



INSTRUCTIONS FOR CANCER/TUMOR REPORTING

Hardcopy Submission of Information on Reportable Tumors

February 2014

**PLEASE DO NOT E-MAIL ANY CONFIDENTIAL
PATIENT INFORMATION**

MARYLAND CANCER REGISTRY

Instructions for Hard Copy Medical Record Abstracts

February 2014

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 on reportable invasive, in situ, and benign tumors, see http://phpa.dhmh.maryland.gov/cancer/SitePages/mcr_reporter.aspx.

The hardcopy abstract format allows a reporter to record 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 310-315-5990

REPORTABLE TUMORS include invasive, in situ tumors, and benign tumors of the brain and central nervous system EXCEPT...

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)

Carcinoma **in situ** of **cervix** or cervical intraepithelial neoplasia (CIN III) of the cervix (C530-C539).

Prostatic intraepithelial neoplasia (**PIN** III) of the prostate (C619)

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 DEMOGRAPHICS

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. Also, enter any supplemental information such as mailing P.O. Box, or Facility Name (e.g., nursing home, or correctional facility)

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

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

GENDER (check one): Male Female Other

PLACE 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/Aleutian/Eskimo, Asian (give country of origin, if known, for example, China, Japan, India, Pakistan, Saudi Arabia), 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.

Dept. Health and Mental Hygiene

Maryland Cancer Registry

Westat – MCR QA/DM

1500 Research Blvd.

TB 150F – Rockville, MD 20850-3195

Telephone 888-662-0016 / 301-315-5990

Fax 240-314-2377

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

PLEASE ATTACH A COPY OF THE PATHOLOGY OR CYTOLOGY REPORT

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

DIAGNOSTIC CONFIRMATION: Check to indicate the method that was used to confirm the presence of the cancer/tumor being reported. Choose one of the following categories which best describes how this tumor was diagnosed.

Microscopically Confirmed

Positive histology (tissue microscopically examined).

Positive cytology (no tissue microscopically examined; fluid cells microscopically examined).

Positive microscopic confirmation, method not specified (Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology).

Not Microscopically Confirmed

Positive laboratory test/marker study (A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is nondiagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as positive marker study).

Direct visualization without microscopic confirmation (The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic examination).

Radiology and other imaging techniques without microscopic confirmation (The malignancy was reported by the physician from an imaging technique report only).

Clinical diagnosis only (other than the methods listed above) (The malignancy was reported by the physician in the medical record).

Unknown whether or not microscopically confirmed death certificate only (A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed).

Other: If diagnosed by a method not listed above. Then, please specify the method.

SITE OF TUMOR: Describe the location on the body where the tumor was located. This is the anatomic site (on the body) where the tumor being reported was found. Please be specific, such as "left shoulder," "bladder, posterior wall," "blood," "brain, right frontal lobe" or "prostate."

LATERALITY: Check the side of a paired organ, or the side of the body on which the reportable tumor was found. Laterality must be recorded for paired organs such as lung, kidney, breast and also brain. Non-paired organs (such as prostate, uterus, pancreas) are coded “Not a paired organ”. Midline origins are coded to “Paired site, but no information concerning laterality, midline tumor.” Check one of the following selections:

Not a paired Organ, not applicable (NA)

Right side only

Left side only

One side, Not otherwise specified

Bilateral Involvement

Midline tumor (cannot determine laterality, middle region of the organ)

Unknown

SIZE OF TUMOR: Give the **largest** dimension or the diameter of the primary tumor in centimeters (cm) (e.g., 1 mm= 00.1 cm; 1 cm = 1.0 cm; 20 cm= 20.0 cm).

TYPE OF TUMOR: Write in the histology that best describes the type of tumor found. This information is generally found in the “Final Diagnosis” portion of the pathology or cytology report. If unknown, please indicate as Unknown.

For example: Adenocarcinoma
 Transitional Cell (Uroepithelial cell)
 Squamous Cell Carcinoma
 Carcinoma in a Tubulovillous Adenoma
 Small Cell Carcinoma
 Non-Small Cell Carcinoma
 Endometrioid Carcinoma
 Cystadenocarcinoma
 Chronic myelogenous leukemia

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

Label on Report Form	Definition or terms that may be in pathology report
Benign	Benign.
Borderline Tumor	Uncertain whether benign or malignant.
	Borderline malignancy.
	Low malignant potential.
	Uncertain malignant potential
In situ (Non-Invasive)	Adenocarcinoma in an adenomatous polyp with no invasion of stalk.
	Comedocarcinoma, noninfiltrating (C50.-).
	Confined to epithelium.
	Intracystic, noninfiltrating.
	Intraductal.
	Intraepidermal, NOS.
	Intraepithelial, NOS.
	Involvement up to, but not including the basement membrane.
	Lobular neoplasia (C50.-).
	Lobular, non-infiltrating (C50.-).
Noninfiltrating.	

	Noninvasive.
	No stromal involvement.
	Papillary, noninfiltrating or intraductal.
	Precancerous melanosis (C44.-).
	Queyrat erythroplasia (C60.-).
Malignant (Invasive)	Invasive
	Microinvasive

GRADE: Review the pathology report for reference to 'Grade'. Check the corresponding Grade, if available from the pathology report. If not documented or not stated, record as Unknown.

Label on Report Form	Grade Number	Definition or terms that may be in pathology report
Grade I	Grade I, 1, i	Well differentiated; differentiated, NOS
Grade II	Grade II, 2, ii I/III or 1/3	Moderately differentiated; moderately well differentiated; intermediate differentiation
Grade III	Grade III, 3, iii II/III or 2/3	Poorly differentiated
Grade IV	Grade IV, 4, iv III/III or 3/3	Undifferentiated; anaplastic
Unknown/ not stated in report	Unknown or Not Stated	
For Lymphomas and Leukemias only		
T-cell		T cell; T-precursor
B-cell		B cell; pre-B; B-precursor
Null Cell		Null cell; non T-non B
NK Cell		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)

TREATMENT INFORMATION—FIRST COURSE OF THERAPY

Indicate "Yes" or "No" to as many types of treatment as you may have information available in your medical record that were given as first course of therapy for this tumor. Treatment options include surgery, chemotherapy, hormone therapy, immunotherapy (vaccine), radiation therapy, and hematologic transplant, or any other treatment the patient may have received for their cancer diagnosis.

Choose the response(s) that best describes the treatment(s) and date(s), if known. Also in the areas labeled "Describe," please type in additional description about the type of surgery and/or other therapy(ies). Choose as many as apply.

Mark as 'Unknown' and disregard the field if you do not know whether or not the therapy was given as the first course of treatment.

Additional Information: Please provide the name of the physician ordering the test and the physician to which the patient was referred and any additional information which may be important regarding the patient's treatment/care.

PLEASE ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS ABSTRACT FORM.

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