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

Texting 101:Best Practices

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March 2024

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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

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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

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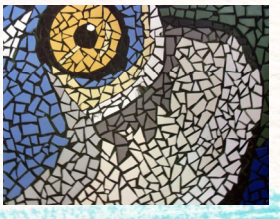
Key Components of Texting

- Dates
- Descriptions
- Details
- Detective work



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Dates

- Every text field starts with a date
- Chronological order if more than one
- Check dates and years. Most common typo.
  - Does op report date match the path report date for that procedure?
  - Is diagnosis late 2022 and treatment or surgery 2023?

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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. Summarize.

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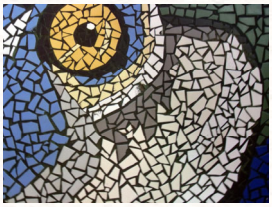

Details of Text

- 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*.

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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

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TEXT FIELD DOCUMENTATION WITHIN ABSTRACT

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

3/17/2023 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 3/10/2023 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)*

3/17/2023 Stereotactic needle core biopsy R breast. *[Should be a corresponding path report from this procedure in the path text field.]*

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

3/24/2023 R breast lumpectomy with SLN bx. *[Should be a corresponding path report from this procedure in the path text field.]*

Pathology: *(Date all procedures)*

3/17/2023 Needle core biopsy R breast DX: MD Ductal carcinoma.
3/24/2023 R breast lumpectomy DX: Infilt ductal carcinoma, 2.0 cm, UOQ R breast. SLN 0/2 pos for mets.

Labs: *(Date all procedures)*

3/17/2023 ER strongly pos, 100%; PR strongly pos, 98%; HER2 by IHC 2+ equivocal. HER2 by FISH neg. Oncotype Dx RS 24. Ki-67 23%.

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Staging Text
3/17/2023 cT1 cN0 cM0; pT2 pN0 cM0 by med onc

Chemo/Rad/Hormone/BRM Text
4/8/2023 Arimidex

Remarks: Include date of discharge, brief final dx, summary of treatment plan. DOLC, subsequent visits, or path reports not related to first course window.

1/24/2024 Onc FU: Con't on Arimidex, NED.

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Texting Examples

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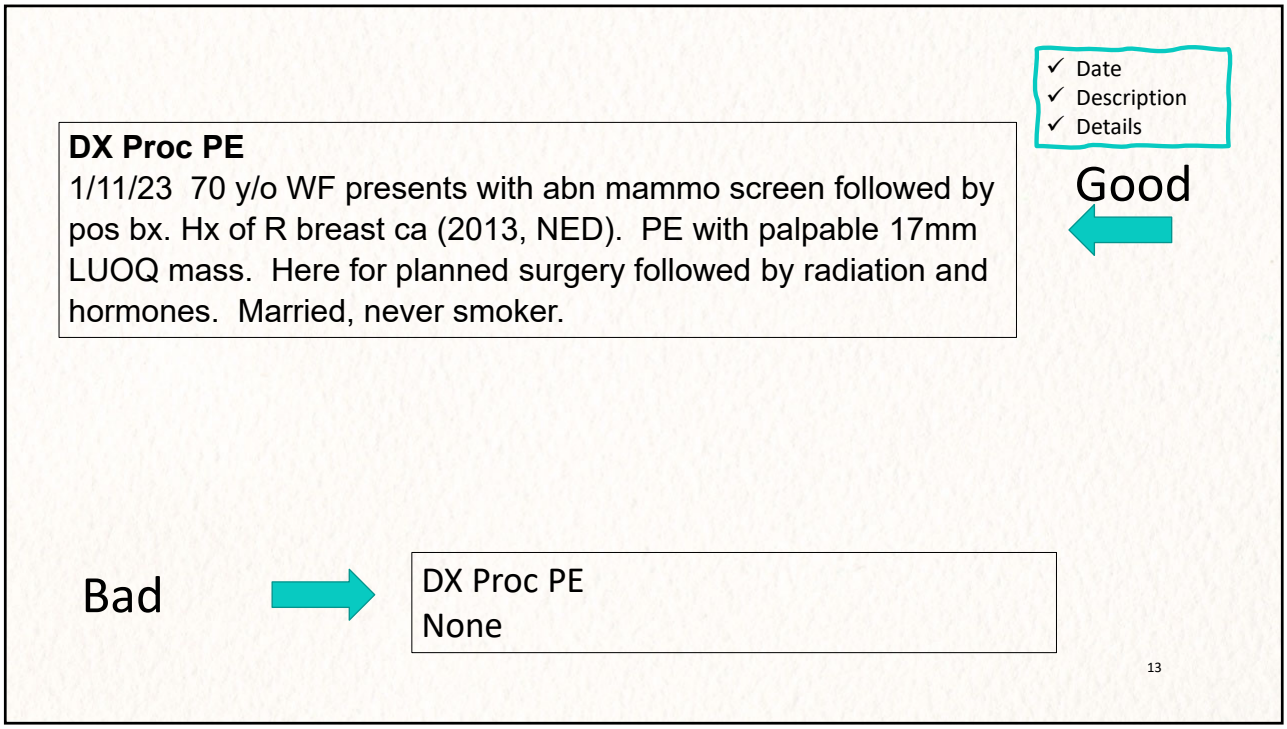
✓ Date
✓ Description
✓ Details
Good
DX Proc PE
1/11/23 70 y/o WF presents with abn mammo screen followed by pos bx. Hx of R breast ca (2013, NED). PE with palpable 17mm LUOQ mass. Here for planned surgery followed by radiation and hormones. Married, never smoker.
Bad
DX Proc PE
None
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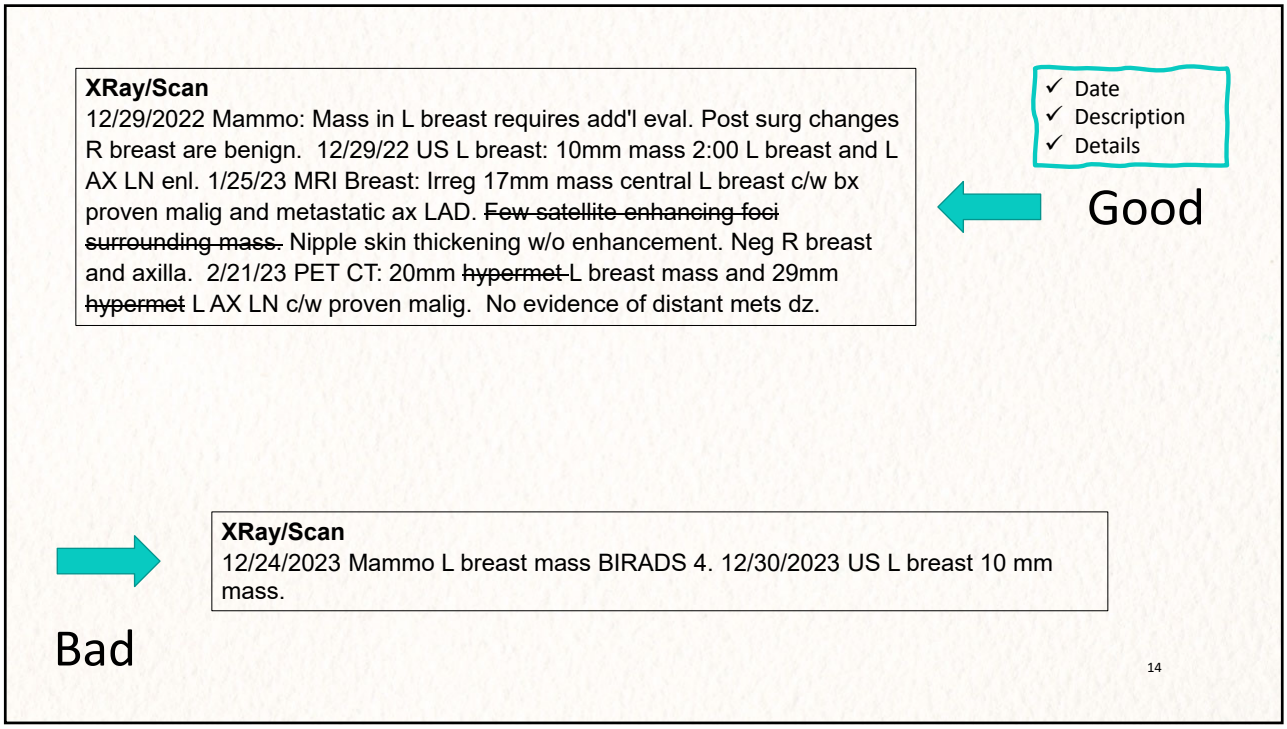
✓ Date
✓ Description
✓ Details
Good
XRay/Scan
12/29/2022 Mammo: Mass in L breast requires add'l eval. Post surg changes R breast are benign. 12/29/22 US L breast: 10mm mass 2:00 L breast and L AX LN enl. 1/25/23 MRI Breast: Irreg 17mm mass central L breast c/w bx proven malig and metastatic ax LAD. ~~Few satellite enhancing foci surrounding mass.~~ Nipple skin thickening w/o enhancement. Neg R breast and axilla. 2/21/23 PET CT: 20mm ~~hypermet~~ L breast mass and 29mm ~~hypermet~~ L AX LN c/w proven malig. No evidence of distant mets dz.
Bad
XRay/Scan
12/24/2023 Mammo L breast mass BIRADS 4. 12/30/2023 US L breast 10 mm mass.
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- ✓ Date
- ✓ Description
- ✓ Details

PROC Lab Test
8/9/2022 PSA = 73.1 (H)

Good

Bad

PROC Lab Test
PSA = 7.8 (H)

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- ✓ Date
- ✓ Description
- ✓ Details

DX Proc Path
8/24/22Breast, Left, 3:00, 4 cm from Nipple, Ultrasound-Guided Core shows INVASIVE ADENOCARCINOMA, LOBULAR TYPE, Nott grade 2. LVI neg. Breast, Left, 3:00, 2 cm from Nipple, Ultrasound-Guided Core Needle Biopsy: Invas adenoca, lobular type, Nott grade 2.
9/28/22BREAST LEFT MASTECTOMY W/SENTINEL LYMPH NODE BIOPSY: INVASIVE LOBULAR CARCINOMA, Nott grade 2 of 3. TUMOR SIZE: 1 CM. LVI neg. PNI neg. Margins neg. 0/1 SLN pos.

Good

Bad

DX Proc Path
6/23/22 RT BREAST; INVASIVE DUCTAL CARCINOMANO PERINEURAL OR LYMPH INVASION8/1/22PROCEDURE: Excision (less than total mastectomy)SPECIMEN LATERALITY: RightTUMOR SIZE: Greatest dimension of largest invasive focus >1mm: 18mmHISTOLOGICAL TYPE: Invasive ductal carcinoma with mucinous features OVERALL GRADE: Grade 2 (scores of 6 or 7)DUCTAL CARCINOMA IN SITU: Not identifiedTUMOR EXTENSION SKIN: Skin is not present NIPPLE: Nipple is not present SKELETAL MUSCLE: No skeletal muscle is presentINVASIVE CARCINOMA MARGINS: Uninvolved by invasive carcinomaREGIONAL LYMPH NODES: Uninvolved Total number of lymph nodes examined: 2 Number of sentinel nodes examined: 2LYMPHOVASCULAR INVASION: Not identified

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- ✓ Date
- ✓ Description
- ✓ Details

DX Proc Scp
7/20/22 colonoscopy: colon ca transverse colon.

Good

Bad

DX Proc Scp
11-12-23 volume study: bladder neg.
10-8-23 volume study: bladder neg.

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- ✓ Date
- ✓ Description
- ✓ Details

DX Proc OP
5/4/23 Laparoscopic hand-assisted Rt hemicolectomy: Mobilized the entire terminal ileum, Rt colon & transverse colon to its mid point. Transverse colon transected. Liver grossly negative.

Good

Bad

DX Proc OP
7/9/23 RT breast mastectomy w/ SLN bx.

DX Proc Path
6/25/23 RT breast bx's: 0.3 cm INV ductal carcinoma, Nottingham Grade 2. Background DCIS. 7/9/23 RT breast mastectomy: 0.6 cm INV ductal carcinoma, Nottingham Grade 2. Margins neg. No LVI, no PNI. High-grade DCIS noted. SLN 2/2 pos. RT axillary LN dissection 4/4 pos for met.

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DX Proc PE
2/8/23: 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 age for future tx) opted mastectomy for exc lesion and no bx. Unable to have chemo.

Proc Lab Test
2/8/23 ER pos 95%, strong intensity. PR pos 80%, strong intensity. HER2 by IHC: equivocal 2+. HER2 by FISH neg. Ki-67 34%.

XRay/Scan
1/10/23 bilat mammo: R breast mass 10-11:00 position, 7.4cm. R breast U/S: solid mass R UOQ 6.2cm.

DX Proc Path
2/8/23 R breast simple mastectomy: Invasive lobular carcinoma, Nott gr 2, MD. Peritumoral LVI pos. Surg margins neg. Synoptic report: TS = 6.5cm. Skin uninvolved by ca. Lobular carcinoma in situ present.

Hormone
3/22/23 Arimidex

Age – Sex – Race
Site – Laterality
Histology – Behavior

Clinical – Path Size
LVI
EOD

SSDI's

Treatment

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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 Location for above text:

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

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Pathology

- Margins nos 19 cm = 190 mm
  - Must state more than margins nos.
  - CRM 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

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Final Tips on Texting

- Avoid duplicating text in more than one field
- 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
  - 2.4 x 1.2 x 0.3 cm in size. Text the largest tumor size, 2.4 cm
- Punctuation is important
  Spaces, periods, comma. Do not use (-) dashes if at all possible.

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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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