The Criterion

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Lost In Translation

Q: My abstracts are very dense (wordy). What can I do to reduce the amount of text without jeopardizing quality?

A: Omit references to unrelated diseases. For example, on a CT for colon cancer, omit "Distended gallbladder w/gallbladder stones" or "atrophic functioning R kidney". Omit unrelated lab tests (unless required by your cancer committee), such as glucose, CBC for non-hematopoietic cancers, especially when the tests are normal. Omit PE findings that are unrelated, for example "Heart is tachycardic but regular" for a colon case.

Use approved abbreviations, such as PTA for prior to admission, R or Rt for right, vasc for vascular. These approved abbreviations are all listed in Volume I, Appendix M. Also note that certain symbols are approved for use as abbreviations.

Remember that punctuation is important to the visual editor. A misplaced, comma (,), semi-colon (;), or period (.) can change the interpretation!

Q: Why do I have to record operative findings? The reports never seem to say anything.

A: Operative reports provide important information on subsite and extension, more so in some sites than others. Findings from an operation for colon cancer are especially important. Here is an example of helpful information:

> Inspection of abd cavity showed a mass in sigmoid colon; the rest of large bowel, small bowel, stomach & liver appeared normal.

This statement could be shortened, for example, 'Mass noted in sigmoid; rest of lg bowel, sm bowel, stomach & liver appeared nl'. This statement confirms the subsite code from the best observer (for this primary site) and documents the absence of any grossly visible extension or metastasis.

On the other hand, some surgeons prefer to use templates and provide very little in the way of a description. In this case, please indicate using the approved abbreviation NSF (no significant findings), or state 'tumor not described' or other appropriate statement that indicates that you reviewed the report and found nothing to document. Please don't leave this field blank (if an operation was performed) and don't simply state the name of the procedure. This field is only helpful if the surgeon's observations are recorded.

Q: Where do I document the Diagnostic and Staging Procedures code?

A: The documentation for the diagnostic and staging procedures code can be the Physical Exam or Operative Findings. Documentation for this field is especially important for biopsies. Is this a biopsy of the primary site, distant site, or a regional or distant lymph node? Is the biopsy a needle core biopsy or an excisional biopsy?

Q: How do I record continuation of text into another text field?

A: In spite of paring down text and the use of abbreviations there are situations where it is necessary to continue text documentation in available text fields. This can only be done by the use of the asterisk *, **, ***, etc as the last entry in the originating field. Remember that it is essential to use the same symbol as the first entry in the new text field! See Volume I, IV.1.1 for a full description of the appropriate labeling of continuation text.

Q: Is there a hierarchy of how to document the staging scans in the text fields?

A: All of the text fields should be formatted beginning with first procedure and then all additional procedures listed sequentially in date order. This applies not only to X-Rays and Scans, but to Scopes, Operative Text, Labs, and

Pathology as well. From a visual editor's perspective, the reader is better able to comprehend the history of the patient's tumor from first symptoms through first course treatment.

Q: Sometimes the discharge summary is not in the medical record at the time of abstracting. How should the final diagnosis field be completed – or should I leave it blank?

A: Indicate "No final dx from MD" in the Final Diagnosis text field. The final diagnosis is intended to only reflect the physician's diagnosis and not be a text field for the abstractor's conclusions regarding the patient's tumor. The visual editor (and researchers) need to be able to trust that the final diagnosis is a reflection of the physician's experience and expertise, not the abstractor's.

Q: How do I document conflicting opinions between physicians in stage or primary site?

A: Document the differing opinion in the text. Always code the case according to the rules in the Multiple Primaries and Histology manual and the Collaborative Staging and Coding Instructions manual. If these two standard manuals are not of assistance, use the stage or primary site according to the treating physician.