

Quick Guide to Abstracting/Cheat Sheet.

A registrar must be able to provide a summary of pertinent information including demographic, cancer information, stage and treatment plans utilizing all reference material through the abstraction of core data sets into a specific database. In order to accomplish this while maintaining all standards and requirements set by the state, AJCC, FORDS, COC, SEER coding system, etc. we have compiled a guide list of useful websites and helpful information.

When a registrar is new to the processes it is important to familiarize ones self with the rules of each coding manual. At the beginning of each book (specifically ICD-0-3 and AJCC) there is a section that the registrar should read through that is not site specific but is in fact rules for the accurate and uniform collection of data across all sites.

LIST OF MANUALS – Necessary for collecting and coding the data.

FORDS manual
TCR Handbook
SEER Manuals
Abstractors Guide
AJCC staging manual
Coding Guide for Hematopoietic Dz
ICD-03 Coding Manual
Multiple Primary and Histology Coding Rules

USEFUL WEBSITES

<http://txtra.org/>

Texas Cancer Registry Reporting Handbook Link. This link will help you to follow the guidelines set by the state of Texas.

<http://www.dshs.state.tx.us/tcr/2011-Cancer-Reporting-Handbook.doc>

It is useful to install the SeerRx Interactive Drug Database at <http://seer.cancer.gov/tools/seerrx/> to look up drugs and categorize them.

For quick and easy access to the Collaborative Staging manual w/ coding for multiple primary/histology the following website is best. <http://seer.cancer.gov/manuals/2010/appendixc.html>

Other helpful websites:

County information by ZIP

<http://zip4.usps.com/zip4/>

Social Security Death Index

<http://ssdi.rootsweb.com/>

Anatomy:

<http://www.healthline.com/human-body-maps>

contain links to information about cancer:

<http://www.sammonscancercenter.com/>

<http://www.oncolink.org/index.cfm>

links to the medical board sites to locate physician licenses:

<http://www.docboard.org/docfinder.html> (US)

<http://www.tmb.state.tx.us/> (Texas)

look up NPI numbers:

<http://www.npinumberlookup.org/>

Drug information:

<http://www.pharma-lexicon.com/>

<http://www.rxlist.com/script/main/hp.asp>

Terminology:

<http://dictionary.reference.com/>

<http://www.books.md/index.html>

<http://www.health-dictionary.com/>

State, National & International Organizations:

<http://www.naaccr.org/> NAACCR

<http://training.seer.cancer.gov/> SEER's training website

<http://seer.cancer.gov/registrars/contact.html> Ask a SEER Registrar

<http://seer.cancer.gov/seer inquiry/index.php> SEER Inquiry System

<http://seer.cancer.gov/tools/casefinding/> SEER casefinding lists

<http://www.dshs.state.tx.us/tcr/default.shtm> TCR

<http://www.dshs.state.tx.us/tcr/data.shtm> (statistics; great for quality studies)

<http://www.who.int/en/> World Health Organization (another excellent source for stats)

<http://www-dep.iarc.fr/> International Agency for Research on Cancer

<http://www.cancer.gov/> National Cancer institute

<http://cancerstaging.org/cstage/> Collaborative Stage

<http://www.facs.org/cancer/index.html> Commission on Cancer

patient care guidelines:

www.nccn.org

<http://www.asco.org/ASCOv2/Practice+%26+Guidelines/Guidelines>

<http://www.adjuvantonline.com/index.jsp> decision-making tools for healthcare professionals

CAP Cancer reporting protocols – synoptic report checklists:

http://www.cap.org/apps/cap.portal?_nfpb=true&cntvwrPtl_t_actionOverride=%2Fportlets%2FcontentViewer%2Fshow&_windowLabel=cntvwrPtl_t&cntvwrPtl_t%7BactionForm.contentReference%7D=committees%2Fcancer%2Fcancer_protocols%2Fprotocols_index.html&_state=maximized&_pageLabel=cntvwr

Ambig Terms

Consider as diagnostic of cancer

apparent(ly)
appears to
comparable with
compatible with
consistent with
favor(s)
malignant appearing
most likely
Neoplasm **(CNS Only)**
presumed
probable
suspect(ed)
suspicious (for)
tumor **(CNS Only)**
typical of

NOT considered diagnostic of cancer

approaching
cannot be ruled out
equivocal
may be
possible
potentially malignant
questionable
rule out
suggests
very close to
worrisome

Lab Value Reference
 “Normal” values

PSA: 00.0-4.0 ng/ml (avg)

Age-Specific Reference for Serum PSA (Reference Range [ng/ml])

Age Range (Years)	Black	Caucasians	Japanese
40 - 49	0.0 - 2.0	0.0 - 2.5	0.0 - 2.0
50 - 59	0.0 - 4.0	0.0 - 3.5	0.0 - 3.0
60 - 69	0.0 - 4.5	0.0 - 4.5	0.0 - 4.0
70 - 79	0.0 - 5.5	0.0 - 6.5	0.0 - 5.0

CEA: <2.5 (non-smoker) <5(smoker)

AFP: <10

CA125 0-35 U/ml

CA 19-9 <40 U/ ml

CA 27.29 0-40 U/ml

Beta HCG <5(male, non-pregnant female)

Bilirubin 0.4-1.5 mg/dl

Creatnine	M	F
	18-59y: 0.8-1.3	0.6-1.0 mg/dL
	60-89y: 0.8-1.3	0.6-1.2 mg/dL
	>89 y: 1.0-1.7	0.6-1.3 mg/dL

Tumor markers: For baseline and observation -- to assess tumor burden and monitor levels of tumor and indicate a recurrence; prognosis (what treatment to use if the tumor should recur); most tumor markers are NOT specific, meaning that positive result does not necessarily mean that the primary stie can be readily identified.

Tumor Marker	Abrev.	Also called	What is it?	Common Sites/Indication	Normal Range	Notes
Adrenocorticotrophic Hormone	ACTH		Elevated level found in paraneoplastic syndrome caused by small cell carcinoma.	Non-diagnostic of lung cancer, but an indicator of metastases.		
Alkaline Phosphatase	ALP	Alk phos, alk f		Elevated in bone and liver disease	20-90 I.U/liter, may vary somewhat according to the brand of laboratory assay materials used.	
Alpha-fetoprotien	AFP, aFP	alpha-fetoglobulin	A serum test used as a tumor marker for hepatocellular cancer.	Liver, testicular, stomach, pancreas, lung, and ovarian	Adults: < 15ng/ml	Observe the date of an AFP study carefully. Record a pre-operative study only.
bcl-2 Oncogene			Diagnostic method to differentiate B-cell and follicular types of lymphomas.	Lymphomas		
&-2 Microglobulin		Beta 2-M	Elevated levels are present in lymphoproliferative disorders; non-specific to chronic lymphocytic leukemia.	CLL, lymphoproliferative disorders		

Cancer Antigen 15-3	CA 15-3		For recurrent breast cancer, elevated levels may be found in cancers of the ovary, lung, and prostate.	Elevated in 76% of metastatic breast cancers.
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Cancer Antigen 19-9	CA 19-9	Monitors post-therapeutic gastrointestinal cancer for recurrence.	Pancreatic, stomach, colon, liver and bile duct cancer	
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Cancer Antigen-125	CA-125	Measures an antigen to epithelial neoplasms circulating in blood serum.	Ovarian cancer, levels may also be elevated by cancers of the uterus, cervix, pancreas, liver, colon, breast, lung and digestive tract.	0-35 U/mL. Normal level may vary somewhat according to institutional experience. Levels above 35 suggest the presence of ovarian tumor.
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Cancer Antigen 195	CA 195		Detects gastrointestinal cancers but cannot differentiate among primary sites.	Changing levels indicates progression or regression of tumor load.
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Cancer Antigen 27-29	CA 27-29		Found in most breast cancer patients, levels may also be elevated by cancers of the colon, stomach, kidney, lung, ovary, pancreas, uterus, and liver.	
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C219		Associated with multidrug resistance.		
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Cancer Antigen 549

CA 549

Breast

Present in 50% of patients with advanced breast cancer.

Calcitonin

Thyroid hormone

Medullary cancer of the thyroid, multiple endocrine neoplasia, myeloma and occasionally with small cell lung cancer.

Increasing levels may indicate progression of disease.

Catecholamines

Helps to distinguish tumor cell type

Most useful in adrenal tumors.

Cathepsin D

Distinguishes node-negative patients who may recur (and therefore should receive adjuvant chemotherapy) from node-negative patients who probably will not recur.

Elevation indicates a poorer prognosis.

Carcinoembryonic Antigen

CEA

A blood test measuring the presence of an antigen in malignancies arising in entodermal (embryonic) or gastrointestinal tissue.

Colon/rectal cancer, levels may also be elevated by melanoma, lymphoma, cancers of the breast, lung, pancreas, stomach, cervix, bladder, kidney, thyroid, liver, and ovary

< 2.5ng/ml. Normal range may vary somewhat depending on the brand of assay used. Levels > 10ng/ml suggest extensive disease, and levels > 20ng/ml suggest metastatic disease.

Persistent elevated levels indicate residual or recurrent metastatic carcinoma. Smokers may have an elevated CEA without

malignant disease; smoking may affect accuracy of CEA results.

C-er B-2

HER-2, neu oncoprotein

Associated with larger sized tumors, shorter relapse type and lower survival rate.

Chromogranin-A

Monitors tumor bulk in neuroblastoma, APUDoma, VOPoma, pheochromocytoms

Non-diagnostic of CNS tumor.

C-myc DNA

Breast cancer (in older women); juxtaposition of this chromosome with a heavy chain immunoglobulin occurs frequently in Burkitt's lymphoma and other B-cell lymphomas, and acute lymphoblastic leukemia

DNA Studies

Flow cytometry

Differentiates between tumors at high and low risk for recurrence. DNA studies are a prognostic tool for non-small cell lung and other solid tumors.

Ploidy Analysis

Aneuploid tumors correlate with more aggressive behavior and a greater risk of recurrence. Diploid tumors have a better prognosis than aneuploid or tetraploid tumors.

S-Phase

Cell Cycle Analysis

Percentage of tumor cells synthesizing DNA; patients with a high S-phase fraction have less favorable prognosis

Proliferation Index

High rates indicate actively growing tumors and a greater risk of relapse.

Epidermal Growth Factor Receptor

EFGR

Negative EFGR results correlate with better prognosis regardless of ER status.

Estrogen Receptor Assay

ERA, ER

A laboratory test of breast cancer tissue to determine the responsiveness of the tumor to endocrine therapy or to removal of the ovaries.

Breast Negative if 3 femtomoles (fmoles) or less.

Tumors with a negative ERA rarely respond to hormone manipulation; about 55% of ERA positive tumors will respond to endocrine therapy. ERA may not be performed if tumor is less than 1.0cm in size or if the tumor is completely in-situ.

Ferritin

Measures iron storage protein in sialic acid

Non-specific for head/neck, and neurogenic tumors, lymphoproliferative disease, may indicate Hodgkin disease or leukemia, monitors cause of disease in neuroblastoma

Low levels in head and neck malignancies suggest good prognosis.

Flow Cytometry

See DNA Studies

Gastrin		Differentiated gastrin secreting non-beta islet cell tumors of the pancreas	Pancreas	Levels above 1000 pg/ml are diagnostic of gastrinoma	Also found in some benign conditions.
Glucagon		Differentiates alpha-cell tumors		Levels above 900 are diagnostic of glucagonoma	Also present in diabetes and other conditions
5-Hydroxy-Indol Acetic Acid	5-HIAA	Quantitative analysis of urine levels	Malignant carcinoid tumors (argentaffinomas), which may also appear in stomach, appendix, or lower intestine.	< 15mg/24 hours	
Human Chorionic Gonadotropin	hCG or a-HCG (Alpha subunit HCG)		For choriocarcinoma, elevated HCG levels may also indicate the presence of cancers of the testis, ovary, liver, stomach, pancreas, and lung.		

Beta Subunit HCG

Beta-HCG, B-HCG

Beta-HCG levels are never found in normal men. When the presence of beta-HCG is detected in serum, it always indicated a malignancy.

Choriocarcinoma and testicular carcinoma

0 ng/ml Record a pre-op study only. Beta-HCG is also used as a marker postoperatively to monitor residual tumor and the effectiveness of therapy. In patients with choriocarcinoma (who have had a hysterectomy and oophorectomy) or in patients with testicular cancer (who have had an orchiectomy), the presence of beta-HCG will confirm the patient has residual cancer

that requires further treatment. However, when beta-HCG does not exist in the serum, the presence of active cancer cannot be excluded, especially in patients who have been previously treated.

Homovanillic Acid

HVA

Elevated levels suggest catecholamine-secreting tumor such as neuroblastoma or ganglioneuroma

High levels rule out pheochromocytoma.

Int-2 DNA

Amplification elevations associated with recurrence of tumor.

Lactic Dehydrogenase	LDH		A blood chemistry study, usually part of a liver panel, useful in assess liver and pulmonary disease.	Liver, pulmonary disease and for monitoring treatment of testicular cancer, non-hodgkin lymphoma, Ewing's sarcoma, and some types of leukemia.	48-115 IU/liter.	All tumors produce LDH.
Liver Function Tests	LFT	Liver panel	A series of blood chemistry tests measuring enzymes excreted by the liver during abnormal functioning due to metastases, obstruction or other conditions.	Elevated if there is liver damage		A LFT/Liver panel may contain any of the following tests: Alk Phos -- 20-90 IU/liter LDH 100-190 u/L at 37 degrees SGOT -- 8-46 u/L (M) SGOT -- 4-35 u/L (F) SGPT -- 7-46 u/L (M) SGPT - 4/35 u/L (F) Leucine aminopeptase (LAP) -- 80-200 Goldbarg-Rutenburg u/ml (M) Leucine aminopept

ase (LAP)
-- 750-185
Goldbarg-
Rutenburg
u/ml (F)
Bilirubin
(total) <
1.5 mg/dl

Neuron Specific Enolase

NSE

Elevated level indicates presence of small cell carcinoma of lung and neuroblastoma; of secondary use in testicular neoplasms, non specific to central nervous system tumors.

Pancreatic oncofetal antigen

POA

An elevated level has been found in about 75% of patients with pancreatic cancer.

Pancreatic Polypeptide

Pancreatic gamma cell tumors; elevated in APUD-omas, VIP-omas, and MEN (Multiple Endocrine Neoplasia).

Philadelphia Chromosome

PH1

Presence of abnormal chromosome in bone marrow

Confirms diagnosis of CML

Absence of Ph1 chromosome does not rule out CML

Placental Alkaline Phosphatase PLAP, PL-AP

Differentiates the source of tumor among liver, bone and germ cell origin, non-diagnostic by itself, but helps confirm malignancy in a small number of patients.

Parathyroid hormone-like Protein PLP

Elevated levels of this circulating hormone are found in squamous cell cancer and in breast cancer.

Progesterone Receptor Assay PRA, PR

A laboratory test of breast cancer tissue to determine the responsiveness of the tumor to endocrine therapy or removal of the ovaries.

Breast

Negative: 5 fmoles or less. PRA increases the reliability of ERA results, a positive PRA indicates greater likelihood that the patient will respond to hormone therapy. The unit of measurement is femtomoles (fmoles) per milligram of tumor. Test cannot be performed

if tumor is less than 1.0cm in size or if tumor is completely insitu.



Proinsulin C-peptide

Differentiates cell type for endocrine-secreting tumors

Elevated in insulinoma and islet cell tumors.



Prostatic Acid Phosphatase

PAP

Acid phos, acid f, acid p'tase.

A test of blood serum to detect a specific enzyme produced by several tissues particularly the prostate.

Prostate

Varies according to the method of processing the serum:

Test results may be affected by recent prostatic massage or palpation; acid phosphatase level should be assayed before digital rectal examination.

1.0-4 -- King Armstrong microns/dl

0.5-2 -- Bodansky or
Gutman microns/dl
0-1.1 -- Shinowara
microns/ml
0.1-0.73 -- Bessy Lowry
microns/nk
0.5-11.0 -- units/L

**Prostate Specific
Antigen**

PSA

Tumor marker assay of
blood serum for antigen
released from cells in
prostate tissue.

Prostate

0.1 - 1.8, normal range
may vary depending on
the brand of laboratory
assay used.

Value may
be
elevated in
BPH;
greatest
elevation
occurs in
stage C
and D.
After
radical
prostatect
omy or
radiation
therapy,
rising
levels of
PSA
indicate
residual
disease or
recurrence
. Test
results
may be
affected by
recent
prostatic
massage
or
malipulatio
n. PSA
level

should be
assayed
before
DRE.

Vanillylmandelic Acid

SMA

Elevated levels suggest catecholamide-secreting tumor

Neuroblastoma or ganglioneurone, nonspecific to SMA

Squamous Cell Carcinoma

SCC

Monitors tumor burden after treatment for squamous cell carcinoma, usually used for advanced disease

Primarily used for head and neck cancer, secondarily used for lung cancer, nonspecific to cervical ca but specific to squamous cell carcinoma.

Thyroglobulin

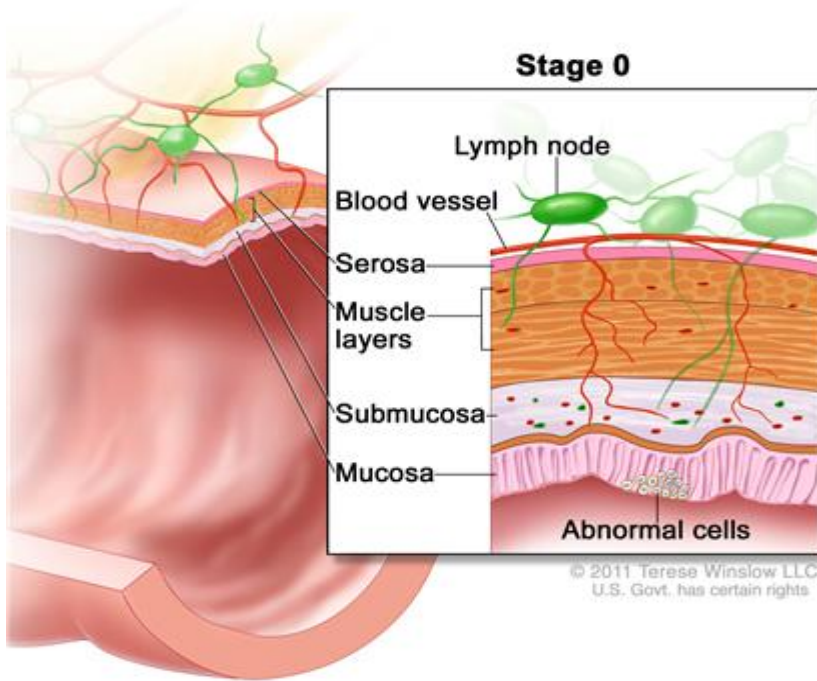
Elevated levels of this serum hormone are found in follicular carcinoma and return to normal following treatment if all tumor is removed.

Follicular thyroid cancer

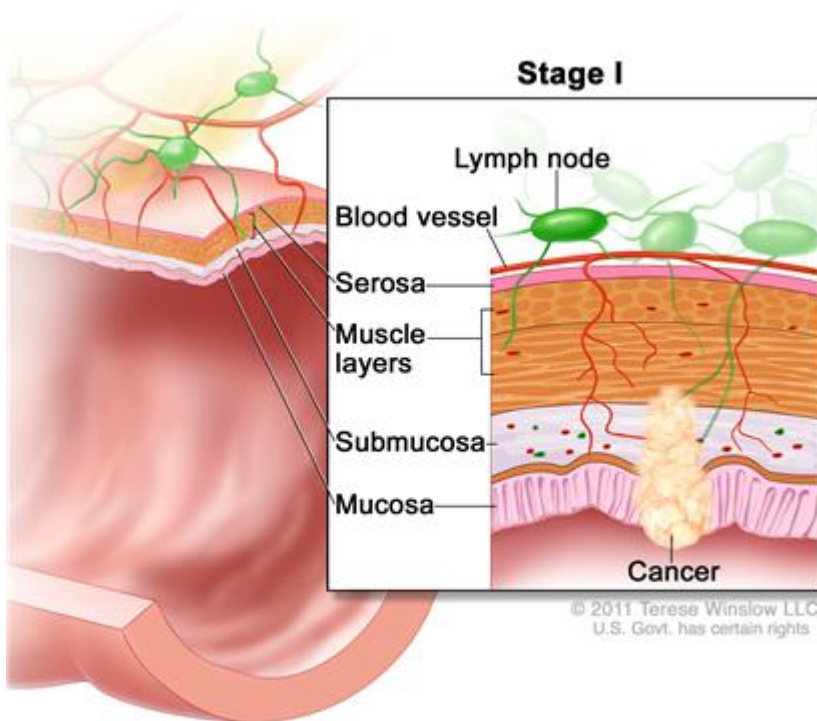
Usefull for monitoring residual disease and recurrence of follicular carcinoma.

Terminal Deoxynucleotidyl Transferase	TDT	Differentiates acute lymphocytic leukemia from acute non-lymphocytic leukemia; differentiates lymphoblastic lymphomas from other non-Hodgkin lymphomas.	Acute lymphocytic leukemia, lymphoblastic lymphoma	TDT levels are absent in patients in remission.
Tissue Polypeptide Antigen	TPA	An antigen marker for cancers of gynecologic sites, bladder and lung	Gynecologic sites, bladder and lung; nonspecific to ovarian and cancer; also used to monitor bladder and lung cancer in males.	Elevated levels indicate presence of malignancy.
Alpha Subunit Thyroid Stimulating Hormone	a-TSH	A marker that can differentiate pancreatic from other hormonal tumors	Differentiates pancreatic from other hormonal tumors; non-specific, also found in pituitary and placental tumors.	
Serum protein electrophoresis		Abnormal gamma globulin (monoclonal "spike") is found in multiple myeloma.	Multiple myeloma	
Serum protein immunoelectrophoresis (IgG, IgA, IgM)		Similar to serum protein electrophoresis, but can classify the type of abnormal gamma globulin present.	Multiple myeloma	

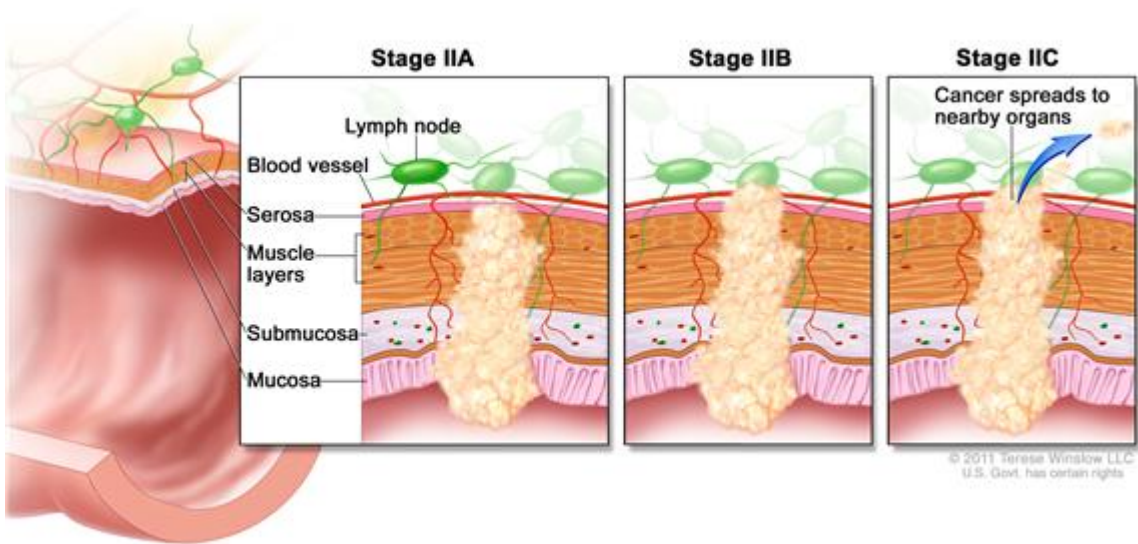
Colon Cancer Staging
Reference
www.cancer.gov



In stage 0, abnormal cells are found in the mucosa (innermost layer) of the colon wall. These abnormal cells may become cancer and spread. Stage 0 is also called carcinoma in situ.



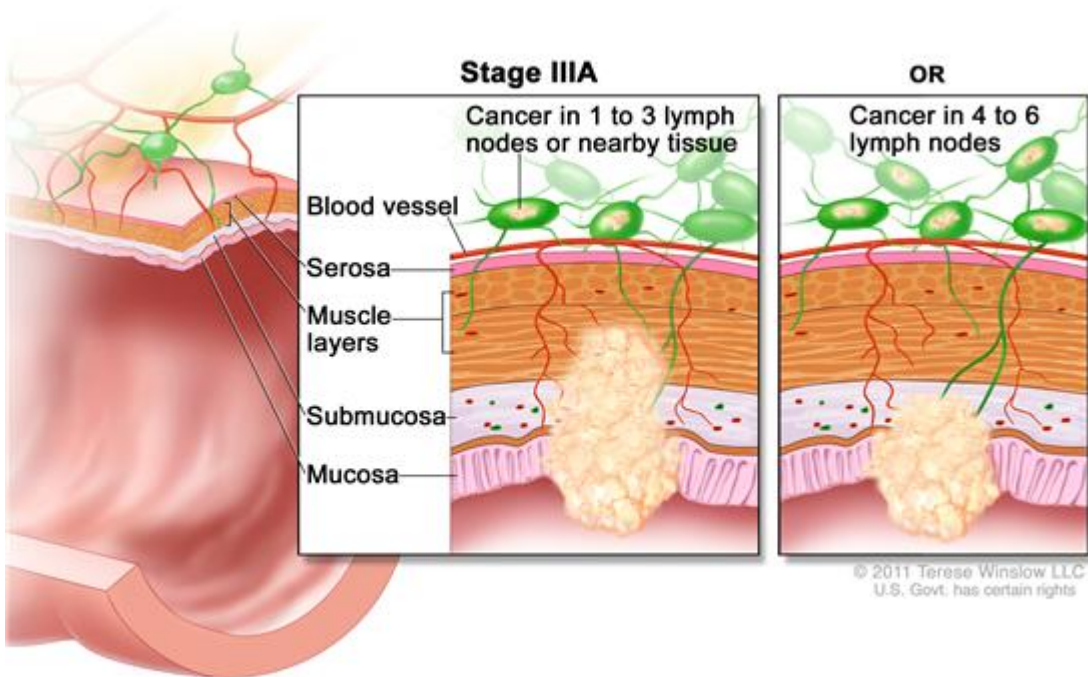
In stage I, cancer has formed in the mucosa (innermost layer) of the colon wall and has spread to the submucosa (layer of tissue under the mucosa). Cancer may have spread to the muscle layer of the colon wall.



Stage IIA: Cancer has spread through the muscle layer of the colon wall to the serosa (outermost layer) of the colon wall.

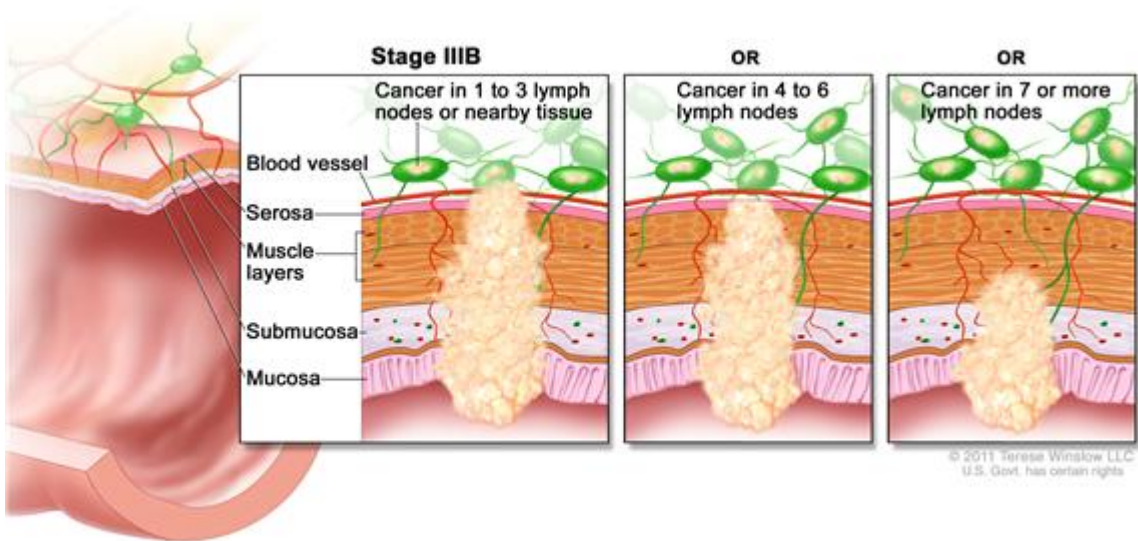
Stage IIB: Cancer has spread through the serosa (outermost layer) of the colon wall but has not spread to nearby organs.

Stage IIC: Cancer has spread through the serosa (outermost layer) of the colon wall to nearby organs.



Cancer may have spread through the mucosa (innermost layer) of the colon wall to the submucosa (layer of tissue under the mucosa) and may have spread to the muscle layer of the colon wall. Cancer has spread to at least one but not more than 3 nearby lymph nodes or cancer cells have formed in tissues near the lymph nodes; or

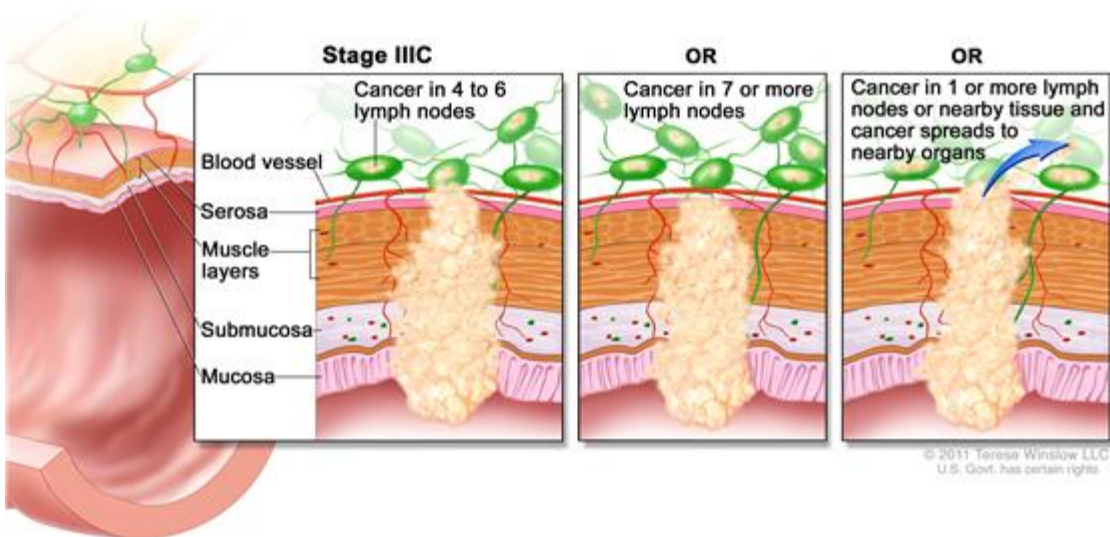
Cancer has spread through the mucosa (innermost layer) of the colon wall to the submucosa (layer of tissue under the mucosa). Cancer has spread to at least 4 but not more than 6 nearby lymph nodes.



Cancer has spread through the muscle layer of the colon wall to the serosa (outermost layer) of the colon wall or has spread through the serosa but not to nearby organs. Cancer has spread to at least one but not more than 3 nearby lymph nodes or cancer cells have formed in tissues near the lymph nodes; or

Cancer has spread to the muscle layer of the colon wall or to the serosa (outermost layer) of the colon wall. Cancer has spread to at least 4 but not more than 6 nearby lymph nodes; or

Cancer has spread through the mucosa (innermost layer) of the colon wall to the submucosa (layer of tissue under the mucosa) and may have spread to the muscle layer of the colon wall. Cancer has spread to 7 or more nearby lymph nodes.

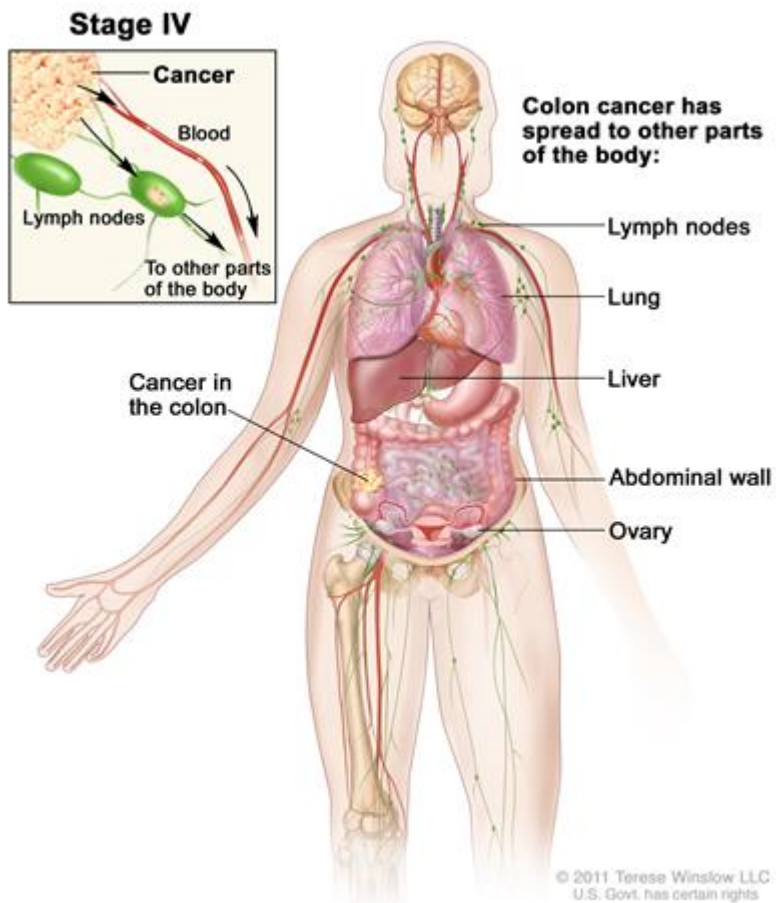


In stage IIIC:

Cancer has spread through the serosa (outermost layer) of the colon wall but has not spread to nearby organs. Cancer has spread to at least 4 but not more than 6 nearby lymph nodes; or

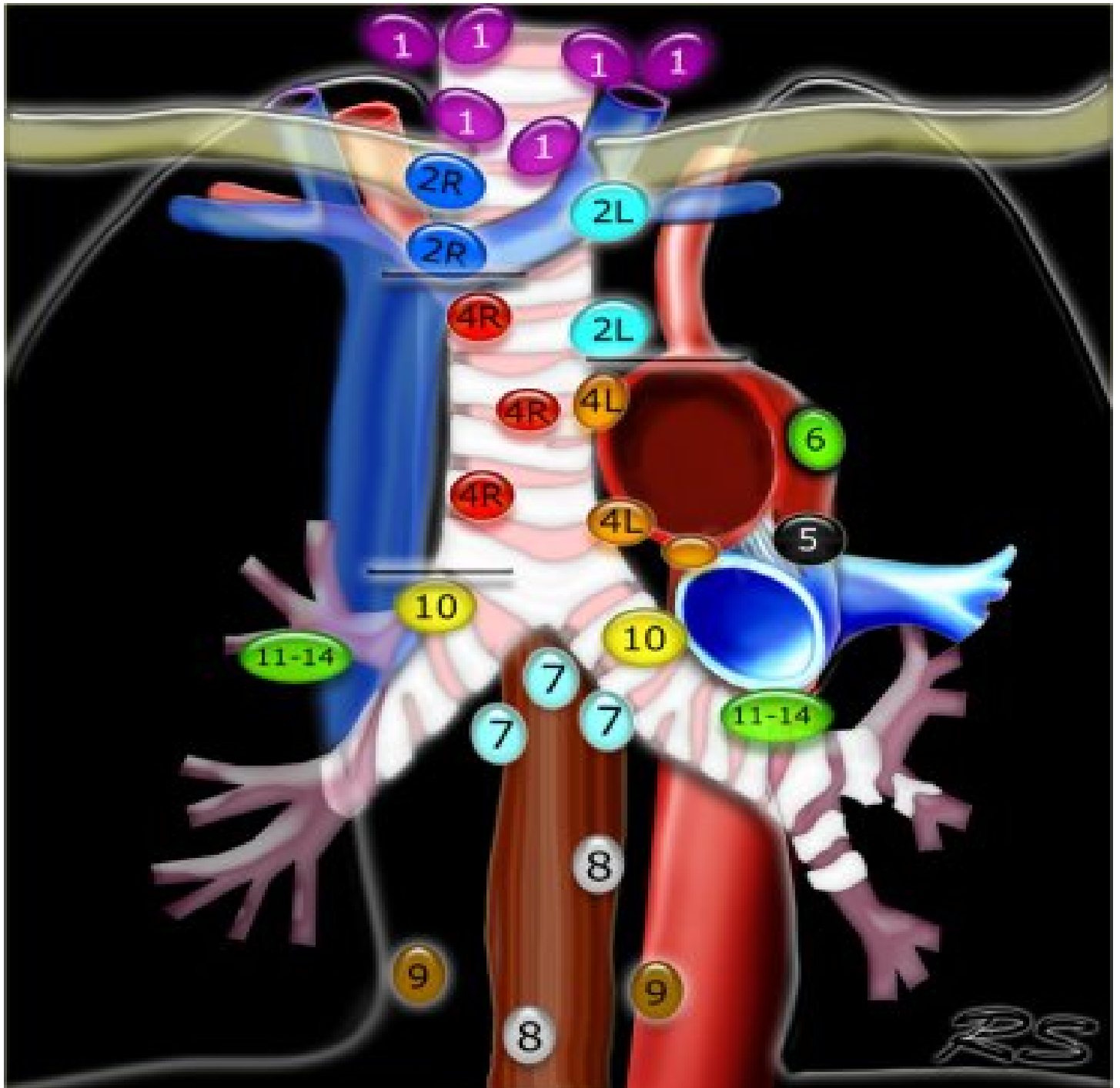
Cancer has spread through the muscle layer of the colon wall to the serosa (outermost layer) of the colon wall or has spread through the serosa but has not spread to nearby organs. Cancer has spread to 7 or more nearby lymph nodes; or

Cancer has spread through the serosa (outermost layer) of the colon wall and has spread to nearby organs. Cancer has spread to one or more nearby lymph nodes or cancer cells have formed in tissues near the lymph nodes.



Stage IV colon cancer. The cancer has spread through the blood and lymph nodes to other parts of the body, such as the lung, liver, abdominal wall, or ovary.

Lung Cancer
Lymph Node Staging Reference



Supraclavicular nodes

1. Low cervical, supraclavicular and sternal notch nodes

From the lower margin of the cricoid to the clavicles and the upper border of the manubrium.

The midline of the trachea serves as border between 1R and 1L.

Superior Mediastinal Nodes 2-4

2R. Upper Paratracheal

2R nodes extend to the left lateral border of the trachea.

From upper border of manubrium to the intersection of caudal margin of innominate (left brachiocephalic) vein with the trachea.

2L. Upper Paratracheal

From the upper border of manubrium to the superior border of aortic arch.

2L nodes are located to the left of the left lateral border of the trachea.

3A. Pre-vascular

These nodes are not adjacent to the trachea like the nodes in station 2, but they are anterior to the vessels.

3P. Pre-vertebral

Nodes not adjacent to the trachea like the nodes in station 2, but behind the esophagus, which is prevertebral.

4R. Lower Paratracheal

From the intersection of the caudal margin of innominate (left brachiocephalic) vein with the trachea to the lower border of the azygos vein.

4R nodes extend from the right to the left lateral border of the trachea.

4L. Lower Paratracheal

From the upper margin of the aortic arch to the upper rim of the left main pulmonary artery.

Aortic Nodes 5-6

5. Subaortic

These nodes are located in the AP window lateral to the ligamentum arteriosum.

These nodes are not located between the aorta and the pulmonary trunk but lateral to these vessels.

6. Para-aortic

These are ascending aorta or phrenic nodes lying anterior and lateral to the ascending aorta and the aortic arch.

Inferior Mediastinal Nodes 7-9

7. Subcarinal

8. Paraesophageal

Nodes below carina.

9. Pulmonary Ligament

Nodes lying within the pulmonary ligaments.

Hilar, Lobar and (sub)segmental Nodes 10-14

These are all N1-nodes.

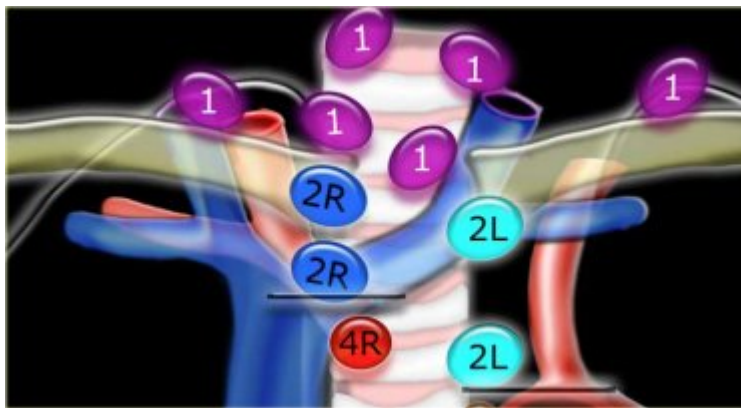
10. Hilar nodes

These include nodes adjacent to the main stem bronchus and hilar vessels.

On the right they extend from the lower rim of the azygos vein to the interlobar region.

On the left from the upper rim of the pulmonary artery to the interlobar region.

Specific Stations



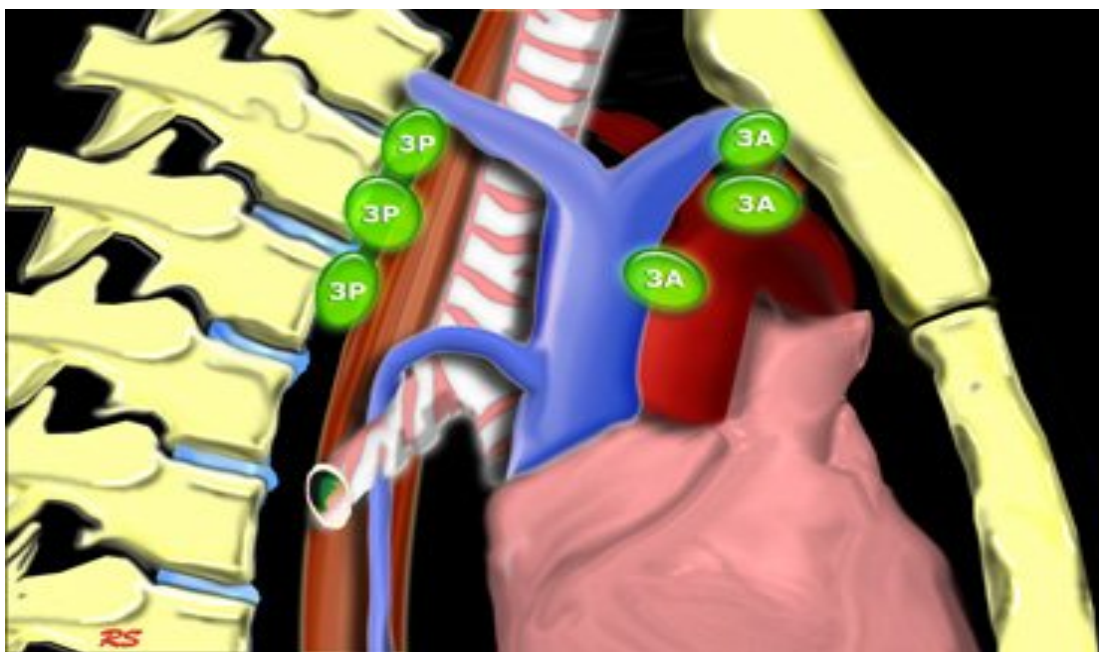
1. Supraclavicular zone nodes

These include low cervical, supraclavicular and sternal notch nodes.

Upper border: lower margin of cricoid.

Lower border: clavicles and upper border of manubrium.

The midline of the trachea serves as border between 1R and 1L.



3. Prevascular and Prevertebral nodes

Station 3 nodes are not adjacent to the trachea like station 2 nodes.

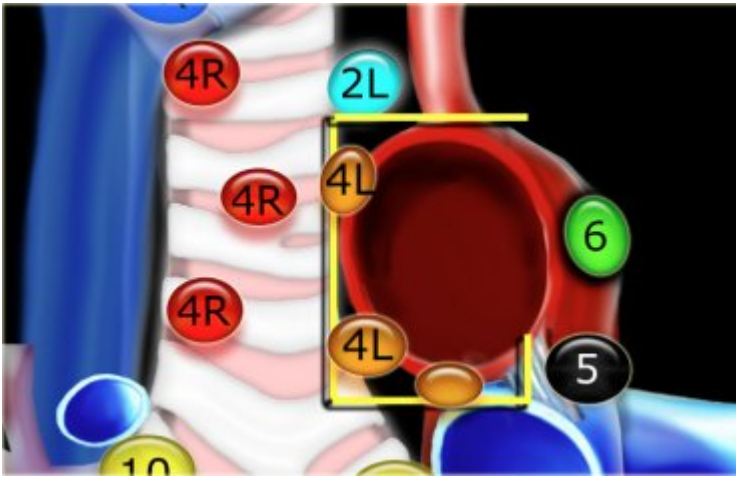
They are either:

3A anterior to the vessels or

3B behind the esophagus, which lies prevertebrally.

Station 3 nodes are not accessible with mediastinoscopy.

3P nodes can be accessible with endoscopic ultrasound (EUS).

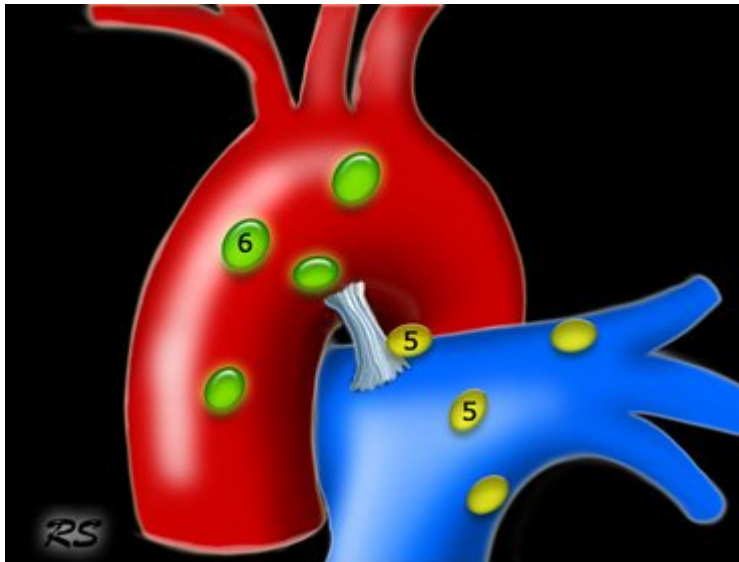


4L. Left Lower Paratracheal

4L nodes are lower paratracheal nodes that are located to *the left of the left tracheal border*, between a horizontal line drawn tangentially to the upper margin of the aortic arch and a line extending across the left main bronchus at the level of the upper margin of the left upper lobe bronchus.

These include paratracheal nodes that are located medially to the ligamentum arteriosum.

Station 5 (AP-window) nodes are located laterally to the ligamentum arteriosum.

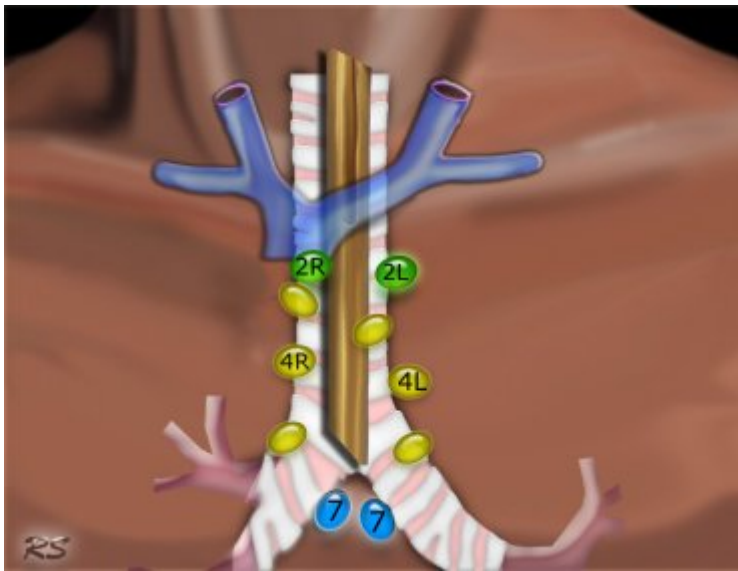


5. Subaortic nodes

Subaortic or aorto-pulmonary window nodes are lateral to the ligamentum arteriosum or the aorta or left pulmonary artery and proximal to the first branch of the left pulmonary artery and lie within the mediastinal pleural envelope.

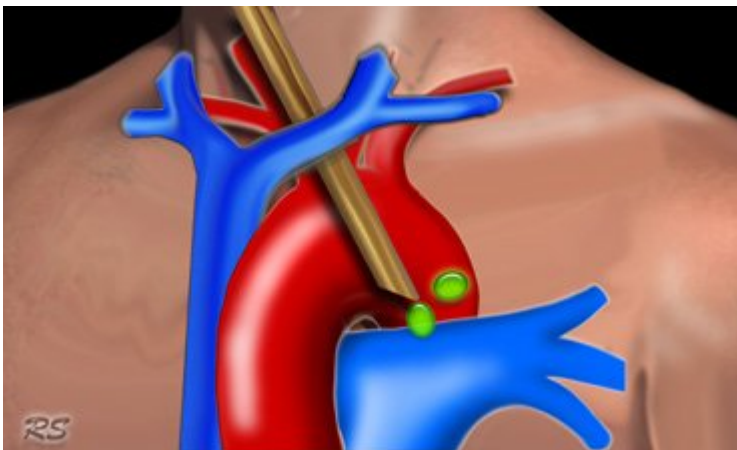
6. Para-aortic nodes

Para-aortic (ascending aorta or phrenic) nodes are located anteriorly and laterally to the ascending aorta and the aortic arch from the upper margin to the lower margin of the aortic arch.



Conventional mediastinoscopy

The following nodal stations can be biopsied by cervical mediastinoscopy: the left and right upper paratracheal nodes (station 2L and 2R), left and right lower paratracheal nodes (station 4L and 4R) and the subcarinal nodes (station 7). Station 1 nodes are located above the suprasternal notch and are not routinely accessed by cervical mediastinoscopy.



Extended mediastinoscopy

Left upper lobe tumors may metastasize to the subaortic lymph nodes (station 5) and paraaortic nodes (station 6). These nodes can not be biopsied through routine cervical mediastinoscopy. Extended mediastinoscopy is an alternative for the anterior-second interspace mediastinotomy which is more commonly used for exploration of mediastinal nodal stations. This procedure is far less easy and therefore less routinely performed than conventional mediastinoscopy.

Casefinding tips by Jennifer Bradley, CTR

Casefinding is an important part of the registry as it is how a registrar finds the cases that need to be abstracted. There are two main ways to find cases. You can have a disease index downloaded into your database or you can have it printed and go thru it manually and you can go thru pathology reports.

In this day and age of electronic medical records it is becoming more popular for facilities to get an electronic copy of a disease index and have it imported directly into the registry database. To do this you need to give a copy of the reportable ICD codes to someone in your IT department and have them pull the patients from the hospital database with those specified ICD codes and then have them import them into your registry database. You then can run a list of patients and go thru the medical record to see if the patient has active disease and needs to be reported or if the case can be made non-reportable. How often you have cases imported electronically depends on how large your facility is. The larger the facility the more often you are going to want to have them imported. If you work for a smaller facility then instead of having your disease index downloaded electronically into your database you may have your IT department print a disease index. You can do this monthly, quarterly or at the end of the year.

The second way to do your casefinding is to give a list of reportable ICD codes to your pathology department and have them set aside a copy of all pathology reports that have those specified codes and then you can enter those cases that have active disease into suspense in your database to abstract. Most facilities use the pathology reports as a way to find “missed” cases rather than a primary way for casefinding.

Once you figure out the method(s) your facility is going to use for casefinding then you need to actually work the list of patients in order to find the ones that need to be abstracted. This process involves reviewing the entire medical record trying to figure out if a patient has active disease or not or if the patient was actively receiving cancer directed therapy either at your facility or at another facility. If the patient has active disease or is actively receiving cancer directed therapy then that patient needs to be abstracted in your database. The FORDS manual and TCR manual has a list of histologies that are to be included in your database and ones that can be excluded.