Details Matter:

Strengthening Your Cancer Registry Abstract Text Documentation

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OBJECTIVES

- Understand the importance of providing pertinent text documentation
- Discuss the elements of quality text documentation
- Discuss which data items require text
- Review the expectations and rationale for text documentation from a quality reviewer’s perspective

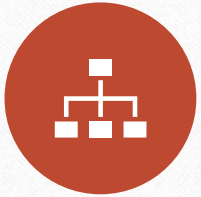
Why Is Text So Important?

- Text documentation is the foundation of a patient's abstract because it provides the narrative backbone that supports and validates all coded data elements in a patient's abstract.
- It ensures that the coded information is accurate, complete, and traceable back to the original medical record.
- It assures quality of data from the facility.
- Your text should briefly detail the patient's cancer story.
- By having important and detailed text documentation, you should be able to abstract your case on the text alone.

Text Documentation Sources

NAACCR Data Standards and Data Dictionary

State Reporting Guidelines



Organization requirements

Software requirements

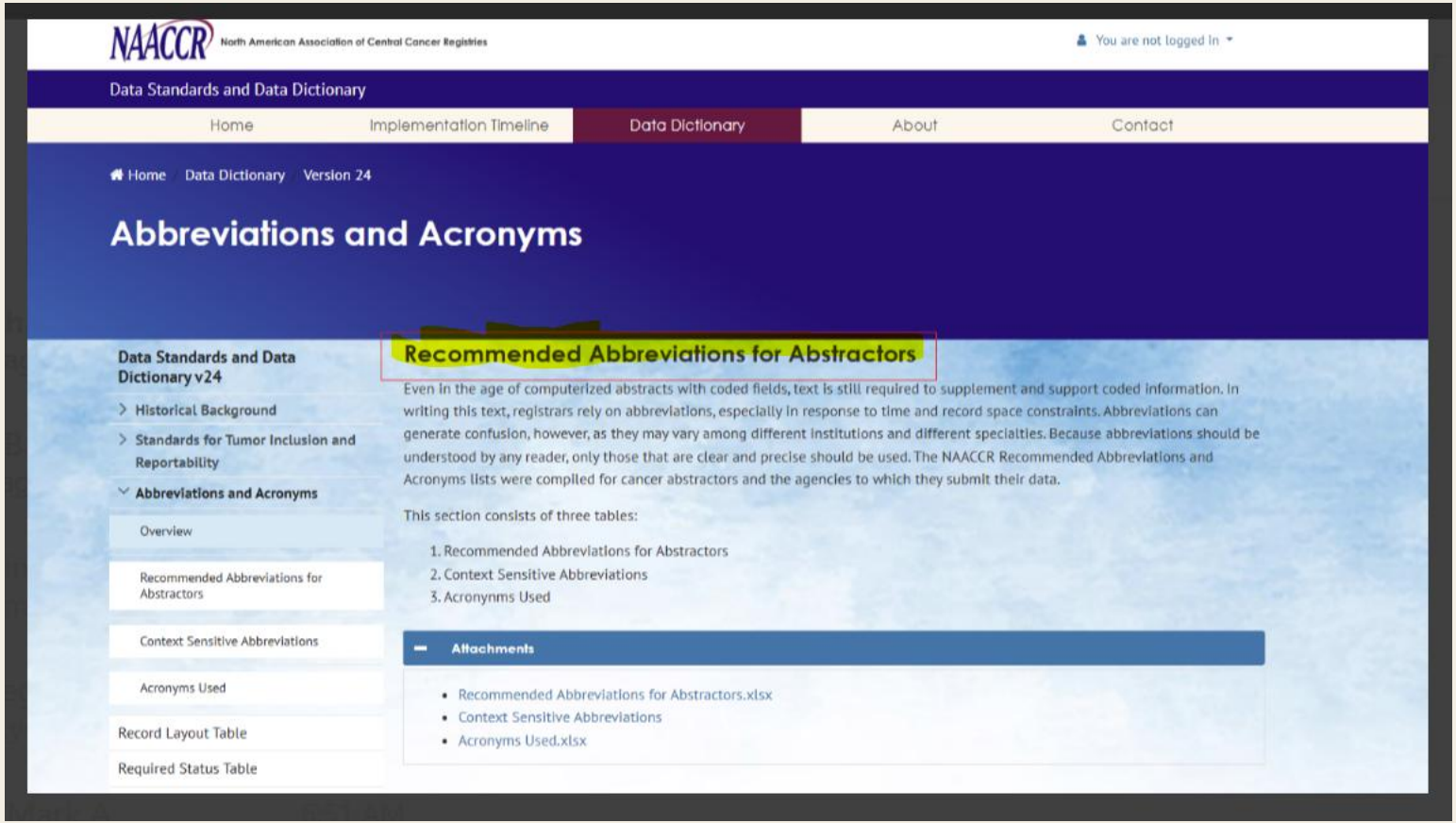
Why is Text Essential?

- **Supports coded values:** Text explains and justifies the codes entered, especially in cases with unique or complex circumstances
- **Supplements missing data**: It fills in details not captured in coded fields, such as treatment plans, delays, or special circumstances.
- **Verification:** Without text, we cannot verify
  - How the patient was diagnosed, staged or treated
  - Class of Case
  - Sequence Number
  - Dates of Procedures

Text Supports Quality Control

- **Quality Text:**
  - Please use appropriate NAACCR-approved abbreviations
  - Quality text addresses all coded data elements and clarifies any discrepancies
  - Must be easy to read and comprehend.
- **Quality Control:**
  - Complete and accurate text is a key data quality indicator and is heavily reviewed during audits and QC checks fcds.med.miami.edu.
- **Case Review:**
  - It allows reviewers to reconstruct the patient's cancer journey without re-reading the entire medical record.

NAACCR RECOMMENDED ABBREVIATIONS



Key Components of Texting

Dates

Start date & end date

Description of Text

Who, what, or why?

Details, Missing Data, or Context

What was done?
Describe procedure, imaging, surgery, etc.
Provide a summary of what is happening

Detective Work: Extracting Info to Text

Pathology: Results, not a summary.
H&P: Summary of why pt is at the facility.

Key Components of Text Documentation

According to NAACCR and FCDS guidelines, each text field should include the following:

- **Dates:** Start and end dates in chronological order. If unknown, estimate date i.e., 06/15/2024.
- **Location:** Facility, Physician, or other location where the event occurred.
- **Description:** What was done (procedure, test, treatment , or visit).
- **Findings:** Positive and negative results, extent of disease, histology, and staging.

Key Components of Text Documentation

According to NAACCR and FCDS guidelines, each text field should include the following:

- **Physician Interpretation:** Any relevant physician statements supporting diagnosis or treatment

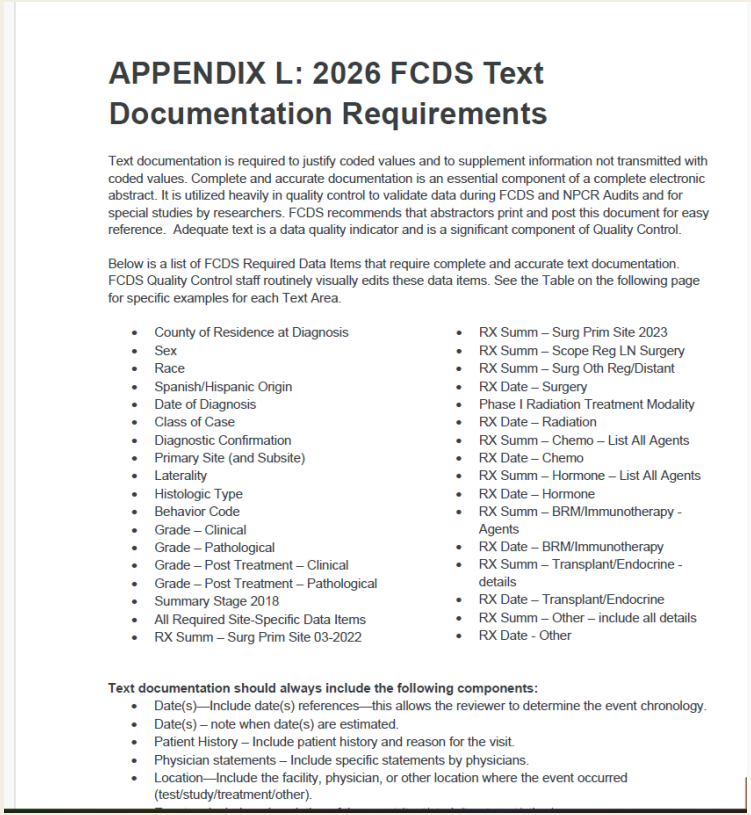
- **Treatment Plans:** Even if not initiated, include any agents, dates, and details of any treatment that was initially planned.

- **Special Circumstances:** Delays, cancellations, patient history, or relocation affecting care..

Description of Text

- *What was done?
- *Describe the procedure, imaging, and/or surgery, etc.
- *Summarize what is happening
- *Minimal use of abbreviations - Use NAACCR List for approved abbreviations
- *Limited use of copy and pasting,

APPENDIX L: 2026 FCDS TEXT DOCUMENTATION REQUIREMENTS



APPENDIX L: 2026 FCDS Text Documentation Requirements

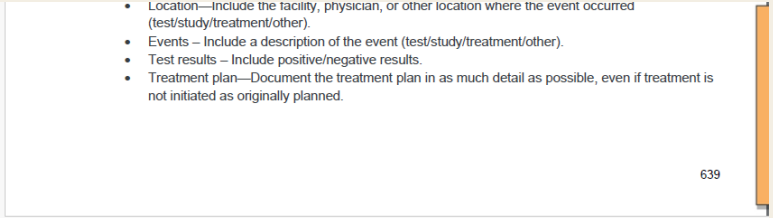
Text documentation is required to justify coded values and to supplement information not transmitted with coded values. Complete and accurate documentation is an essential component of a complete electronic abstract. It is utilized heavily in quality control to validate data during FCDS and NPCR Audits 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. FCDS Quality Control staff routinely visually edits these data items. See the 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 the 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 the facility, physician, or other location where the event occurred (test/study/treatment/other).



- Location—Include the facility, physician, or 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—Document the treatment plan in as much detail as possible, even if treatment is not initiated as originally planned.

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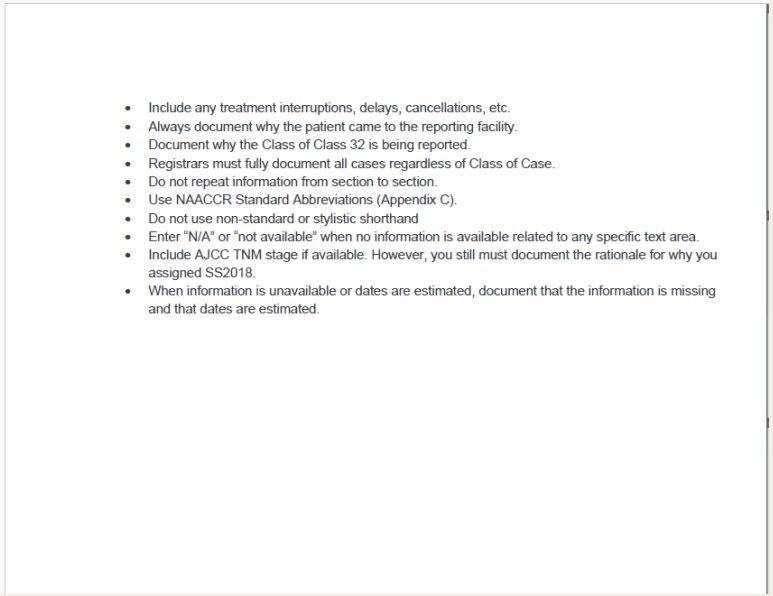


- Include any treatment interruptions, delays, cancellations, etc.
- Always document why the patient came to the reporting facility.
- Document why the Class of Class 32 is being reported.
- Registrars must fully document all cases regardless of Class of Case.
- Do not repeat information from section 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 are estimated, document that the information is missing and that dates are estimated.

Rationale for Text

- Utilized for Quality Control
- Justification of coded values
- Documents supplemental information
- Helps facilitate tumor consolidation

TEXT DOCUMENTATION REQUIREMENT

Text documentation has always been a requirement. It is not just an FCDS requirement; it is a federally mandated requirement. It is an essential component of a complete electronic abstract and is heavily utilized for the following:

- Visual Editing / QC Review
- Record Consolidation / Validation of Data
- Other Central Registry Quality Control
- National Program Quality Control
- Research Studies
- Other Studies

DATA QUALITY ASSESSMENT

DATA QUALITY ASSESSMENT

- Data Validation
- Reabstracting Studies
- Visual Review
  - Quality Control Sampling Reports (One of every 25th Record)
  - Has become critical to Central Registry Operations
- Edits and Edit Overrides (Forces
  - Edits test the logical effects of coding rules
  - Edit overrides (Forces) Allow unique case data to pass edits
  - Quality Control Sampling Reports (One of every 25th Record)
  - Critical to Central Registry Operations

Problem Areas in Text Documentation

- Duplicate text in treatment area
- Too much text documentation
- Excessive abbreviations

- Coding nodes examined/nodes positive; scope regional lymph nodes surgery for FNA or other regional nodes (not distant nodes)
- Cases coded as “Unstaged” when clinical staging is clearly present
- No operative findings documented; only procedure
- Pathology report findings not documented
- Race, Sex, Ethnicity, & History not coded
- Text or stage is only coded to TNM; Summary Stage not coded
- Treatment recommended, treatment refused, or coded as 99

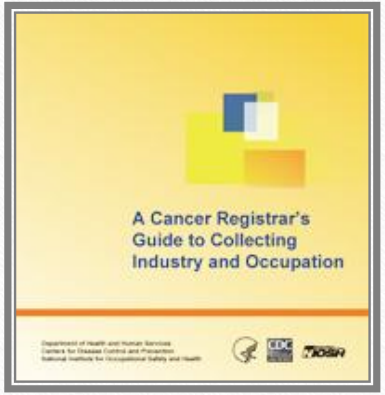
- Missing radiation treatment modality
- Tumor Markers

OCCUPATION & INDUSTRY TEXT

Occupation & Industry Text Fields

"Retired" should never be in these 2 text fields. Please refer to this resource for guidelines on Occupation & Industry

- 310 Usual Occupation
- 320 Usual Industry



NCRA INFORMATIONAL ABSTRACTS

Informational Abstracts

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research: therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment. To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. (Updated July 2025)

Check out the Information Abstract Quizzes to earn CE credit.

Learn How to Use the Informational Abstracts

Informational Abstracts provide guidance on what to include—and exclude—when compiling data and writing abstract text. This presentation, *Using the Information Abstracts in Your Registry*, introduces registrars to these resources and how to use them effectively. (October 2016)

Information Abstracts by Site

Click the links below to view, print, or save an abstract.

- Benign Brain
- Bladder
- Breast
- Cervix
- Colon
- Endometrial
- Kidney
- Larynx
- Lung
- Lymphoma
- Malignant Brain
- Melanoma
- Ovarian
- Pancreas
- Prostate
- Renal Pelvis
- Testis
- Thyroid

IN SUMMARY

- Text documentation is not just supplementary—it is the core that makes cancer registry abstracts reliable, auditable, and clinically meaningful. Properly structured, concise, and accurate text ensures that coded data is both correct and defensible.
- By having quality text documentation, you should be able to accurately recode an abstract by reviewing the text field documentation only.
- In addition, the Field Coordinators will not have to send messages back and forth to the facility with questions and clarifications.

Resources

- Recommended Abbreviations for Abstractors
- https://www.naaccr.org/?s=abbreviations
- Evidence-Based Treatment Guidelines
- https://www.nccn.org/guidelines/category_1
- NCI Understanding Labs Test/Values
- https://www.cancer.gov/about-cancer/diagnosis-staging/diagnosis
- NCI Physician Data Query
- https://www.cancer.gov/publications/pdq
- SEER RX Antineoplastic Drugs Database
- https://seer.cancer.gov/tools/seerrx/

References

Surveillance, Epidemiology and End Results Program

https://seer.cancer.gov/

National Program of Cancer Registries/CDC

https://www.cdc.gov/national-program-cancer-registries/about/index.html

The NAACCR Data Standards and Data Dictionary

https://apps.naaccr.org/data-dictionary/home

Florida Cancer Data Systems

https://fcds.med.miami.edu/inc/welcome.shtml

Thank you

Questions