





# INSTRUCTIONS FOR MEDICAL RECORD ABSTRACT

# Hardcopy Submissions of Information on Reportable Tumors BLADDER CANCER

February 2014

# PLEASE DO NOT EMAIL ANY CONFIDENTIAL PATIENT INFORMATION

#### MARYLAND CANCER REGISTRY

# <u>Instructions for Hard Copy Medical Record Abstracts</u>

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 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 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

**Ouestions?** Call 1-888-662-0016 or 301-315-5990

### DO NOT REPORT THESE TUMORS TO THE MCR:

If cytology is reported as *suspicious*, **do not** interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

If a final diagnosis is reported as *possible* carcinoma of the bladder, *possible* **is not** a diagnostic term for cancer.

#### INSTRUCTIONS FOR EACH FIELD

### REPORTER IDENTIFICATION

FACILITY NAME: Enter the full name of your facility

**ABSTRACTOR 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 #:** Enter the medical record number assigned by your facility, if applicable. Leave blank if this does not apply.

#### PATIENT DEMOGRAPHICS

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

**SOCIAL SECURITY #:** XXX-XX-XXXX

DATE OF BIRTH: YYYY/MM/DD

PATIENT RESIDENTIAL ADDRESS: Enter the patient address ## and Street Name only.

PATIENT RESIDENTIAL ADDRESS: Include identifiers such as Apt #, RR # or PO Box #.

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

**COUNTY OF RESIDENTIAL:** Please indicate county of residence if known, otherwise, leave blank.

GENDER (check one): Male Female Other

**PLACE OF BIRTH** (if known): Enter the patient's <u>Country or U.S. State</u> 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:** This refers to the anatomic site (on the body) where the tumor being reported was found. Bladder tumors are delineated as follows:

Anterior Wall	Dome	Internal Urethral Orifice	Base
Lateral Wall	Trigone	Urachus	Floor
Posterior Wall	Neck	Urinary, NOS	Roof
Sidewall	Wall, NOS	Bladder, NOS	Overlapping

If you cannot tell the area of the bladder in which the biopsy was taken, please use Bladder, NOS (Not Otherwise Specified) as your choice.

**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. Conversly, 10mm would equal 01.0cm.

If tumor size is not stated, please leave blank.

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

Transitional Cell Carcinoma is the most common type of bladder cancer.

Other histologies include:

Transitional Cell Carcinoma, In-Situ

Papillary

Flat

With squamous differentiation

With glandular differentiation

With squamous and glandular differentiation

Squamous Cell Carcinoma

Adenocarcinoma

**Undifferentiated Carcinoma** 

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

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

DHMH 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

	Low malignant potential.	
	Uncertain malignant potential	
	Clark level 1 for melanoma (limited to epithelium).	
Synonymous with	Confined to epithelium.	
in situ (non-invasive)	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	1
Well differentiated	
Fairly well differentiated	I
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

**METASTATIC DISEASE:** Check 'Yes' box if distant site metastasis was identified at diagnosis. If yes, please indicate the site of the distant metastasis such as Lung, Bone, or Liver. Check 'No' box if metastasis was not identified or not stated. Check 'Unknown' box if metastasis at diagnosis is unknown.

<u>Tumor Characteristics</u> (for Staging). Check 'Yes' box if condition if present and/or described in the pathology report. If Unknown, skip to the next selection and leave blank. Also indicate the extension of the disease within the organ and to neighboring organs with the appropriate checkbox.

Non-Invasive Papillary Tumor Solid/nodule Carcinoma "in-situ": Flat Lymphovascular Invasion Other Specify:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No			
☐No tumor type known	□Not applicable, tumor type is not transitional □Unknown			
TREATMENT INFORMATION – First Course of Therapy				

**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)

Size of Metastasis in lymph nodes: If available, indicate of size pf metastasis in lymph nodes. Extranodal Extension: If available, indicate whether there is extranodal extension by checking the "Yes" or the "\No" box.

<u>OTHER TREATMENT</u> - This category includes chemotherapy, radiation therapy, hormonal, 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.

Mail or Fax [DO NOT email] 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