Abstracting a Medical Record

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Objective

• Develop an understanding of usual methods and procedures used to diagnose cancer
• Develop and understand of what should be recorded on your registry abstract
Composition and organization of a medical record

• May be simple: just a few pages
• May be extremely complex: containing a variety of reports and handwritten notes
• All have characteristic in common
• Mastering medical terminology to best of your ability is imperative
Why is medical terminology so important?

- You will encounter unfamiliar terms
- It will be difficult to read the doctor’s handwriting if you do not know the terms
- Help give you a clue to what the incomprehensible term might be
- Need to know what information may be missing or incomplete
- A medical dictionary can help but knowing root words, prefixes, and suffixes most helpful
Composition of a medical record (not necessarily in this order)

- Patient identification
- Referral information
- Biographical information
- Medical history & Physical exam
- Diagnostic examination
- Pathology reports
- Treatment reports
- Progress notes (doctor and nurse)
Composition of a medical record (continued)

• Discharge summary
• Follow-up reports
• Autopsy reports
• Death certificate
• Reports from other facilities
Forms used to record information in a medical record
(handout)
Clinical notes

- **S** = Subjective: symptoms (what the patient says to the doctor)
- **O** = Objective (physical exam – what the doctors see, feel, hear)
- **A** = Assessment (the doctor takes the patient’s complaints and add the information to what he/she has observed)
- **P** = Plan (what the doctor decides to do)
How to abstract cancer registry information

• Patient identification
  – Name
  – Hospital medical record number
  – Local registry number
  – Address and phone number
  – Social security or country identification number
  – Spouse
  – Nearest relative or friend
  – Physicians
  – Employer
How to abstract cancer registry information

• Biographical information
  – Sex
  – Age at diagnosis
  – Birthdate
  – Place of birth
  – Race/ethnic group
  – Marital status
  – Occupation history
  – Social history
How to abstract cancer registry information

• Medical history
  – Previous diagnosis of this neoplasm
  – Previous treatment for this neoplasm
  – Other previous neoplasms

• Admission date
• Diagnosis date
• Discharge date
Abstracting diagnostic procedures

• Always record certain basic information
  – Date of examination or procedure
  – Name of examination or procedure
  – Results of the examination or procedure
    • Any pertinent positive or negative information

• Document in text section
Let’s look at an X-ray Report

- Handouts: Example E1
Abstract X-ray as follows:

- 10/8/1991 2 to 3 cm mass in left midlung extending toward the left hilum, IMP: probably adenocarcinoma
Let’s look at another X-ray report

• Handout: Example E2
Abstract X-ray as follows

• 4/19/91 x-ray Lt femoral head, Lt ilium and skull: probable osteoblastic mets lesion

• Note: date, type of x-ray, pertinent findings are all recorded
Let’s look at an esophagram

• Handout: Example E3
Abstract Esophagram as follows

- 7/14/91 Esophagram: irreg narrow area 5.5 cm in length in midportion of esophagus at level of aortic knob, no obs. Imp: carcinoma of esophagus
Let’s look at an ultrasound

• Handout: Example E4
Abstract Ultrasound as follows

• 12/31/91 Ultrasound: mass lesion, superior & posterior portion Lt kidney, not cystic. Rt kidney WNL
Let’s look at a mammogram

• Handout: Example E5
Abstract mammogram as follows

• 1/13/91 Mammogram rt breast: UOQ area of increased opacification, 2 opacities in rt axilla sugg Ins; Imp: possible UOQ carcinoma suggest repeat mammogram
Let’s look at a CT scan

• Handout: Example E11
Abstract CT scan as follows

- 6/6/91 CT scan: no evidence of superior mediastinal mass, probable mets lesions in both upper lobes
Manipulative Procedures

• Diagnostic procedures that involve
  – Direct viewing
  – Direct feeling
  – Direct hearing
  – Direct smelling of body

• Often with special instrument devised to directly view interior of body (endoscope)
Let’s look at a proctoscopy

• Handout: Example F1
Abstract proctoscopy finding as follows

- 2/31/91 Procto: mass palpable posteriorly, feels fixed to sacrum. Multiple bx taken. Obstruction @ 8cm – could not examine above
Let’s look at a laryngoscopy

• Handout: Example F2
Abstract laryngoscopy findings as follows

- 8/17/91 Laryngoscopy: Fungating mass in supraglottic area from false cord up to aryepiglottic fold, does not pass the midline; pyriform sinuses and glottis free of dz. Cords moving normally, bx taken
Let’s look at a cystoscopy

• Handout: Example F3
Abstract cystoscopy as follows

• 1/14/91 Cystoscopy: localized sessile lesion in rt superior lateral portion of bladder. No other overt lesions. Multi bx taken. Dx carcinoma of bladder

• Make note of other studies in specified place on abstract
  – X-ray section: Date: NIC (not in chart)
    Pyelogram: prob cyst upper pole rt kidney, lt nml, no ureteral defects
  – Surgery section: Date NIC (not in chart) TURB done
OPERATIVE PROCEDURES

Exploratory Surgery

• Sometimes cancer of an internal organ may be suspected but the organ may be so located that direct access to it is possible only with surgery.

• Exploratory surgery may then be performed to determine whether or not a cancerous condition exists and the degree to which the cancer may have affected other organs and structures within the observed area. In most instances, biopsies will be performed and the material examined histologically.
Let’s look at an operative report for a exploratory laparotomy

• Handout: Example F15
Abstract the exploratory laparotomy as follows:

PATHOLOGICAL EXAMINATIONS

• Most accurate methods for diagnosing cancer – microscopic examination of tissue and cells
  – Cytological examination: study of cells
  – Histological examination: study of tissue

• Purpose: determine characteristics of tissues and cells indicative of malignancy
HISTOLOGIC EXAMINATION

• Best evidence regarding presence or absence of cancer
• May have more than one path report in record
• Summarize each
  – Name and date of procedure
  – Slide number
  – Source of specimen
  – Pertinent positive and/or negative findings
Types of histologic specimens

- Biopsy specimens
- Surgical specimens
- Autopsy
Types of biopsy reports

• Aspiration: fluid, cell or tissue obtained by suction through a needle attached to a syringe
• Usually called a FNA (fine needle aspiration)
Types of biopsy reports

• Bone marrow biopsy: examination of piece of bone marrow by puncture or trephine (removing a circular disc of bone)
Types of biopsy reports

- Curettage: removal of material by scraping with a curette usually done in cervix.
Types of biopsy reports

- Excisional biopsy (total): the removal of a growth in its entirety and having a therapeutic as well as a diagnostic purpose.
Types of biopsy reports

- Incisional biopsy: incomplete removal of a growth for the purpose of diagnostic study
Types of biopsy reports

• Percutaneous biopsy: a needle biopsy with the needle going through the skin
Types of biopsy reports

• Punch biopsy: Biopsy of material obtained from the body tissue by a punch technique
Types of biopsy reports

- Shave biopsy: biopsy of material obtained by shaving off a layer of tissue with a blade.
Let’s abstract multiple biopsies of bladder

• Handouts: Example G1
Abstract the multiple biopsies of bladder as follows:

• 3/31/91 Bx of bladder: rt anterior bladder wall—Pap trans cell carcinoma, gr III, invading into lamina propria but not muscularis. Other bx moderate atypia
ANATOMY OF A PATHOLOGY REPORT

• DATE OF REPORT: Date should coincide with date of corresponding operative report, not the date the slides were received, read nor the date of dictation

• CLINICAL HISTORY: Brief information that describes the reason why the tissue was removed
ANATOMY OF A PATHOLOGY REPORT

• PRE-OPERATIVE DIAGNOSIS OR CLINICAL DIAGNOSIS: brief description of the diagnosis as based on the physical examination and/or a statement provided by a referring physician

• CAUTION: some physicians use a rule-out diagnosis
  – A rule out diagnosis is not a statement of diagnosis of cancer
ANATOMY OF A PATHOLOGY REPORT

• GROSS DESCRIPTION: contains a description of the material received for examination and will include:
  – Source of specimen
  – Size of tissue fragments and how they are received
  – Size of surgical specimen

• Do not confuse the size of specimen with the size of the tumor
ANATOMY OF A PATHOLOGY REPORT

• MICROSCOPIC DESCRIPTION:
  – Pathologist description of specimen examined
  – Total size of tumor
  – Were the tumor has extended or metastasized
  – Size usually reported in cm and length, breadth and thickness of tumor will be given
  – Registrar reports only the largest dimension of the tumor
ANATOMY OF A PATHOLOGY REPORT

• FINAL DIAGNOSIS
  – Summarizes the microscopic finding
  – Diagnosis confirms or denies gross finding of malignancy
  – Gives information on histologic type of cancer, the grade and sometimes the extension, margins of tumor positive or negative

• THE HISTOLOGY IS CODED FROM THE FINAL DIAGNOSIS
ANATOMY OF A PATHOLOGY REPORT

• COMMENTS: Pathologist will comment or clarify information found on the pathology report and will sometimes offer an opinion on a more exact type of histology.

• Comments offers pathologist to offer an opinion as to the characteristics of the tumor which are not included in the “official” part of the report.
Example of a comment

FINAL DIAGNOSIS: Non-small cell carcinoma

COMMENTS: non-small cell carcinoma of the lung most consistent with Adenocarcinoma

In this case the registrar would code the histology to Adenocarcinoma NOT Non-small cell carcinoma
Let’s abstract a biopsy of bladder with left scalene nodes

• Handout: Example G2
Abstract biopsy of bladder with left scalene nodes as follows

- TURB means transurethral resection of bladder
- TCC means transitional cell carcinoma
Let’s abstract a left radical mastectomy path report

- Handout: Example G3
Abstract  left rad mastectomy  
path report as follows 

- 7/20/91 Lt Rad Mast (#S91-1700): 4 cm tumor infiltrates deep fatty tissue; no invasion of muscle, nipple, or lactiferous sinuses. Mets carcinoma 1/17 Lt axillary LN. DX: infiltrating duct carcinoma Lt breast
Let’s abstract a cancer of floor of mouth path report

• Handout: Example G4
Abstract cancer of FOM pathology report as follows

• 5/23/91 Floor of mouth contiguous with tongue and mandible plus Lt rad neck dis (S91-0100): lesion 1.2x0.1 cm on Lt side of FOM; extranodal fibrous connective tissue contains foci of squamous cell ca. All lymph nodes neg 0/19. Dx: Mod well diff. quamous cell ca of Lt floor of mouth
Let’s abstract a vagotomy & subtotal gastrectomy path report

• Handout: Example G5
Abstract vagotomy & subtotal gastrectomy path report

- 9/11/91 Vagotomy & subtotal gastrectomy (S91-999): Stomach—tumor does not extend below mucosa but a single nest of malignant cells is seen in submucosal lymphatic space. Surgical margins free. Perigastric lymph nodes free. Dx: superficial spreading carcinoma arising in margins of chronic gastric ulcer.
THE AUTOPSY (NECROPSY POSTMORTEM) REPORT

• FINAL DIAGNOSIS: most important part for registrar
• Can confirm dx of cancer made prior to death
• Can be incidental finding of cancer at time of autopsy
• Abstract same as you would a path report
• Can be a gross observation alone (no microscopic exam)
CYTOLOGIC EXAMINATION

• Study of cells
  – Shed from tissues
  – Floating in fluid and mucous material
• Examined microscopically to determine origin
Cytologic Examination

- Bronchial washing
- Sputum
- Breast secretions
- Gastric fluid
- Peritoneal fluid
- Pleural fluid
- Bone marrow aspirations
Cytologic Examinations

• Bronchial brushing
• Prostate secretion
• Spinal fluid
• Urinary sediment
• Cervical & vaginal smears
• Tracheal washing
Let’s abstract a bronchial washing cytology report

- Handout: Example G 13
Abstract a bronchial washing cytology report as follows

- 10/6/91 Bronchial washing (#03166): Pap Class III very suspicious of epidermoid carcinoma
Let’s abstract a cervical pap smear report

• Handout: Example G14
Abstract a cervical pap smear as follows

- Fem. Gen. Tract (#01000) Pap Class V, epidermoid carcinoma with atypical glandular elements
BREAK

STOP
TIME FOR PRACTICE