Texting is what makes the difference between a good abstractor and a great abstractor! ~Jim Hofferkamp

Texting 101:Best Practices

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Text Documentation

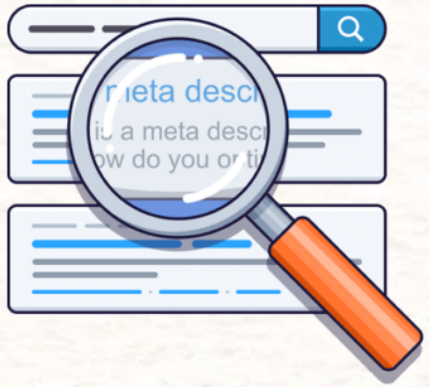
- The art of documentation is the *brief* summary of cancer diagnosis, staging workup, treatment, and outcome of a cancer patient from your facility.
- Purpose:
  - Supports all coded fields
  - Assures quality of data from facility
  - Assists abstractor in summarizing the big picture

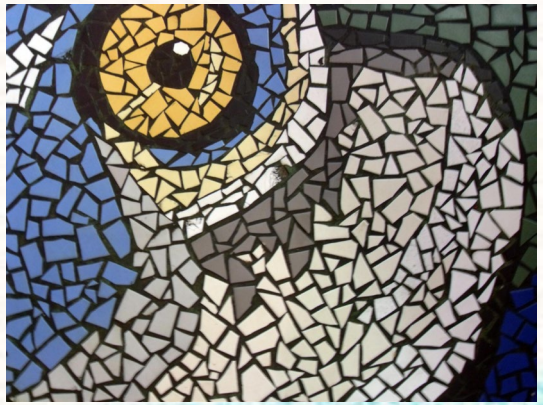
SEER Quality Data

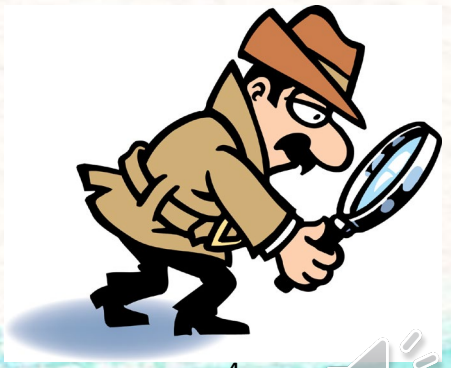
- Text Documentation allows for:
  - Review of the case in medical edit
  - Review of the case for QC audits
  - Reduces the need to return to original hospital medical record to verify information
  - Quality cancer data

Key Components of Texting

- Dates
- Descriptions
- Details
- Detective work

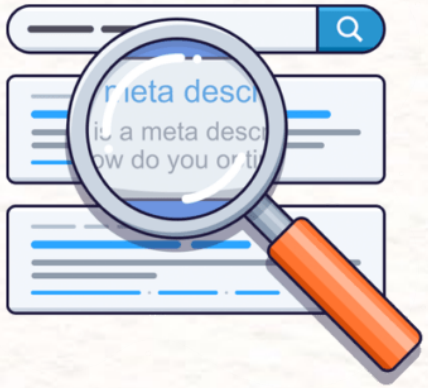






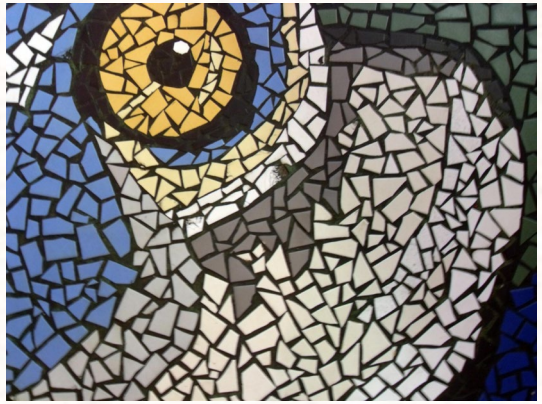
Dates

- Every text field starts with a date
- Chronological order
- Check dates and years. Most common typo.
  - Does op report date match the path report date for that procedure?
  - Is diagnosis late 2021 and treatment or surgery 2022?



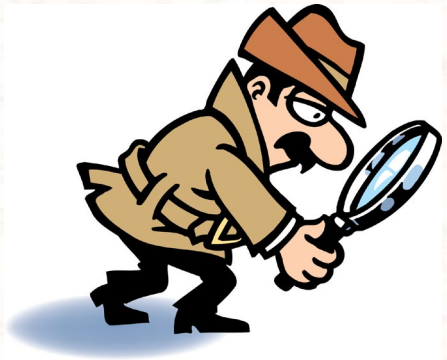
Description of Text

- What was done?
- Describe procedure, imaging, surgery etc.
- Summarize what is happening
- Easy to read
- Correct and minimal use of abbreviations
  - NAACCR Abbreviation list
- Limited use (if any) copy and pasting from EMR.



Details of Text

- Date | Description
- Results of exam or procedure, impression
  - Include both positive or negative results
- Imaging: Diagnostic impression gives some final thoughts but more *details* usually in body of report.
- Operative Report: If a hemicolectomy was done, part of the transverse colon must be transected. Look in body of report for *details*.



Detective Work: Extracting information to text

- Pathology: not a “summary”
- Lab: general time frame rules
- H&P: summary of why at facility
- Imaging: look for pos and neg results
- Visits: follow up info goes in remarks not H&P
- Treatment: dates, drugs

TEXT FIELD DOCUMENTATION WITHIN ABSTRACT

History/Physical: ***TIP:*** *Remember to document negative exam findings as well as positive finding if pertinent to site.*

3/17/2022 83yo WF with ABN screening MMG here for biopsy R breast. EXAM in office PTA, no lesions palpable, no adenopathy. Current smoker.

X-ray/scan: *(Date all procedures)*

PTA 3/10/2022 BIL Mammo: R breast lesion UOQ measures 0.5 cm in size. L breast neg for lesions. No BIL axillary adenopathy.

Scopes/Manipulative procedures/Diagnostic proc: (*Date all procedures)*

3/17/2022 Stereotactic needle core biopsy R breast. *[Should be a corresponding path report from this procedure in the path text field.]*

Surgery/OP Reports: *(Date all procedures)*

3/24/2022 R breast lumpectomy with SLN bx. *[Should be a corresponding path report from this procedure in the path text field.]*

Pathology: *(Date all procedures)*

3/17/2022 Needle core biopsy R breast DX: MD Ductal carcinoma.
3/24/2022 R breast lumpectomy DX: Infilt ductal carcinoma, 2.0 cm, UOQ R breast. SLN 0/2 pos for mets.

Labs: *(Date all procedures)*

3/17/2022 ER strongly pos, 100%; PR strongly pos, 98%; HER2 by IHC 2+ equivocal. HER2 by FISH neg. DP ratio 1.0. HER2 copy number 2.24. Oncotype Dx RS 24.
COVID-19 neg viral 3/15/2022

Staging Text:

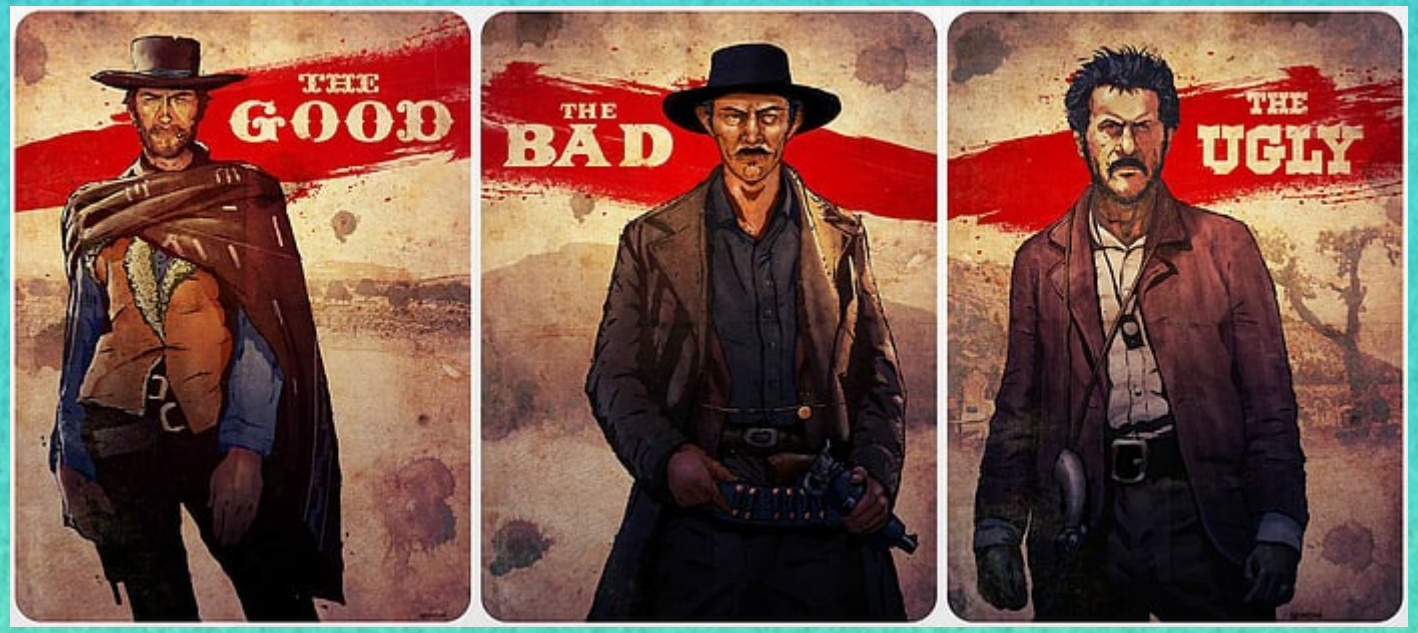
3/17/2022 cT1 cN0 cM0; pT2 pN0 cM0 by med onc

CHEMO/RAD/HORM/BRMText:

4/8/2022 Arimidex

REMARKS:

Date of discharge, brief final diagnosis, summary of treatment plan. If last known follow-up date is different from the discharge date note why patient was seen and CA status if known. Any subsequent visits, path reports not related to first course.



Texting Examples

DX Proc PE

1/29/18 53 wm to ER due to headache and nausea. CXR id large L lung mass. Pt usual health until yesterday. no hemoptysis. all neg. Pt is active smoker 1-1.5 ppd x 40 yrs. Hx of exposure to asbestos. PE: neg, no LAD, no palp mass, no HSM. Plan: scans & CT guided bx lung mass & poss bronchoscopy. Pt refuses hospitalization. Pt tx'd w rad tx at [redacted]- rad tx to brain in conjunction w chemo/ BRM tx- Alimta, carboplatin and keytruda- 3 cycles. given. Rad tx scheduled to treat large lung mass. DOLC: June 15/18 pt requests no further tx- to hospice.

Good

Bad

DX Proc PE

none

XRay/Scan

6/6/18 CT Chest: Spiculated 2.6 cm mass LUL, consistent with new bronchogenic carcinoma.
6/25/18 MRI Head: No mets.

- ✓ Date
- ✓ Description
- ✓ Details

Good

Bad

XRay/Scan

PTA 3/19/18 US Breast: 3/22/18 CXR: neg.

- ✓ Date
- ✓ Description
- ✓ Details

Proc Lab Test

7/16/18: ER neg, 0%; PR neg 0%; HER2 equivocal, 2+ by IHC, FISH neg, HER2 ratio 1.5, HER2 avg signals 5.0
genetic testing, no mutations per [redacted]

Good

Bad

Proc Lab Test

per 8/27/18 urology: pt had bladder tumor resected May 2018, final path high grade urothelial ca w/o invasion into detrusor.

Proc Lab Test

ER+ >95% PR+ 65% FISH CEN 17 ratio 2.2, copy number 1.1

- ✓ Date
- ✓ Description
- ✓ Details

Labs: 7-20-20 Breast ER + 91-100%, Strong Stain, Allred Score 8. PR + 91-100%, Strong Stain, Allred Score 8. ~~LN is ER +, 91-100%, Strong Stain, Allred Score 8, PR + 91-100%%, Strong Stain, Allred Score 8.~~

Bad

7-22-20 HER2 breast Equivocal 2+. FISH neg. [?HER2?] Signals 2.2. Signal ratio 1.0. ~~HER2 LN Equivocal 2+, FISH NEG, signals 2.3, & signal ratio 1.0.~~ No multigene or KI-67, or Oncotype.

DX Proc Path

11/16/18 PS-18-5087 prostate bx's: LT & RT apex, LT & RT lateral apex, LT & RT mid, LT base, LT lateral base all neg. LT & RT lateral mid, RT base, and RT lateral base bx's all with adenoCA, Gleason 3+3=6. 4/15 total cores involved. 1/28/19 PS-19-371 Prostatectomy: Acinar adenoCA, Gleason 3+4=7, tertiary pattern NA. Approx 60% of prostate involved by tumor. No extraprostatic extension. Seminal vesicles and bladder neck all neg. Margins neg. LVI neg. PNI neg. 0/1 LT pelvic LN pos for mets. No LN ID'd in RT pelvic exc.

- ✓ Date
- ✓ Description
- ✓ Details

Good

Bad

DX Proc Path

Per Oncology Consult, Lt MRM, [redacted] DX= Invasive ductal carcinoma, multifocal (3). Focal DCIS. Metastatic carcinoma in 3/8 Lt axillary LNs (Levels I-II), largest mets deposit 25 mm. Synoptic Report: Multifocal: Tumor #1, 6:00, 21 mm. Tumor #2, 7:00, 15 mm. Tumor #3, 8:00, 16 mm. Invasive ductal carcinoma, with mucinous features, Nottingham Grade II/III (3+2+1). LVI present. DCIS present in tumor #1 comprises 5-10% of tumor. Margins negative. pT2(m)N1a.

DX Proc Scp

4/20/18 Colonoscopy with BX & polypectomy: Polyp in Lt colon, snared and removed. Large mass in hepatic flexure, that took up at least half of the bowel circumference, BX taken.
4/20/18 EGD with BX: Upward migration of columnar mucosa at 43 cm SCJX.
5/2/18 Colonoscopy for tattoo of Lt colon polpectomy & removal 2 polyps from rectum.

- ✓ Date
- ✓ Description
- ✓ Details

Good

Bad

DX Proc Scp

11-12-19 volume study: bladder neg.
10-8-19 volume study: bladder neg.

- ✓ Date
- ✓ Description
- ✓ Details

DX Proc OP

5/4/18 Laparoscopic hand-assisted Rt hemicolectomy: Mobilized the entire terminal ileum, Rt colon & transverse colon to its mid point. Liver grossly negative. Tattoo in hepatic flexure.

Good

Bad

DX Proc OP

7/9/18 RT breast mastectomy w/ sLN bx.

DX Proc Path

6/25/18 [redacted] RT breast bx's: 0.3 cm INV ductal carcinoma, Nottingham Grade 2. Background DCIS. 7/9/18 [redacted] RT breast mastectomy: 0.6 cm INV ductal carcinoma, Nottingham Grade 2. Margins neg. No LVI, no PNI. High-grade DCIS noted. 0/2 LNs in mastectomy specimen, 0/4 RT xaillary LNs all pos for met.

Hmmm, FNA of lung tissue or LN?

Proc Lab Test

PTA 05/01/2018 BRONCHOSCOPY W/FNA: MD adenocarcinoma, PDL-1 60%

DX Proc Scp

EW 05/29/18 BRONCHOSCOPY W/EBUS: no endobronchial disease identified

DX Proc Path

EW 05/29/18 BRONCHOSCOPY W/EBUS(STATION 7 SUBCARINAL LN BX): metastatic carcinoma with adenocarcinoma features

DX Proc OP

6/29/18 [redacted] L partial/simple Mastectomy w 2 SN bxs. mass noted 3:00 L breast.

DX Proc Path

6/7/18 Two Nodules bx'd: A. L breast @ 3:00, 5 cm from nipple core bx: Invasive ductal carcinoma, NH G2 of 3(3+2+2=7) TS: 6mm by imaging; 5 mm on given core ; LVI: not id, PNI: not id, DCIS present; intermed grade,solid & micropapillary pattern, focal extent. B. L breast @ 3:00, 8 cm from nipple core bx: invasive ductal carcinoma, NH G2 of 3; score: 3+2+2=7; LVI: not id, PNI: not id, TS: 6 mm by imaging, 5.5mm on given core. DCIS presnt, intermed grade,solid pattern, extent: focal 7/2/18: L Partial/Simple mastectomy w 2 SNs: residual invasive ductal carcinoma, NH G2 of 3; score=6 (3+2+1=6); residual tumor meas 7 mm LVI:not id PNI: not id, residual DCIS: present, intermed grade solid pattern, several ducts involved including in section of nipple and breast away from mass, margins:clear, invasive tumor at least 1 cm from margins, 2 neg sentinel nodes. pT1b pN0 pMx.

DX Proc PE

11/16/18 51 YOM presents to Urology office due to elevated PSA. PE: (11/2/18 Urology) DRE reveals prostate to be symmetrical, not enlarged, non-tender, smooth/no nodules. Rest of exam neg.

Proc Lab Test

PTA 6/2/18 PSA 8.36 high.

XRay/Scan

12/7/18 NM Bone scan: neg. 12/7/18 CT A/P: neg.

DX Proc Scp

11/16/18 TRUS w/ prostate bx's

DX Proc Path

11/16/18 PS-18-5087 prostate bx's: LT & RT apex, LT & RT lateral apex, LT & RT mid, LT base, LT lateral base all neg. LT & RT lateral mid, RT base, and RT lateral base bx's all with adenoCA, Gleason 3+3=6, 4/15 total cores involved. 1/28/19 PS-19-371 Prostatectomy: Acinar adenoCA, Gleason 3+4=7, tertiary pattern NA. Approx 60% of prostate involved by tumor. No extraprostatic extension. Seminal vesicles and bladder neck all neg. Margins neg. LVI neg. PNI neg. 0/1 LT pelvic LN pos for mets. No LN ID'd in RT pelvic exc.

Remarks

*DC 11/16/18 Dr. Alameddine office: prostate bx. *FU 8/16/19 Urology f/u: NED.

Good Example

Dates in each section

Brief summary of

- Cancer diagnosis
- Staging workup
- Treatment
- Outcome

Easy to read

- ✓ Date
- ✓ Description
- ✓ Details

Able to verify codes

DX Proc PE

2/8/18: 87wf w/ mild/mod confusion and dementia. Found to have R breast lesion palpable clinically and suspicious for breast cancer on mammo & U/S. Due to pt's condition, (anxiety and agefor furutre tx) opted mastectomy for exc lesion and no bx.

Proc Lab Test

2/8/18 ER + >95%, strong intensity. PR + 70-80%, strong intensity. Her2/neu IHC: equivocal 2+. Ki-67: approx 34%. Her2/neu FISH: equivocal. Avg Her2 signals/nucleus: 4.6. Avg CEN 17 isgnals/nucleus: 2.6. Her2/CEN 17 signal ratio: 1.8. Number of observers: 4. Referred to Neogenomics for Her2/neu Breast equivocal by FISH panel results: NEGATIVE

XRay/Scan

1/10/18 bilat mammo: R breast mass 10-11:00 position, 7.4cm. R breast U/S: solid mass R UOQ 6.2cm.
3/30/18 PET/CT: s/p mastectomy. No residual or mets.

DX Proc Path

2/8/18 [redacted] R breast simple mastectomy: Invasive lobular carcinoma, MD grade 2/3. Peritumoral LVI +. Surg margins neg. Synoptic report: TS = 6.5cm. Skin uninvolved by ca. Lobular carcinoma in situ present, minor component. Scores: nuclear 1, tubule 3, mitosis 3.

Age – Sex – Race

Site – Laterality

Histology – Behavior

Clinical – Path Size

LVI

EOD

SSDI's

Treatment

Example of good and bad abbreviations

- Missing details

- Path Text: ER – Positive, PR – positive, HER2/Neu – positive.

- Looking at epath – the above information came from the ‘clinical history’ on the path report and not the path report itself.

Better…from epath report

Path: ERA: Positive 100% strong staining. PRA: Positive 25%, mod staining. Her2/Neu: Equivocal 2+. Her2/FISH: Positive.

Best:

LABS: ER/PR and other SSDI go in this text field.

Pathology

- Margins nos 19 cm = 190 mm
  - Must state more than margins nos.
  - Coded in mm (convert from cm)
  - Look for terms to text:
    - Circumferential radial margin
    - Circumferential resection margin
    - Mesenteric (mesocolon) margin
    - Radial margin
    - Soft tissue margin

Final Tips on Texting

- Avoid duplicating text
- Keep in mind what information to provide and place text in the most appropriate section
- If procedure/scan/lab was done at facility you're abstracting at, no need to put name of facility after date – **ONLY** when the results are not from your facility
- Tumor size: text the largest dimension – no need to text all 3 dimensions
- Punctuation is important
  - Spaces – periods – comma
  - All caps are hard to read

Final Tips on Texting

- Abbreviations
  - –One abbreviation – Multiple definitions
    - The use of the dash –
      - –Used to separate sections of a report/dates or as a space
      - –Stands for negative
- All procedures should have a corresponding result

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