes skin of labia majora, skin of vulva, skin of penis, And skin of scrotum</i>].
C51.0	Labium Majus
C51.1	Labium Minus
C51.2	Clitoris
C51.8	Overlapping lesion of Vulva
C51.9	Vulva, NOS
C60.0	Prepuce
C60.1	Glans Penis
C60.2	Body of Penis
C60.8	Overlapping lesion of Penis

C60.9 **Penis**
C63.0 **Scrotum, NOS**

LATERALITY: Check the appropriate box to indicate laterality. Choose the side of a paired organ, or the side of the body on which the reportable tumor was found.

Laterality must be recorded for the following list of paired organs. Non-paired organs (those not on this list and those explicitly excluded) are coded “Not a paired organ”. Midline origins are coded to “Paired site, but no information concerning laterality, midline tumor.”

Laterality Site
Skin of eyelid
Skin of external ear
Skin of other and unspecified parts of face
Skin of trunk
Skin of upper limb and shoulder
Skin of lower limb and hip
Connective, subcutaneous, and other soft tissues of upper limb and shoulder
Connective, subcutaneous, and other soft tissues of lower limb and hip

SIZE OF TUMOR: Record in Centimeters in the following format XX.X. If a tumor is recorded in terms of millimeters, you may convert by moving the decimal for the number, for example: if a tumor is reported as 8mm, it would be recorded as 00.8cm. Conversely, 10mm would equal 01.0cm.

TYPE OF TUMOR (Histology): Record the histology that best describes the type of tumor found. If unknown, please indicate as Unknown. For example:

Melanoma	Malignant Desmoplastic Melanoma
Superficial Spreading Melanoma	Malignant Neurotropic Melanoma
Nodular Melanoma	Malignant Melanoma in a giant pigmented lesion
Regressing Melanoma	Spindle Cell Melanoma
Melanoma in a Junctional Nevus	Malignant Blue Nevus
Lentigo Maligna Melanoma	Mixed Epithelioid and Spindle Cell Melanoma
Acral Lentiginous Melanoma, Malignant	
Malignant Melanoma	
Balloon Cell Melanoma	
Amelanotic Melanoma	Merkel Cell Carcinoma
Malignant Melanoma in a precancerous melanosis	
Malignant Melanoma in a Hutchinson’s melanotic freckle	

BEHAVIOR: Pathologists use these terms to describe the type of tumor.

Label	Definition
Benign	Benign.
Borderline	Uncertain whether benign or malignant.
	Borderline malignancy.
	Low malignant potential.
	Uncertain malignant potential

	Clark level 1 for melanoma (limited to epithelium).
Synonymous with in situ (non-invasive)	Confined to epithelium.
	Hutchinson melanotic freckle, NOS (C44.-).
	Intracystic, noninfiltrating.
	Intraepidermal, NOS.
	Intraepithelial, NOS.
	Involvement up to, but not including the basement membrane.
	Lentigo maligna (C44.-).
	Noninfiltrating.
	Noninvasive.
	No stromal involvement.
	Precancerous melanosis (C44.-).
Malignant (Invasive)	Invasive or microinvasive.

GRADE: Review the pathology report for reference to 'Grade'. Record either the terms or the number if available from the pathology report. If not documented, record as Unknown.

Description	Grade
Differentiated, NOS	I
Well differentiated	I
Fairly well differentiated	II
Intermediate differentiation	II
Low grade	I-II
Mod differentiated	II
Moderately differentiated	II
Moderately well differentiated	II
Partially differentiated	II
Partially well differentiated	I-II
Relatively or generally well differentiated	II
Medium grade, intermediate grade	II-III
Moderately poorly differentiated	III
Moderately undifferentiated	III
Pleomorphic	III
Poorly differentiated	III
Relatively poorly differentiated	III
Relatively undifferentiated	III
Slightly differentiated	III
Dedifferentiated	III
High grade	III-IV
Undifferentiated, anaplastic, not differentiated	IV
Unknown	Not stated

TREATMENT INFORMATION – First Course of Therapy
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Tumor Characteristics (for Staging). Check 'Yes' box if condition is present and/or described in the pathology report:

Ulceration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitotic Rate: _____ /mm ²	
Regression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic Clark's Level: _____ (I, II, III, IV, greater)	
Clinical Lymph Node Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breslow's Thickness: _____ (mm)	
Satellite Lesions Present	<input type="checkbox"/> Yes <input type="checkbox"/> No	LDH Value (prior to treatment or w/in 6 weeks of Diagnosis): _____	
Multiple Nodules	<input type="checkbox"/> Yes <input type="checkbox"/> No	Normal LDH Range Upper Limit: _____	
In-Transit Metastasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metastatic Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
		Describe Metastatic Site: _____	

Level of Invasion (describe with text): _____

SURGERY – Check the appropriate box that best describes the surgery performed. Check as many as apply. If the response is 'Yes', provide a date the procedure was performed. If no surgery was performed, please check the appropriate box, state a brief reason why no surgery was performed and the Date that decision was made.

If Lymph Nodes were involved, please describe name of lymph nodes or area, total number examined, and total number positive.

Lymph node region: Describe the region of the body where the lymph nodes were examined.
 Total Number Nodes Examined: ### (up to 3 numbers) Total Number Nodes Positive:###
 (up to 3 numbers)

OTHER TREATMENT - This category includes chemotherapy, radiation therapy, immunotherapy (vaccine), or any other treatment the patient may have received for their diagnosis. Choose the response that best describes the treatment and date, if known.

Otherwise, mark as 'unknown' and disregard the date field. Choose as many as may apply.

Please provide any additional information which may be important regarding the patient's treatment/care. If no additional information is available, leave blank.

Additional Information (if available)

Referring or Managing Physician:

Medical Oncologist:

Radiation Oncologist:

PLEASE ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS ABSTRACT FORM.
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<p>Mail or Fax [DO NOT email] report to: WESTAT, Inc., Maryland Cancer Registry 1500 Research Boulevard, TB 150F Rockville, MD 20850-3195</p>
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Fax: 240-314-2377

DHMH

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