

# Creating the perfect text For your Abstract

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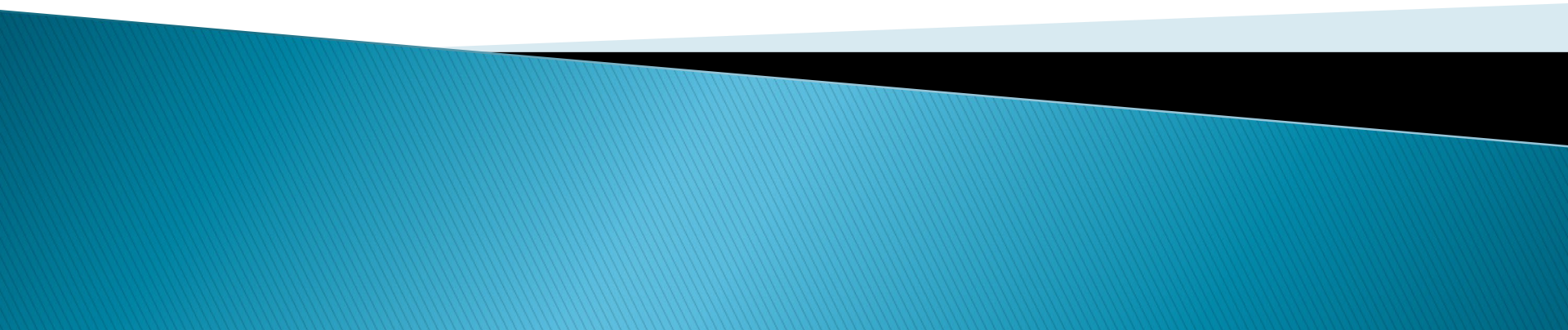
# ABC

## Does Text Support Matter ?

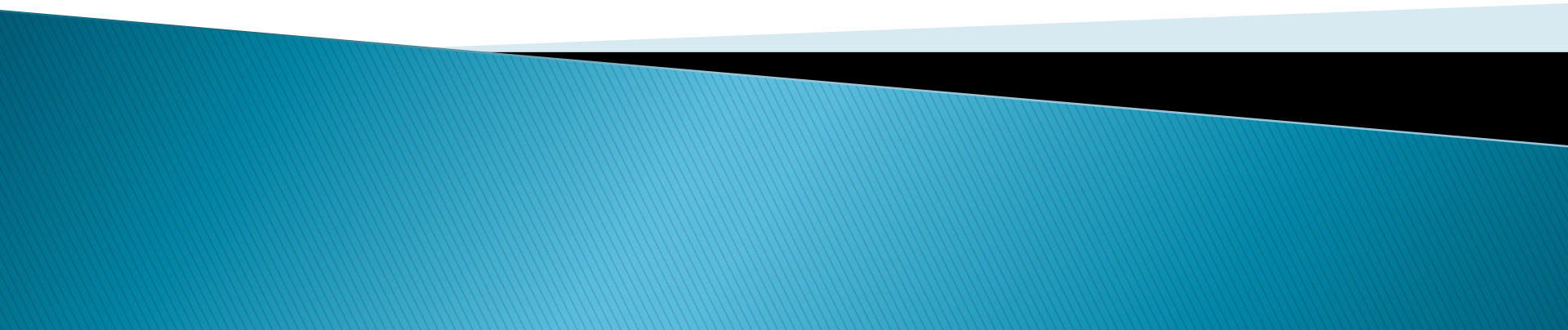
Yes !

- Every Pt has a story. Text tells “the story” in readable language that supports the coding
- Text should provide accurate, concise summary of the patient’s cancer

# Text Uses.....

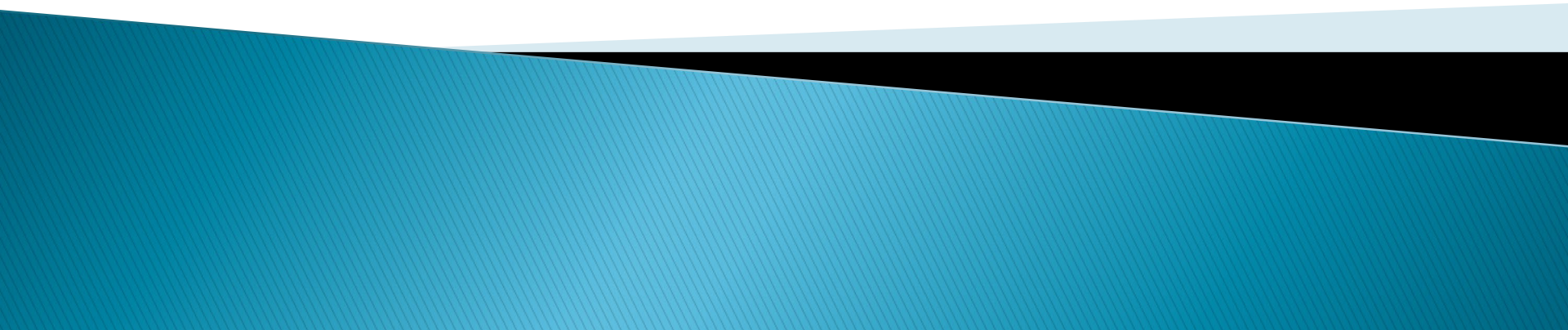
- Support Coding
  - Support unusual site /histology combos
  - Explain unusual abstract entries
  - Document ambiguous terminology
  - Document additional info or questions
- 

## More Uses For Text .....

- Support accuracy and validity of data
  - Eliminate the need to pull charts or review EMR again
  - Edit check verification
  - Re-coding /re-staging of historical data
  - Researcher/facility use
- 

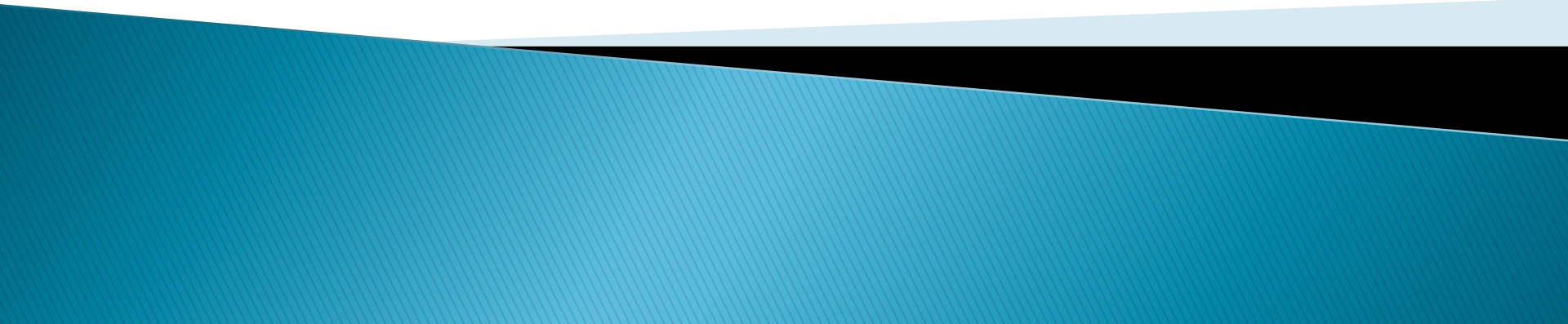


# Text Uses At The Central Registry

- Validates codes in the abstract
    - Sequence
    - Extent
    - Treatment
  - Reconcile codes and consolidate abstracts from different facilities
  - QA / QC audits
- 

# Critical Data Items

|                     |                                  |
|---------------------|----------------------------------|
| Age                 | Sequence                         |
| Date of Birth (DOB) | Grade                            |
| Sex                 | Stage                            |
| Race                | Dates and Types of All Treatment |
| Primary Site        | Date of diagnosis                |
| Histology           | Laterality                       |
| Behavior            |                                  |





# Abbreviations ? Sure !

Use accepted abbreviations from the Abstractors Manual available at:

[Appendix I](#)

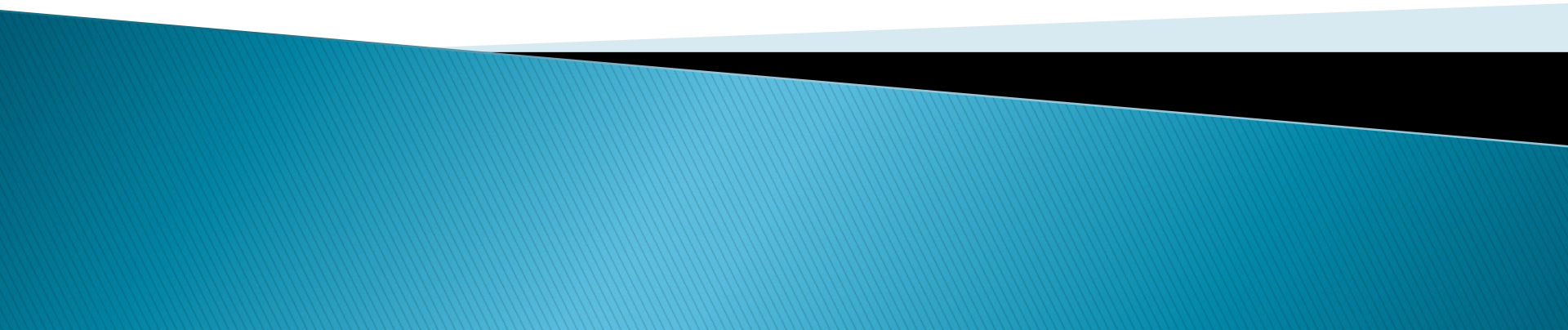
(Common Acceptable Abbreviations)

<https://confluence.kcr.uky.edu/display/KAM/Appendix+I+-+Common+Abbreviations>





## .... But Use Caution !

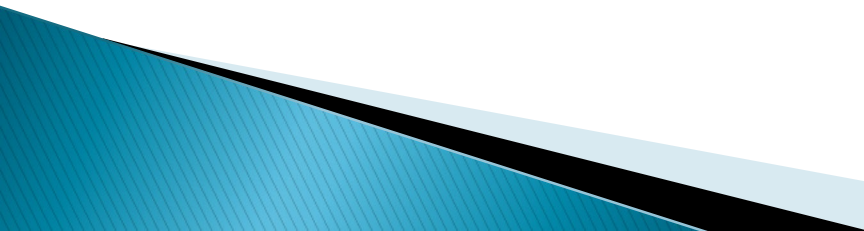
- Make sure your abbreviations aren't confusing
  - Spell out, at least once, any abbreviation that might not be easily recognized
  - Use abbreviations in context
- 

# Are Symbols acceptable ?

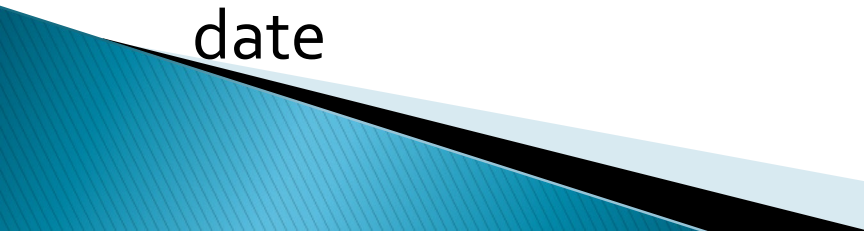
Yes !

Some examples:  $<$ ,  $>$ ,  $=$ ,  $+$  (positive),  $\times$  (times)  
 $\frac{2}{7}$  (two of seven)

# Physical Exam...

- Begin with Age, Race, & Sex
  - Insert information relating to previous primary cancer sequences here (date & type)
  - Include symptoms leading to current hospital in or out patient admission for diagnosis &/or treatment
  - Include diagnosis date/ procedure/ facility if this took place prior to current visit
  - Remember to include reason for current visit!
  - End each text section with your initials & date entered
- 

# Workup tests & procedures...

- X-ray reports: Date, Scan, Facility where performed, & pertinent findings; insert initials & date entered at end of box
  - Scopes: Date, Type of Scope, Facility where performed, & pertinent findings; initials & date
  - Lab Tests: Date, Test name, Facility where performed, & pertinent results (include normal range); initials & date
  - Operative Reports: Date, Name of procedure, Facility where performed, & pertinent findings (may include important site, size or staging information); initials & date
- 



# Pathology & more!

- Pathology: Date, report #, facility, & final diagnosis; include results such as size, location, histology, grade, extension information, lymph node results; **Comments or Addendum** results are equally important to record; initial & date
  - Site: topography (be BRIEF!); initials & date
  - Histology: primary tumor type); initials & date
- (You are not required to repeat this info in an additional text field, if it is already documented once.)

# More on Pathology

- It is helpful to list Path reports in date order. Oldest Paths at top of Path section
- Include all pertinent information from Path report including behavior and grade.
- Path reports can be copied and pasted from E Path in the Path text field. Epath can also be attached to your abstract which helps Central and when your abstract is used for Research

# Staging is critical...

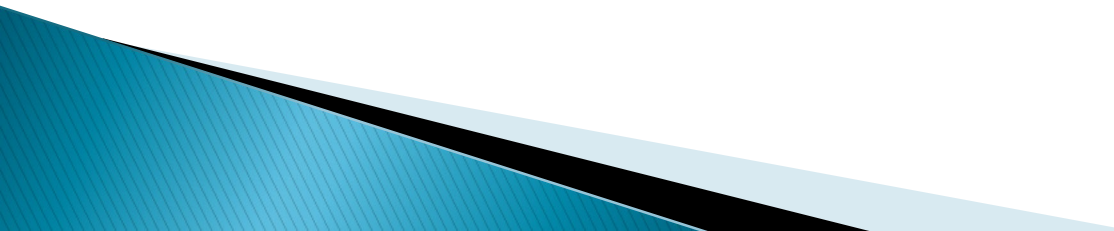
- Record TNM staging & who staged clinical &/or pathologic staging; initials & date
  - Collaborative Staging: show original measurements (pre-coding); include sources of these data choices; include info for all Site Specific Factors if not covered in previous text sections; initials & date
- \* Re-abstracting Audits are often performed using text information only; data not documented will be counted as errors.**

# Treatment Plan

- Use this text field to document what the physician plans for the treatment of the patients cancer.
- An example : Per Dr Smith's 1/1/2016 note : after Pt's surgery, plan to have six cycles of Chemo (name drug if known), at name of facility-if other than reporting facility, followed by Radiation Therapy (name of facility-if other than reporting facility). Plan for CT every 6 weeks to verify treatment progress.



# General Remarks...

- Diagnosis date & source should be included here, if not covered earlier in text.
  - Treatment information may be included here (type, date started; radiation also requires date ended, tx volume, & tx modality) if not covered thoroughly in Treatment Notes box.
  - Following physicians/ specialties included here
  - Followup information is typically added here each year; initials & date
- 

# Your text is perfect...

IF you can code your case by looking at your text without referring back to the chart!

**Cover your codes by backing them up in text.**

Good job – you're ready to go to work now!

