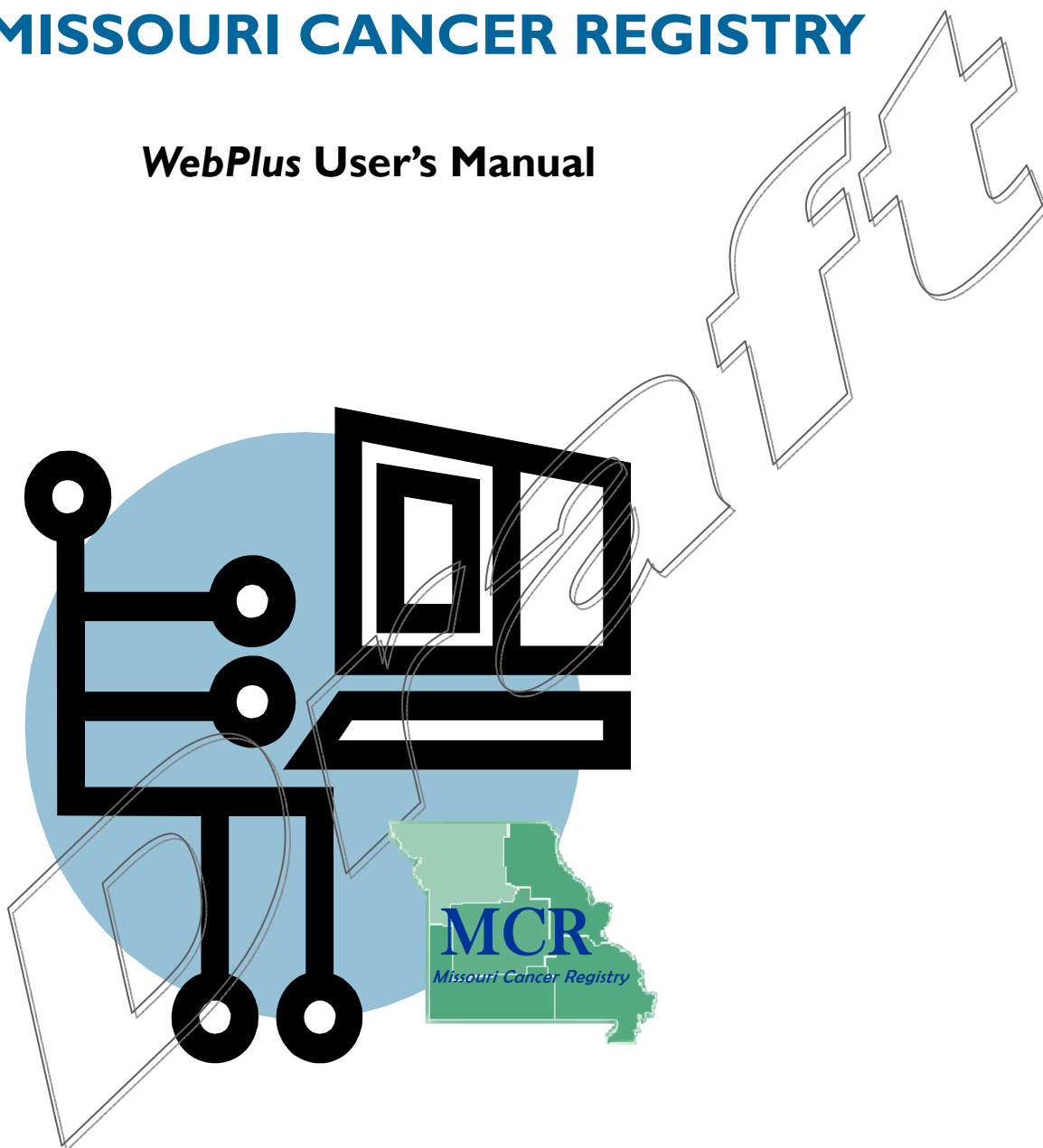


MISSOURI CANCER REGISTRY

WebPlus User's Manual



Urological Cancer Reporting

- *Reporting requirements*
- *Entering/ Saving Abstracts*
- *Reports*

URL:

<https://webplus.umh.edu/webplus/>

Username: _____

Password: _____

This project was supported in part by a cooperative agreement between the Centers for Disease Control and Prevention (CDC) and the Missouri Department of Health and Senior Services (DHSS) (#U55/CCU721904) and a Surveillance Contract between DHSS and the University of Missouri.



University of Missouri Health Care

Missouri Cancer Registry

WebPlus User's Manual
1st Edition

Urological Cancer
February 2006

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Missouri Cancer Registry

PO Box 718, Columbia, Missouri 65205
866-240-8809 or 573-884-2491



Missouri Department of Health
and Senior Services

The Missouri Cancer Registry (MCR) was established by a group of forward-thinking physicians more than 30 years ago as a means to collect and provide accurate, up-to-date information about cancer in Missouri. Since 1984, reporting has been mandated by the State. The original legislation involved only hospital inpatients; nevertheless, in 1999, legislation was amended to include reporting of all hospital patients (outpatients as well as inpatients). Because of changes in healthcare delivery and advances in medical practices, non-hospital health care providers, such as long-term care facilities, pathology laboratories, freestanding cancer treatment facilities, ambulatory surgery centers, and in some instances, physician offices, were also included in this legislation (192.650-192.657 RSMo). However, physicians need report only those cancers that are diagnosed or treated in the office setting; cases in which the patient does not enter a hospital or other treatment facility.

Reporting by non-hospital facilities is being phased in gradually so that MCR staff can work with facilities, providing education and training to facility staff and developing reporting processes that minimize the burden on reporting facility staff without compromising data quality or completeness. While the overall quality and completeness of Missouri's cancer incidence data is high, gaps remain that can only be closed by implementing physician office reporting. The two largest groups that have been identified are patients diagnosed with melanoma skin cancer or prostate cancer.

In 2004, MCR began working with dermatologists around the state, who are now submitting cases on paper cancer-reporting forms. In less than 18 months, MCR identified approximately 500 cases of invasive melanoma that would otherwise have gone unreported. As evidenced, reporting of melanoma skin cancers has been greatly improved with the initiation of reporting by dermatologists.

Underreporting of prostate cancer cases is not only an issue in Missouri but also nationwide. Recently, Missouri was one of six states that the Centers for Disease Control & Prevention/National Program of Cancer Registries (CDC/NPCR) selected to participate in a special one-year pilot project to increase the reporting of prostate and other urological cancers by physicians. With funding and technical assistance from CDC, MCR will be able to offer a web-based cancer reporting option, using free software developed by CDC, to urologists. (Eventually, the software will be customized to accommodate melanoma cases as well.)

MCR is pleased to be involved in this pilot project. It offers an advantage to Missouri urologists who otherwise would have been asked to complete paper forms. While we do not have specific details to share with you, we wanted to inform you about physician cancer reporting in Missouri and alert you to the upcoming project. Our website -- <http://mcr.umh.edu> -- provides details about HIPAA, as well as cancer reporting information for both hospital and non-hospital facilities.

Thank you in advance for your cooperation. We welcome your input and assistance in establishing effective procedures for capturing cancer data. If you or your staff have questions or comments about physician cancer reporting, please contact Nancy Cole, MCR's non-hospital reporting coordinator, at 866-240-8809 or colen@health.missouri.edu.

Sincerely,

Jeannette Jackson-Thompson, MSPH, PhD
Operations Director

PREFACE

The primary purpose of the Missouri Cancer Registry (MCR) *WebPlus Manual* is to assist physicians offices in reporting cancer cases. As *WebPlus* is a new software developed by the Centers for Disease Control and Prevention (CDC) for collection of cancer information, this is the first edition of the manual which includes recent changes in coding structures and requirements from the National Program of Cancer Registries (NPCR), the North American Association of Central Cancer Registries (NAACCR) and the Commission on Cancer (CoC) Facility Oncology Required Data Standards (FORDS).

Since the passage of Public Law 102-515, entitled the *Cancer Registries Amendment Act*, by the 102nd Congress in October 1992, there has been a tremendous effort by all agencies collecting cancer data to unify and standardize data sets. With the establishment of NPCR in 1994, all central registries funded by the CDC through NPCR are required to follow stringent data management procedures; provide training for state personnel, all reporting facility staff; publish an annual report; and conduct case-finding/re-abstracting audits at selected facilities.

Although MCR began receiving CDC/NPCR funding in 1995, our index (reference) year is 1996. MCR collects data that: 1) is compliant with required NPCR data elements; 2) meets standard requirements designated by NAACCR for incidence reporting and endorsed by CDC; and 3) assists in determining data quality. Data collected also provides useful feedback to submitting facilities that can be used for QA activities and administrative purposes.

Data collected is submitted annually to NAACCR for Registry Certification and publication in *Cancer in North America (CINA)*. Registries whose data meet established criteria, including criteria for timeliness, accuracy and completeness, are recognized annually as Silver Certified or Gold Certified registries. MCR became a Silver Certified registry following submission of 1998 data in December 2000 and retained its status as a Silver Certified registry following submission of 1999 data in December 2001. MCR was also recognized as a Gold Certified registry with the submission of 2000 data and data for 1999 was later certified Gold for CINA publication in 2001.

MCR staff are available to answer registry-related questions and to provide workshops, educational presentations and one-on-one training. For additional information and contact information, please refer to the MCR website (<http://mcr.umh.edu/>).

INTRODUCTION

MISSOURI CANCER REPORTING REQUIREMENTS

Missouri statutes, National Program of Cancer Registries (NPCR) and North American Association of Central Cancer Registries (NAACCR) requirements, data quality and projected needs of the citizens of this state govern reporting requirements. In 1999, the statutes were revised to include patients diagnosed and/or treated as hospital outpatients and in non-hospital facilities (e.g., pathology laboratories, ambulatory surgery centers, freestanding treatment centers, physician offices and long-term care facilities) in an effort to become a true population-based central registry.

For reportability, MCR generally follows the rules of the Surveillance Epidemiology and End Results (SEER) program of the National Cancer Institute. Data requirements are based on NPCR and NAACCR recommendations for central registries collecting incidence data. Additional requirements may include fields required by the American College of Surgeons Commission on Cancer (CoC).

ROLE OF NON-HOSPITAL REPORTING FACILITIES

The primary sources for obtaining information of prostate cancer cases treated outside of a hospital may be freestanding treatment centers, pathology labs and physicians offices. Facilities may be large or small, and the extent of information submitted varies, depending on size and reporting methods. Each reporting facility is however responsible for providing pertinent information regarding the patient's disease, and some non-hospital facilities have already begun reporting incidences of cancer, as initiated by the Missouri expanded cancer reporting requirements.

ROLE OF MISSOURI CANCER REGISTRY

In an effort to effectively monitor the incidence of cancer within the state, the Missouri Cancer Registry (MCR) gathers information from multiple types of reporting facilities. This data is then used for epidemiological research and may later be used to develop and evaluate cancer prevention control. Data received from reporting facilities on a regular basis is an invaluable tool in determining risk factors in certain populations, environmental impacts, ethnic and social variations and impact of state cancer control programs.

CONFIDENTIALITY

Per Missouri statute (192.655, RSMo 1999), the “department of health shall protect the identity of the patient, physician, health care provider, hospital, pathology laboratory, ambulatory surgical center, residential care facilities I or II, intermediate care facilities or skilled nursing facilities, and free-standing cancer clinic or treatment center...and that such identity shall not be revealed except...only upon written consent...” This confidentiality provision is necessary to ensure all reporting entities that neither their identity nor the confidential data they submit will be released.

In addition, MCR employees are required to sign confidentiality agreements and follow confidentiality procedures set forth in the Missouri Cancer Registry Policy and Procedure Manual. These regulations include the use of locked offices and cabinets for confidential data, procedures for handling requests for data and policies for handling breaches of confidentiality.

INTRODUCTION (continued)

HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the reporting of identifiable cancer data to public health entities. Because the Missouri Cancer Registry falls under the definition of a public health authority, HIPAA allows your facility to report cancer incidence data in compliance with state statutes (192.650-192.657RSMo) and regulations (19 CSR 70-21). Written informed consent from each cancer patient reported to public health entities is not required under HIPAA nor is a Business Associate Agreement required; rather, reporting facilities must simply document that reporting has occurred.

BASIC RULES/INFORMATION

The following information provides some basic rules/information regarding cancer reporting to the state central cancer registry.

- Physicians offices are required by Missouri statute (192.650-192.657 RSMo, 1999) to submit requested information on patients not diagnosed or treated for the cancer at another healthcare facility (i.e. hospital, freestanding cancer treatment center, freestanding ambulatory surgery center, etc.). The inclusion of these cases was effective with patients diagnosed January 2000 and later.
- WebPlus is available to the physician at no charge. The hardware and software are maintained by the Missouri Cancer Registry, with the assistance and support of the CDC.
- Abstracting Resources (<http://mcr.umh.edu/>), includes a list of the required data elements. This list is based on Missouri statutes NPCR and NAACCR requirements, data quality requirements and projected needs of the citizens of this state. Hospital-based registries are required to submit additional data items that may or may not be available in a physician's office.
- Completed cases ***should be submitted quarterly*** to the MCR within six months of diagnosis for that facility.

For additional help or information, please contact:

Nancy Cole

Assistant Project Manager

Toll-free: 866 240 8809

Phone: 573 884 2491

Email: colen@health.missouri.edu

Sharon El Shoubasi

Web Plus Coordinator

Toll free: 866 240 8809

Phone: 573 884 6928

Email: elshoubasis@health.missouri.edu

Alena Headd

System Support Analyst

Toll-free: 866 240 8809

Phone: 573 882 0315

Email: headda@health.missouri.edu

Website: <http://mcr.umh.edu/>

DETERMINING REPORTABILITY

ELIGIBILITY/REPORTABILITY

1. Invasive prostate cancer only (no prostate intraepithelial neoplasia PIN)
2. Diagnosed and/or treated in Missouri (for now)
3. Newly diagnosed cases or
4. Patients with continuing hormonal therapy who have never had radiation therapy or surgery for this diagnosis
5. Patients who are **not** going to be treated at a hospital with surgery or brachytherapy
6. Patients who are **not** going to be treated at a freestanding treatment center with external beam radiation
7. Cases where planned treatment is:
 - Hormonal therapy
 - Observation only (also known as watchful waiting) or
 - No treatment (due to other health conditions, patient refusal, etc.)
8. Clinical diagnosis

METHODS OF CASEFINDING

1. Pathology Reports
 - Flag each chart when prostate cancer is diagnosed
 - Colored paper
 - Colored tab
 - Visible reminder that chart needs to be reviewed to determine case eligibility/reportability
2. Office reports
 - Used to 'rule out' cases
 - ICD-9: 185.9
 - CPT procedure codes (radical prostatectomy, brachytherapy)
 - Place of service codes (hospital IP, hospital OP, etc.)
 - Exception—patients referred for external beam radiation
3. Central registry follow-back
 - Based on path reports submitted directly to MCR from the path lab. As pathology reports are intended as a means of case finding and do not include the details needed to adequately report cancer cases (as in race, social security number, patient address, etc.), MCR is currently developing a method by which to notify physicians when cases have been identified through pathology reports so that completeness (of cancer reporting) may be met by both parties.
 - Would only follow-back on patients that have **not** been reported by other facilities
 - Means delay of 12-15 months from date of diagnosis

DETERMINING REPORTABILITY (continued)

4. Other
 - This is where you can help us
 - Most efficient?
 - Least time consuming?
 - Logical for your practice?

Remember: Physician's offices are only required to report patients who are/have not been treated elsewhere for the current cancer diagnosis.

HELPFUL TIPS FOR USING WEBPLUS

The following items serve as quick reminders for users of WebPlus.

- MCR staff will set up an account for each practice that will include a **Facility ID**. In addition, MCR will set up an account for each user (**User ID**). After the account is set up, WebPlus will generate an e-mail to the person who will be completing the web-based data form (also known as an abstract). This e-mail will provide a **password** that may be used to enter the system, but may be changed later if desired.
- **Multiple users for one practice**—More than one person may submit information for a single practice. The practice will have a single facility ID. Each user will have their own password.
- **Multiple physicians—One person** may submit information for more than one physician. The practice will have a single facility ID. The physicians will be identified by the license number or national provider identification (NPI) number in each web-based data form.
- **Single practice —One person** may submit information. The practice will have a single facility ID. The physician will be identified by the license number or national provider identification (NPI) number in each web-based data form.
- Users will create a new case or “abstract” for each patient. The abstract or web-based data form may be saved whether or not information entered is complete. Users may return to the abstract at any time by using the “open” feature. Users may view the abstract even after it has been “released” or sent to MCR via the web.
- Abstract information is divided into 7 main areas: Physician/Facility Specific, Patient Confidential, Patient Demographic, Cancer Identification, Stage/Prognostic Factors, Treatment/1st Course and Follow-up/Death.
- **Reportable cases** are those cases (prostate) identified either thru patient/treatment information or pathology reports which indicate the patient as having been diagnosed with cancer at your facility, and who will not receive treatment elsewhere.
- When users click on the **“Save”** button, edits are activated. Edit messages contain helpful information to explain how to correct the information. Once a case has passed all edits, it may then be released to MCR.
- WebPlus is configured with an automatic **‘time-out’ mechanism** after 30 minutes of idle time in which users will have to log-in again to access the system. Therefore, please remember to save work frequently to prevent this occurrence.
- For security, WebPlus is also configured with an **automatic ‘lock-out’** after users have attempted unsuccessfully (3 times) to log-in. If this occurs, please contact the MCR administrator so that your password can be re-set.
- MCR recommends the use of **Internet Explorer** to access WebPlus as users of other browsers will sometimes experience difficulties.
- MCR staff recognizes that many users will not have any previous experience in ‘abstracting.’ If having difficulties, for most fields it is permissible to enter **‘9’** for **‘Unknown.’** However, we would like to stress that this

HELPFUL TIPS FOR USING WEBPLUS

should be reserved for cases in which information is not readily obtainable and not as a routine practice. MCR staff are also available to answer questions at 866-240-8809 (toll free).

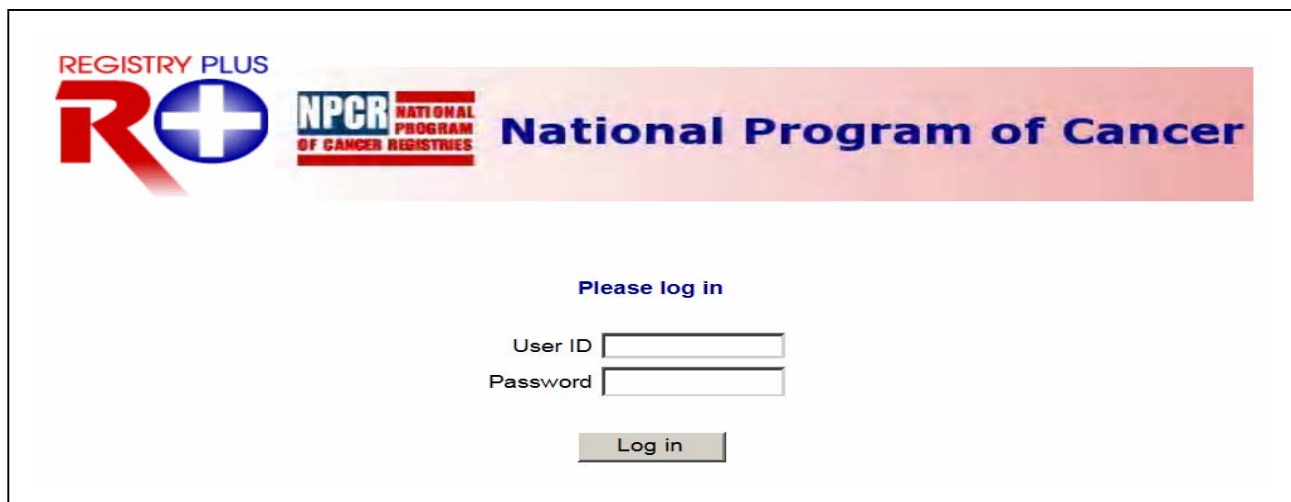
- For patient confidentiality concerns, we ask that users remember to keep all patient information in a secure location while entering information into WebPlus.
- Please remember that for test purposes (johndoe and test ID and password), only
- **Glossary**—a helpful list of acronyms is included in the glossary located at the end of this manual for understanding terms/abbreviations used throughout this manual.

OPENING WEBPLUS

1. Access website: <https://webplus.umh.edu/webplus/>
2. Log on to application by using either the MCR assigned username and password, or the **test** User ID: johndoe (one word) and Password: test

(Note: Please remember to use ONLY 'practice' cases with the TEST ID and password)

3. Select either 'New Abstract' or 'Find/Open Abstract'



REGISTRY PLUS

NPCR NATIONAL PROGRAM OF CANCER REGISTRIES

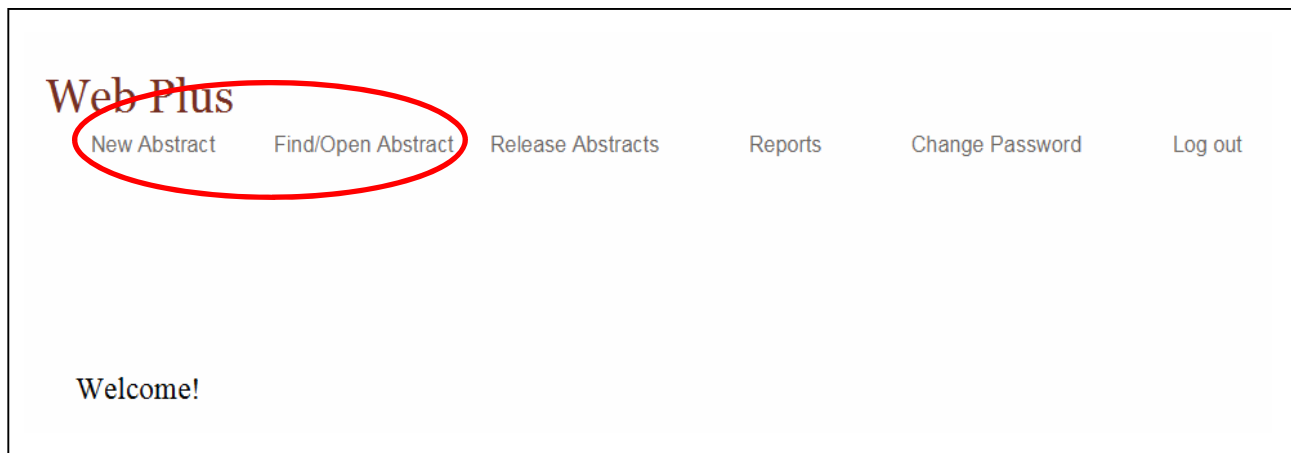
National Program of Cancer

Please log in

User ID

Password

Log in




Web Plus

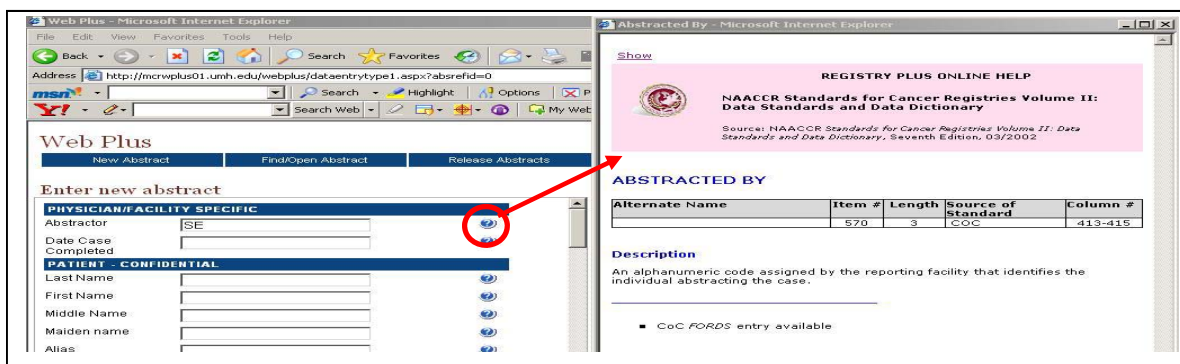
New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out


Welcome!

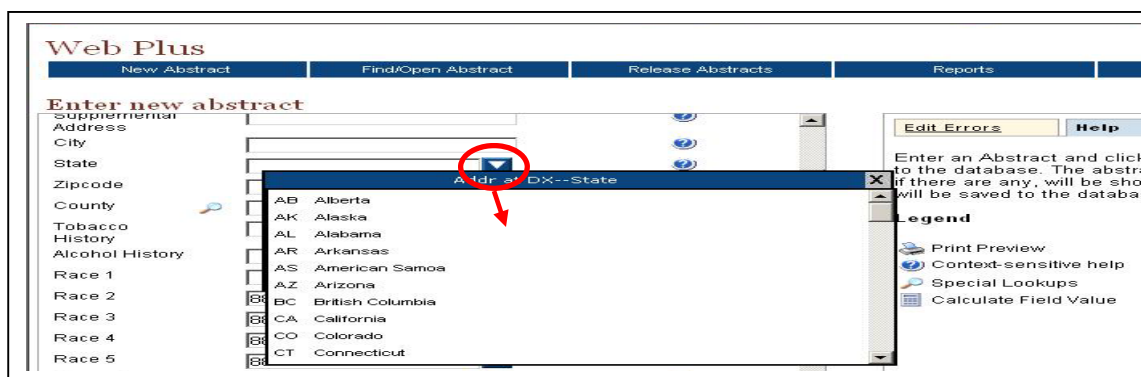
ENTERING A NEW ABSTRACT/DATA ENTRY PROCEDURE

The following are data entry instructions for each data item. However, please remember to review the patient summary and/or pathology report before proceeding further. (**Note:** For additional help, please refer to pages 39-40 for a complete listing of fields and corresponding locale in documentation.)

1. Select "new abstract" from the menu. A blank abstract (data form) will appear.
2. Begin entering the requested information in each field. By clicking on the special help icon  a RegistryPlus on-line screen appears based on the NAACCR Standards for Cancer Registries Volume II. It includes information about the size of the field, what information to input and the organization that requires the field. (**Note:** Help titles may not match field titles. MCR administrators have re-set many titles due to usability issues.) Please remember to press 'Enter' before moving to the next data item.



3. There are also "drop-down boxes"  that provide choices for your answer. By double-clicking on the correct response, the field will become populated.



Note: Remember to close the help screen as only one help item may appear at a time. If you forget to close the help screen, it will remain open, preventing other help items from appearing.

DATA ENTRY PROCEDURE (continued)

4. Certain fields become tan-colored when you click on them. This usually provides additional help (how to show an unknown social security number, the use of punctuation, etc.).

The screenshot shows a data entry form with fields for Middle Name (E), Maiden name, Alias, Spouse Name (JUNE), Social Security Number (999999999), PATIENT DEMOGRAPHICS, and Street Address (1234 ANYWHERE AVE). The Social Security Number field is highlighted in tan and circled in red. A tooltip box next to it contains the text: "Social Security Number Calculate Field Value Enter 999999999 for Unknown." To the right of the form are links for Print Preview, Context-sensitive help, and Special Lookups.

5. For some fields you will also see a magnifying glass, or special-help icon, which allows you to search for the proper codes. Click on the symbol for options or instructions required to populate the appropriate field.

The screenshot shows a data entry form with fields for City (BOONVILLE), State (MO), Zipcode (65233), County (053), and Tobacco History (0). The County field is highlighted in tan and circled in red. A red arrow points from the County field to a search window titled "Search" which displays a list of Missouri counties with their corresponding codes. The search window has a search bar and a search button. The list of counties is as follows:

Code	Label
001	Adair County
003	Andrew County
005	Atchison County
007	Audrain County
009	Barry County
011	Barren County
013	Bates County
015	Benton County
017	Bollinger County
019	Boone County
021	Buchanan County
023	Butler County
025	Callaway County
027	Callaway County
029	Camden County
031	Cape Girardeau County
033	Carter County

PHYSICIAN/FACILITY SPECIFIC INFORMATION

Please note: All fields are required, however specific Missouri/MCR required fields are indicated with an asterisk (*).

Abstractor: This field records the initials of the person completing the form. This field defaults to the initials created in the user profile.

Date Case Completed: This field will be populated automatically once the case/abstract has been saved.

DATA ENTRY PROCEDURE (continued)

PATIENT-CONFIDENTIAL INFORMATION

Last Name: Enter the patient's last name in the spaces provided. If the name exceeds the number of spaces provided, enter as much as possible. Use the following rules when recording patient last names:

1. Name fields should contain alpha characters and blanks only -- no special characters such as apostrophes, commas, hyphens, etc.
2. Any name titles or suffixes, such as DR, MD, MR, MS, JR, SR, III, IV, and so on, should be recorded in the middle name field after, or instead of, the middle name. These data are optional.
3. When a patient has two last names, or a hyphenated last name, you may type both in the last name field separated by a blank space.
4. Patients with two-part last names, such as VAN HORN or ST JOHN, may have a space between the two parts, but no special punctuation marks.
5. Names like 'MCCOY' or 'O'BRYAN' should be typed 'MCCOY' or 'OBRYAN' with no spaces and no punctuation.

First Name: Enter the patient's first name in the spaces provided. If the name exceeds the number of spaces provided, enter as much as possible. Use the following rules when recording the patient's first name:

1. Name fields should contain alpha characters and blanks only -- no special characters such as apostrophes, commas, hyphens, etc.
2. Patients with two-part first names, or two first names, may have them both recorded in the first name field, separated by a blank space. For example: MARY JO MARY ANN JOHN ED etc.
3. Patients who go by their initials may have them both typed in the first name field, separated by a blank space, but with no punctuation.
4. Patients with a name and an initial should have them recorded in separate fields. For example: H. EDWARD SMITH should have 'H' in first name and 'EDWARD' in middle name.

Middle Name: Enter the Middle Name or Middle Initial. If the name exceeds the number of spaces, enter as much as possible. If only an initial is given, enter the initial. You may also record the patient's title or name suffix in this field -- such as: DR, JR, SR, III, MD, etc. If there is no middle name or initial, press **Enter** and the field will remain blank.

Maiden Name: Enter the Maiden name of married females. If there is no maiden name or you do not know the maiden name, press **Enter** and the field will remain blank.

Alias: Record the patient's alias if chart indicates there is one. If there is no alias, press **Enter** and the field will remain blank. (For example, "Bob" for a man named "Robert.")

Spouse Name: Type the name of the spouse. If unmarried, press **Enter**, and the field will remain blank.

Social Security Number: Type the 9-digit number (123456789) leaving no spaces or hyphens. If unknown, enter all 9's (999999999).

DATA ENTRY PROCEDURE (continued)**PATIENT DEMOGRAPHICS**

Street Address: Type the number and street address at diagnosis. **No punctuation** is allowed in this field. If the address contains '1/2' the words '**one half**' must be typed out. Leave a blank between numbers and words if space permits. Do not use periods after abbreviations.

Supplemental address field: Type in any additional address information. For example, the name of a nursing home or apartment complex. **No punctuation** is allowed in this field.

City: Type the City at time of diagnosis. **No abbreviations** are allowed in this field.

State: Type the two-letter abbreviation (example: **MO** for **Missouri**). Or use the drop-down icon and click on the appropriate state.

Zipcode: Type the nine-digit extended zip code if available; if unavailable, type the five-digit zip code and press **Enter**.

County: Click on the special help icon to bring up the county codes, and click on the appropriate code to populate field. If unknown, use the MCR link (<http://www.dhss.mo.gov/Geocodes/GeocodeList.html>) to find the appropriate three-digit county code.

Tobacco History: Use the drop-down icon to enter the appropriate code. If you do not know the tobacco history, enter the unknown value (**9**).

Alcohol History: Use the drop-down icon to enter the appropriate code. If you do not know the alcohol history, leave blank.

Race 1: Use the drop-down icon to select a code from the available options in order to populate this field. If you do not know the race, enter the unknown value (**99**).

Race 2-5: These fields are used when the patient has more than one race. For example a person who is both caucasian and black. Race 1 would be coded as "white" 01 and Race 2 would be coded "black" 02. The same rules would apply for any combination of races. (Fields 2-5 are currently set on a default value of "88" for no further race documented.) If you do not know the race, enter the unknown value (**99**).

Spanish/Hispanic Origin: Use the drop-down icon to select a code from the available options to populate the field. If unknown, enter the unknown value (**9**).

Date of Birth: Type the patient's date of birth in the *MMDDYYYY* format (no slashes).

Sex: Use the drop-down icon to enter the appropriate code for patient's gender.

Marital: Use the drop-down icon to enter the appropriate code for patient's marital status.

DATA ENTRY PROCEDURE (continued)

***Primary Payer at Diagnosis:** Use the drop-down icon to select the appropriate code regarding insurance status of patient.

Occupation: Enter the patient's occupation as listed on medical/accounting records; if unknown, type UNKNOWN.

Industry: Enter the patient's industry as listed on medical/accounting records; if unknown, type UNKNOWN.

CANCER IDENTIFICATION

Before entering information (i.e., codes to describe Primary Site, Histology, Treatment, etc.), be sure to review the entire medical record. For additional help, please refer to pages 39-40.

***Diagnosis Date:** Enter the date the cancer was first diagnosed as listed in Diagnostic/Op/Path reports.

Age at Diagnosis: Once diagnosis date has been entered, use calculator to calculate correct age at diagnosis. (If left blank, and edit error will appear when saving abstract.)

Primary Site: For prostate cases, the primary site defaults to 'C619,' the ICD-O-3 site code. If necessary, use the special look-up icon to determine the appropriate code.

Histology: Histology is the tissue diagnosis made by the pathologist. For prostate cases, the histology code will almost always be "adenocarcinoma, nos." (code **8140**). Occasionally a prostate case will be diagnosed as "acinar cell carcinoma" with a code of **8550**. If the histology is one of these two terms, simply the code (**8140** or **8550**). Otherwise, click on the special lookup icon and a search screen will appear. Type the text for the histology, click on search and a list of codes will appear. Scroll down the list until you see the correct histology term.

Text—Histology: Include text describing histology and grade as detailed in the medical record.

***Text—Pathology Report Info.:** Include other pertinent text from the pathology report, including Gleason score.

Prostate Grade Conversion Table

Code	Gleason Score	Gleason Pattern	Terminology	Hist Grade
1	2,3,4	1,2	Well differentiated	I
2	5,6	3	Moderately differentiated	II
3	7,8,9,10	4,5	Poorly differentiated	III

DATA ENTRY PROCEDURE (continued)

Grade: Review the pathology report to determine the correct grade. Use the drop-down box to **include information about grade by number**. The terms will be: 1 = *well differentiated*, 2 = *moderately differentiated*, 3 = *poorly differentiated* or 4 = *undifferentiated*. If the pathology report does not indicate a grade use the “nos” value (9). The Gleasons score may be used with the table on the previous page to determine grade.

STAGE/PROGNOSTIC FACTORS

Collaborative Stage (CS). Please use the drop-down icons and/or special look-up icons to select the appropriate code for the following fields. For additional help, please refer to pages 46-57.

***Text—Imaging Studies:** Type text information from diagnostic imaging reports. Use standard abbreviations (CXR=chest x-ray, etc.). Document positive and negative findings—see pages 35-36 for examples. If no test performed, state same.

***Text—Physical Exam:** Type text information from the history & physical examination—see pages 35-36 for examples.

Tumor Size—CS1: This field is currently defaulted to ‘999’ as most commonly there will be no tumor size indicated in prostate cases. If however, tumor size is indicated, please refer to the codes listed when using the special look-up icon.

Extent of Disease—CS2: Identifies primary tumor growth within the organ of origin or its extension into neighboring organs. Also corresponds to the “T” in TNM staging and is based on clinical information. **Example:** Patient summary reveals patient as ‘T1cN0 M0;’ therefore by using the table provided when using the help screen, we can determine that the code for this field will be ‘15.’

Lymph Node Involvement—CS4: Identifies the regional lymph nodes involved with cancer at the time of diagnosis. Also corresponds to the “N” in TNM staging (T1cN0M0). Typically, because these are non-surgery patients, there will be no lymph node involvement, therefore, this field will most commonly be ‘00.’ (Clinically positive nodes would be recorded here.)

Mets at Diagnosis—CS6: Identifies the site(s) of metastatic involvement (if any) at time of diagnosis. Corresponds to the “M” in TNM staging. For most of the patients you are reporting, the diagnosis is very early or localized disease, represented in the staging by T1cN0M0. For those patients you would use code ‘00’ - no metastasis. However, some patients may not have surgery because the physician has determined there is metastatic disease. For these patients, use the help screen to select the code that identifies the type of metastatic disease (distant lymph node, or other distant metastasis).

CSSF1-PSA Value: Record the highest PSA lab value prior to diagnostic biopsy or treatment. **Example:** Patient summary reveals an elevated PSA of 6.56. By using these numbers, a three digit code will be recorded as ‘065’ for this field. Otherwise, use the special look-up icon for help in selecting the appropriate code or ‘000’ if none and ‘999’ if unknown. (**Note:** Lab values for SSFs 1 and 2 should be from the same laboratory test.)

DATA ENTRY PROCEDURE (continued)

CSSF2-PSA (+ or -): Occasionally the information says the PSA is elevated but does not tell the specific value. By using CSSF2 we can code if the test was elevated, normal, or unknown. **Example:** Information used from the previous field '065' tells us that this patient had an elevated PSA of 6.56; therefore we can determine that the code for this field will be '10' - "positive/elevated."

CSSF5-Gleason Pattern: Used to record the Gleason's pattern as given in the pathology report. **Example:** The pathology report reads "Adenocarcinoma, Gleason score 3+3=6." Use the special look-up icon to select the appropriate code. For this example, the three digit code will be recorded as '033' for this field— (primary pattern 3, secondary pattern 3).

CSSF6-Gleason Value: Records the total Gleason's score by adding the primary and secondary pattern (as shown in the pathology report). **Example:** Gleason score 3+3 = 6. The field must be 3 characters in length, so the code will be recorded as '006.'

Derived SS2000: When CS data items are coded, a computer algorithm determines SEER Summary Stage 2000. This is automatically calculated when the form is saved.

***Text - Stage:** Type text to support CS/summary stage information. If the physician provides the TNM staging, include that as well. Terms like 'localized' are acceptable. See pages 35-36 for examples if needed.

TREATMENT—1ST COURSE

Date of 1st Contact: Type the date of the first office visit for this diagnosis using *MMDDYYYY* format.

***Reason No Surgery:** As nearly all cases involved will not have had surgery performed, this field is currently defaulted to '1' - 'surgery of primary site not performed—not part of planned 1st course.'

Hormone Therapy: Record hormone therapy administered, if any. Use the drop-down box to enter the appropriate code or if no hormone therapy was given, enter '00' or '99' if unknown.

Hormone Therapy Date: If hormone therapy was given, type the date in the *MMDDYYYY* format. If hormone therapy was not given, leave blank.

***Text—Hormone Treatment:** Detail any hormone therapy administered. Include date of treatment initiated. If none given, type N/A.

Reason No Hormone Therapy: Use the drop-down box to enter the appropriate code or if hormone therapy was given, enter '00' or '99' if unknown. Example, if patient refused, or if hormone therapy was not recommended, use the drop-down box to record the reason it was not administered.

DATA ENTRY PROCEDURE (continued)**FOLLOW-UP/DEATH**

Date Last Contact: Type the date of last contact or date of death in *MMDDYYYY* format. If the exact date of last contact or death is not available, record an approximate date. **Example:** 03992005 if exact day of month is unknown.

Vital Status: Enter the appropriate vital status of patient (dead or alive).

Cancer Status: Enter the appropriate cancer status (evidence, no evidence, unknown) of patient.

Place of Death: For deceased patients, You may simply enter “063” - Missouri. For residents of other states, use the special look-up icon to find code.

Cause of Death: Field currently defaulted to ‘0000’ (patient currently alive). If patient is not living, use one of the corresponding codes available using the special look-up icon to populate field.

***Reporting Physician:** Enter the reporting physician's license number or NPI in this field. If a number is not available, enter the first 8 characters of the physician's name.

Physician Other: Enter the referring physician's license number or NPI in this field. If a number is not available, enter the first 8 characters of the physician's last name.

Text—Remarks: Type any other pertinent information which may be contained within the medical record (e.g., history of previous cancer, family history of cancer, smoking history, etc.) and which would be relevant in determining multiple primary/secondary sites.

SAVING AN ABSTRACT

After all data items are entered, select **Save**.

If there are no errors, the abstract will be saved and marked complete. The first time the abstract is saved, the '**Date Case Completed**' field will be set with the current date. Once the report is saved, you may enter a new abstract, perform other WebPlus functions, or exit WebPlus.

If there are errors, appropriate error messages will appear in the EDIT field/box, detailing all errors. (For information about correcting errors see the Edits Section, on the following page.) Errors can then be corrected and the abstract can be saved again. You may save the abstract despite errors; however, only abstracts that are considered COMPLETE, (i.e., they have passed all edits and have no critical fields missing) will be exported. If the saved abstract has edit errors or contains missing critical fields, the abstract is considered INCOMPLETE by the system. For more information on 'Saving an Abstract,' see page 83 in the appendix section of this manual

Users may update abstracts by clicking on the 'SAVE' button at the bottom of the page to save changes. Edits run each time you save and the EDIT result will be shown in the EDIT area. (**Note:** Abstracts are always saved to the database when the 'SAVE' featured is utilized, whether or not there are Edit errors in it.)

The screenshot displays the 'Web Plus' interface for updating an abstract. The form is divided into two main sections: 'PHYSICIAN/FACILITY SPECIFIC' and 'PATIENT DEMOGRAPHICS'. The 'PHYSICIAN/FACILITY SPECIFIC' section includes fields for Reporting Facility/Physician (00200000), Abstractor (SEL), Date Case Completed (11/17/2005), Last Name (MONTEREY), First Name (JIM), Middle Name (E), Maiden name, Alias, Spouse Name (JUNE), and Social Security Number (999999999). The 'PATIENT DEMOGRAPHICS' section includes fields for Street Address (1234 ANYWHERE AVE), Supplemental Address, City (BOONVILLE), State (MO), Zipcode (65233), County (053), Tobacco History (0), Race 1 (01), Race 2 (88), Race 3 (88), Race 4 (88), Race 5 (88), Hispanic (3), and Date of Birth (02/07/1957). On the right side, the 'Edit Errors' section shows a list of 10 missing critical fields, including DX Proc--PE, DX Proc--X-ray/scan, DX Proc--Lab Tests, DX Proc--Op, DX Proc--Path, Histology Title, Staging, RX Text--Hormone, and Remarks. The 'Save' button at the bottom left is circled in red.

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician 00200000
Abstractor SEL
Date Case Completed 11/17/2005
PATIENT - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999

PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 02/07/1957

Edit Errors Help
Print Preview

EDIT RESULT
Editset Name: Central: Vs10 NPCR Required
There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.
Total edit errors: 10

1. Missing Critical Field: Text--DX Proc--PE
2. Missing Critical Field: Text--DX Proc--X-ray/scan
3. Missing Critical Field: Text--DX Proc--Lab Tests
4. Missing Critical Field: Text--DX Proc--Op
5. Missing Critical Field: Text--DX Proc--Path
6. Missing Critical Field: Text--Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Save

EDITS

In cases where errors are found, information is displayed in the EDIT ERRORS tab. A list of fields containing errors will be displayed below the error message. Users can click on an error message to return to the active grid cell of the corresponding field in order to correct data. Once data is corrected, click on **SAVE** to save the changes and rerun Edits. For further information, please refer to Chapter 5, "Correcting Errors" located on pages 98-103 in the back of this manual.

Remember, abstracts containing errors may be saved (INCOMPLETE), but only those with no errors (COMPLETE) maybe released to MCR.

Users can check for incomplete abstracts by either running detailed reports, listed under **REPORTS** heading or by going to the **FIND/OPEN ABSTRACT** and entering either last name or social security number for a case. The case will give the option to either **OPEN** or **DELETE**.

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician 00200000
Abstractor SEL
Date Case Completed 11172005

PATIENT - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999

PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 02071957

Edit Errors Help

-----EDIT RESULT-----
Editset Name: Central: Vs10 NPCR Required
There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 10

1. Missing Critical Field: Text--DX Proc--PE
2. Missing Critical Field: Text--DX Proc--X-ray/scan
3. Missing Critical Field: Text--DX Proc--Lab Tests
4. Missing Critical Field: Text--DX Proc--Op
5. Missing Critical Field: Text--DX Proc--Path
6. Missing Critical Field: Text--Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Save

PRINT and PRINT PREVIEW**To print one abstract:**

Click on the PRINT PREVIEW icon in the upper right hand corner to preview abstract/patient information. Users can then return to the abstract to correct any errors, or go to FILE, and PRINT to print the abstract.

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician 00200000
Abstractor SEL
Date Case Completed 11/17/2005

PATIENT - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999

PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 02/07/1957

Edit Errors **Help**

Print Preview

-----EDIT RESULT-----
Editset Name: Central: Vs10 NPCR Required

There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 10

1. Missing Critical Field: Text--DX Proc--PE
2. Missing Critical Field: Text--DX Proc--X-ray/scan
3. Missing Critical Field: Text--DX Proc--Lab Tests
4. Missing Critical Field: Text--DX Proc--Op
5. Missing Critical Field: Text--DX Proc--Path
6. Missing Critical Field: Text--Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Save

Patient's Name: MONTEREY, JIM E

Reporting Hospital:	
Abstracted By:	SEL
Date Case Completed:	11/17/2005
Name--Last:	MONTEREY
Name--First:	JIM
Name--Middle:	E
Name--Maiden:	
Name--Alias:	
Name--Spouse/Parent:	JUNE
Social Security Number:	999999999
Addr at DX--No & Street:	1234 ANYWHERE AVE
Addr at DX--Supplemental:	
Addr at DX--City:	BOONVILLE
Addr at DX--State:	Missouri
Addr at DX--Postal Code:	65233
County at DX:	053

To print more than one abstract:

Click on REPORTS, and select the appropriate report to print multiple abstracts.

FIND/OPEN ABSTRACTS

WebPlus provides an abstract query system. This query system allows you to search your database to retrieve a desired abstract.

Select FIND/OPEN ABSTRACT.

Abstracts may be searched by either name (both first and last) or social security number. When searching by name, a partial name search is also allowed. For example, entering "SMITH" will produce a list of all patients with the last name Smith, Smithson, or any other name beginning with "Smith". Entering "SM" will produce a list of all patients with the last name beginning with Sm, such as Smith, Smothers, or Smuckers. Entering "S" will produce a list of all patients with a last name beginning with S.

Once the specific abstract is found, select OPEN to either edit data, or DELETE to delete record.

Web Plus
 New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Find Abstract
 Enter patient's name or social security to search for. Search on partial name and social security is supported.

Name Social Security

AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Abstractor	Edit Errors	Status	Actions
4285	MONTEREY	JIM	09/14/2004	999999999	02/07/1957	SEL	0	Complete	Open Delete

Web Plus
 New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Find Abstract
 Enter patient's name or social security to search for. Search on partial name and social security is supported.

Name Social Security

AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Abstractor	Edit Errors	Status	Actions
4103	SMITHTON	DON	02/23/2003	999999999	06/23/1945	NFC	6	Incomplete	Open Delete
4256	MALPH	RALPH	04/05/1998	999999999	01/08/1957	SEL	5	Incomplete	Open Delete
4274	JONES	ALLEN		999999999		nfc	16	Incomplete	Open Delete
4285	MONTEREY	JIM	09/14/2004	999999999	02/07/1957	SEL	0	Complete	Open Delete
4286	SAMSON	JOSEPH	05/15/2004	999999999	08/24/1934	SEL	0	Complete	Open Delete
4288	MANN	GLENN	12/14/2004	999999999	07/03/1932	SEL	0	Complete	Open Delete
4291	JONES	ELMER	01/01/2005	999999999	10/10/1944	nfc	0	Complete	Open Delete
4292	JONES	JACK		999999999		nfc	17	Incomplete	Open Delete
4293	JONES	JACK	01/01/2005	999999999	01/05/1945	nfc	1	Incomplete	Open Delete

RELEASING ABSTRACTS

Click on RELEASE ABSTRACTS. Only COMPLETE abstracts will be selected.

A list of abstracts will appear with 'check boxes' appearing after each item.

For those abstracts determined as ready for release, users can either select each item individually or by using the menu bar at the bottom of the page, select either SELECT ALL, UNSELECT ALL, or RELEASE SELECTED ABSTRACTS. For further information on releasing abstracts, please refer to page 102 in the appendix section of this manual.

Web Plus
New Abstract
Find/Open Abstract
Release Abstracts
Reports
Change Password
Log out

Release Abstracts

Please select the abstracts you want to release to your central registry. Only completed abstracts are available for release.

AbsRefID	Last Name	First Name	Abstractor	Date Case Completed	Release
4285	MONTEREY	JIM	SEL	11/20/2005	<input checked="" type="checkbox"/>
4286	SAMSON	JOSEPH	SEL	11/20/2005	<input checked="" type="checkbox"/>
4288	MANN	GLENN	SEL	11/20/2005	<input checked="" type="checkbox"/>
4291	JONES	ELMER	nfc	11/20/2005	<input type="checkbox"/>

Select All

Unselect All

Release selected abstracts

REPORTS

To run reports, simply choose REPORTS, and select the appropriate option on the Reports page. For further information on running reports, please refer to Chapter 6, "Running Reports" on pages 106-110 located in the back of this manual.

Web Plus
New Abstract Find/Open Abstract Release Abstracts **Reports** Change Password Log out

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician

Abstractor 00200000
Date Case Completed 11172005
PATIENT - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999

PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 02071957

Edit Errors Help

-----EDIT RESULT-----
Editset Name: Central: Vs10 NPCR Required

There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 10

1. Missing Critical Field: Text--DX Proc--PE
2. Missing Critical Field: Text--DX Proc--X-ray/scan
3. Missing Critical Field: Text--DX Proc--Lab Tests
4. Missing Critical Field: Text--DX Proc--Op
5. Missing Critical Field: Text--DX Proc--Path
6. Missing Critical Field: Text--Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Web Plus
New Abstract Find/Open Abstract Release Abstracts **Reports** Change Password Log out

Local Reports

[Cases Submitted Sorted by Abstractor](#)
[Cases Accessed Sorted by Patient Name](#)
[Descriptive Statistics on Released Cases](#)
[Activity Report](#)
Audit Reports
[System Log-ins](#)
[Abstract Updates](#)
[Abstract Searches](#)
[Abstract Deletions](#)
[Abstract Releases](#)

CHANGING PASSWORDS

To change passwords, simply choose CHANGE PASSWORDS and type in the new password on the New Password page. Once new passwords have been typed, enter CHANGE to save new data. For further information regarding passwords, please refer to page 77 located in the back of this manual.

Note: If you forget your password, an MCR administrator can re-set it for you.

The image shows two screenshots of the Web Plus application. The top screenshot is the 'Update abstract' page, where the 'Change Password' link in the top navigation bar is circled in red. A red arrow points from this link to the bottom screenshot. The bottom screenshot shows the 'Change Password' page, which has a header with the 'Web Plus' logo and navigation links. The main content area is titled 'Change Password' and contains two text input fields: 'New password' and 'Retype Password'. Below these fields is a button labeled 'Change'.

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports **Change Password** Log out

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician
Abstractor 00200000
Date Case Completed 11172005
PATIENT - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999
PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 02071957

Edit Errors Help

-----EDIT RESULT-----
Editset Name: Centra: Vs10 NPCR
Required

There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 10

1. Missing Critical Field: Text-DX Proc--PE
2. Missing Critical Field: Text-DX Proc--X-ray/scan
3. Missing Critical Field: Text-DX Proc--Lab Tests
4. Missing Critical Field: Text-DX Proc--Op
5. Missing Critical Field: Text-DX Proc--Path
6. Missing Critical Field: Text-Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports Change Password Log out

Change Password

New password

Retype Password

Change

LOG OUT

Once all tasks are completed within WebPlus, the user is required to log out. Simply choose LOG OUT to exit the system. See also, page 77 located in the back of this manual for further instructions regarding logging out of WebPlus.

Web Plus
New Abstract Find/Open Abstract Release Abstracts Reports Change Password **Log out**

Update abstract

PHYSICIAN/FACILITY SPECIFIC
Reporting Facility/Physician 00200000

Abstractor SEL
Date Case Completed 11172005
Last Name - CONFIDENTIAL
Last Name MONTEREY
First Name JIM
Middle Name E
Maiden name
Alias
Spouse Name JUNE
Social Security Number 999999999

PATIENT DEMOGRAPHICS
* Street Address 1234 ANYWHERE AVE
Supplemental Address
* City BOONVILLE
* State MO
* Zipcode 65233
* County 053
Tobacco History 0
Race 1 01
Race 2 88
Race 3 88
Race 4 88
Race 5 88
Hispanic 3
Date of Birth 12071957

Edit Errors Help

-----EDIT RESULT-----
Editset Name: Central: Vs10 NPCR Required

There are edit errors in the abstract. Error messages along with the error fields are listed below. Click on a field below any error message to move to it in the data entry area. Click on Save to save the changes and rerun Edits.

Total edit errors: 10

1. Missing Critical Field: Text--DX Proc--PE
2. Missing Critical Field: Text--DX Proc--X-ray/scan
3. Missing Critical Field: Text--DX Proc--Lab Tests
4. Missing Critical Field: Text--DX Proc--Op
5. Missing Critical Field: Text--DX Proc--Path
6. Missing Critical Field: Text--Histology Title
7. Missing Critical Field: Text--Staging
8. Missing Critical Field: RX Text--Hormone
9. Missing Critical Field: RX Text--Other
10. Missing Critical Field: Text--Remarks

Save

SAMPLE CASE

The following pages contain sample documents similar to those which will be used by your facility when entering data in WebPlus. By using the following data, we have completed an abstract, and printed the results to be used as an easy reference guide when entering cases into the WebPlus system.

METRO AREA UROLOGY ASSOCIATES

Date: 07/31/04

Name: Samuel Johnston

Address: 1234 Waterfront Drive, Columbia MO 65202

Phone: (573) 987 6543

Date of Birth: 11/27/27

Age:

Diagnosis/site for Tx: PSA check

Referring Physician: Dr. Cowell

Referring Physician Phone: 888 6625

Primary Care Physician: Dr. Cowell

Referring Office Contact Person: Susan

INSURANCE INFORMATION

Primary Insurance: Medicare

If Insurance requires a referral, referring office to notify patient to bring referral to initial office visit:

Secondary Insurance: None

Patient Notified:

Hospital called:

SAMPLE CASE

1200 Paris Road
Suite 150

METRO AREA UROLOGY ASSOCIATES

Kansas City, MO 64116
Tel: 816 425 1572

Carmen R Smith, MD
Randy D Jones, MD
Russell R Stephens, MD

08/06/04

PATIENT SUMMARY

RE: Johnston, Samuel—PR9887 DOB: 11/27/27

Referring Doctors: Steve Cowell, MD
Ryan David, MD

HISTORY OF PRESENT ILLNESS: 07/25/04 Mr. Johnston is a now a 77-year old white male presenting with a slightly elevated PSA performed by his account either in early 2002 or late 2001. This was subsequently repeated in June and further elevated to 6.56. He believed that the prior reading had been just over 4.0.

The patient has an enlarged prostate on digital rectal exam but it is free of any specific nodules or areas of induration. The overall size was 51.0-cc, therefore we plan to biopsy.

08/05/04 Biopsies were obtained with pathology returned showing a Gleason score of 3+3 adenocarcinoma involving one of the cores from the right side of the gland. Approximately 30% involvement was noted. From the left, a Gleason score of 2+3 was identified involving 5% of one needle core biopsy. This is clinical stage T1C N0 M0.

The patient was relatively asymptomatic. He had good urinary flow with nocturia at most once per night and no hesitancy. He was not sexually active. Discussed treatment options with patient and recommendations.

Patient agreed to begin Zoladex as a neoadjuvant hormonal therapy.

PREVIOUS MEDICAL HISTORY/MEDICATIONS: His previous medical history is otherwise significant for cardiac disease. He has an arrhythmia and has both a pacemaker and a defibrillator. He is also on amiodarone and diltiazem. He has hypercholesterolemia for which he takes Zocor. He is on omeprazole for reflux disease. He also has Parkinson's disease for which he takes ropinirole.

The patient is not diabetic. He does have vascular disease and has had a past abdominal aortic aneurysm repair. He has had a TURB, and some type of a bladder lesion 18-years ago. He has had spinal surgery in the cervical area, a remote appendectomy and herniography.

FAMILY HISTORY: Noncontributory

SOCIAL HISTORY: Pertinent for tobacco use which he discontinued in 1996. The patient is married; he lives in the Columbia Missouri area.

SAMPLE CASE

PATIENT SUMMARY:**RE: Johnston, Samuel—PR9887****Page 2**

REVIEW OF SYSTEMS: Negative for any constitutional problems such as fevers or weight loss. Patient denies any HEENT symptoms such as change in vision, hearing, nasal stuffiness, change of voice quality, or dysphagia. Chest is negative for exertional chest pain or palpitations. No cough, sputum production or hemoptysis noted. Gastrointestinal review of systems is negative for change in bowel habits, melena or hematochezia. Genitourinary review of systems is as per the history of the present illness. Musculoskeletal review of systems is negative for bone pain. No skin problems such as pruritis or rash. No stigmata of diabetes such as polyphagia or polydipsia. No hemologic symptoms such as easy bruising, bleeding or anemia at this time. No lymphatic trouble such as peripheral edema or nodules. No neurologic symptoms of seizures, or focal motor or sensory deficits. No psychiatric disturbance such as change of cognition or affect.

PHYSICAL EXAMINATION: On exam, this is a well appearing elderly white male. Weight is 176-pounds. Blood pressure 120/62. Pulse 60. Respirations 20. Extraocular movements are intact, and sclerae are non-icteric. Pupils are equal and reactive. Examination of the oral cavity reveals the patient is edentulous. There are no nodules or masses present. Neck is soft and supple. There is no evidence of thyromegaly or thyroid nodules. Chest is clear with breath sounds throughout. There are no rales, rhonchi or wheezes present. Cardiac exam is unremarkable with the patient having a regular rate and rhythm without rubs or murmurs. There are no carotid bruits. Abdomen is soft and nontender. There is no sign of ascites or mass. There is no hepatomegaly appreciated. There is no CV angle tenderness. No pain to palpation of the chest-wall or spine appreciated. Digital rectum examination was not performed. Extremities are otherwise without deformity; there is no joint swelling or nail clubbing. Skin is warm and dry. The lymph node areas of the cervical and supraclavicular areas are negative. Neurologically the patient is intact with not focal motor or sensory deficits or cranial nerve deficits.

Carmen R Smith MD

CRS/sel

DD: 08/06/04 DT: 08/06/04

SAMPLE CASE

KCM Pathology Laboratory
1234 Ridgeway, Suite 501
Kansas City, KS 63211

Tel: 913 314 6572

Fax: 913 314 6573

JOHNSTON, SAMUEL

Age: 76

Male

DOB: 11/27/1927

Dr. Carmen R. Smith

1200 Paris Road, Suite 150

Kansas City, MO 64116

Tel: 816 425 1572

SURGERY DATE: 08-18-04

RECEIVED DATE: 8-19-04

Page 1 of 1

SURGICAL PATHOLOGY REPORT

CLINICAL INFORMATION:

PATHOLOGY # S04-00805

PHYSICIAN: Smith, C

HISTORY: DRE (-)..PSA 6.56..51 cc

TISSUE: 1. Prostate biopsy right 2. Prostate biopsy left

DIAGNOSIS AFTER MICROSCOPY:

1. Needle biopsy of right prostate:

- Adenocarcinoma, Gleason score 3+3=6 involving 30% of one core biopsy.

2. Needle biopsy of left prostate:

- Adenocarcinoma, Gleason score 2+3=5 involving 5% of one core biopsy.

GROSS DESCRIPTION:

1. Received in zinc formalin labeled "Johnston right prostate biopsies" are 5 tan cylindrical core biopsies each averaging 1.0-1.2 x 0.1 cm. Submitted entirely in one cassette 1.

2. Received in zinc formalin labeled "Johnston left prostate biopsies" are 5 tan cylindrical core biopsies each averaging 0.5-1.5 x 0.1 cm. Submitted entirely in one cassette 2.

1. right prostate

2. left prostate /bas

Randy M Booker, MD

Diagnosis Date: 8/20/2004

PATHOLOGY # S04-00805

JOHNSTON, SAMUEL

SAMPLE CASE

Patient's Name: JOHNSON, SAMUEL


Abstractor:	SE
Date Case Completed:	//
Last Name:	JOHNSON
First Name:	SAMUEL
Middle Name:	
Maiden name:	
Alias:	
Spouse Name:	
Social Security Number:	999999999
Street Address:	1234 WATERFRONT DRIVE
Supplemental Address:	
City:	COLUMBIA
State:	Missouri
Zipcode:	65202
County:	109
Tobacco History:	Previous use
Alcohol History:	Unknown
Race 1:	White
Race 2:	No further race documented
Race 3:	No further race documented
Race 4:	No further race documented
Race 5:	No further race documented
Hispanic:	Non-Spanish; non-Hispanic
Date of Birth:	11/27/1927
Sex:	Male
Marital:	Married (including common law)
Primary Payer at Diagnosis:	Medicare, other than described in codes 51 and 52
Occupation:	UNKNOWN
Industry:	UNKNOWN
Diagnosis Date:	08/02/2004
Age at Diagnosis:	076
Primary Site:	Prostate gland
Histology ICD-0-3:	8140
Text - Histology:	Adenocarcinoma
Text - Pathology Report Info:	Moderately differentiated; Gleasons 3+3
Grade:	Grade II; moderately differentiated
Text - Imaging Studies:	No documentation
Text: Physical exam:	DRE negative, nothing palpable. Lymph node areas of cervical and supraclavicular areas negative.
Tumor Size (CS 1):	999
Extent of Disease (CS 2):	15
CS 3. How evaluated:	0
Lymph Node Involvement (CS 4):	00

Continued...

SAMPLE CASE (continued)

CS 5. How Nodes Evaluated:	0
Mets at diagnosis (CS 6):	00
CS 7. How Mets Evaluated:	0
CSSSF 1 - PSA value:	065
CSSSF 2 - PSA (+ or -):	010
CSSSF 3 :	097
CSSSF 4 - Apex involvement:	550
CSSSF 5 - Gleason Pattern:	033
CSSSF 6 - Gleason value:	006
DerivedSS2000:	1
Text: Stage:	T1C N0 M0 - one core from Rt side 30%; one core from Lt side 5%
Date of First Contact:	07/31/2004
Reason No Surgery:	Surgery of primary site not performed: not part of planned 1st course
Hormone Therapy:	Hormone therapy
Hormone Therapy Date:	01/09/2005
Text: Hormone Treatment :	Zoladex
Reason No Hormone Therapy:	Hormone therapy administered
Date of Last Contact:	01/09/2005
Vital Status:	Alive
Cancer Status:	Evidence of this cancer
Place of Death:	
Cause of Death:	0000
Reporting Physician:	12345678
Physician - Other:	91011121
Text: Remarks:	HX of cardiac disease; Metro Area Urology Associates; Cowell/Smith

---End of Abstract---



Please log in

User ID

Password

1 log on

The process of creating an abstract, (entering data and ultimately releasing it to the central registry) can all be done in WebPlus. Entries may be saved at any time and returned to later until the abstract is complete. If the built-in edits reveal any errors, you may make corrections and then release the abstract to MCR.

1. Log on to URL:

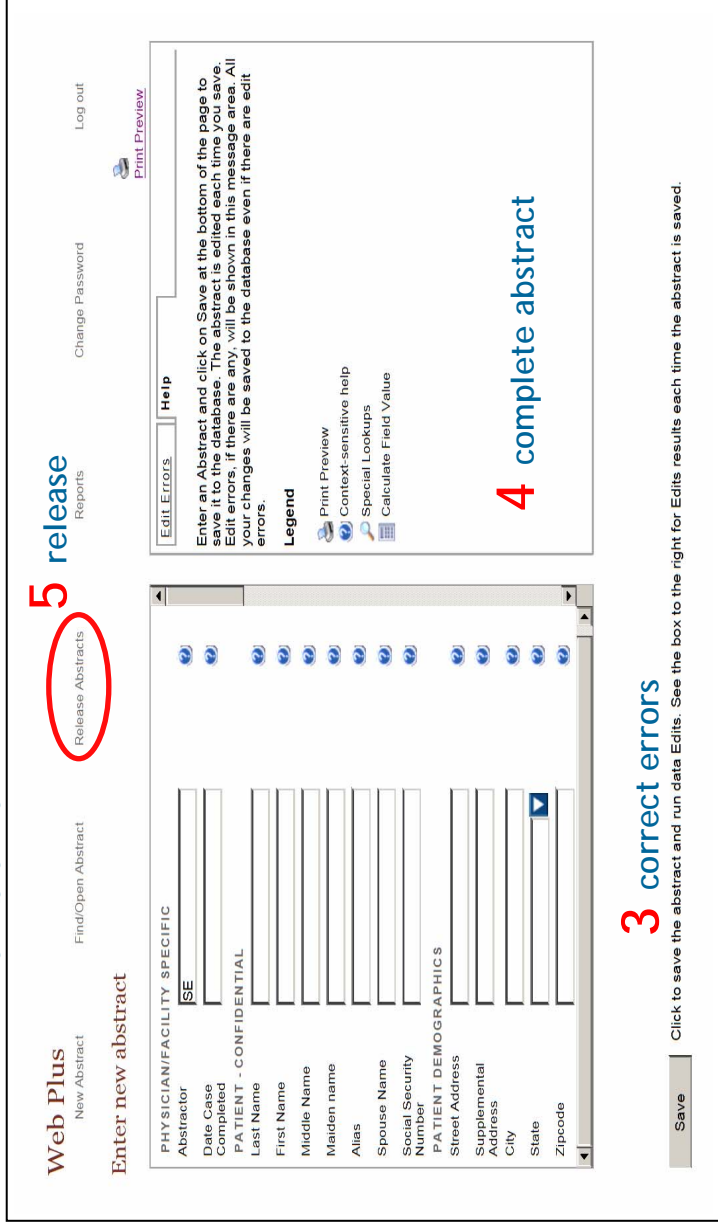
<https://webplus.umh.edu/webplus/>

WebPlus: Quick Reference Guide

Username: _____

Password: _____

2 create abstract



4 complete abstract

3 correct errors

2. Create abstract

Create the abstract with the patients' name and other demographic information. You may choose to save at this point and return later or you can enter other relevant medical information in the fields (and text fields) provided using the codes provided by WebPlus. Save the abstract to retain your information and to allow the system to edit the abstract (and show errors).

3. Correct errors

Correct errors. Each time you open or save the abstract, WebPlus automatically checks the entered information and edits the fields for accuracy and thoroughness using any of a variety of edit sets provided by your administrator.

4. Complete abstract




After you have entered all data and corrected all errors, the system saves your new abstract as completed.

5. Release abstract

Release the completed abstract to the central registry. You can release abstracts one at a time or several at a time.

QUICK REFERENCE GUIDE FOR USING WEBPLUS

Log on to WebPlus at: <https://webplus.umh.edu/webplus/>

1. Log on to application by using the MCR assigned User ID and Password, or the **test** ID: **johnndoe** (one word) and Password: **test**
(*Note: Please remember to use ONLY 'practice' cases with the TEST ID and password*)
2. Select '**New Abstract**' or '**Find/Open Abstract**'
3. Begin by thoroughly reviewing the medical report/records and/or pathology report before entering any patient information.
4. If choosing '**New Abstract**' begin entering the patient information. By clicking on the special help icon  a help screen will appear that provides information such as the size of the field, what information to input and who requires the field. There are also drop-down boxes  for a number of fields which will correctly complete the field if clicked.* For some fields, you will also see a  which allows you to search for the proper codes. Certain other fields have a tan 'pop-up' box which will automatically appear upon entering the corresponding field, which provides additional help (e.g. how to show an unknown social security number, the use of punctuation, etc.). For further information regarding icons and their uses, please refer to page 76 of the training manual.
5. **Cancer Identification:** If the user has not reviewed the medical report and/or pathology report, please do so before attempting to enter any further information. Use information from the medical and/or pathology report to complete these items.
6. A. **Histology field:** This field is for the tissue diagnosis made by the pathologist. For prostate cases, it will almost always be 'adenocarcinoma, nos.' histology code of "8140." Occasionally a prostate case will be diagnosed as 'adinar cell carcinoma' with a code of "8550." Use the search option and type 'adenocarcinoma,' then hit enter to go to the appropriate code or simply type in the code, if known.
B. **Grade:** This may also be found on the pathology report (well-differentiated, moderately differentiated, etc.). Use the drop-down box for this field.
7. **Stage/prognostic factors:** The CDC and NPCR are now using a combination of the TNM and SEER summary staging. Use the help buttons to see what type of information needs to be recorded in each field. Scroll past the gray 'notes' section in the first part of the help screen to see the actual codes. You will notice some of the codes correspond to the TNM fields.
8. Most of the treatment fields are self-explanatory using the help codes. **Remember, we are only asking you to report patients who are NOT going to another healthcare facility for treatment (hospital, radiation center, etc.).**
9. Be sure to complete the **Text Fields**. Use these fields to document specific details from either the pathology report or patient medical records. Most of the text fields correspond to coded fields. The fields are important because here you can use the text fields to document the codes. For example, if you chose "8140" for histology, then the text field should say adenocarcinoma." This will help MCR staff reviewing the abstracts to know if you are coding items correctly.
10. You may save information at any time without leaving the abstract. Once all information is complete, click on the '**Save**' button to save information. This function will automatically run edits, displaying any errors in the text area on the right of the screen. Simply correct errors, and re-save.
11. Once a case is saved, you may either choose the option of entering a new abstract, find/open an existing case to edit/enter additional information, or you may log off of the system.
12. To prevent loss of work, please remember to save data frequently, as WebPlus is configured with an automatic 'time-out' after 30 minutes of idle time.

*** NOTE: If you know the corresponding code for a field, simply type in the code; you do not have to use the drop-down boxes to populate a field.**

(Example: '8550' for Histology, - type '8550' and press enter.)

MCR DATA SET

Physician/Facility Specific		
Abstractor	Defaults to your initials	Facility Specific information
Date case completed	Defaults when saved	Facility Specific information
Patient Confidential		
Last name		Medical/Accounting Records
First name	Enter any nicknames in 'alias' field	Medical/Accounting Records
Middle name	May leave blank	Medical/Accounting Records
Maiden name	May leave blank	Medical/Accounting Records
Alias	Leave blank if none	Medical/Accounting Records
Spouse name	Leave blank if unknown	Medical/Accounting Records
Social security number	Use 9s if unknown	Medical/Accounting Records
Patient Demographics		
Street address	Do not use periods	Medical/Accounting Records
Supplemental address	Use this for Apartment #, nursing home name, etc.	Medical/Accounting Records
City		Medical/Accounting Records
State		Medical/Accounting Records
Zip code		Medical/Accounting Records
County	Use list found at http://mcr.umh.edu in Abstracting Resources section	Medical/Accounting Records
Tobacco History	Use 99 if unknown	Medical/Accounting Records
Alcohol History	Use 99 if unknown	Medical/Accounting Records
Race 1	01 = white; 02 = black,	Medical/Accounting Records
Race 2—5	Defaults to 9s	Medical/Accounting Records
Spanish/Hispanic Origin	Select code or use "9"	Medical/Accounting Records
Date of Birth	No slashes	Medical/Accounting Records
Sex		Medical/Accounting Records
Marital	Use 9 if unknown	Medical/Accounting Records
Primary payer at diagnosis*	Choose most appropriate code	Medical/Accounting Records
Occupation	Use "9" if unknown	History & Physical
Industry	Use "9" if unknown	History & Physical
Cancer Identification		
Diagnosis date*	Date of Biopsy	Diagnostic/Op/Path Reports
Age at diagnosis	Automatically calculated when you click on the calculator icon	Diagnostic/Op/Path Reports

MCR DATA SET

Cancer Identification (continued)		
Primary site (C619)	Defaults to prostate	Diagnostic/Op/Path Reports
Histology ICD-0-3	Most often adenocarcinoma (8140)	Path/Cytology/Lab Reports
Text—Histology*	Use words to describe codes used in above field	Path Reports
Text—Pathology Report Info*	Document Gleason's score, grade	Path Reports
Grade	Use code for term that describes differentiation	Path Reports
Stage/Prognostic Factors		
Text—Imaging Studies*	List any tests and results: CXR, BNS, etc.	Diagnostic Reports, including imaging
Text—Physical Exam*	DRE results, etc.	H&P, consult
Tumor Size—CS1	Defaulted to 999, unless physician states otherwise	Path report
Extent of disease—CS2	Corresponds to the "T" value	H&P, consult, path report
Lymph node involvement—CS4	Corresponds to the "N" value	H&P, diagnostic imaging
Mets at diagnosis—CS6	Corresponds to the "M" value	Diagnostic Reports, including imaging
CSSSF1—PSA value	Three digits—6.5—065	Lab Report
CSSSF2—PSA (+ or -)	010=positive; 020=negative; see other values	Lab Report
CSSSF5—Gleason pattern	Example: 3+3	Pathology Report
CSSSF6—Gleason value	Total score	Pathology Report
Derived SS2000	Automatically calculated when you save	Calculated field
Text—Stage*	Ex: TNM, "localized," "confined to prostate," "palpable nodes," "Distant mets to bones," etc.	Office notes
Treatment—1st Course		
Date of first contact	First date for this diagnosis	Office notes
Reason no surgery*	Use codes: "Not recommended," "Patient declined," etc.	Office notes
Hormone therapy	00-none; 01-given; see other values	Office notes
Hormone therapy date	Date of first treatment	Office notes
Text—Hormone treatment*	List names of drugs; if none given, state reason	Office notes
Reason no hormone therapy*	"0" if given	Office notes
Follow-up/Death		
Date of last contact		Medical/Accounting Records
Vital status	0 = deceased, 1 = alive	Medical/Accounting Records
Cancer status	1 = NED, 2 = w/disease, 3 = unk	Medical Records
Place of death	Missouri = 063	Medical Records
Cause of death	Code "7777" unless you have death certificate	Medical Records
Reporting Physician*	License # or NPI	Medical/Accounting Records
Physician—Other	License # or NPI for referring physician	Medical/Accounting Records
Text—Remarks	Hx previous ca, # years smoked, etc.	Medical Records/Office notes

ACRONYMS/GLOSSARY

ACoS	= American College of Surgeons
ASC	= Ambulatory Surgical Center
CDC	= Centers for Disease Control and Prevention
CoC	= Commission on Cancer
CTR	= Certified Tumor Registrar
DHSS	= Missouri Department of Health and Senior Services
IRB	= Institutional Review Board
LTCF	= Long-term care facility, a generic term for residential care facilities I and II, intermediate care facilities and skilled nursing facilities (SNFs)
HIM	= Health Information Management
HMI	= Department of Health Management and Informatics, MU
MCR	= Missouri Cancer Registry
MICA	= Missouri Information for Community Assessment (DHSS's interactive web-based tool)
NAACCR	= North American Association of Central Cancer Registries
NPCR	= National Program of Cancer Registries, CDC

Adenocarcinoma—a form of cancer that develops from a malignant abnormality in the cells lining a glandular organ such as the prostate; almost all prostate cancers are adenocarcinomas.

Age-adjusted—modified to take account of the age of an individual or group of individuals; for example, prostate cancer survival data and average normal PSA values can be adjusted according to the ages of groups of men.

Alpha-blockers—pharmaceuticals that act on the prostate by relaxing certain types of muscle tissue; these pharmaceuticals are often used in the treatment of BPH.

Antiandrogen—A substance which interferes with the function of an androgen, or male sex hormone by taking over the androgen's receptors.

Apex—the tip or bottom of the prostate, e.g., the part of the prostate farthest away from the bladder.

Benign—relatively harmless; not cancerous; not malignant.

Benign Prostatic Hyperplasia (or Hypertrophy) (BPH) - a noncancerous condition of the prostate that results in the growth of both glandular and stromal (supporting connective) tumorous tissue, enlarging the prostate and obstructing urination (see prostatitis).

Bilateral—both sides; for example, a bilateral orchiectomy is an orchiectomy in which both testicles are removed and a bilateral adrenalectomy is an operation in which both adrenal glands are removed.

Biopsy—sampling of tissue from a particular part of the body (e.g., the prostate) in order to check for abnormalities such as cancer; in the case of prostate cancer, biopsies are usually carried out under ultrasound guidance using a specially designed device known as a prostate biopsy gun; removed tissue is typically examined microscopically by a pathologist in order to make a precise diagnosis of the patient's condition.

BPH—see Benign Prostatic Hyperplasia

Brachytherapy—a form of radiation therapy in which radioactive seeds or pellets which emit radiation are implanted in order to kill surrounding tissue (e.g., the prostate, including prostate cancer cells).

GLOSSARY

CAB—Complete Androgen Blockade (see CHT)

Carcinoma—a form of cancer that originates in tissues which line or cover a particular organ; see Adenocarcinoma.

CGA—chromogranin A; a small cell prostate cancer or neuroendocrine cell marker.

CHT—Combined Hormonal Therapy—the use of more than one hormone in therapy; especially the use of LHRH analogs (e.g., Lupron, Zoladex) to block the production of testosterone by the testes, plus antiandrogens (e.g., Casodex (bicalutamide), Eulexin (flutamide), Anadron (nilutamide), Androcur (cyproterone) to compete with DHT for cell sites therapy thereby depriving cancer cells of DHT needed for growth.

Combination Therapy—see CHT

Cryoabulation—see cryosurgery

Cryosurgery—the use of liquid nitrogen probes to freeze a particular organ to extremely low temperatures to kill the tissue, including any cancerous tissue; when used to treat prostate cancer, the cryoprobes are guided by trans-rectal ultrasound.

Cyproterone—an antiandrogen

DES—see diethylstilbestrol

DHT—see dihydrotestosterone

Diethylstilbestrol—(DES) a female hormone commonly used in the 1960s and 1970s for treatment of prostate cancer.

Dihydrotestosterone—(DHT—5 alpha-dihydrotestosterone) the male hormone which is most active in the prostate; it is made when an enzyme (5 alpha reductase) in the prostate stimulates the transformation of testosterone to DHT.

Differentiation—the use of the differences between prostate cancer cells when seen under the microscope as a method to grade the severity of the disease; well differentiated cells are easily recognized as normal cells, while poorly differentiated cells are abnormal, cancerous and difficult to recognize as belonging to any particular type of cell group.

Dysplasia—see PIN

Dysuria—urination which is problematic or painful

Eulexin—the brand or trade name of flutamide in the USA

External Radiation Therapy (also External Beam Therapy) - a form of radiation therapy in which radiation is delivered by a machine pointed at the area to be radiated.

Flutamide—an antiandrogen used in the palliative hormonal treatment of advanced prostate cancer and sometimes in the adjuvant and neoadjuvant hormonal treatment of earlier stages of prostate cancer.

GLOSSARY

Gleason Score—a widely used method for classifying the cellular differentiation of cancerous tissues; the less the cancerous cells appear like normal cells, the more malignant the cancer; two numbers, each from 1-5 are assigned successively to the two most predominant patterns of differentiation present in the examined tissue sample and are added together to produce the Gleason score; high numbers indicate poor differentiation and therefore cancer.

GNRH—enadotropin-releasing hormone—see LHRH Analogs.

Grade—a means of describing the potential degree of severity of a cancer based on the appearance of cancer cells under a microscope; see also Gleason Score.

Histology—the study of the appearance and behavior of tissue, usually carried out under a microscope by a pathologist (who is a physician) or a histologist (who is not necessarily a physician).

Hormone Therapy—the use of hormones, hormone analogs, and certain surgical techniques to treat disease (in this case advanced prostate cancer) either on their own or in combination with other hormones or in combination with other methods of treatment; because prostate cancer is usually dependent on male hormones to grow, hormonal therapy can be an effective means of alleviating symptoms and retarding the development of the disease.

Interstitial—within a particular organ; for example, interstitial prostate radiation therapy is radiation therapy applied within the prostate using implanted radioactive pellets or seeds; see also brachytherapy.

LHRH Analogs (or agonists)—Synthetic compounds that are chemically similar to Luteinizing Hormone Releasing Hormone (LHRH), but are sufficiently different that they suppress testicular production of testosterone by binding to the LHRH receptor in the pituitary gland and either have no biological activity and therefore competitively inhibit the action of LHRH, or has LHRH activity that exhausts the production of LH by the pituitary; used in the hormonal treatment of advanced prostate cancer and in the adjuvant and neoadjuvant hormonal treatment of earlier stages of prostate cancer; LHRH agonist (mimics natural LHRH but then shuts down LH production after continuous exposure).

Lymph Nodes—the small glands which occur throughout the body and which filter the clear fluid known as lymph or lymphatic fluid; lymph node filter out bacteria and other toxins, as well as cancer cells.

Malignancy—a growth or tumor composed of cancerous cells.

Malignant—cancerous; tending to become progressively worse and to result in death; having the invasive and metastatic (spreading) properties of cancer.

Metastasis—(plural metastases) a secondary tumor formed as a result of a cancer cell or cells from the primary tumor site (e.g., the prostate) traveling through the body to a new site and then growing there.

Metastatic—having the characteristics of a secondary tumor.

Neoplasia—the growth of cells under conditions that would tend to prevent the development of normal tissue (e.g., a cancer)

Palliative—designed to relieve a particular problem without necessarily solving it; for example, palliative therapy is given in order to relieve symptoms and improve quality of life, but does not cure the patient.

GLOSSARY

Palpable—capable of being felt during a physical examination by an experienced physician; in the case of prostate cancer, this normally refers to some form of abnormality of the prostate which can be felt during a digital rectal exam.

PAP—Prostatic Acid Phosphate; an enzyme now measured only rarely to decide whether prostate cancer has escaped from the prostate.

PIN—Prostatic Intraepithelial (or intraductal) Neoplasia; a pathologically identifiable condition believed to be a possible precursor of prostate cancer; also known more simply as dysplasia by many physicians.

Prolactin—(PRL) a trophic hormone produced by the pituitary that increases androgen receptors, increases sensitivity to androgens, & regulates production & secretion of citrate.

Prostatectomy—surgical removal of part or all of the prostate gland.

Prostate-Specific Antigen—see PSA

Prostatic Acid Phosphatase—see PAP

PSA—Prostate-Specific Antigen; a protein secreted by the epithelial cells of the prostate gland including cancer cells; an elevated level in the blood indicates an abnormal condition of the prostate gland, either benign or malignant; it is used to detect potential problems in the prostate gland and to follow the progress of Pca therapy (see SCREENING).

PSA Velocity—(PSAV); the rate at which PSA values increase assuming that the rate does not change.

Radical Prostatectomy—an operation to remove the entire prostate gland and seminal vesicles.

Refractory—resistant to therapy; e.g., hormone refractory prostate cancer is resistant to forms of treatment based on the use of hormones; (see mutation).

Resection—surgical removal.

Retropubic Prostatectomy—surgical removal of the prostate through an incision in the abdomen.

RP—see Radical Prostatectomy.

RT-PCR—see RT-PCR

RT-PCR—reverse transcriptase polymerase chain reaction; a technique which allows a physician to search for tiny quantities of protein, such as PSA in the blood or other body fluids and tissues; because today's reproducibility is poor, the test results are reported in vague terms like 'positive' or 'negative' rather than as numbers; see PSA RT-PCR.

Screening—to separate patients with tumors from those without tumors; multiple criteria are often used; the following PSA screening 'cutoff' levels for PCa are replacing the older 4.0 value. Age PSA 'cutoff': 40-49 2.5ng/ml; 50-59 3.5ng/ml; 60-69 4.5ng/ml; 70-79 6.5ng/ml

Stage—a term used to define the size and physical extent of a cancer.

GLOSSARY

Staging—the process of assigning a stage to a particular cancer in a specific patient in light of all the available information; it is used to help determine appropriate therapy; there are two staging methods: the Whitmore-Jewett staging classification (1956) and the more detailed TNM (tumor, nodes, metastases) classification (1992) of the American Joint Committee on Cancer and the International Union Against Cancer.

TNM—(tumor, nodes, metastases) see Staging.

TRUS—Transrectal ultrasound; a method that uses echoes of ultrasound waves (far beyond the hearing range) to image the prostate by inserting an ultrasound probe into the rectum; commonly used to visualize prostate biopsy procedures.

TURP—Transurethral Resection of the Prostate; a surgical procedure to remove tissue obstructing the urethra; the technique involves the insertion of an instrument called a resectoscope into the penile urethra, and is intended to relieve obstruction of urine flow due to enlargement of the prostate.

TUR/P—see TURP

Watchful Waiting—active observation and regular monitoring of a patient without actual treatment.

Zoladex—trade or brand name for goserelin acetate, a LHRH agonist.

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

Prostate

C61.9

C61.9 Prostate gland

Note: Transitional cell carcinoma of the prostatic urethra is to be coded to primary site C68.0, Urethra, and assigned Collaborative Stage codes according to the urethra scheme.

CS Tumor Size
CS Extension-Clinical Extension
CS TS/Ext-Eval
CS Lymph Nodes
CS Reg Nodes Eval
Reg LN Pos
Reg LN Exam
CS Mets at DX
CS Mets Eval

CS Site-Specific Factor 1 -
Prostatic Specific Antigen (PSA)
Lab Value
CS Site-Specific Factor 2 -
Prostatic Specific Antigen (PSA)
CS Site-Specific Factor 3 - CS
Extension - Pathologic Extension
CS Site-Specific Factor 4 -
Prostatic Acid Phosphatase (PAP)
CS Site-Specific Factor 5 -
Gleason's Primary Pattern and
Secondary Pattern Value
CS Site-Specific Factor 6 -
Gleason's Score

The following tables are available
at the collaborative staging
website:
Histology Exclusion Table
AJCC Stage

Prostate

CS Tumor Size

SEE STANDARD TABLE

Prostate

CS Extension-Clinical Extension

Note 1: This field and Site-Specific Factor 3, CS Extension – Pathologic Extension, must both be coded, whether or not a prostatectomy was performed. Information from prostatectomy is EXCLUDED from this field and coded only in Site-Specific Factor 3.

Note 2:

A. Codes 10-15: 1) CODES 10 to 15 are used only for clinically inapparent tumor not palpable or visible by imaging and incidentally found microscopic carcinoma (latent, occult) in one or both lobes. Within this range, give priority to codes 13-15 over code 10. 2) When tumor is found in one lobe or in both lobes by needle biopsy but is not palpable or visible by imaging, use code 15.

B. CODES 20 to 24 are used only for clinically/radiographically apparent tumor, i.e., that which is palpable or visible by imaging. Codes 21 and 22 have precedence over code 20. Code 20 has precedence over code 24.

C. CODE 30 is used for localized cancer when it is unknown if clinically or radiographically apparent. An example would be when a diagnosis is made prior to admission for a prostatectomy with no details provided on clinical findings prior to admission.

D. CODES 31, 33 and 34 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the T classification.

E. CODES 41 to 49 are used for extension beyond the prostate.

Note 3: Prostate Apex Involvement: This field and Site-Specific Factor 4, Prostate Apex Involvement, are both coded whether or not a prostatectomy was performed.

Note 4: Use codes 13-14 when a TURP is done, not for a biopsy only. Do not use code 15 when a TURP is done.

Note 5: Involvement of the prostatic urethra does not alter the extension code.

Note 6: "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 60.

Note 7: AUA stage. Some of the American Urological Association (AUA) stages A-D are provided as guidelines for coding in the absence of more specific information in the medical record. If physician-assigned AUA stage D1-D2 is based on involvement of lymph nodes only, code under CS Lymph Nodes or CS Mets at DX, not CS Extension.

Note 8: This schema includes evaluation of other pathologic tissue such as a biopsy of the rectum.

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

Note 9: For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c, p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 3. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT. If Site-Specific Factor 3 (Pathologic Extension) code is 095 or greater (meaning that prostatectomy was not performed, or it was performed but the information is not usable for staging), the mapping values are taken from the CS Extension (Clinical Extension) mapping, and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 (Pathologic Staging) code is 000 (in situ), and if CS Extension code (Clinical Extension) is greater than 00 and less than 95 (not in situ), the mapping values are taken from the CS Extension (Clinical Extension) mapping and the c, p, y, or a indicator is taken from the TX Ext Eval mapping. If Site-Specific Factor 3 is 000 (in situ) and CS Extension code is 00 (in situ) or greater than 95, the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT.

Prostate**CS Extension–Clinical Extension**

Code	Description	TNM	SS77	SS2000
00	In situ: noninvasive; intraepithelial	Tis	IS	IS
10	Clinically inapparent tumor, number of foci or percent involved tissue not specified Stage A, NOS	T1NOS	L	L
13	Incidental histologic finding in 5% or less of tissue resected (clinically inapparent)	T1a	L	L
14	Incidental histologic finding more than 5% of tissue resected (clinically inapparent)	T1b	L	L
15	Tumor identified by needle biopsy, e.g., for elevated PSA (clinically inapparent)	T1c	L	L
20	Involvement in one lobe, NOS (clinically apparent only)	T2NOS	L	L
21	Involves one half of one lobe or less (clinically apparent only)	T2a	L	L
22	Involves more than one half of one lobe, but not both lobes (clinically apparent only)	T2b	L	L
23	Involves both lobes (clinically apparent only)	T2c	L	L
24	Clinically apparent tumor confined to prostate, NOS Stage B, NOS	T2NOS	L	L
30	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Not stated if Stage A or B, T1 or T2, clinically apparent or inapparent	T2NOS	L	L
31	OBSOLETE (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
33	OBSOLETE (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
34	OBSOLETE (See Notes 2, 3 and Site-Specific Factor 4)	T2NOS	L	L
41	Extension to periprostatic tissue (Stage C1) Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3NOS	RE	RE

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

42	Unilateral extracapsular extension	T3a	RE	RE
43	Bilateral extracapsular extension	T3a	RE	RE
45	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
49	Periprostic extension, NOS (Unknown if seminal vesicle(s) involved) Stage C, NOS	T3NOS	RE	RE
50	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
52	Levator muscles Skeletal muscle, NOS Ureter(s)	T4	D	RE
60	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 5)	T4	D	D
70	Further contiguous extension (Stage D2) including to: Bone Other organs Penis Sigmoid colon Soft tissue other than periprostic	T4	D	D
95	No evidence of primary tumor	T0	U	U
99	Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Prostate

CS TS/Ext-Eval

Note 1: For this site, use this item to evaluate the coding of tumor size and extension as coded in both CS Extension (clinical for prostate) and Site-Specific Factor 3, Pathologic Extension if prostatectomy was performed.

Note 2: The codes for this item for prostate differ from the codes used for most other sites. AJCC allows pathologic staging to be assigned on the basis of some biopsies without resection. According to the AJCC manual, "In general, total prostatectomy-vesiculectomy, including regional node specimen, and histologic confirmation are required for pathologic T classification. However, under certain circumstances, pathologic T classification can be determined with other means. For example, (1) positive biopsy of the rectum permits a pT4 classification without prostatectomy-vesiculectomy, and (2) a biopsy revealing carcinoma in extraprostatic soft tissue permits a pT3 classification, as does a biopsy revealing adenocarcinoma infiltrating the seminal vesicles." (P. 310)

Note 3: For this site, the T category and its associated c, p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 3. For details, see Note 7 under CS Extension.

Note 4: According to AJCC, staging basis for transurethral resection of prostate (TURP) is clinical and is recorded as CS TS/Ext-Eval "1" (c).

Code	Description	Staging Basis
0	No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used.	c

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

1	No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques including surgical observation without biopsy. No autopsy evidence used. Does not meet criteria for AJCC pathologic T staging.	c
2	No surgical resection done, but positive biopsy of extraprostatic tissue allows assignment to CS Extension Codes [(41) to (70)] (see Note 2)	p
3	No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy)	p
4	Surgical resection performed WITHOUT pre-surgical systemic treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed. Evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. Meets criteria for AJCC pathologic T staging.	p
5	Surgical resection performed WITH pre-surgical systemic treatment or radiation, BUT tumor size/extension based on clinical evidence	c
6	Surgical resection performed WITH pre-surgical systemic treatment or radiation; BUT tumor size/extension based on pathologic evidence	y
8	Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record	c

Prostate

CS Lymph Nodes

Note: Code only regional nodes and nodes, NOS, in this field. Distant nodes are coded in the field Mets at DX.

Code	Description	TNM	SS77	SS2000
00	None; no regional lymph node involvement	N0	NONE	NONE
10	Regional nodes, including contralateral or bilateral lymph nodes: Iliac, NOS External Internal (hypogastric), NOS: Obturator Pelvic, NOS Periprostatic Sacral, NOS Lateral (laterosacral) Middle (promontorial) (Gerota's node) Presacral Regional lymph node(s), NOS	N1	RN	RN
80	Lymph nodes, NOS	N1	RN	RN
99	Unknown; not stated Regional lymph node(s) cannot be assessed	NX	U	U

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

Prostate
CS Reg Nodes Eval
SEE STANDARD TABLE

Prostate
Reg LN Pos
SEE STANDARD TABLE

Prostate
Reg LN Exam
SEE STANDARD TABLE

Prostate
CS Mets at DX

Code	Description	TNM	SS77	SS2000
00	No; none	M0	NONE	NONE
11	Distant lymph node(s), NOS Common iliac	M1a	RN	D
12	Distant lymph node(s): Aortic, NOS: Lateral (lumbar) Para-aortic Periaortic Cervical Inguinal, NOS Deep, NOS Node of Coquet or Rosenmuller (highest deep inguinal) Superficial (femoral) Retroperitoneal, NOS Scalene (inferior deep cervical) Supraclavicular (transverse cervical) Distant lymph node(s), NOS	M1a	D	D
30	Metastasis in bone(s)	M1b	D	D
35	(30) + [(11) or (12)]	M1b	D	D
40	Distant metastasis, other than distant lymph node(s) (codes 11 or 12) or bone(s) Carcinomatosis	M1c	D	D
45	Distant metastasis, NOS Stage D2, NOS	M1NOS	D	D
50	(40) + any of [(11) or (12)]	M1c	D	D
55	(40) + any of [(30) or (35)]	M1c	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	MX	U	U

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

Prostate**CS Mets Eval**

SEE STANDARD TABLE

Prostate**CS Site-Specific Factor 1 Prostatic Specific Antigen (PSA) Lab Value**

Note 1: Record the highest PSA lab value prior to diagnostic biopsy or treatment. For example, a pretreatment PSA of 20.0 ng/ml would be recorded as 200.

Note 2: Lab values for SSFs 1 and 2 should be from the same laboratory test.

Code	Description
000	Test not done (test was not ordered and was not performed)
001	0.1 or less ng/ml (actual value with implied decimal point)
002-989	0.2 - 98.9 ng/ml (actual value with implied decimal point)
990	99.0 or greater ng/ml
999	Unknown or no information Not documented in patient record

Prostate**CS Site-Specific Factor 2 Prostatic Specific Antigen (PSA)**

Note 1: Use the highest PSA lab value prior to diagnostic biopsy or treatment.

Note 2: Lab values for SSFs 1 and 2 should be from the same laboratory test.

Code	Description
000	Test not done (test was not ordered and was not performed)
010	Positive/elevated
020	Negative/normal; within normal limits
030	Borderline; undetermined whether positive or negative
080	Ordered, but results not in chart
999	Unknown or no information Not documented in patient record

Prostate**CS Site-Specific Factor 3 CS Extension - Pathologic Extension**

Note 1: Include information from prostatectomy in this field and not in CS Extension - Clinical Extension. Use all histologic information including the prostatectomy if it was done within the first course of treatment. Code 097 if there was no prostatectomy performed within the first course of treatment.

Note 2: Limit information in this field to first course of treatment in the absence of disease progression.

Note 3: Involvement of the prostatic urethra does not alter the extension code.

Note 4: When the apical margin, distal urethral margin, bladder base, or bladder neck margin is involved and there is no extracapsular extension, use code 040.

Note 5: Codes 031, 033 and 034 have been made OBSOLETE, CODES NO LONGER USED. Information about prostate apex involvement has been moved to Site-Specific Factor 4, Prostate Apex Involvement. AJCC does not use prostate apex involvement in the T classification.

Note 6: When prostate cancer is an incidental finding during a prostatectomy for other reasons (for example, a cystoprostatectomy for bladder cancer), use the appropriate code for the extent of disease found (for example, one lobe, or both lobes, or more).

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

Note 7: "Frozen pelvis" is a clinical term which means tumor extends to pelvic sidewall(s). In the absence of a more detailed statement of involvement, assign this to code 060.

Note 8: AUA stage. Some of the American Urological Association (AUA) stages A-D are provided as guidelines for coding in the absence of more specific information in the medical record. If physician-assigned AUA stage D1-D2 is based on involvement of lymph nodes only, code under CS Lymph Nodes or CS Mets at DX, not CS Extension - Pathologic Extension.

Note 9: For the extension fields for this site, the mapping values for TNM, SS77, and SS2000 and the associated c, p, y, or a indicator are assigned based on the values in CS Extension, CS TS/Ext Eval, and Site-Specific Factor 3. If the value of Site-Specific Factor 3 is greater than 000 and less than 095 (i.e., prostatectomy was done, extension information is available for staging, and invasive tumor was present in the prostatectomy specimen), the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT. If Site-Specific Factor 3 (Pathologic Extension) code is 095 or greater (meaning that prostatectomy was not performed, or it was performed but the information is not usable for staging), the mapping values are taken from the CS Extension (Clinical Extension) mapping, and the c, p, y, or a indicator is taken from the TS/Ext Eval mapping. If Site-Specific Factor 3 (Pathologic Staging) code is 000 (in situ), and if CS Extension code (Clinical Extension) is greater than 00 and less than 95 (not in situ), the mapping values are taken from the CS Extension (Clinical Extension) mapping and the c, p, y, or a indicator is taken from the TX Ext Eval mapping. If Site-Specific Factor 3 is 000 (in situ) and CS Extension code is 00 (in situ) or greater than 95, the mapping values are taken from the Site-Specific Factor 3 mapping, and the T category is identified as a pT.

Prostate

CS Site-Specific Factor 3 CS Extension - Pathologic Extension

Code	Description	TNM	SS77	SS2000
000	In situ; non-invasive; intraepithelial	Tis	IS	IS
020	Involvement in one lobe, NOS	T2NOS	L	L
021	Involves one half of one lobe or less	T2a	L	L
022	Involves more than one half of one lobe, but not both lobes	T2b	L	L
023	Involves both lobes	T2c	L	L
030	Localized, NOS Confined to prostate, NOS Intracapsular involvement only Stage B, NOS	T2NOS	L	L
031	OBSOLETE (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
032	Invasion into (but not beyond) prostatic capsule	T2NOS	L	L
033	OBSOLETE (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
034	OBSOLETE (See Note 5 and Site-Specific Factor 4)	T2NOS	L	L
040	No extracapsular extension but margins involved (See Note 4)	T2NOS	L	RE
041	Extension to periprostatic tissue (Stage C1): Extracapsular extension (beyond prostatic capsule), NOS Through capsule, NOS	T3a	RE	RE
042	Unilateral extracapsular extension	T3a	RE	RE
043	Bilateral extracapsular extension	T3a	RE	RE
045	Extension to seminal vesicle(s) (Stage C2)	T3b	RE	RE
048	Extracapsular extension and margins involved (Excluding seminal vesicle margins—see code 045)	T3a	RE	RE

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

050	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
052	Levator muscle Skeletal muscle, NOS Ureter	T4	D	RE
060	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 6)	T4	D	D
070	Further contiguous extension (Stage D2) including to: Bone Penis Sigmoid colon Soft tissue other than periprostatic tissue Other organs	T4	D	D
095	No evidence of primary tumor	T0	U	U
096	Unknown if prostatectomy done	TX	U	U
097	No prostatectomy done within first course of treatment	TX	U	U
098	Prostatectomy performed, but not considered first course of treatment because of, for example, disease progression.	TX	U	U
099	Prostatectomy done: Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Prostate**CS Site-Specific Factor 4 Prostate Apex Involvement****(OBSOLETE: Prostatic Acid Phosphatase (PAP))**

Note: Historically, apex involvement has affected the stage classification, although it does not affect the AJCC 6th edition. This item allows collection of information about the involvement of the prostate apex with cancer, both clinically and at prostatectomy. In codes 110-550, the first digit represents the clinical status of apex involvement and the second digit represents apex involvement found at prostatectomy, following these definitions:

- 1 – No involvement of prostatic apex
- 2 – Into prostatic apex/arising in prostatic apex, NOS
- 3 – Arising in prostatic apex
- 4 – Extension into prostatic apex
- 5 – Apex extension unknown

When abstracting and coding apex involvement, try to determine if the cancer has extended into the apex from another part of the prostate or has arisen in the apex.

Code	Description
000	OBSOLETE PAP: Test not done (test was not ordered and was not performed)
010	OBSOLETE PAP: Positive/elevated
020	OBSOLETE PAP: Negative/normal; within normal limits
030	OBSOLETE PAP: Borderline; undetermined whether positive or negative

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

050	Extension to or fixation to adjacent structures other than seminal vesicles: Bladder neck Bladder, NOS Fixation, NOS Rectovesical (Denonvillier's) fascia Rectum; external sphincter	T4	RE	RE
052	Levator muscle Skeletal muscle, NOS Ureter	T4	D	RE
060	Extension to or fixation to pelvic wall or pelvic bone "Frozen pelvis", NOS (See Note 6)	T4	D	D
070	Further contiguous extension (Stage D2) including to: Bone Penis Sigmoid colon Soft tissue other than periprostatic tissue Other organs	T4	D	D
095	No evidence of primary tumor	T0	U	U
096	Unknown if prostatectomy done	TX	U	U
097	No prostatectomy done within first course of treatment	TX	U	U
098	Prostatectomy performed, but not considered first course of treatment because of, for example, disease progression.	TX	U	U
099	Prostatectomy done: Extension unknown Primary tumor cannot be assessed Not documented in patient record	TX	U	U

Prostate

CS Site-Specific Factor 4 Prostate Apex Involvement

(OBSOLETE: Prostatic Acid Phosphatase (PAP))

Note: Historically, apex involvement has affected the stage classification, although it does not affect the AJCC 6th edition. This item allows collection of information about the involvement of the prostate apex with cancer, both clinically and at prostatectomy. In codes 110-550, the first digit represents the clinical status of apex involvement and the second digit represents apex involvement found at prostatectomy, following these definitions:

- 1 – No involvement of prostatic apex
- 2 – Into prostatic apex/arising in prostatic apex, NOS
- 3 – Arising in prostatic apex
- 4 – Extension into prostatic apex
- 5 – Apex extension unknown

When abstracting and coding apex involvement, try to determine if the cancer has extended into the apex from another part of the prostate or has arisen in the apex.

Code	Description
000	OBSOLETE PAP: Test not done (test was not ordered and was not performed)
010	OBSOLETE PAP: Positive/elevated
020	OBSOLETE PAP: Negative/normal; within normal limits
030	OBSOLETE PAP: Borderline; undetermined whether positive or negative

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

080	OBSOLETE PAP: Ordered, but results not in chart
110	No involvement of prostatic apex.
120	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Into/arising in, NOS.
130	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Arising in.
140	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Extension into.
150	Clinical apex involvement: No involvement AND Prostatectomy apex involvement: Unknown.
210	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: No involvement.
220	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Into/arising in, NOS.
230	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Arising in.
240	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Extension into.
250	Clinical apex involvement: Into/arising in, NOS AND Prostatectomy apex involvement: Unknown.
310	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: No involvement.
320	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Into/arising in, NOS.
330	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Arising in.
340	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Extension into.
350	Clinical apex involvement: Arising in AND Prostatectomy apex involvement: Unknown.
410	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: No involvement.
420	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Into/arising in, NOS.
430	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Arising in.
440	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Extension into.
450	Clinical apex involvement: Extension into AND Prostatectomy apex involvement: Unknown.
510	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: No involvement.
520	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Into/arising in, NOS.
530	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Arising into.

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

540	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Extension into.
550	Clinical apex involvement: Unknown AND Prostatectomy apex involvement: Unknown.
999	OBSOLETE PAP: Unknown or no information. Not documented in patient record

Prostate

CS Site-Specific Factor 5 Gleason's Primary Pattern and Secondary Pattern Value

Note 1: Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, that is, the pattern occupying greater than 50% of the cancer is usually indicated by the first number of the Gleason's grade and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score ranging from 2 to 10.

If there are two numbers, assume that they refer to two patterns (the first number being the primary and the second number being the secondary) and sum them to obtain the score.

If only one number is given and it is less than or equal to 5, assume that it describes a pattern and uses the number as the primary pattern and code the secondary as '9'.

If only one number is given and it is greater than 5, assume that it is a score.

If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.

Note 2: Following AJCC guidelines for coding multiple Gleason's Scores for prostate cancer, if there is more than one primary and secondary pattern value, the value to be coded is the one based on the larger tumor specimen. Please note that this rule is not the same as the rule for coding grade.

Code	Description
000	Test not done (test was not ordered and was not performed)
011	Primary pattern 1, secondary pattern 1
012	Primary pattern 1, secondary pattern 2
013	Primary pattern 1, secondary pattern 3
014	Primary pattern 1, secondary pattern 4
015	Primary pattern 1, secondary pattern 5
019	Primary pattern 1, secondary pattern 9
021	Primary pattern 2, secondary pattern 1
022	Primary pattern 2, secondary pattern 2
023	Primary pattern 2, secondary pattern 3
024	Primary pattern 2, secondary pattern 4
025	Primary pattern 2, secondary pattern 5
029	Primary pattern 2, secondary pattern unknown
031	Primary pattern 3, secondary pattern 1
032	Primary pattern 3, secondary pattern 2
033	Primary pattern 3, secondary pattern 3
034	Primary pattern 3, secondary pattern 4
035	Primary pattern 3, secondary pattern 5

COLLABORATIVE STAGING/CODING INSTRUCTIONS

Collaborative Staging Manual and Coding Instructions Part II: Primary Site Schema

039	Primary pattern 3, secondary pattern unknown
041	Primary pattern 4, secondary pattern 1
042	Primary pattern 4, secondary pattern 2
043	Primary pattern 4, secondary pattern 3
044	Primary pattern 4, secondary pattern 4
045	Primary pattern 4, secondary pattern 5
049	Primary pattern 4, secondary pattern unknown
051	Primary pattern 5, secondary pattern 1
052	Primary pattern 5, secondary pattern 2
053	Primary pattern 5, secondary pattern 3
054	Primary pattern 5, secondary pattern 4
055	Primary pattern 5, secondary pattern 5
059	Primary pattern 5, secondary pattern unknown
099	Primary pattern unknown
999	Unknown or no information Not documented in patient record

Prostate**CS Site-Specific Factor 6 Gleason's Score**

Note 1: Usually prostate cancers are graded using Gleason's score or pattern. Gleason's grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, that is, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason's grade and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10.

If there are two numbers, assume that they refer to two patterns (the first number being the primary and the second number being the secondary) and sum them to obtain the score.

If only one number is given and it is less than or equal to 5, assume that it describes a pattern and uses the number as the primary pattern and code the secondary as '9'.

If only one number is given and it is greater than 5, assume that it is a score.

If the pathology report specifies a specific number out of a total of 10, the first number given is the score.

Example: The pathology report says "Gleason's 3/10". The Gleason's score would be 3.

Note 2: Record the Gleason's score based on the addition of the primary and secondary pattern.

Note 3: Following AJCC guidelines for coding multiple Gleason's Scores in prostate cancer, if there is more than one primary and secondary pattern value, the value to be coded is the one base on the larger tumor specimen. Please note that this rule is not the same as the rule for coding grade.

Code	Description
000	Test not done (test was not ordered and was not performed)
002-010	Gleason's Score (See Notes)
999	Unknown or no information Not documented in patient record

LINKS TO IMPORTANT CANCER RESOURCES

The screenshot shows a web browser window with the address bar displaying <http://mcr.umh.edu/>. The browser's toolbar includes a back button, a search icon, and a favorites icon. The website's header features the text "Missouri Cancer Registry" in large, bold letters, accompanied by a map of Missouri and a laptop icon. Below the header, a navigation bar lists "Quick Links" with links to Home, ACoS, DHSS, NPCR, NAACCR, SEER, NCI, ACS, HMI, NCRA, and MICA. The main content area is titled "IMPORTANT LINKS TO CANCER RESOURCES" and lists several resources: American Cancer Society, American College of Surgeons, Behaviour Risk Factor Surveillance System (BRFSS), Cancer Control Planet - Links to resources for comprehensive cancer control, and Center for Disease Control and Prevention (CDC). On the left side, a vertical menu contains links to Home, About MCR, Data, Cancer Reporting, Abstracting Resources, Links, and Contact Info. The "Links" link is circled in red.

Address: <http://mcr.umh.edu/>

Missouri Cancer Registry

Quick Links : [Home](#) | [ACoS](#) | [DHSS](#) | [NPCR](#) | [NAACCR](#) | [SEER](#) | [NCI](#) | [ACS](#) | [HMI](#) | [NCRA](#) | [MICA](#)

Click here for text menu format

Site Map

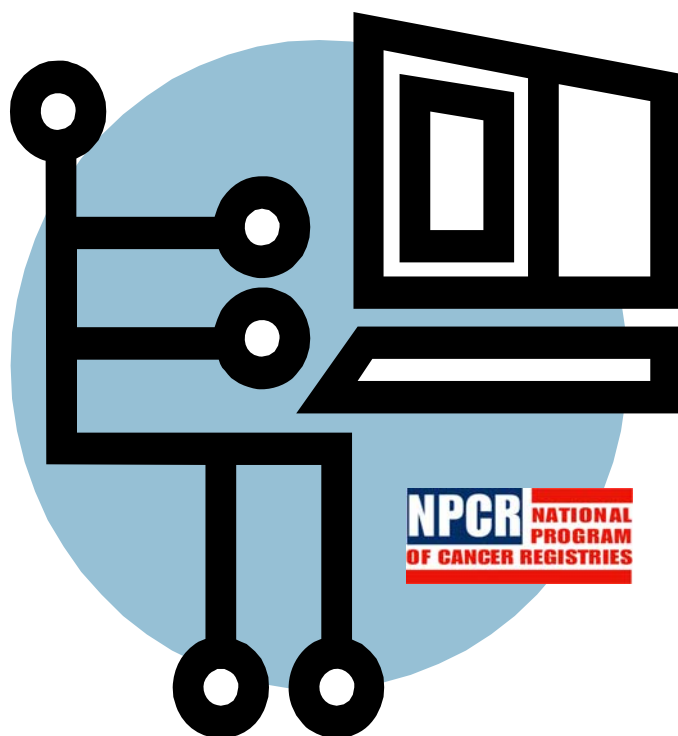
- [Home](#)
- [About MCR](#)
- [Data](#)
- [Cancer Reporting](#)
- [Abstracting Resources](#)
- [Links](#)
- [Contact Info](#)

IMPORTANT LINKS TO CANCER RESOURCES

- [American Cancer Society](#)
- [American College of Surgeons](#)
- [Behaviour Risk Factor Surveillance System \(BRFSS\)](#)
- [Cancer Control Planet - Links to resources for comprehensive cancer control](#)
- [Center for Disease Control and Prevention \(CDC\)](#)

CENTERS FOR DISEASE CONTROL

WebPlus Tutorial



**Please note that this section was created by the CDC and meant to serve as a separate tutorial; therefore accuracy of information cannot be guaranteed by the MCR. Screen set-up and placement of some fields have changed since the initial phase of this project and time of creation. However, information contained in this section can be used as a more detailed reference guide for correctly entering information into required fields.*

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Chapter 1

Introduction





CHAPTER 1

Overall Learning Objectives

These are the overall learning objectives for this WebPlus training course for abstractors:

1. Learn the major functions of WebPlus
2. Create an abstract using a medical record
3. Correct errors so that the complete abstract is error free
4. Release abstracts
5. Create abstracts in compliance with cancer registry standards
6. Recognize the major reports of WebPlus

Overview of the WebPlus Training Manual

The WebPlus Abstractor Training Manual provides you with the information to understand and use this web application. In this manual you not only learn about the tools in WebPlus, you also create an abstract and follow the process of abstracting a medical case until it is complete and released to the central registry. Also, each chapter contains questions that test your knowledge of WebPlus and activities that allow you to practice your new skills on your own.

Although WebPlus can use any of a number of edit sets, this manual uses the edit set “Central: VS10 NPCR Required.” The edit sets you use at your facility may differ.

WebPlus Features

WebPlus is a web-based application used to collect cancer data securely over the public Internet. It is most suited for physicians’ offices and other low-volume reporting sources that do not have facility-based cancer registries.

Records are saved in a database at the hosting central registry and cases entered by one facility or office are not visible to other facilities. Data entered are validated by the CDC EDITS Engine running on a web server. User display types and edit configurations are managed at the hosting central registry.

WebPlus is hosted on a secure web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology.

CHAPTER 1

Users

The results from the design staff and usability testing have identified these types of WebPlus users:

Users	Description
Facility Abstractor	Works in a local facility and handles patients' medical records and paperwork. When a patient is diagnosed with cancer, the facility administrator reports the case to the state's central cancer registry.
Central Registry Abstractor	Reviews abstract submitted by hospitals and doctors' offices for completeness and accuracy; compares text in the abstract against codes submitted to make sure they are the correct codes; corrects any errors or discrepancies found.
Central Registry Administrator	Sets up the local facilities with access to the WebPlus software to report their data; creates a configuration for the facilities and defines their required fields and validation rules.

Requirements for Web Access

WebPlus requires Microsoft Internet Explorer version 5.0 or later to operate the system fully. Although WebPlus works at 800 X 600 resolution, it can be best viewed at 1024 X 768 or higher resolution.



CHAPTER 1

Notes

Chapter 2

The Basics



CHAPTER 2

Learning Objectives

In this lesson, you will learn to:

- Identify the menu options of WebPlus
- Understand the process of working on an abstract
- Log in and out of WebPlus
- Change your password

Overview

This lesson covers the basics of WebPlus. You'll learn about logging in and out of WebPlus and the key elements of WebPlus.

Log In

To log in, complete these steps:

1. Open your Internet browser and type the web address for the WebPlus in the Address field.
2. Press Enter.

Result: Either the network password window or the WebPlus window opens.

- If the Enter Network Password window opens, go to step 3.
- If the WebPlus window opens, go to step 5.



3. Click within the User ID field to place your cursor there.

CHAPTER 2

4. Type **demo** into each field and click **OK**.

Result: The WebPlus log in page opens.

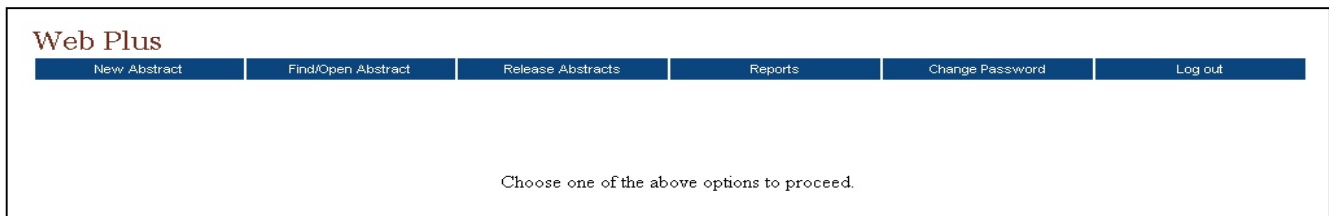
A login form titled "Please log in" in blue text. It contains two input fields: "User ID" and "Password". Below the fields is a "Log in" button.

5. Type **johndoe** in the User ID field and **abstractor** in the Password field.
6. Click **Log in**.

Result: The WebPlus home page opens.

Home Page

After you log in, the Home page is displayed.

The WebPlus home page. At the top left is the "Web Plus" logo. Below it is a horizontal menu bar with six options: "New Abstract", "Find/Open Abstract", "Release Abstracts", "Reports", "Change Password", and "Log out". Below the menu bar is a large white area with the text "Choose one of the above options to proceed."

From this page you can access the main parts of WebPlus. Click on an option to open the page for the option. This table describes the menu options on the home page:

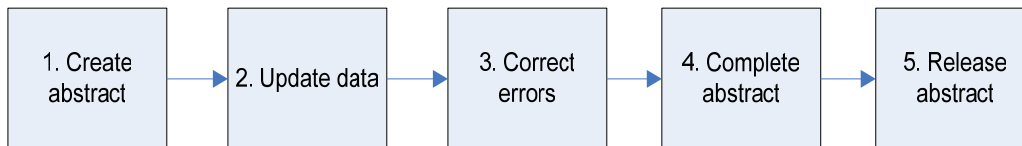
Menu option	Description
New Abstract	Opens the page that contains the fields and other information to create an abstract
Find/Open Abstract	Opens the page to search for existing abstracts
Release Abstracts	Opens the page that lists all abstracts that are ready for release
Reports	Opens the page that lists the reports available to abstractors
Change Password	Opens the change password page
Log off	Logs off WebPlus and opens the Log in page

To create a New Abstract, go to "Entering Information into Fields," on page 80.

CHAPTER 2

Process

The process of creating an abstract, entering data and ultimately releasing it to the central registry can all be done in WebPlus. After you create the abstract, you can save your entries at any time and then return to your work until you have completed the abstract. You can release the abstract only after you have eliminated all errors.



1. Create the abstract with the patient's name and social security number and save. You can add more information to the abstract whenever you want and save it until it is completed.
2. Enter other relevant medical information in the fields) provided using the codes provided by WebPlus. Save the abstract to retain your information and to allow the system to edit the abstract (and show errors).
3. Correct errors. Each time you open or save the abstract, WebPlus automatically checks the entered information and edits the fields for accuracy and thoroughness using any of a variety of edit sets provided by your administrator.
4. After you have entered all your data and corrected all errors, the system saves your new abstract as completed.
5. Release the completed abstract to the central registry. You can release abstracts one at a time or several at a time.

Data Entry Page

You enter your case information on the Data Entry page. To open the Data Entry page and view its content, follow these steps:

1. Log in to WebPlus.
2. On the WebPlus menu, click **New Abstract**.

Result: The Data Entry page opens.

CHAPTER 2

Enter new abstract

PATIENT - CONFIDENTIAL

LastName
 FirstName
 MiddleName
 MaidenName
 NamePrefix
 NameSuffix
 SpouseName
 SocSec
 DxNumAndSt
 DxSupp
 Phone

DEMOGRAPHIC

DxCity
 DxState
 DxCounty
 DxPostalZip
 Race1
 Race2

Data Entry Fields

Information Tabs

Legend

- Print Preview
- Context-sensitive help
- Special Lookups
- Calculate Field Value

Notice that the page has two boxes. The box on the left contains the fields where you enter your case information. The box on the right contains two tabs: Help and Edit Errors.

3. In the entry box on the left, scroll down the list to see all of the fields.

The fields you see depend on your facility or center and the set up done by your administrator. The headings, such as Patient and Demographic, can vary. These are only headings; they do not signify a group of required fields. Your administrator uses them to organize the fields for clearer viewing and to help with data entry.

Note: Refer to "Creating an Abstract," (Chapter 3 - beginning on page 80) to learn how to enter data in these fields.

4. In the right box, click each of the tabs to see the content.

These are the WebPlus tabs:

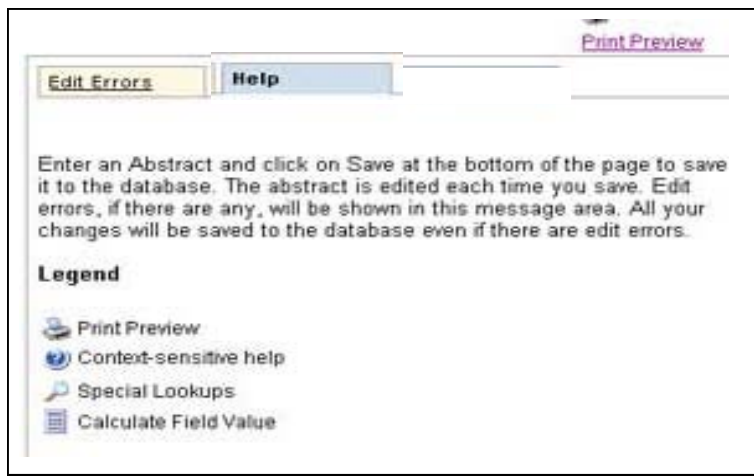
Tab	Description
Help	This area describes the saving and editing of an abstract and provides a legend of the field icons.
Edit Errors	This area lists the errors after you have opened or saved an abstract. This editing feature helps you complete the abstract until it meets the standards acceptable to the central registry.

Note: You will learn more about the edit errors tab on page 98.






CHAPTER 2

- Click the Help tab, if the section is not already open. This area provides a legend for the icons and briefly describes the process of saving your abstract.

Result: The Help box opens.



These are the WebPlus icons:

Icon	Description	Click the icon to . . .
	Print Preview	open page that shows all of the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.
	Context-sensitive Help	open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.
	Special Lookups	open a listing of codes and terms to choose from. Find the term that best applies, and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.
	Drop-down boxes	open a listing of codes or specific data items to choose from. Find the item that best applies, and click on the code to populate the field. When a specific code is clicked, it is automatically filled into the abstract for the data item.
	Calculate Field Value	calculate a field value.

CHAPTER 2

Changing Your Password

To change your password, complete these steps:

1. On the Home page menu, click **Change Password**.

Result: The Change Password page opens.

A screenshot of a web form titled "Change Password" in a dark red serif font. Below the title are two text input fields. The first field is labeled "New password" and the second is labeled "Retype Password" in a dark gray sans-serif font. Below the second field is a gray button with the word "Change" in white text.

2. Type your new password in both of the password fields.
3. Click **Change**.

Log Out

To log off, click **Log out** on the Home page menu.

Result: The Log In page opens.

Questions

Answer the following questions about the basics of WebPlus:

1. Which icon do you click to open a separate window to insert a code into a field?
2. How do you log out?
3. Do you have to complete filling out the abstract at one time? What can you do to begin an abstract and then return to it later?



CHAPTER 3

Notes

Chapter 3

Creating an Abstract



CHAPTER 3

Learning Objectives

In this lesson, you learn to:

- Enter information into the entry fields
- Understand the process for completing an abstract
- Use these entry tools: drop-down lists, help, and lookups

Overview

In this chapter you create an abstract that you use throughout this book. In succeeding chapters you will complete and release this abstract. This chapter also introduces you to some basic entry tools to help you enter information in WebPlus.

Entering Information into Fields


In this section, you create an abstract by entering essential data into the designated fields. You will also learn to use Help, drop-down lists, and special lookups.

To create an abstract, complete these steps:

1. Log in, as described in “Log In,” page 72.
2. On the home page, click **New Abstract**.

Result: The Data Entry page opens.



3. Click your cursor in the Last Name field and type **Johnson**.
4. Click the Help icon  beside the Last Name field.


Result: A separate window opens giving you information about the field.

The Help information for WebPlus is from the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary. Each field has a help icon that you can click to open a page with information about the field.

CHAPTER 3

5. Close the Help window.
6. Type this information into these fields:

Field	Value
First Name	Samuel
Social Security	666600000
DxCity	Decatur

7. Go to the DxState field and click the arrow  for the drop-down list.


Result: A list of states opens.




8. Select **GA Georgia** from the list.

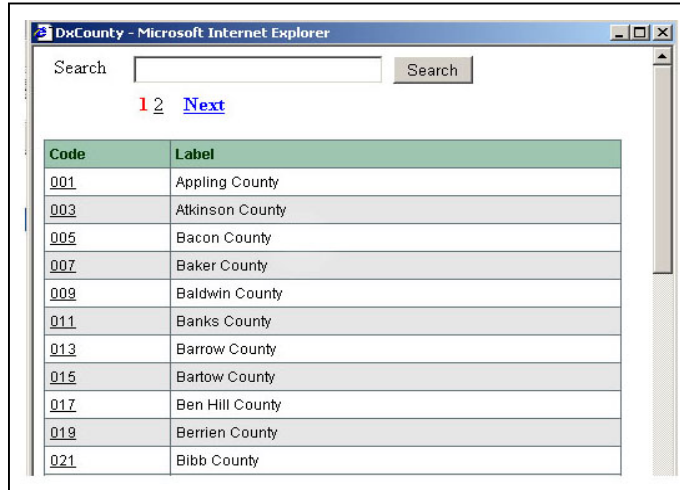
Result: The state code is entered in the field.

Note: If you know the two-letter code for the state, you can type it in the field.

9. Now that you have designated the state of the patient's residence, you can select the county. At the DxCounty field, click the Special Lookup icon .

CHAPTER 3

Result: A separate window opens. Special Lookup pages provide the coding information for the WebPlus fields. Clicking the Special Lookup icon  opens a separate window with a listing of the codes for your selected field.



10. In the Search field, type **Dekalb** and click **Search**.

Result: The system finds DeKalb county and its code.

Note: You can also find the code by scrolling down the page and by clicking the number at the top of the page to see other codes in the list.

11. Click the code number for DeKalb county.

Result: The system enters the code in the DxCounty field.

12. Click in the DxPostalZip field.

Result: A text box opens with a description of the format and codes needed for the zip code field.

DxCity	<input type="text" value="DECATUR"/>		Addr at DX--Postal Code US: Enter 5 or 9 digits. Blanks follow the 5-digit code. Canada: Enter 6 alphanumeric characters. Blanks follow code. Other countries: Enter postal code if known. Blanks follow code. 888888888 Not US, not Canada, postal code unknown. 999999999 US/Canada, postal code unknown; OR residence unknown.
DxState	<input type="text" value="GA"/>		
DxCounty	 <input type="text" value="089"/>		
DxPostalZip	<input type="text"/>		
Race1	<input type="text"/>		
Race2	<input type="text"/>		

CHAPTER 3

13. In the DxPostalZip field, type '30030.'

14. To save your entries, click **Save**.

Result: The WebPlus system saves your new abstract. You can open it later and continue to work on it until completion.

In the next chapter, "Adding Data to an Abstract," you continue to add data to this abstract.

Questions

Answer the following questions about entering data:

1. Which icon do you click to learn more about a field?
2. What is the purpose of a Special Lookup page?

Activity - Creating an Abstract

Create a new abstract of your own. Provide this information and then save your new abstract:

- Patient name
- Social Security number
- City
- State
- County
- Zip Code

Remember this abstract name because you will use this information in another activity, "Activity - Adding Information and Deleting," page 94.



CHAPTER 4

Notes

Chapter 4

Adding Data to an Abstract



CHAPTER 4

Learning Objectives

In this lesson, you will learn to:

- Find a specific abstract
- Use text fields for entering information
- Identify and use tools necessary for entering an abstract
- Preview an abstract for printing

Overview

In this chapter you continue to enter data in the abstract you have already started. This chapter does not address correcting edits; this will be done in Chapter 5 “Correcting Errors,” beginning on page 78.

First you will find your abstract and then add data to the abstract.

Opening and Updating an Abstract

In this section, you learn to find an abstract, select reasons, use a calculator field, and use pop-up window information.

To update an abstract, follow these steps:

1. Log in, as described in “Log In,” page 52.
2. On the WebPlus menu, click **Find/Open Abstract**.

Result: The Find Abstract page opens.

Find Abstract

Enter patient's name or social security to search for. Search on partial name and social security is supported.

Name Social Security

Find

Note: To find a specific abstract you can type in a name or a social security number such as 784500000, or even a partial name or number.

3. Click **Find**.

CHAPTER 4

Result: A list of all abstracts opens.

AbsRefID	Last Name	First Name	DxDate	Social Security	Birth Date	Abstractor	Edit Errors	Status	Actions
1	SHEPARD	MARGARET	12/14/1994	750401515	09/09/1918	SRB	0	Released	Open
3	BAGIN	HENRY	01/14/1995	750008679	10/27/1929	SRB	0	Released	Open
5	CANNON	JOHN	02/15/1995	761180000	07/14/1916	SRB	0	Released	Open
7	SHEPHERD	SARAH	03/25/1995	761005483	11/06/1925	SRB	0	Released	Open
8	CAQUELIN	JEAN	04/11/1995	750489101	11/11/1959	SRB	0	Released	Open
10	MORGAN	BENEDICT	03/23/1995	763007349	01/30/1932	SRB	0	Released	Open

The list of abstracts has ten columns. This table describes these columns:

Column Head	Description
AbsRefId	A system-generated number identifying the abstract
Last Name	Last name of patient
First Name	First name of patient
DxDate	Diagnosis date
Social Security	Patient's social security number
Birth Date	Patient's date of birth
Abstractor	Code for the person who created the abstract
Edit Errors	The number of errors found in the edit process after an abstract has been saved
Status	WebPlus has three types of statuses: <ul style="list-style-type: none"> • incomplete (not all data have been entered) • complete (all errors have been addressed) • released (sent to the central registry)
Actions	You have the option to open or delete an abstract.

4. Click **Open** in the Action column of the incomplete abstract you started for Samuel Johnson.

Result: The Reason for Opening page opens.

Select the reason for opening this case (HIPPA requirement):

Enter the reason if its is not in the list above:

☒ Add my reason to the list

CHAPTER 4

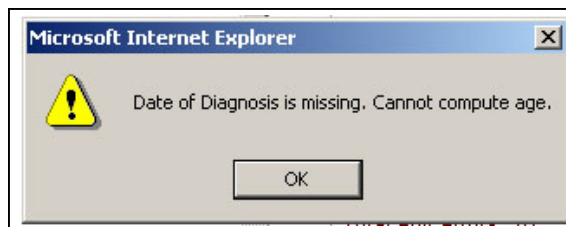
Note: Any time that you open an abstract, you must give a reason for your action. It is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Your WebPlus administrator has ready-made reasons for you to select. However, you can create your own in the Enter the reason ... Field.

5. Select a reason from the drop-down list and click **Open**.

Result: The Data Entry page opens and displays the previously entered data for the abstract. The heading above the entry fields now is "Update Abstract" because the abstract already contains some information.

6. At the AgeDx field, click the calculator icon  .

Result: An error message is displayed.



In order to use the calculator to calculate patient age at diagnosis, you must first enter the date of diagnosis and the patient's birth date.

7. Type **06211945** in the BirthDate field and **03252004** in the DxDate field.

8. At the AgeDx field, click  again.

Result: The age of the patient is automatically computed and the age entered into the field.

9. Click in the DthCause (Cause of Death) field.

Result: A pop-up box appears. The pop-up window is another method of providing a field code to you.

Update abstract	
DthCause	<input type="text"/>
ICDRevNum	<input type="text"/>
PhysFup	<input type="text"/>
Cause Of Death 0000 Patient alive at last contact 7777 Death certificate not available 7797 Death certificate available but underlying cause of death not coded	

10. Type **0000** (alive) in the DthCause (Cause of Death) field.
11. Click **Save** to retain your changes to the abstract.

CHAPTER 4

Activity - Adding Data, Part One

Continue entering information into your abstract. Enter the following information in the appropriate fields (use the fields' drop-down lists to get the proper codes):

Field	Content
DxNumAndSt	101 Clairemont Ave.
Phone	404-555-1212
Race 1	Black
Sex	Male
Marital	Married

After you have finished entering the information, save your work.

Adding Data, Part Two

More data can be added that pertains to the medical history of the patient.

1. Add this information to the entry fields as shown:

Field	Content	Values
PSite	Prostate NOS	C619
Lateral	Not a paired site	0
HistTypeICD02	Carinoma, acinar	8550
BehaviorICD02	Malignant	3
Grade	Grade 3, poorly differentiated	3

2. Click **Save**.

CHAPTER 4

**Please note that the screen set-up and placement of text fields has changed since the initial phase of this project when this tutorial was created. However, information contained in this section can be used as a more detailed reference guide for correctly entering information into required text fields.*

Text Fields

One of the WebPlus tabs that you need to use to complete your abstract is the Text Fields tab. This is an area where you use text to describe diagnostic and treatment information such as X-rays or surgery. You use the fields to document supplemental information not contained within the coded values. You can also provide information that you are uncertain how to code so that a central abstractor/reviewer can be able to code it properly in the data fields when the abstract is released to the central registry. The text is limited only by the maximum number of characters indicated for each field. The information in text fields are not subject to WebPlus edits. However, some text fields can be designated as critical and required to have information in the fields. In this case, the system does not read the information; it only requires the field to have text.

These are the text fields available, which are divided into three sections:

Diagnosis	Treatment	Miscellaneous
• PE (physical exam)	• Surgery	• Remarks
• X-ray/scan	• Radiation (beam)	• Place of Diagnosis
• Scopes (endoscopic procedures such as cystoscopy)	• Radiation (other)	
• Lab tests	• Chemotherapy	
• Operation	• Hormone	
• Pathology	• BRM (Biological Response Modifier; also known as immunotherapy)	
• Primary site title	• Other	
• Histology title		
• Staging		

CHAPTER 4

In the Text Fields area, follow these steps to enter information:

1. On the Data Entry page, click the **Text Fields** tab.
Result: The Text Fields open. The first set of text fields is for diagnosis.
2. Click in the DX Proc - PE field and type the following information:
Susp Firm RT Lobe Prostate
3. Click the **Treatment** link.
The treatment fields open.
4. Click in the Radiation (beam) field and type this information:
2/19-4/12/95 38F 52D 7040 CGY total tumor dose. 5040 CGY to Pelvis with 2000 CGY boost prostate (St Joe's)
5. Click the **Miscellaneous** link.
The Miscellaneous text fields open.
6. Click in the Place of Diagnosis field and type **St. Joseph's**.
7. Save your work.

Activity - Using Text Fields

Practice entering information into text fields by typing more information for your abstract.

1. In the Diagnosis text fields, type this information:

Field	Content
DX Proc - Lab tests	Slightly elevated PSA
DX Proc - OP	2/15/1995 Ultrasound guided BX RT lobe prostate
DX Proc - Path	2/15/95 S95-354: Prostate BX R lobe:Adenoca, presumably infil, acinar type, GR2
Primary Site title	Prostate
Histology title	Adenoca acinar cell type

CHAPTER 4

2. Click **Save** and check that the data you entered in the fields have been saved.

If there are any critical text fields, indicated by an asterisk (*), that do not have an entry, type **NA** in the fields. Once the field has an entry, the next edit of the abstract will eliminate the error for an empty critical field.

Work on correcting abstract errors begins in Chapter 5, "Correcting Errors," beginning on page 78.

Print Preview

The Print Preview feature allows you to view all of the fields and the content you have entered in your abstract. You can also print a copy of the abstract from the Print Preview window.

1. Open an abstract.

2. Click the **Print Preview** link .

Result: A separate window opens that displays all of your abstract entry fields and content.

3. To print a copy of the abstract, use your browser's printer.

Deleting an Abstract

To delete an incomplete abstract, use the Find Abstract page. To delete an abstract:

1. Log in, if you are not already, as described in "Log In," page 52.
2. On the WebPlus menu, click **New Abstract**.

Result: The Data Entry page opens.

3. Create a new abstract by typing **Derrick Chung** in the name fields and **891234567** as a Social Security Number.
4. Click **Save**.

Result: The system saves the abstract to the database.

5. On the WebPlus menu, click **Find/Open Abstract**.

Result: The Find Abstract page opens.

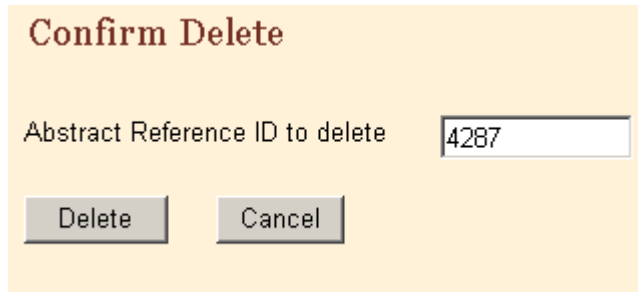
6. Type 891234567 in the Social Security number field.

Result: The results display the Chung abstract entry.

CHAPTER 4

7. Click **Delete** in the Action column. Be sure to note the Abstract Reference ID (AbsRefID) number.

Result: The Confirm Delete window opens. It displays the ID number of the abstract you want to delete.

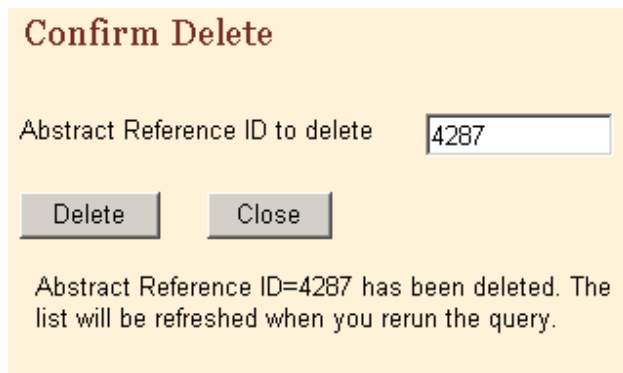


Confirm Delete

Abstract Reference ID to delete

8. Click **Delete**.

Result: On the Confirm Delete window a message confirms the deletion.



Confirm Delete

Abstract Reference ID to delete

Abstract Reference ID=4287 has been deleted. The list will be refreshed when you rerun the query.

9. Click **Close**.
10. On the Find Abstract window, click **Find** and confirm in the results window that the system has deleted the abstract.

Questions

Answer these questions about adding data to an abstract:

1. What is the purpose of the text fields?
2. How can you print your abstract and what does the printed copy contain?
3. Which menu option do you click to open the page where you can delete your abstract?

CHAPTER 4

Activity - Adding Information and Deleting

In this activity you continue with the abstract you created on page 63, view a print preview, and delete the abstract.

1. Find your own abstract you created and add this information into the text fields:

Field	Content
Diagnosis: Dx Proc - PE	N.A.
Diagnosis: Dx Proc - X-ray/scan	9/11/97 CT Neck Showed no def abnormalities noted.
Treatment: Rx Text - Chemo	9/27/97 Chemo
Misc: Text - remarks	Lesion Tongue. BX Proven CA 9/9. ADM for def TRX. According to obit

If there are any critical text fields, indicated by an asterisk (*), that do not have an entry, type **NA** in the fields. Once the field has an entry, the next edit of the abstract will eliminate the error for an empty critical field.

2. Calculate the diagnosis age by first adding the patient's birth date and his diagnosis date.
3. View a print preview of your abstract.
4. Delete the abstract.

CHAPTER 4

Notes

Correcting Errors



CHAPTER 5

Learning Objectives

In this lesson, you will learn to:

1. Correct errors to complete an abstract
2. Understand how edit sets affect the completion of an abstract
3. Understand the Edit Errors messages

Overview

In this chapter you continue working on your abstract. You will use the Edit Errors feature of WebPlus to find errors or blank required fields and work toward the completion of your abstract. You can only release completed abstracts, which have no errors.

Understanding Edit Sets

Each abstract is edited whenever you save or open it. The edits applied to the information depend on the edit set selected by your administrator for your facility. These edit sets may differ from ones at the local and the state level. The edit set used for this training guide is "Central: VS10 NPCR Required."

As an abstractor you must correct all identified errors to complete your abstract before you release it to the central registry.


Edit Errors Tab

The edit errors pane lists edits in the abstract. The edit set runs each time the abstract is saved.

To correct your abstract errors, complete these steps:

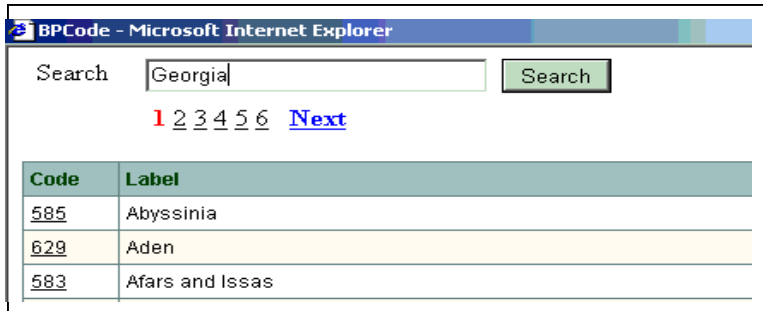
1. Log in, as described in "Log In," page 52.
2. Find and open the Johnson abstract.
3. On the Data Entry page, click the **Edit Errors** tab in the information pane, if it is not already open.
4. Click the **BPCode** link.

Result: The cursor moves to the BPCode field.

5. At the BPCode field, click  .

Result: A separate window opens for the birthplace codes.

CHAPTER 5



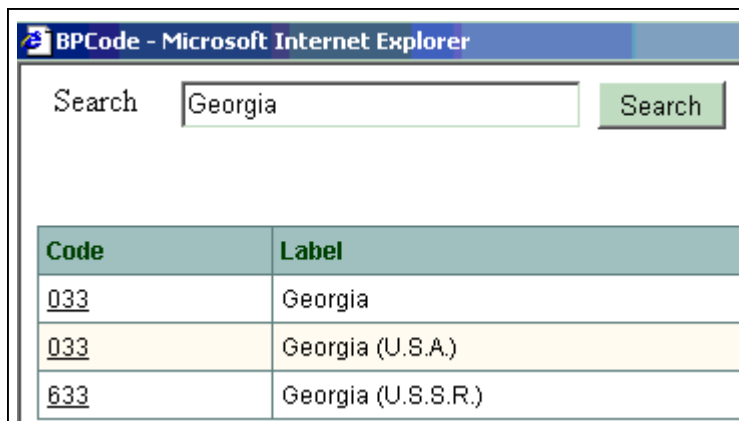
Search

[1](#) [2](#) [3](#) [4](#) [5](#) [6](#) [Next](#)

Code	Label
585	Abyssinia
629	Aden
583	Afars and Issas

6. In the Search field, type **Georgia** and click **Search**.

Result: The Birthplace Code page displays the code for Georgia.



Search

Code	Label
033	Georgia
033	Georgia (U.S.A.)
633	Georgia (U.S.S.R.)

7. Click the **Georgia (USA)** code number.

Result: The system enters the code in the BPCode field.

8. Click **Save**.

Result: The system again runs an edit check. View the Edit Errors area now: the system has deleted the error for the BP code.

The procedure for correcting errors is the same for each error. Find an error identified by the system and correct or add the field information for the field.

CHAPTER 5

9. In the Edit Errors box, scroll until you see the error for the Date of Diagnosis:

11. If year of Date of Diagnosis > 2000, then Behavior Code ICD-O-3 cannot be blank
 - i. [DxDate = 03252004](#)
 - ii. [BehaviorICDO3 =](#)
12. If year of Date of Diagnosis > 2000, then Histologic Type ICD-O-3 cannot be blank
 - i. [DxDate = 03252004](#)
 - ii. [HistTypeICDO3 =](#)

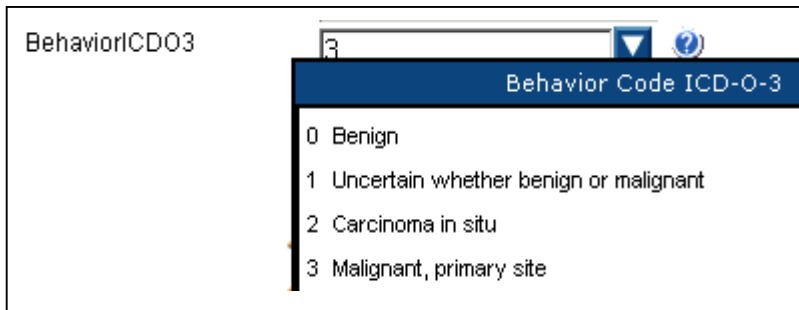
The message shows that the field for Behavior ICDO3 must be filled in because the date of diagnosis is *after* (> greater than) the year 2000.

10. In the Edit Errors list, click the BehaviorICDO3 link.

Note: You do not have to click the link for the diagnosis date because it is correct. This field link is shown to indicate the correlation between it and the Behavior field.

Result: The cursor is moved to the BehaviorICDO3 field in the data entry section of the page.

11. At the BehaviorICDO3 field, click the drop-down arrow and select **3 Malignant** from the list.



The screenshot shows a form field labeled "BehaviorICDO3". The field contains the value "3". A dropdown menu is open, displaying the following options: "0 Benign", "1 Uncertain whether benign or malignant", "2 Carcinoma in situ", and "3 Malignant, primary site". The title of the dropdown menu is "Behavior Code ICD-O-3".

Result: The system places the value in the BehaviorICDO3 field.

12. Click in the HistTypeICDO3 field above the Behavior ICDO3 field and click .

Result: The Histology Type ICD03 lookup window opens.

13. Type 8850 in the Search field and click **Search**.

8550	Carcinoma, acinar
------	-------------------

CHAPTER 5

14. Click the **8850** code for Carcinoma, acinar.

Result: The code fills the HistTypeICD03 field.

15. Click **Save** and check the errors box to ensure that the errors have been eliminated.

Activity - Correcting Errors

Continue correcting the errors, saving the abstract, and re-running Edits until no errors remain. Use the information in this table to complete the abstract.

1. Click on the field in the Edit Error area and enter the values listed in this table:

Field/error	Description	Values
DthCause	Cause of death	0000 - patient alive
Date1st Cont	Date of first contact	06032003
DateLastContact	Date of last contact	07152004
ICDRevNum	ICD revision number	0 - patient alive
RxCodSysCur	Treatment Coding System - Current	06 - FORDS Manual codes
RxSumScopeRegLN	Scope of Regional Lymph Node Surgery	9 - Unknown or not applicable
RxSumSurgOthReg	Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Nodes (SEER/COC)	9 - Unknown
RxSumSurgPSite	Surgery of Primary Site	00 - None
Spanish/Hispanic	—	0 - non-Spanish
Race 2 - 5	—	88 - No further race documented
DateLastContact	Date of last contact	08252005
Site and Morphology conflict: OvrSiteType	Override Site/Type	1

CHAPTER 5

2. Save your work until the Edit Result shows no errors:

Edit Errors | Text Fields | Help

-----EDIT RESULT-----

Editset Name: Central: Vs10 NPCR Required

This abstract passed all edits and can be released to your central cancer registry.

Do you want to release it?

3. Do not release the abstract now. Click **No** and go to the next section, "Releasing the Abstract."

Note: You can release your abstract here by clicking **Yes**, but you can also release one or more abstracts on the Release Abstract page. For further details, see the next section, "Releasing the Abstract."

Releasing the Abstract

Once your abstract has no errors, it is completed, and you can release it to the central registry.

Follow these steps to release an abstract:

1. On the WebPlus menu, click **Release Abstract**.

Result: The system displays a list of completed abstracts.

Release Abstracts					
Please select the abstracts you want to release to your central registry. Only completed abstracts are available for release.					
AbsRefID	Last Name	First Name	Abstractor	Date Case Completed	Release
35	WHITE	MARTH	SRB	10/20/2005	<input type="checkbox"/>

2. Click the Release box of the abstracts you want to release.

Note: To select all of the abstracts listed, click the **Select All** button.

3. Click **Release Selected Abstracts**.

Result: The system releases the selected abstracts to your designated central registry and changes the status of the abstracts to Released. Use the Find/Open page to view the released abstracts. You can view them but cannot amend them.

CHAPTER 5

Questions

Answer these questions about correcting abstracts:

1. How can you release more than one abstract at a time?
2. What are two ways to release a single abstract?
3. Where do you find the errors list?



CHAPTER 5

Notes

Chapter 6

Running Reports



CHAPTER 6

Learning Objectives

In this chapter, you will learn to:

1. Open a report
2. Describe the reports available in WebPlus
3. Set a date range for a report

Overview

WebPlus provides reports for auditing activity and for analyzing cancer reporting. You can view and print several types of reports. You can also set the date ranges for the information in the report.

Opening Reports

To open a report after you have logged in, complete these steps:

1. On the WebPlus menu, click **Reports**.

Result: WebPlus displays a list of reports available for you.

Local Reports

[Cases Submitted Sorted by Abstractor](#)
[Cases Accessed Sorted by Patient Name](#)
[Descriptive Statistics on Released Cases](#)
[Activity Report](#)
Audit Reports
[System Log-ins](#)
[Abstract Updates](#)
[Abstract Searches](#)
[Abstract Deletions](#)
[Abstract Releases](#)

2. Click the **Cases Submitted Sorted by Abstractor** link.

Result: A separate window opens with a list of transmitted or released cases sorted by name of the abstractor.

CHAPTER 6

Web Plus for State Cancer Registry Cases Submitted Sorted by Abstractor

Choose a date range: From: 09/30/2005 To: 10/31/2005

Abstractor: DOE

Patient Name	Soc Sec	Birth Date	Date Entered	Date Completed	Date Transmitted
BOMPASSE, EDWARD	784500000	07/29/1955	1/1/2005	08/03/2005 (214 d)	08/03/2005 (214 d)
ENDICOTT, ANNA	760006229	01/16/1918	1/1/2005	05/17/2005 (136 d)	08/18/2005 (229 d)
KEAYNE, BENJAMIN	790037349	01/30/1902	1/1/2005	03/31/2005 (89 d)	03/31/2005 (89 d)
WILLIAMS, ANNE	790000740	06/12/1934	1/1/2005	03/31/2005 (89 d)	03/31/2005 (89 d)

Abstractor: SRB

Patient Name	Soc Sec	Birth Date	Date Entered	Date Completed	Date Transmitted
BAGIN, HENRY	750008679	10/27/1929	1/1/2005	03/31/2005 (89 d)	03/31/2005 (89 d)
BEALE, WILLIAM	770228679	10/27/1929	1/1/2005	03/31/2005 (89 d)	03/31/2005 (89 d)
CANNON, JOHN	761180000	07/14/1916	1/1/2005	03/31/2005 (89 d)	03/31/2005 (89 d)

Reports

This table describes reports that may be part of your WebPlus display. Click the name of the report to open a separate window displaying the report.

This report . . .	Lists . . .
Cases Submitted Sorted by Abstractor	all cases that a facility has transmitted/released for a given time period. The cases are sorted first by the name of the abstractor and then by patient name
Cases Accessed Sorted by Patient Name	all cases that a facility has transmitted/released for a given time period by patient name.
Descriptive Statistics on Released Cases	descriptive statistics on released cases such as demographics and site group
Audit Reports	
Activity Report	the number of cases released or unreleased for each month of the selected date range
System Logins	the users and their times for logging in and out of WebPlus within a selected date range
Abstract Updates	the dates and times that abstracts have been updated
Abstract Searches	the abstractor and the time for all searches
Abstract Deletions	the dates and times that abstracts have been deleted
Abstract Releases	information about abstract releases including release time and date, abstractor, and facility



CHAPTER 6

Changing the Date Range of a Report

To change the date range of a report, complete these steps:

1. On the WebPlus menu, click **Reports**.
2. Click **Cases Accessed Sorted by Patient Name**.

Result: The Case Accessed sorted by Patient Name window opens.

Choose a date range:	From: 10/01/2005 	To: 11/01/2005 	<input type="button" value="Select"/>
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3. Click the calendar icon beside the From date field.

Result: The calendar window opens.

Tip: You can also type the date in the window by using the mm/dd/yyyy format, such as 10/01/2005 for October 1, 2005.

4. Double-click the date you want. The system inserts the date in the field.
5. Click **Select**.

Result: WebPlus displays the report again with the information in the date range you selected.

Modifying the Report for Descriptive Statistics on Released Cases

To modify the report for Descriptive Statistics on Released Cases date range of a report, complete these steps:



1. On the WebPlus menu, click **Reports**.
2. Click **Descriptive Statistics on Released Cases**.


Result: The Descriptive Statistics on Released Cases window opens.

CHAPTER 6

Web Plus for State Cancer Registry
Descriptive Statistics on Released Cases

[Printable Form](#)

Select a Date Range: From:  To:  ☒ Select all released

Select Level of Site Group Detail: 

Include Site Groups with no cases? ☐ Yes ☒ No Group by managing physician? ☐ Yes ☒ No

County of Residence	
County	Count of cases (%)
Out of State	26(100%)
Total	26(100%)

3. In the Select all released box, clear the check mark.
4. In the From date field, click the date one month before today's date.
5. In the To date field, click today's date.
6. In the Select Level of Site Group Detail field, select **Aggregate** from the drop-down list.

The site Group Detail includes these options:

Report	Description
Aggregate	18 categories
Subaggregate	60 categories
Recode	78 groups

7. Click **Run**.

Result: The system runs with the new criteria and displays a new report.

8. Click **Printable Form**.

Result: A separate window opens with the data of the report. Print the report using your browser's printer.



CHAPTER 6

Activity - Finding Report Information

Look at the list of reports and find this information:

- The case you abstracted earlier
- The number of updates done to abstracts in the last month
- The last user to update the John Wilson abstract

CHAPTER 6

Notes

Chapter 7

Final Learner Activity



CHAPTER 7

Overview

For your final activity you will use a medical record and create an abstract. Enter the information into the appropriate fields, save it, correct errors, and release the abstract.

Medical Record

Seaford Nantucket Memorial Hospital Discharge Summary

Reporting Physician: Anne Bobula

Patient Information

Medical Record Number: 67234

Last Name: Orvis
First Name: John
Middle Name: Wayne
Address: 2276 Waverly St., Philadelphia, PA 19101
County: Philadelphia
Race: Black
Sex: Male
Date of Birth: February 28, 1925
Social Security Number: 456456456

Admission: June 12, 2004
Discharge: June 18, 2004

Notes:

Mr. Orvis was admitted for follow-up of prostate biopsy positive for cancer performed May 30 in Doctor's Clinic. Radical prostatectomy was performed on 6/13/04. Findings included a 1.5cm adenocarcinoma in prostate, grade 1. All nodes negative. Patient was discharged in good condition. No further treatment is contemplated.

Hints

These are a few hints to help you complete your abstract:

- Fill in what you know at first and then save your work. WebPlus will run the edit check and show the entry fields' blanks or errors.
- Look at the Help page for a field if you need to interpret the field name.
- Use the Search feature on the Lookup page to find the proper code.

CHAPTER 7

Notes

