APPENDIX L – 2024 FCDS TEXT DOCUMENTATION REQUIREMENTS

Text documentation is required to justify coded values and to supplement information not transmitted with coded values. Complete and accurate documentation is an essential component of a complete electronic abstract and is utilized heavily in quality control to validate data at the time of FCDS and NPCR Audits and for special studies by researchers. FCDS recommends that abstractors print and post this document for easy reference. Adequate text is a data quality indicator and is a significant component of Quality Control.

Below is a list of FCDS Required Data Items that require complete and accurate text documentation. These data items are routinely visually edited by FCDS Quality Control staff. See Table on the following page for specific examples for each Text Area.

County of Residence at Diagnosis
Sex
Race
Spanish/Hispanic Origin
Date of Diagnosis
Class of Case
Diagnostic Confirmation
Primary Site (and Subsite)
Laterality
Histologic Type
Behavior Code
Grade – Clinical
Grade – Pathological
Grade – Post Treatment – Clinical
Grade – Post Treatment – Pathological
Summary Stage 2018
All Required Site-Specific Data Items

RX Summ – Surg Prim Site 03-2022
RX Summ – Surg Prim Site 2023
RX Summ – Scope Reg LN Surgery
RX Summ – Surg Oth Reg/Distant
RX Date – Surgery
Phase I Radiation Treatment Modality
RX Date – Radiation
RX Summ – Chemo – List All Agents
RX Date – Chemo
RX Summ – Hormone – List All Agents
RX Date – Hormone
RX Summ – BRM/Immunotherapy - Agents
RX Date – BRM/Immunotherapy
RX Summ – Transplant/Endocrine - details
RX Date – Transplant/Endocrine
RX Summ – Other – include all details
RX Date - Other

Text documentation should always include the following components:

- Date(s) – include date(s) references – this allows the reviewer to determine event chronology.
- Date(s) – note when date(s) are estimated.
- Patient History – Include patient history and reason for the visit.
- Physician statements – Include specific statements by physicians.
- Location – include facility/physician/other location where the event occurred (test/study/treatment/other).
- Events – Include a description of the event (test/study/treatment/other).
- Test results – Include positive/negative results.
- Treatment plan- Include as much detail as possible when documenting the treatment plan, even if treatment is not initiated as originally planned.
- Include any treatment interruptions, delays, cancellations, etc.
- Always document why the patient came to the reporting facility.
- Document why the Class of Class 32 is being reported.
- Registrars must fully document all cases regardless of Class of Case.
- Do not repeat information from section to section.
- Use NAACCR Standard Abbreviations (Appendix C).
- Do not use non-standard or stylistic shorthand
- Enter “N/A” or “not available” when no information is available related to any specific text area.
- Include AJCC TNM stage if available. However, you still must document the rationale for why you assigned SS2018.
- When information is unavailable or dates estimated, document that the information is missing and dates are estimated.

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The National Cancer Registrars Association (NCRA) is also a source of tools and resources for registrars. NCRA's Education Committee created a series of informational abstracts for common cancers and a presentation entitled *Using the Informational Abstracts in Your Registry* that shows registrars how to use informational abstracts as an abstracting resource. These are available as cancer site-specific abstracts that provide an outline to follow when determining what text to include. The NCRA Informational Abstracts can be found at https://www.cancerregistryeducation.org/rr.

(NCRA - Updated 2022)

- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Benign Brain**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Bladder**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Breast**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Cervix**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Colon**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Endometrial**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Kidney**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Larynx**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Lung**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Lymphoma**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Malignant Brain**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Melanoma**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Ovarian**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Pancreas**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Prostate**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Renal Pelvis**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Testis**
- INFORMATIONAL ABSTRACTS - DOCUMENTING TEXT FOR: **Thyroid**

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Text Data Item Name **NAACCR Item #** **Field Length**	**Text Documentation Source and Item Description** *FCDS Required Text Documentation – description of the minimum text required for this text field* **Example:**
Text - Physical Exam H&P NAACCR Item #2520 Field Length = 1000	Enter dates and text information from history and physical exams. History and physical examination findings related to family history or personal history of cancer diagnosis, physical findings on examination, type, and duration of symptoms, and reason for admission. Every abstract should include a statement as to the reason for the patient encounter at your facility. **Example: Hx RCC Rt Kidney – Dx 1/2024 in Georgia. Adm to this facility on 6/1/2024 c/o fever and night sweats. Physical Exam noted enlarged bilateral axillary lymph nodes, which on biopsy revealed diffuse large cell B-cell lymphoma (DLBCL).**
Text - X-rays/Scans NAACCR Item #2530 Field Length = 1000	Enter dates and text information from diagnostic imaging reports, including x-rays, CT, MRI, PET scans, ultrasound, and other imaging studies. *Please try to list imaging in chronological order.* *Date, the facility where the procedure was performed, type of procedure, detailed findings (primary site, size of tumor, location of tumor, nodes, metastatic sites), clinical assessment, positive/negative results* **Example: 7/12/24 (Breast Center) 3-D Mammo – Rt Breast mass central at 12:00 o'clock 1.5cm size**
Text - Scopes NAACCR Item #2540 Field Length = 1000	Enter dates and text information from diagnostic endoscopic examinations. *Date of Procedure, the facility where the procedure was performed, type of procedure, detailed findings (primary site, extent of tumor spread, satellite lesions), clinical assessment, positive/ negative results* **Example: 7/12/24 (Endoscopy Ctr xyz) EGD: gastric mucosa w/ evidence of large tumor occupying half of the stomach. Numerous satellite tumors were seen on the opposite wall of the stomach**
Text - Lab Tests NAACCR Item #2550 Field Length = 1000	Enter dates and text information from diagnostic/prognostic laboratory tests (not cytology or histopathology). Include all relevant laboratory tests, whether indicated as an SSDI or as other labs. **Include Documentation, Dates and Text for Site Specific Date Items (SSDIs).** *Date(s) of Test(s), facility where test was performed, type of test(s), test results (value and assessment)* **Example: 7/12/24 (Hosp xyz) ER +, PR - , HER2 neg by IHC method, PSA 5.3 (elevated)**
Text - Operative Report NAACCR Item #2560 Field Length = 1000	Enter dates and text information from surgical operative reports (not diagnostic needle or incisional biopsy). Include observations at surgery such as tumor size and extent of direct involvement of primary with regional organs or other structures or observed at surgery metastatic sites. *Date of procedure, facility where procedure was performed, type of surgical procedure, detailed surgical findings, documentation of residual tumor, evidence of invasion of surrounding areas* **Example: 7/12/24 (Hosp xyz) right colon resection - Pt was found to have extensive disease in the pelvis (carcinomatosis) and resection was aborted, no biopsies were taken, no specimen obtained.**
DX Text - Pathology NAACCR Item #2570 Field Length = 1000	Enter dates and detailed text information from the final diagnosis on cytology and histopathology reports. *Date of specimen/resection, facility where specimen examined, pathology accession #, type of specimen, final diagnosis, comments, addenda, supplemental information, histology, behavior, size of tumor, tumor extension, lymph nodes (removed/biopsied), margins, molecular pathology, genetics. Include grade information.* **Example: 7/5/24 (Hosp xyz) – Path Acc # - Rectum: Final Dx: adenoca, 2.5cm, ext. to pericolic fat. 1/22 lymph nodes + , margins neg, S100 stain is positive (melanoma, sarcoma), pT3a pN1b cM0**

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DX Text - Staging NAACCR Item #2600 Field Length = 1000	Enter rationale and details for all cancer staging (TNM and SS2018). Please document the stage clearly. Organs involved by direct extension, size of tumor, status of margins, sites of distant metastasis, special consideration for staging, overall stage, etc. **Text for SSDI documentation if not under Labs**. **Example: 7/15/24 - T2aN1a per path, distant mets in lungs, ER/PR neg, HER2 neg by IHC method**
RX Text - Surgery NAACCR Item #2610 Field Length = 1000	Enter dates and text describing each surgical procedure(s) performed as part of 1st-course treatment. Treatment plan, date surgery performed, type of procedure, facility where surgery was performed **Example: 7/15/24 (Hosp xyz) - rt breast mrm w/ax ln dissection**
RX Text **Radiation (Modality)** NAACCR Item #2620 Field Length = 1000	Enter dates and detailed information regarding radiation treatment for the tumor being reported. Treatment Plan (if no treatment given), date treatment initiated/completed, facility where treatment administered, type of radiation, and dose if known. Radiation treatment modality is typically found in the radiation oncologist's treatment summary. **Example: 2/15/24-3/15/24 (Hosp xyz) – 45 Gy orthovoltage with 20 Gy boost to tumor bed**
RX Text - Chemo NAACCR Item #2640 Field Length = 1000	Enter dates and agents given as chemotherapy for the treatment of the tumor being reported. Refer to SEER*Rx for agents, type of chemotherapy and information on each agent. Do not enter the protocol acronym only. Please spell out each chemotherapy agent so it can be verified in SEER*Rx. *Date treatment initiated, facility/physician office where administered/prescribed, name of agent(s)/protocol, dose/cycle (if known), treatment plan(if known)* **Example: 7/15/24 (Dr Smith) – Start 6 cycles R-CHOP – standard dose at 2-week intervals** (note that R-CHOP includes multi-agent chemo, hormone (prednisone) and BRM (rituximab) – not just chemo.
RX Text - Hormone NAACCR Item #2650 Field Length = 1000	Enter dates and agents given as hormone therapy for the treatment of the tumor being reported. Refer to SEER*Rx for agents, type of hormone therapy, and information on each agent. Do not enter the protocol acronym only. Please spell out each hormone agent so it can be verified in SEER*Rx. *Date treatment initiated, facility/physician office where administered/prescribed, name of hormone/anti-hormone agent or procedure, dose (if known), Treatment Plan.* **Example: 7/15/24 (Dr Jones) - tamoxifen (dose/duration not stated)**
RX Text - BRM NAACCR Item #2660 Field Length = 1000	Enter dates and agents given as BRM or immunotherapy for the treatment of the tumor reported. Refer to SEER*Rx for agents, type of BRM/Immunotherapy, and information on each agent. Do not enter the protocol acronym only. Please spell out each immuno/BRM agent to be verified in SEER*Rx. *Date treatment initiated, facility/physician office where administered/prescribed, name of BRM or immunotherapy agent or procedure, dose (if known), Treatment Plan.* **Example: 2/15/23 (Hosp xyz) - interferon or BCG (dose/duration not stated), rituximab is BRM**
RX Text - Other NAACCR Item #2670 Field Length = 1000	Enter information regarding treatment that cannot be defined as surgery, radiation, or systemic therapy. Do not code pain medication for palliation in this data item contrary to CoC instructions. *Date treatment planned/initiated, name of other therapy, agent or procedure, dose (if known), facility where performed.* **Example: 2/15/23 (Hosp xyz) - blinded clinical trial or hyperthermia (may include study number)**

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Text - Remarks NAACCR Item #2680 Field Length = 1000	Document information not provided in any other text field or overflow from text fields. Document personal history of carcinogenic exposure (arsenic, drinking water, uranium, asbestos), other. **Example: 40 years h/o of working in shipbuilding and construction with lots of asbestos exposure**