

The abstract is the basis of all registry functions. It is a tool used to help accurately determine stage and to aid cancer research; therefore, the abstract must be complete, containing all the information needed to provide a concise analysis of the patient's disease from diagnosis to treatment.

To assist registrars in preparing abstracts, NCRA's Education Committee has created a series of informational abstracts. These site-specific abstracts provide an outline to follow when determining what text to include. The outline has a specific sequence designed to maximize efficiency and includes eight sections: Physical Exam/History; X-Rays/Scopes/Scans; Labs; Diagnostic Procedures; Pathology; Primary Site; Histology; and Treatment. A list of relevant resources is located at the end of each informational abstract. The sources of information noted in the various sections below are not inclusive, but they are the most common. You may need to do additional research to complete the abstract.

When using the informational abstract, follow the outline and strive to complete all the sections. Be concise by using phrases, not sentences. Make sure to use text relevant to the disease process and the specific cancer site and to use NAACCR Standard Abbreviations. When the abstract is completed, review thoroughly to ensure accuracy.

PHYSICAL EXAM/HISTORY

Include:

- **Demographics:** Age, sex, race, ethnicity of the patient.
- **Chief Complaint (CC):** Brief statement about why the patient sought medical care.
- **History:** Personal or family history of any cancer and the family member involved. List the smoking and alcohol history of the patient—type, frequency, and amount. Note exposure to any cancer-causing chemicals, workplace exposure, and/or relevant environmental factors. List chronic health problems, irritations, or infections. Make sure to note previous chemotherapy or radiation therapy. Other relevant information as deemed appropriate.
- **Genetics:** Include birth defects or other related genetic conditions.
- **Past Treatment:** Include past treatment if applicable.

Example: 49-year-old white female presented to her ophthalmologist with a headache and decreased visual acuity. H/A nonspecific in nature and unresponsive to analgesics. Patient reported gradual visual changes over time attributed to age. Patient's visual field testing demonstrated classic bitemporal field loss (bitemporal hemianopia) consistent with (c/w) optic nerve chiasmal compression. PMH significant for diabetes and hypertension. FH: non-contributory. Toxic habits: tobacco, EtOH, street drugs – all negative. No workplace exposures noted.

Where to Find Information: H&P consultations, nursing notes, admission notes, physician progress notes, discharge summary.

X-RAYS/SCOPES/SCANS

Include:

- **Imaging Tests:** Date, name, and a brief summary of test results. MRI is the preferred imaging modality for pituitary adenomas.

Note: Pituitary adenomas are classified based on size as either a microadenoma (<10mm) or a macroadenoma (>10mm). The optic chiasm lies directly above the pituitary.

Example: 10/20/2015: MRI-Brain: 4x4mm sella/suprasellar homogeneous mass in keeping with a pituitary microadenoma.

LABS

Include:

- List each test, date, and results. Include pituitary function tests and endocrine studies for hormone hyposecretion or hypersecretion.

Note: The pituitary gland produces hormones that can be characterized as secretory or non-secretory (functioning or non-functioning) based on the presence or absence of those hormones. Non-secretory tumors usually present with vision loss. Patients with secretory tumors usually present after evaluation by an endocrinologist for symptoms related to

hormonal imbalances (weight changes, mood changes, fatigue, loss of libido, etc).

The anterior lobe of the pituitary secretes six (6) hormones: thyroid stimulating hormone (TSH), adrenocorticotrophic hormone (ACTH); follicle stimulating hormone (FSH); leuteinizing hormone (LH), growth hormone (GH), and prolactin (PRL), the most common pituitary adenoma.

The posterior lobe of the pituitary secretes two (2) hormones: vasopressin and oxytocin.

Example: 10/9/15 Prolactin 19.7 (H); range (4-15.2).

DIAGNOSTIC PROCEDURES

These are procedures that detect the cancer, but do **not** remove it.

Include:

- **Biopsy:** List date, name of procedure, and brief description of findings.
Most often performed at the time of surgical resection. Stereotactic CT or MRI guided biopsy may be performed without surgical resection in patients considered surgically unresectable or not considered a good surgical candidate.

- **Example:** 10/20/2015: (performed during surgery): Biopsy of the abnormal tissue submitted to pathology. Dx-pituitary microadenoma.

PATHOLOGY

Include:

Date and a brief summary of findings of all pathological reports, particularly the three listed below. List in chronological order (i.e. first to most recent).

- **Extent (extension) of the primary tumor:** Often found in the microscopic description of the pathology report.
- **Any evidence of further spread:** Often found in the microscopic description of the pathology report.
- **Margins:** note extent of involvement of surgical margins.

Example: Microscopic, macroscopic, extent of involvement not stated.

- Specific lobe of the brain
- Laterality
- Cancer cell type
- Grade of the tumor
- Size of tumor (not specimen size)

PRIMARY SITE

Include:

- The primary site where the cancer started.

Example: Pituitary gland – C75.1

Where to Find Information: Surgical and diagnostic (imaging and biopsy) reports.

HISTOLOGY

Include:

- The exact cell type of the cancer.

Example: Pituitary adenoma (M-8272/0/9)

TREATMENT

Include:

- **Surgery:** The most commonly performed surgery is trans-sphenoidal resection. It addresses tumors confined within the sella turcica and that are Adrenocorticotrophic hormone (ACTH) secreting. This is a definitive surgery that removes the TUMOR. It removes visibly abnormal tissue as seen on imaging or intraoperatively and is completed to a degree that is consistent with preservation of functional neurologic tissue.

Example: 10/25/15: Trans-sphenoidal resection performed using an endoscopic endonasal approach. Pituitary adenoma is noted compressing the optic chiasm. Gross resection is performed with successful decompression of the anterior visual pathways, leading to visual recovery.

- **Radiation:** Beginning and end dates of treatment, type of radiation, to what part of body it was given, dosage and reaction to treatment, if noted. Note: any boost dosages, date, and to where it was administered.

Note: Radiation therapy is most often reserved for incomplete resection or for patients who continue to be hypersecretory after surgery.

Indications for Radiation Therapy:

- **Non-functioning adenomas:**
 1. non-surgical candidate
 2. recurrence of progression after surgery
 3. surgically inaccessible (e.g. cavernous sinus)
- **Functioning adenomas:**
 1. hormonally uncontrolled after maximal surgical or medical therapy
 2. tumor growth or extension that cannot be surgically addressed.

Radiation Therapy Options:

These are examples of common approaches, but do not address variances in dosage or duration or modality.

- **Stereotactic Radiosurgery (SRS):** At least 3-5mm from optic chiasm and less than 3cm in diameter. SRS for non-functioning adenoma, 18Gy (180cGy), for functioning adenoma, 20Gy (200cGy).
- **Fractionated Radiation Therapy:** May be the only option if less than 5mm from optic nerve or greater than 3cm in diameter. Fractionated Radiotherapy for non-functioning adenoma, 45-50.4Gy (4500-5040cGy) at 18Gy (180cGy) daily. Slightly higher dosage for functioning adenoma 50.4 – 54Gy (5040 – 5400cGy) also at 18Gy (180cGy) daily.

Example: 12/1/15-12/31/15: 45Gy (4500cGy) to Gross Tumor Volume at 18Gy (180cGy) in 25 fxs over 30 days.

- **Chemotherapy/Hormone Therapy:** Beginning and end dates of chemotherapy, names of drugs, and route of administration. If available, include response to treatment. Note if any changes in drugs: state new drug names and why the drug was changed and when the new drug started.

Note: Responses may evolve slowly over many years, so continued endocrine surveillance and medical management are required.

Example: Bromocriptine (Parlodel) initially 1.25mg nightly with food, gradually increasing to 2.5mg BID (twice daily) as tolerated within 1-2 weeks.

TREATMENT *(continued)*

- **Clinical Trials:** The name and number of the clinical trial in which the patient is enrolled, the date of enrollment, and any other details of the patient’s experience. May include patients who have not yet been treated. Some trials test treatments for patients who have not gotten better; other trials test new ways to stop cancer from recurring or reduce the side effects of cancer treatment.

Example: Participation in PASSION 1 Trial – Evaluate the Efficacy and Safety of Pasireotide LAR on the Treatment of Patients with Clinically Non-Functioning Pituitary Adenomas.

- **Other:** Any other treatment that does not fit into one of the categories above.

RESOURCES

Abbreviations: Use NAACCR Recommended Abbreviations for Abstractors (Appendix G)
<http://datadictionary.naacr.org/?c=17>

College of American Pathology
http://www.cap.org/web/oracle/webcenter/portalapp/pagehierarchy/cancer_protocol_templates.jspx

Evidence-Based Treatment by Stage Guidelines
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp.

The NCCN Guidelines are most frequently used for treatment and are also used for information on diagnostic workup.

Labs/Tests – NCI: Understanding Lab Tests/Test Values
<http://www.cancer.gov/cancertopics/factsheet/detection/laboratory-tests>

Multiple Primary & Histology Coding Rules
<http://seer.cancer.gov/tools/mphrules/>

NCI Physician’s Data Query (PDQ)
<http://www.cancer.gov/cancertopics/pdq>

SEER Appendix C
<http://seer.cancer.gov/archive/manuals/2010/appendixc.html>

SEER RX Antineoplastic Drugs Database
<http://seer.cancer.gov/tools/seerrx/>

Site-Specific Surgery Codes: FORDS Appendix B
<https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual>

Treatment
www.cancer.gov/types/brain/hp/adult-brain-treatment-pdq#section_233

WHO Classification of Tumors of the CNS
<http://braintumor.org/wp-content/assets/WHO-Central-Nervous-System-Tumor-Classification.pdf>.