



ONCOLOGY

USER MANUAL

Version 2.11

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Department of Veterans Affairs
VISTA Technical Services

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I. Introduction

What is VISTA Oncology?

VISTA Oncology is an integrated collection of computer programs and routines which work together to assist you, the Oncology Data Manager, to create and maintain a cancer patient database. The program allows you to identify potential cases for inclusion in your registry, enter the pertinent data directly into your computer system, and maintain patient follow-up information on an annual basis.

The Case Finding/Suspense Module enables an automated case finding search of relevant hospital databases (pathology, radiology and patient treatment files) for cases meeting specific criteria for inclusion the registry.

Abstracting/Printing allows you to enter coded data directly into the database or by utilizing autocoding techniques. The program is site specific prompt driven: only data elements pertinent to the site being abstracted are presented as choices.

Oncology also assists you in following your patients. The database acts as a tickler file, and will automatically remind you when it is time to follow each patient. In addition, the program comes with a variety of follow-up letters which may be customized to fit your individual facilities' needs. And with a touch of a few more keys, you can update each patient's record with new follow-up information.

This system is divided into modules representing the major facets of registry operations. There are three files maintained by this system: Oncology Primary (all data pertaining to the tumor/primary), Oncology Patient (data relevant to patient identification and demographics), and Oncology Contact (all information regarding the patients' follow-up contacts).

Oncology provides special programs which allow you to send your abstract data and corrections electronically to a state central registry, the National Cancer Data Base and the VA Central Cancer Registry. Call for Data and Patient Care Evaluations (PCEs) are updated yearly to encourage facilities to participate in the national data submission.

The program has the ability to create case listings and registry reports for Tumor Boards, special studies, and the Annual Report required by the American College of Surgeons.

Oncology is a dynamic, menu driven program that exceeds the North American Association of Central Cancer Registry (NAACCR), American College of Surgeons (ACoS) and Surveillance, Epidemiology and End Results (SEER) requirements. As a menu driven program, Oncology uses menus, prompts and pop-up coding to help you abstract cases. It contains all the required data items listed in the ACoS Registry Operations and Data Standards (ROADS); SEER Extent of Disease Codes and Coding Instructions. The manuals, as well as the 3rd, 4th, and 5th American Joint Commission on Cancer (AJCC) Manual for the Staging of Cancer, International

Classification of Diseases-Oncology (ICD-O), and International Classification of Diseases, 9th Revision (ICD-9), have been incorporated into the package and can be readily accessed.

Although there are detailed instructions for most operations in the manual, it is expected that you have a working knowledge of the hospital computer system. Individuals requiring additional training should contact the facility's Information Resource Management Service.

How to Use this Manual

This manual is intended to be a reference manual, to assist you when you have a question or get stuck in some part of the system. This manual is divided into sections which correspond to the basic tasks of Oncology: case finding and suspense, abstract entry and printing, follow-up, registry lists, and reporting.

In many cases, examples of the computer dialogue for the option are shown in the manual. When the dialogue is displayed it is in `Courier New` font so it is easy to recognize. User response is shown in **bold type**. Example from the Define Tumor Registry Parameters (TR) option:

```
HOSPITAL NAME: Maywood Medical Center
STREET ADDRESS: 1st and Roosevelt Road
ZIPCODE: 60609
TR REFERENCE DATE: 010195
TUMOR REGISTRAR: Jane Doe, CTR
```

Suggested Bibliography for Registries

Self Instructional Manual for Tumor Registrars, U.S. Department of Health and Human services. (301-496-8510)

Cancer Registry Management Principles & Practice, National Cancer Registrars Association, Inc, Lenexa, Kansas, 1997. Editors: Carol Hutchinson, Steven Roffers, and April Fritz. (ISBN-0-7872-2120-1)

Standards of the Commission on Cancer Volume I: Cancer Program Standards, Commission on Cancer, 633 North St. Clair St., Chicago, Il., 60611. (312) 202-5085 Web Site: www.facs.org

Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS), Commission on Cancer, 633 North St. Clair St., Chicago, Il., 60611. (312) 202-5085 Web Site: www.facs.org

American Cancer Society Textbook of Clinical Oncology, 2nd ed., American Cancer Society. (Call local ACS or 1-800-ACS-2345) (ISBN 0-944235-10-7)

Dorland's Illustrated Medical Dictionary, W.B. Saunders Co. (ISBN 0-7216-2858-1)

Atlas Of Human Anatomy, Frank H. Netter, M.D. Ciba-Geigy Corp. (ISBN 0-914168-18-5)

Cancer Principles & Practice of Oncology, Vincent DeVita, Samuel Hellman, Steven Rosenberg. J.B. Lippincott Co.

Gray's Anatomy, Editors, Peter Williams, Roger Warwick, Mary Dyson, & Lawrence Bannister. Churchill Livingstone.

Cancer Dictionary: Cancer Symptoms, Surgical Procedures, Anticancer Drug, Risk Factors. Roberta Altman & Michael Sarg, M.D. Facts on File. (ISBN 0-8160-2608-4)

SEER Extent of Disease, 1998. Codes and Coding Instructions, 3rd Ed. National Cancer Institute, U.S. Department of Health and Human services. (301-496-8510)

Cancer Facts & Figures-(published yearly). American Cancer Society. 1-800-acS-2345.

ICD-O: International Classification of Diseases for Oncology, 2nd ed. Editors: Constance Percy, Valerie Van Holten, Calum muir. World Health Organization, Geneva. 1990. (ISBN 92 4 154414 7)

AJCC Cancer Staging Manual, 5th ed. American Joint Committee on Cancer. Lippincott-Raven. (ISBN 0-397-58414-8)

II. Orientation

General VISTA Orientation

General VISTA Conventions

<ret>	This is the symbol for the return or enter key. Type <ret> after every response, or when you wish to bypass a prompt, or accept a default. Be careful not to press it more than necessary since you may bypass an opportunity to enter valuable information.
?	One question mark will usually produce a message explaining what information is being requested or how it should be entered.
??	Two question marks will usually cause detailed instructions and/or a list of choices to appear.
//	Double slash marks after text indicate that a default response has been provided. If you agree with the default answer, press <ret> to continue to the next prompt. If you would like a different choice, type that choice and press <ret> .
Space Bar Return	A VISTA convention that re-enters the last selection made at a particular level (e.g., At a submenu, it enters the last submenu option accessed. When used at a field, it re-enters whatever was last entered in that field).
^jump	<i>^field name</i> allows you to go from one field to any other field within the same option. (This feature may be limited for some options.)
@	The symbol (shift 2) used to delete data values stored in files.
Caret (^)	The ^ symbol (shift 6) on your keyboard (also known as the up arrow symbol). This is used to exit an option and return to the menu.
dots (...)	Seen after a menu option, indicates that the option has a submenu.

Dates

Examples of Valid Dates:

JAN 20 1999 or 20 JAN 99 or 1/20/99 or 012099

T (for TODAY), T+1 (for TOMORROW), T+2, T+7, etc.

T-1 (for YESTERDAY), T-3W (for 3 WEEKS AGO), etc.

If the year is omitted, the computer uses CURRENT YEAR.

Device Prompts

Enter the name of the printer that you want to send your report to. If the printer is used by others, it is courteous to queue your report by entering "Q" at this prompt and then a device at the next prompt. To view a report on your computer screen, press the <ret> key at the Device prompt.

Note: Report options with (132c) in their name mean that the report requires a printer that can print landscape or on wide paper. These reports do not print well to your screen; text will wrap.

Package Orientation

Oncology uses menus to access functions, i.e., the user is presented with a list of choices for what to do next. You are guided by menus through the tasks that Oncology can do so that you don't have to know computer programming to use it.

The main Oncology Menu appears when you first sign onto the program:

```
SUS    *..Case Finding/Suspense ...
ABS    *..Abstracting/Printing ...
FOL    *..Follow-up Functions ...
LIS    *..Registry Lists ...
ANN    *..Annual Reports ...
STA    *..Statistical Reports ...
UTL    *..Utility Options ...
```

Select DHCP Tumor Registry Option:

The above prompt, Select DHCP Tumor Registry Option, is the starting point for all of the modules within the package. By typing in the three letter synonym (SUS, ABS, etc.) you are taken directly to a group of related submenu options.

III. Package Implementation

Before using Oncology for the first time, it is necessary for you to define your registry's parameters. This may be done by using the Define Tumor Registry Parameters (**TR**) option under the Utilities Menu (**UTL**). If any of the following information changes, such as the name of the Tumor Registrar, use this option to update the parameters. Information entered here is used by the follow-up options.

¹**Note:** Each division may have a unique set of site parameters.

- **If you are in a multi-divisional facility and want to maintain separate registries, you need to enter site parameters for each division.**
- **If you are a multi-divisional facility but there is a primary division that is responsible for one or more other division's cancer cases, this relationship should be recorded in the new Oncology Site Parameters field, Affiliated Division.**

You need to enter the following information:

Hospital Name: Enter the name of your medical center as you want it to appear on letters.

²**Oncology Site Parameters Division:** This is a required response even if you are a single division site. Enter your division or site number.

Street Address: Enter the street address of your medical center.

Zipcode: Enter the Zip Code for your medical center. This determines the city and state so you will not need to enter them.

TR Reference Date: This is the first day of the first month of the year the registry first started keeping data. So if you began keeping data in August 1996, the date to enter would be 1/1/96.

Tumor Registrar: This is the name of the tumor registrar (3 - 30 characters in length) as you want it to appear on letters and reports.

Phone Number: This is the tumor registrar's office phone number.

State Hospital Number: This is the number assigned by the state to your medical center.

VA Station: This is the 3 digit number assigned to your medical center by the VA.

¹ Patch ONC*2.11*25 April 2000 New fields for Multidivisional functionality.

² Patch ONC*2.11*25 April 2000 New fields for Multidivisional functionality.

Institution ID Number: This is the registry number assigned by the American College of Surgeons. It is used to define the registry in the ACoS Call for Data.

Central Registry #: This is the registry number assigned by the state central registry where applicable.

¹**VISN:** This is the Veterans Integrated Service Network.

Division: This is the default response from the entry in the Oncology Site Parameters Division field.

Affiliated Division:

1. If you **are not** an integrated site, bypass this prompt by pressing the <RET> key.
2. If you **are** an integrated site and each site/division manages its own tumor registry, bypass this prompt by pressing the <RET> key.
3. If you **are** an integrated site and one or more sites/divisions do not have a tumor registry and you are responsible for tracking patients from one or more of those sites in your tumor registry, enter each of those here.

Basal Cell Indicator: This response tells the program whether it should eliminate basal cell carcinoma cases from the laboratory pathology searches.

Enter YES to eliminate basal cell carcinoma cases.

Enter NO to include basal carcinoma cases.

Authorized QA User: This is the person who is authorized to run QA reports. Enter the last name <comma> first name with no spaces. Example: Jane Doe would be entered as DOE,JANE. Entering "DOE," will bring up a list of users with the name of DOE.

The following is an example only. User input is shown in bold.

```
Select ONCOLOGY SITE PARAMETERS HOSPITAL NAME: HINES OI
Are you adding 'HINES OI' as a new ONCOLOGY SITE PARAMETERS (the 4TH)? No// Y (Yes)
ONCOLOGY SITE PARAMETERS DIVISION: HINES ISC IL ISC 499

ONCOLOGY SITE PARAMETERS
-----
HOSPITAL NAME.....: HINES OI// <RET>
STREET ADDRESS.....: 123 FIRST AVE.
ZIP CODE.....: 66666
REFERENCE DATE.....: 1/1/96 (JAN 01, 1996)
TUMOR REGISTRAR.....: Jane Doe, CTR
PHONE NUMBER.....: 708-786-7800
STATE HOSPITAL #....: 546
VA STATION #.....: 499
INSTITUTION ID #....: 444444 HINES OI HINES IL
CENTRAL REGISTRY #..: 500
VISN.....: 32
DIVISION.....: HINES ISC// <RET>
```

Select AFFILIATED DIVISION: **ANOTHER VAMC**

¹ Patch ONC*2.11*25 April 2000 New fields for Multidivisional functionality.

Are you adding 'ANOTHER VAMC' as a new AFFILIATED DIVISION (the 1ST for this ONCOLOGY SITE PARAMETERS)? No// **Y** (Yes)
Select AFFILIATED DIVISION: **<RET>**

BASAL CELL INDICATOR: **Y** Yes - Eliminate Basal Cells
Select QA USER: **WILLIAMSON,QA**

Are you adding 'WILLIAMSON,QA' as a new AUTHORIZED QA USER (the 1ST for this ONCOLOGY SITE PARAMETERS)? No// **Y** (Yes)
Select QA USER: **<RET>**

IV. Case Finding and Suspense

(ROADS: Case Eligibility 13-15)

Case finding is a systematic method of locating all eligible cases. Case finding must include all points of service from which a patient may enter the VA health care system for diagnostic or therapeutic services for the management of cancer. Once cases are found, they are held in Suspense (having a date in the Suspense Date field in the Oncology Patient file #160) until they are accessioned for abstracting or manually deleted.

One of the unique features of the Oncology program is Automatic Case Finding. By entering a start and end date, the computer will search pathology, radiology and the Patient Treatment File (PTF) for the date range you selected. Cases meeting the defined criteria are captured electronically and added to suspense.

Since all eligible cases are not necessarily VA patients, the module also provides a means to manually add Non-VA patients to suspense (see Add/Edit/Delete 'Suspense' Case).

Case Finding/Suspense Menu

CF	Automatic Case Finding-(Lab) Search
LR	Print Case Finding-(Lab) Report
RA	Automatic Case Finding-Radiology Search
PT	Automatic Case Finding-PTF Search
SE	Add/Edit/Delete 'Suspense' Case
SP	Print Suspense List by Suspense Date (132c)
TD	Print Suspense List by Month/Terminal Digit (132c)
CS	Print Complete Suspense List by Term Digit (132c)
NP	Oncology Patient List-NO Primaries/Suspense

Case Finding/Suspense ...

Automatic Case Finding-(Lab) Search

Use this option to search the Lab files and build a Suspense list of cases from the search. At the end of the search, you can print the Suspense list on a selected device/printer. The search does not include the Autopsy section.

You can search all Anatomic Path labs or a particular lab and you can choose to include/exclude "suspicious for malignancy cases (Cytopathology)".

Start with Date: This is the date you want the search to begin. Example: If you want the search to cover January 1 - January 31, 1999, your Start with Date would be 1/1/99 or 010199 or JAN 1 1999.

Go to Date: This is the date you want the search to end. For our example, this would be 1/31/99 or 013199 or JAN 31 1999.

Device: Enter the name of your printer here.

CASE FINDING LIST		HINES DEVELOPMENT		07/06/1998	
Patient Name	PtID#	Lab Test	Organ/Tissue	CODE-Morphology (SNOMED)	
DOE, JANE	D1111	01/01/98	BREAST	8140/3	ADENOCARCINOMA
SMITH, JOHN	S9987	01/15/98	PROSTATE	8140/3	ADENOCARCINOMA
JOHNSON, RICH	J2389	01/22/98	SKIN, TRUN	9907/3	CUTANEOUS LYMPH

Case Finding/Suspense ...

Print Case Finding-(Lab) Report

This option generates a list of patients from Suspense that were identified as having reportable malignancies in the pathology package. This report is similar to the findings of the Automatic Case Finding - (Lab) Search and may be printed for previously run lab searches.

You may choose to print all lab cases in Suspense by entering <ret> at the start date prompt or print only those cases within a specified date range.

Start with Suspense Date: First//: Enter the date you want the search to begin or press the <ret> key to pick all cases.

Go to Suspense Date Last: Enter the date you want the search to end or press the <ret> key to accept the last date available. This prompt does not appear if you chose to pick all cases in Suspense.

Device: Enter the name of your printer here.

Case Finding/Suspense ...

Automatic Case Finding-Radiology Search

Use this option to search the Rad/Nuc Med (Radiology/Nuclear Medicine) Patient file for suspicious malignancies and add the cases it finds to Suspense in the Oncology Patient file.

Select Start Date: Enter the date you want the search to begin.

Select Ending Date: Enter the date you want the search to end.

Device: Enter the name of your printer here.

RADIOLOGY CASEFINDING LIST		HINES DEVELOPMENT		07/07/1998	
Patient Name	PtID#	Exam Date	Procedure		
SMITH, PAULA	S1987	06/10/1998	CHEST XRAY		
DOE, MARY JANE	W1212	06/12/1998	MAMMOGRAM UNILAT		
Last Contact: 01/01/1994					
Acc/Seq#	Primary Site	Last Tumor	Status	Date DX	Abst Status
1995-00002/01	LUNG, UPPER LOBE	Evidence this CA		01/01/1993	Complete
1995-00002/02	SKIN, UPPER LIMB	Evidence this CA		01/01/1996	Complete
1995-00002/03	OVARY	Evidence this CA		09/17/1996	Complete
JONES, JACK	J3289	06/15/1998	BONE SCAN		
RADIOLOGY CASE FINDING RESULTS					
3 Cases found					
0 New Patients added					
3 New cases added					

NOTE: In the above printout, the data beneath MARY JANE DOE indicates that the patient has three previous primaries. When the patient has a history of a malignancy, it is necessary to verify whether this new finding is a recurrence versus a new primary.

This option will only yield results if the Radiology Service is entering "diagnostic codes" into their software package at the time of transcription. Please verify if this is the practice at your facility.

Case Finding/Suspense ...

Automatic Case Finding-PTF Search

Use this option to search the PTF (Patient Treatment File) file and add the cases found to your Suspense list in the Oncology Patient file. After entering the dates for your search, the program lists the codes it will capture in the search.

Note: Suspense date = Admission day +1.

Select Start Date: Enter the date you want the search to begin.

Select Ending Date: Enter the date you want the search to end.

Device: Enter the name of your printer here.

PTF-CASE FINDING LIST		HINES DEVELOPMENT		07/07/1998
Patient Name	PtID#	Admit - Disch	Level/ICD9	Description
WALK, FRANK	W9491	03/19/1998-06/08/1998	ICD-2/185.0	MALIGN NEOPL PROSTATE
SAEED, MOHAM	S5878	05/13/1998-06/11/1998	DXLS*/155.2	MALIGNANT NEO LIVER
MOODY, JOHN	M9008	05/19/1998-06/15/1998	ICD-5/189.0	MALIG NEOPL KIDNEY

PTF CASEFINDING RESULTS

73 Cases found
3 New Patients added
3 New cases added

Case Finding/Suspense ...

Add/Edit/Delete 'Suspense' Case

Use this option to manually add patients to the Oncology Patient file (Suspense). These are cancer cases that you have identified through an examination of the medical record/chart and intend to enter into the registry. The patient may be a patient at your facility (VA patient) or a referral patient (Non-VA or ambiguous patient).

If you enter an incorrect suspense date or want to delete the record, you can also use this option to edit the entry or delete the case.

Adding a VA Patient

Patient Name: To add a patient, enter the last name <comma> first name in **caps**, no spaces: E.g., George Will would be entered as WILL,GEORGE. If you know this to be a patient at your site, you may enter just the last name or the first initial of the last name plus the last four numbers of the SSN, e.g., George Will 123-45-6789 would be entered as W6789. The program will search the Patient file to find patients that meet your entry.

When the program finds the patient you want, it will ask if you want to add the patient as a New Oncology Patient. Answer YES.

Suspense Date: Use the date of the exam/test as the Suspense Date.

Adding a Non-VA or Ambiguous Patient

Patient Name: To add a Non-VA or ambiguous patient, enter the last name <comma> first name in **caps**, no spaces: E.g., George Will would be entered as WILL,GEORGE. The program will search your site's database first. If the patient is found, then follow the information under Adding a VA Patient. If the patient is not found, it will ask:

```
Searching for a Non-VA or Ambiguous Patient
Are you adding 'WILL,GEORGE' as a new REFERRAL PATIENT (the 55TH)? No// YES
```

Answer YES to add this person as a new Referral Patient.

Because this is a referral patient, it needs certain information about the patient, so the following questions are also asked:

Referral Patient Sex: Enter M for Male or F for Female.

Referral Patient DOB: Enter the patient's date of birth.

Referral Patient Identifier: This field is looking for something that will identify the patient. This could be a record keeping number or SSN, etc. The SSN is generally used.

Suspense Date: Use the date of the exam/test as the Suspense Date.

Editing/Deleting a Suspense Case

Patient Name: To edit a patient or delete the record, enter an existing patient name: the last name <comma> first name, just the last name, or the first initial of the last name plus the last four numbers of the SSN.

Suspense Date: Enter the correct Suspense Date or enter an "@" to delete the record.

Case Finding/Suspense ...

Print Suspense List by Suspense Date (132c)

Use this option to print a list of patients currently in Suspense. The printout lists patients according to how they were identified, the Source (through Surgical Pathology, Cytopathology, Electron Microscopy, Autopsy, PTF, Radiology, or Manual Entry) and then in the order of the Suspense Date. This report prints the patient's name, the patient's SSN or identifier, Organ/Tissue, Lab Morphology, and Suspense, Admission and Discharge Dates.

Start with Suspense Date: FIRST//: If you accept First by hitting the <ret> key, you will get all the cases with Suspense Dates. If you enter a date at this prompt you will also be prompted for a **Go to Suspense Date**.

Go to Suspense Date: Enter the end date of the range you want the report to cover.

Start with Source:

1. You may select all sources to get all cases within the date range by hitting the <ret> key at this prompt.
2. You may select a single source by entering the code (LS, LC, LE, etc.) for the source (**note: be sure to use capital letters**) at this prompt and the **Go to Source** prompt.
3. You may select a range of sources, a **Start with Source** and a **Go to Source**.

LS	Surgical Pathology
LC	Cytopathology
LE	Electron Microscopy
LA	Autopsy
PT	PTF
RA	Radiology
SE	Manual Entry

Device: Enter the name of your printer here. Choose a printer that prints 132 columns.

SUSPENSE PATIENT LIST					
Patient Name	Med Rec#	Organ/Tissue	Lab Morphology	Suspense Dt	Admission Discharge

SOURCE: PATHOLOGY					
MOODY, JOHN	343-12-4420	PROSTATE	ADENOCAR	02/18/1998	
SOURCE: RADIOLOGY					
LOE, LOEY	222-33-2043			03/20/1996	
DOE, MARY	212-12-1212			06/12/1998	
SOURCE: MANUAL ENTRY					
HILL, BILL	525-30-8292			06/13/1998	

Case Finding/Suspense ...

Print Suspense List by Month/Terminal Digit (132c)

This option will print out a list of patients currently in the suspense file by month and within the month, by the last two digits of the patient's social security number. This report provides the same information as the Print Suspense List by Suspense Date option.

Start with Suspense Month: FIRST//: If you accept First by hitting the <ret> key, you will get all the cases with Suspense Dates. If you enter a date at this prompt you will also be prompted for a **Go to Suspense Month**.

Go to Suspense Month: LAST//: Enter the end date of the range you want the report to cover or accept the Last date by hitting the <ret> key.

Device: Enter the name of your printer here. Choose a printer that prints 132 columns.

```
*****
ONCOLOGY 'Suspense' CHART Request - FILEROOM          JUL 07, 1998
Patient Name      Med Rec#      Organ/Tissue      Lab Morphology      Suspense Dt      Admission Discharge
*****
                                SUSPENSE MONTH:  MAY 1998
BROWN,JIM        785-22-0838
CROW,JOHN        879-23-2945  COLON,ASC          CARCINOID          05/15/1998
                                05/19/1998
                                SUSPENSE MONTH:  JUN 1998
DOE,MARY         212-12-1212
MOODY,JOHN       343-12-4420
HILL,BILL        525-30-8292
                                06/12/1998
                                06/13/1998
                                06/18/1998
```

Case Finding/Suspense ...

Print Complete Suspense List by Term Digit (132c)

This report prints out every case in Suspense providing the same information as the Print Suspense List by Suspense Date and Print Suspense List by Month/Terminal Digit options. The patients are listed according to their social security numbers.

Device: Enter the name of your printer here. Choose a printer that prints 132 columns.

Case Finding/Suspense ...

Oncology Patient List-NO Primaries/Suspense

This option prints a listing of Oncology patients that do not have a Primary or Suspense Date.

Device: Enter the name of your printer here.

ONCOLOGY PATIENT ONLY				
Patient Name	Med Rec#	Suspense Dt	Last Admit	Last Dischg

NO PRIMARY: 1				
BIRD, K G	342-56-9870	01/28/1999	04/03/1998	
BOLTON, MITCH	301-40-5531	03/10/1998		
BRANDMEIER, JON	123-45-6979		01/18/1995	
COOPER, ALICE	258-42-8623	02/05/1998		
HENDERSON, MICHAEL	222-18-9831	05/10/1998		
HEARTBURN, AUDREY	235-28-3126	06/10/1998		
KANGAR, KAPTAIN	893-83-2788	02/05/1998		
LANDAU, MARTIE	001-22-9748	04/16/1998		
LOE, LOEY JR	222-33-2043	03/20/1996	02/13/1997	
LOLA, GINA	221-38-9483	03/04/1998		
LU, LULU	111-77-2043	04/13/1995	04/12/1995	05/22/1995
MCDONALD, THOMAS	345-54-1234	01/23/1999		
NIMOY, LEO	239-38-4012	04/28/1998		

V. Abstract Entry and Printing

An abstract must be completed for all analytic and nonanalytic cases that meet the criteria for inclusion in the registry. The abstract is a summary of pertinent information about the patient, the cancer, the treatment, and outcome. Components include patient information, cancer identification, extent of disease, stage at diagnosis, first course of treatment, recurrence and subsequent therapies or progression and follow-up. The abstract must contain the items in the required ACoS' ROADS Manual.

If a patient has multiple primary malignancies, an abstract must be prepared for each additional primary diagnosed or treated at the reporting institution. Abstracts must be completed within six months from the date of the initial diagnosis.

Abstracting/Printing Menu

AI	Complete Abstract
EE	Abstract Edit Primary
NC	Print Abstract NOT Complete List
IR	Patient Summary
BA	Print Abstract-Brief (80c)
EX	Print Abstract-Extended (80c)
PA	Print Complete Abstract (132c)
MA	Print QA/Multiple Abstracts
AS	Abstract Screens Menu (80c) ...
PI	Patient Information
FH	Family History
PC	Physician Contact
CI	Cancer Information
ED	Extent of Disease at Diagnosis
TR	Treatment - (First Course)
RC	Recurrence
ST	Subsequent Therapy
FU	Follow-up
CA	Complete Abstract

¹WS Edit/print worksheet

¹ Patch ONC*2.11*23 New option.

Abstracting/Printing ...

Complete Abstract

The Complete Abstract option is the main entry point for abstracting each new case or editing existing abstracted cases. You can add new primaries, edit existing primaries, and enter follow-up. The program is prompt driven: once a specific site group (Site/Gp) has been selected, all further prompts displayed will only permit data to be entered that is pertinent to the specific site currently being abstracted.

Some of the data previously captured in the Case Finding and Suspense process as well as demographics data will be automatically transferred and inserted into the appropriate fields within the abstract.

Entering one question mark (?) at any prompt will usually produce a message explaining what information is being requested and how it should be entered. Two question marks (??) will usually cause detailed instructions and/or a list a choices to appear. More in-depth coding instructions and rules are found in the ROADS Manual and in the SEER Codes and Coding Instructions Manual. While this program makes extensive use of help screens, it is not intended to replace the need to reference appropriate manuals. A worksheet can be found at the back of this manual and duplicated for use in gathering your information.

Patient Name: Enter the patient's name LAST,FIRST or identifier here. If this is a new patient to Oncology, then the program will take you through the same entries you made when adding a new patient to suspense using the Add/Edit/Delete 'Suspense' Case option. You will add the patient to Suspense and then to the Oncology Patient file.

When a patient is new to abstracting, then information on the patient from the Patient file or the Referral file will be displayed and is not editable. After the display, the following prompts appear for editing.

Adding a New Primary

Patient Data

(ROADS: 70-75)

Most of the prompts within the Patient Data section have a list of selections that can be seen by entering ? or ?? at each prompt.

Place of Birth: Enter the name of a country or state where the patient was born.

Race: Enter the patient's race.

Spanish Origin: Select from the list of choices or strike the <ret> key.

Sex: Select from the list of choices.

Note: The following fields are VA specific and will not be found in the ROADS Manual.

Was the patient exposed to any of the following? Enter the appropriate answer.

Agent Orange Exposure: YES, NO or UNKNOWN.

Ionizing Radiation Exposure: YES, NO or UNKNOWN.

Persian Gulf Service: YES, NO or UNKNOWN.

Chemical Exposure: YES, NO or UNKNOWN.

Asbestos Exposure: YES, NO or UNKNOWN.

Patient History Module

(ROADS: 84-87)

The following prompts cover the patient's occupation, tobacco and alcohol use, and family cancer history. Remember to use ?? to bring up a list of choices.

Occupation: Select the patient's occupation.

Years in Occupation: Enter the duration of employment in the occupation in years.

Last Date in Occupation: Enter the last date of employment in the occupation.

Industry/Address: Enter the industry in which patient worked, or the name and address of patient's employer in 3 - 40 characters.

¹**Tobacco History:** Use codes 0-9 for patients accessed in 1999 or later. Use Y, N and U for patient accessed prior to 1999. The selections are screened for the accessed year.

Y	Yes
N	No
U	Unknown
0	Never used
1	Cigarette smoker, current
2	Cigar/Pipe smoker, current
3	Snuff/Chew/Smokeless, current
4	Combination use, current
5	Previous use
9	Unknown

²**Alcohol History:** Use codes 0-9 for patients accessed in 1999 or later. Use Y, N and U for patient accessed prior to 1999. The selections are screened for the accessed year.

Y	Yes
N	No
U	Unknown
0	No history of alcohol use
1	Current use of alcohol
2	Past history of alcohol use
9	Alcohol usage unknown

Family History of Cancer: Code whether the patient has a family history of any reportable malignancy. Enter YES, NO, or UNKNOWN.

If YES, you are asked further questions (specific to the VA) concerning the family history.

¹ Patch ONC*2.11*22 Tobacco History dialog changed for patients accessed in 1999 or later.

² Patch ONC*2.11*22 Alcohol History dialog changed for patients accessed in 1999 or later.

Family Member with Cancer: Select the family member.

F Father
M Mother
B Brother
S Sister
U Uncle
A Aunt
NI Niece
NE Nephew

Note: When there is a history of occurrence of multiple Family members of the same type (e.g., two sisters or two uncles) the second entry should be typed enclosed in quotation marks. Typing it in quotation marks allows the System to recognize all additional entries. Example:

First entry = SISTER

Second entry = "SISTER"

Location of Cancer: Select from the list of locations.

BLADDER	GALLBLADDER	MELANOMA	STOMACH
BONE	HEAD & NECK	MYELOMA	TESTIS
BRAIN	KIDNEY	OTHER	THYROID
BREAST	LEUKEMIA	OVARY	UNKNOWN
CERVIX	LIVER	PANCREAS	UTERUS
COLON & RECTUM	LUNG	PROSTATE	
ESOPHAGUS	LYMPHOMA	SKIN	

Registering a Primary

(ROADS: 38-42)

Register a Primary for this patient? Yes// <ret>

Primary 'SITE/GP': By entering either the site group name or the ICDO Topography code (C code), the program will assign the case to the appropriate group and trigger all subsequent fields to display only the information relating to the selected site.

All cases must be assigned to one of the following site groups.

Note: Be sure to type the site/gp in UPPERCASE.

AMPULLA OF VATER	HEMATOPOIETIC/RE, OTHER	PANCREAS, EXOCRINE
BLADDER	KIDNEY & OTHER URINARY	PHARYNX
BONE	LARYNX	PLASMA CELL DISORDERS
BRAIN	LIP	PROSTATE
BREAST	LIVER	RECTUM/ANUS
CERVIX	LUNG	SKIN
COLON	LYMPH NODES	SMALL INTESTINE
DIGESTIVE, OTHER	MALE GENITAL, OTHER/PENIS	SOFT TISSUE
ENDOCRINE, OTHER	NASAL CAVITY/SINUS/EAR	STOMACH
ESOPHAGUS	NERVOUS SYSTEM, OTHER	TESTIS
EXTRAHEPATIC BILE DUCTS	ORAL CAVITY	THYROID
FEMALE GENITAL, OTHER	OTHER/MISCELLANEOUS	UNKNOWN
GALLBLADDER	OVARY	UTERUS

If this is the first primary entered for this patient, a new primary record is created for this patient and you are asked for:

Accession Year: Enter the year this case was entered into the registry. Generally you can accept the default year.

Accession No.: Strike the <ret> key to accept the accession number.

Sequence No.: Strike the <ret> key to accept the sequence number.

If this is not the first primary entered for this patient, then all the primaries for the patient will be listed, and you will be given the opportunity to edit any or all of the primaries or add another.

```
Acc/Seq#   Primary Site           Last Tumor Status   Date DX   Abst Status
1998-00010/00  BREAST, LOWER-OUTER  QU No evid this CA  04/25/1998  Incomplete
```

Note: The above status line reflects this patient's accessioned primaries.

Editing a New or an Existing Primary

After entering a new primary, the program takes you to this edit portion. If you want to edit an existing primary and bypass all the previous information in the abstract, enter NO at the "Edit patient data? YES/" and the "Continue with Patient History? Yes/" prompts to bring you to the following:

```
E      EDIT existing Primary
A      ADD another Primary
F      Follow-Up
Q      Quit Patient
```

EDIT/ADD primary for this patient: Edit// **E**

Select A below to edit all the information or select the portion of the abstract you want to edit.

```
-----
                          Primary Sub-menu Options
-----
```

1. Patient Identification
2. Cancer Identification
3. Stage of Disease at Diagnosis
4. First Course of Treatment
5. Patient Care Evaluation

A All - Complete Abstract

Enter option: All// **A**

Patient Identification

(ROADS: 53-88)

Patient Name	Patient Identification	Site
SSN		

Reporting hospital.....:		
Marital status at Dx.....:	Unknown	
Patient address at Dx.....:		
City/town at Dx.....:		
State at Dx.....:		
Postal code at Dx.....:		
County at Dx.....:		
¹ Census Tract.....:		
Primary surgeon.....:		
Following physician.....:		
Managing physician.....:		
Other physician (3).....:		
Other physician (4).....:		
Primary payor at Dx.....:		
Type of reporting source.....:		

Reporting Hospital: This answer may be stuffed for you with no entry required.

Marital Status at Dx: Record the patient's marital status at time of diagnosis.

- 1 Single/Never married
- 2 Married/Common Law
- 3 Separated
- 4 Divorced
- 5 Widowed
- 9 Unknown

Patient Address at Dx: Enter the number and street address of the patient's usual residence when the tumor was diagnosed and treated. If the patient's address is not known, enter UNKNOWN.

City/Town at Dx: Enter the city or town of the patient's usual residence when the tumor was diagnosed and treated. If the city is not known, record UNKNOWN.

State at Dx: Record the state or Canadian province of the patient's usual residence when the tumor was diagnosed and treated. If the patient is a resident of a country other than Canada or the United States, record XX. If it is known that the patient is not a resident of Canada or the United States and the country of residence is unknown, code YY.

Postal Code at Dx: For US residents, record the patient's 9-digit extended postal code at the time of diagnosis and treatment for this primary. When the 9-digit code is unavailable, record the 5-digit postal code. When available, record the postal code for other countries. Record 8s when the postal code is not known.

¹ Patch ONC*2.11*26 August 2000 New field.

888888888 Permanent address in a country other than Canada, United States, or US possessions AND postal code is unknown.

999999999 Permanent address in Canada, United States, or US possessions AND postal code is unknown.

County at Dx: Enter the county of the patient's usual residence when the tumor was diagnosed. This data item is required for residents of the reporting institution's state only.

998 Patient resides outside of the state of the reporting institution

999 Unknown county/country

¹**Census Tract:** enter a 6 digit number identifying the patient's usual residence at the time the tumor was diagnosed. To code Census Tract, assume the decimal point is between the fourth and fifth positions of the field. Add zeros to fill all six positions.

Example: Census Tract 409.6 would be coded 040960, and Census Tract 516.21 would be coded 051621.

000000 Area is not census tracted

999999 Area is census tracted, but census tract is not available

Note: For the following fields, if you enter a surgeon or physician new to the Oncology package, you will also be asked to define the type of contact (Patient, Physician, Contact Person, Institution, Other, or Government Agency). This information is used when creating follow-up contact letters.

Primary Surgeon: If the patient had surgery, enter the primary surgeon's name.

Following Physician: Enter the primary following physician.

Managing Physician: Enter the name of the physician primarily responsible for managing the patient.

Other Physician (3....): Enter any other physician who might be a contact.

Primary Payor at Dx: Code the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment. This item is used in financial analysis and as an indicator for quality and outcome analyses.

10 Private insurance

20 Managed care provider, NOS

21 Health Maintenance Organization (HMO)

22 Preferred Provider Organization (PPO)

30 State funded, NOS

31 Medicaid

¹ Patch Onc*2.11*26 August 2000 New field.

- 32 Welfare
- 40 Federally funded, NOS
- 41 Medicare
- 42 Medicare with supplement
- 43 Champus
- 44 Military
- 45 Veterans Administration
- 46 Indian Health Service
- 47 Public Health Service
- 88 Insured, NOS
- 99 Unknown
- 00 Not insured, NOS
- 01 Not insured, charity write-off
- 02 Not insured, self-pay

Type of Reporting Source: Enter the appropriate code.

- 1 Hospital inpatient/outpatient, clinic
- 3 Laboratory only (hospital or private)
- 4 Physician office
- 5 Nursing/convalescent home, hospice
- 6 Autopsy only
- 7 Death certificate only

Note: The hospital record for an inpatient with a cancer diagnosis (before death) takes precedence over other types of reports.

Cancer Identification

(ROADS: 91-120)

Patient's Name	Cancer Identification	Site
SSN	ICDO Topography	

Class of Case.....:
Referring Facility.....:
Transfer Facility.....:
First Admit Date.....:
Discharge Date.....:
IP/OP Status.....:
Screening Result.....:
Screening Date.....:
Date Dx.....:
Laterality.....:
Histology.....:
Grade/Differentiation.....:
Dx Confirmation.....:
Tumor Marker 1.....:
Tumor Marker 2.....:
Tumor Marker 3.....:
Pres at Cancer Conference...:
Referral to Supp Services...:

Note: The Tumor Marker fields appear only when applicable.

Date DX: The diagnosis date refers to the first diagnosis of this cancer by any recognized medical practitioner. This is often a clinical diagnosis and may not ever be confirmed histologically. Even if confirmed later, the diagnosis date refers to the date of the first clinical diagnosis and not to the date of confirmation. If upon medical and/or pathological review of a previous condition the patient is deemed to have had cancer at an earlier date, then the earlier date is the date of diagnosis, i.e., the date of diagnosis is back-dated.

Note:

Death Certificate Only cases: The date of diagnosis is the date of death.

Autopsy Only cases: The date of diagnosis is the date of death.

Absence of Exact Date of Diagnosis: Make the best approximation.

1. If the only information is "Spring of," "Middle of the year," "Fall," approximate these as April, July, and October respectively. For "Winter of" it is important to determine whether the beginning or end of the year is meant before approximating the month.
2. If there is no basis for approximation of month, simply enter the year.
3. If the year is not known exactly, approximate as best you can.
4. Date of first cancer-directed therapy may be used as the date of diagnosis if the cancer-directed therapy has been initiated and cancer is later confirmed, but prior to therapy the diagnosis was not definitive.

Class of Case: The Class of Case divides the data into analytic and nonanalytic categories.

0 Dx here, 1st rx ew

- First diagnosed at the reporting institution since the registry's reference date and all of the first course of therapy elsewhere.
- 1 Dx here & 1st rx here
First diagnosed and all or part of the first course of therapy at the reporting institution.
 - 2 Dx ew, 1st rx here
First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution after the registry's reference date.
 - 3 Dx ew, 1st rx ew
First diagnosed and all of the first course of therapy elsewhere
 - 4 Dx or 1st rx before ref date
First diagnosed and first course of therapy at the reporting institution before the reference date of the registry.
 - 5 Dx at autopsy
First diagnosed at autopsy.
 - 6 Dx & [1st] rx in staff MD office
Diagnosed and all of the first course of treatment only in a staff physician's office.
 - 8 Dx by death cert only
Diagnosis established only by death certificate.
 - 9 Unknown

Note: For the next two facility prompts, if you wish to add a new facility, enter the assigned ACOS ID Number. (Enter ?? to bring up a list of hospitals.) If the new facility does not have an assigned ACOS ID Number, use the next available local ACOS ID Number.

Referring Facility: Enter facility that referred the patient to your hospital.

Transfer Facility: This field identifies the institution to which the patient was referred for further care after discharge from the reporting institution.

First Admit Date: Enter the date of the first admission to your site or the reporting facility. If the patient was diagnosed in an outpatient clinic, this date and the date of discharge will be the same as the diagnosis date.

Discharge Date: Enter the date of discharge from the reporting facility. If the patient was diagnosed in an outpatient clinic, this date and the date of first admission will be the same as the diagnosis date.

Inpatient/Outpatient Status: Identify the point of access used to initially diagnose and/or treat the patient.

- 1 Inpatient only
- 2 Outpatient only

- 3 In and outpatient
- 8 Other, including physician's office
- 9 Unknown

Screening Result: This item categorizes findings from the most recent screening(s), serves as a triage for patient notification, and acts as a tickler file to aid the institution in meeting patient notification requirements.

- 0 Within normal limits
- 1 Abnormal/not suggestive of cancer
- 2 Abnormal/suggestive of cancer
- 3 Equivocal/no follow-up necessary
- 4 Equivocal/evaluation recommended
- 8 NA
- 9 Unknown result, not specified

Screening Date: Record the most recent date on which the patient participated in a screening program related to this primary cancer.

Dx Facility: Record the ACOS ID number of the facility diagnosing this case. If you wish to add a new facility, enter the assigned ACOS ID Number. (Enter ?? to bring up a list of hospitals.) If the new facility does not have an assigned ACOS ID Number, use the next available local ACOS ID Number.

ICDO-Topography: Answer with the appropriate code.

The Topography section of the International Classification of Diseases for Oncology (ICD-O-2, 1990) is used for coding the Primary Site of all cancers.

Note: The "C" preceding the number is automatically included by the package, type only the code (e.g., Lip - C00.9, type only 00.9).

Text-Primary Site: Record any additional primary site information (1 - 40 characters in length).

Laterality: Laterality at diagnosis describes this primary site only. Note that bilateral involvement (code '4') concerns tumors stated to be a single primary where lateral origin is unknown.

- 0 Not a paired site
- 1 Right (origin of primary)
- 2 Left (origin of primary)
- 3 Only one side involved, unknown which
- 4 Bilateral involvement, side of origin unknown, stated to be a single primary
Including:
 - Both ovaries involved simultaneously, single histology
 - Bilateral retinoblastomas
 - Bilateral Wilms's tumors
- 9 Paired site, but no information concerning laterality

Note: The package automatically stuffs 0 for all sites which are not paired sites.

Histology: The International Classification of Diseases for Oncology, Morphology ICD-O-2, 1990, is used for morphology of all cancers. In the Alphabetic Index, all morphology codes are indicated by 'M-' preceding the code number. The 'M-' should not be coded. The '/' appearing between the histology and behavior may optionally be entered. Note: 5th digit behavior codes of 6 and 9 are never used in a tumor registry.

Text Histology: Record any additional information.

Grade/Differentiation: Describe the tumor's resemblance to normal tissue. Well differentiated (grade I) is the most like normal tissue.

- | | | |
|---|---------------------|---|
| 1 | Grade I | Well differentiated, NOS |
| 2 | Grade II | Moderately, moderately well, intermediate |
| 3 | Grade III | Poorly differentiated |
| 4 | Grade IV | Undifferentiated/anaplastic |
| 5 | T-cell | Lymphomas and leukemias, T-cell |
| 6 | B-cell | Lymphomas and leukemias, B-cell, Pre-B |
| 7 | Null cell | Leukemias only, Null cell, Non T-non B |
| 8 | Natural killer cell | Lymphomas and leukemias |
| 9 | Unknown | Not determined, stated or applicable |

Diagnostic Confirmation: Diagnostic Confirmation specifies whether a malignancy was confirmed microscopically **at any time** during the disease course. This is a priority coding scheme with code 1 taking precedence. A low number takes priority over all higher numbers. This data item is dynamic and must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.

Microscopically Confirmed

- 1 Positive Histology
- 2 Positive Cytology
- 4 Positive Microscopic, method NOS

Not Microscopically Confirmed

- 5 Positive lab test
- 6 Direct visualization
- 7 Radiography/other imaging techniques
- 8 Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

- 9 Unknown if microscopically confirmed

Tumor Marker 1:

Tumor Marker 2:

Tumor Marker 3:

} Note: These Tumor Marker fields appear only when applicable.

Presentation at Cancer Conf: This item documents case presentation at a cancer conference and the type or format of presentation.

- 0 Not presented
- 1 Prospective (diagnostic)
- 2 Prospective (treatment)
- 3 Prospective (follow-up)
- 4 Prospective (combinations)
- 5 Prospective, NOS
- 6 Retrospective
- 7 Follow-up
- 8 Presentation, NOS
- 9 Unknown

Date of Cancer Conf: If there was a presentation at a conference, this prompt will appear for editing. Otherwise it will be bypassed with 00/00/0000 for a date.

Referral to Support Services: Record if the patient was referred to any of the following services.

- 0 No
 - 1 Yes
 - 9 Unknown
- Enterostomal/stomal therapy
Home care
Hospice
Infusion/parenteral therapy
Nutritionist
Occupational therapy
Other
Patient services (American Cancer Society)
Patient services (other)
Patient support group (American Cancer Society)
Patient support group (hospital operated)
Patient support group (other organization/agency)
Physical therapy
Referral; service unspecified
Rehabilitation facility
Respiratory therapy
Speech therapy
Visiting nurse assistance

Note: Use the following word processing fields to justify staging of the patient.

Text-Dx Proc-PE: This is an unlimited text field for entering chief complaint, presenting symptoms and any other pertinent data pertaining to the diagnosis.

Text-Dx Proc-X-ray/Scan: This is an unlimited text field for entering diagnostic radiology results. Entries should include: date of test, test type, facility where test performed, and test result.

Text-Dx Proc-Scopes: This is an unlimited text field for entering diagnostic procedures and endoscopies.

Text-Dx - Lab Tests: This is an unlimited text field for entering laboratory test results.

Text-Dx Proc-Op: This is an unlimited text field for entering diagnostic operative procedures.

Text-Dx Proc-Path: This is an unlimited text field for entering the results of cytology, surgical pathology, autopsy, electron microscopy, flow cytometry, immunoassay, etc results.

Stage of Disease at Diagnosis

(ROADS: 121-178E)

Many of the prompts below contain selections that are specific to the tumor. Enter ?? to obtain a list of choices.

```
-----
Patient's Name          Stage of Disease at Diagnosis          Site
SSN                    ICDO Topography
-----
Size of Tumor.....:
Extension.....:
Lymph Nodes.....:
Nodes Examined.....:
Nodes Positive.....:
Metastasis #1.....:
Metastasis #2.....:
Metastasis #3.....:
Summary Stage.....:

Clinical Staging      TNM edition:      Pathologic Staging
-----
TNM.....:            TNM.....:
Stage Group:         Stage Group:
Staged By..:         Staged By..:

Other Stage.....:
1st Positive Biopsy:
-----
```

Size of Tumor: Record the exact size of the primary tumor in millimeters as specified in the pathology report. If the pathology report does not have the tumor size recorded, use information from the operative report followed by X-rays, scans, or physical exam.

Round decimals to the nearest tenth. If more than one size of tumor is given, code to the largest size.

Examples: A 3x4.4x2.5 cm tumor is recorded 44. 2.5x1.0 cm tumor is recorded 25.

The size of the tumor is not applicable for the following sites. Record 999 for the size.

Hematopoietic neoplasms

Leukemia

Multiple myeloma

Lymphomas, including mycosis fungoides

Kaposi's sarcoma

Letterer-Siwe's disease

Reticuloendotheliosis

Unknown or ill-defined primary site(s)

Note: When tissue specimens are fragmented, use code 999 - DO NOT ADD THEM TOGETHER.

Melanomas are measured in depth (Breslows scale) and are usually in .00 mm. Record the actual depth of invasion instead of size.

Extension: Enter the Seer Extent of Disease coding schema. Type a ? and a site specific list of selections will be displayed.

Lymph Nodes: Record SEER lymph node involvement. Type a ? and a site specific list of selections will be displayed.

Note: For the fields, Nodes Examined and Nodes Positive, use code 99 for the following:

- Brain
- Leukemia
- Lymphoma
- Multiple myeloma
- Reticuloendotheliosis
- Letterer-Siwe's disease
- Unknow primary

Nodes Examined (Regional): Record the total number of regional nodes examined by a pathologist. Use only regional lymph nodes (identify regional nodes using the pN classification from the AJCC Cancer Staging Manual, Fifth Edition) or ROADS Appendix D, Cancer-Directed Surgical Codes.

For primaries with a DATE DX before 1998:

- 97 Ninety-seven or more regional lymph nodes examined
- 98 Nodes Examined, but number NOT specified, including positive lymph node aspiration
- 99 Unknown if nodes were examined; Not applicable

For primaries with a DATE DX of 1998 or later:

- 90 Ninety or more regional lymph nodes removed
- 95 No regional lymph nodes removed but aspiration was performed
- 96 Lymph node removal documented as a sampling, number of nodes unknown
- 97 Lymph node removal documented as dissection, number of nodes unknown
- 98 Lymph nodes surgically removed, but number of nodes unknown and not documented as a sampling or dissection
- 99 Unknown; not stated; death certificate only

Nodes Positive (Regional): Describe the number of regional nodes examined by the pathologist and reported as containing cancer. Code only regional lymph nodes.

- 00 All nodes negative

01	1
02	2
..	
10	10
..	
96	96 or more positive nodes
97	Positive nodes, # not specified
98	No nodes examined
99	Unk if nodes + or -, NA

Metastasis 1: Record the code for the site of distant metastasis. Enter '0' if there are no distant metastasis.

0	None (when there are less than three sites of distant metastasis.)
1	Peritoneum (includes the peritoneal surfaces of all structures within the abdominal cavity and positive ascitic fluid.)
2	Lung (includes the visceral pleura.)
3	Pleura (includes the pleura surface of all structures within the thoracic cavity and positive pleural fluid.)
4	Liver (includes only the liver.)
5	Bone (includes bones other than the primary site.)
6	Central nervous system (includes the brain and spine. This does not include the external eye.)
7	Skin (includes skin other than the primary site.)
8	Lymph nodes (distant) (includes lymph nodes not classified as regional. Refer to a staging scheme for a description of lymph nodes considered distant for a particular site.)
9	Other/Gen/Carcinomatosis/Unkn (includes bone marrow.)

Metastasis 2: Same as Metastasis 1.

Metastasis 3: Same as Metastasis 1.

Summary Stage: Record the General Summary Stage of the tumor at initial diagnosis or treatment.

0	In situ
1	Localized
2	Regional Extension
3	Regional Nodes
4	Regional Extension & Nodes
5	Regional NOS
7	Distant Mets/systemic disease
	Includes:
	Leukemia
	Multiple Myeloma

- Reticuloendotheliosis
- Letterer-Siwe's Disease
- 9 Unknown/Unstaged
 - Includes:
 - Unknown primaries
 - Class 3 or 4 when the stage at initial diagnosis is unknown

Multiple Tumors: Document the existence and (if known) number of multiple tumors at an anatomic site. If there are NOT multiple tumors at this site, leave this field BLANK. If there ARE multiple tumors at this site, enter the exact number of tumors here if known, or a 1 if the exact number is not known.

Clinical T: Enter the Primary Tumor (T). Use ?? to obtain a list of choices.

Clinical N: Enter the Regional Lymph Nodes (N). Use ?? to obtain a list of choices.

Clinical M: Enter the Distant Metastasis (M). Use ?? to obtain a list of choices.

Staged By (Clinical Stage): Identify the person who documented the clinical AJCC staging elements and the stage group.

- 0 Not staged
- 1 Managing physician
- 2 Pathologist
- 3 Other physician
- 4 1, 2, or 3
- 5 Registrar
- 6 5 with 1, 2, or 3
- 7 Other
- 8 Staged, indiv unspecified
- 9 Unknown if staged

Multimodality Therapy (Path): The first method of therapy is other than cancer-directed surgery. The patient is first treated with radiation therapy, chemotherapy, hormone therapy, immunotherapy, "other" therapy, or any combination of these therapies. The stage is based on a pathologic resection of the primary done after at least one of the other therapies has started. The other therapy may or may not be complete. This stage should supplement the clinical AJCC stage, not replace it. This field corresponds to the ROADS field called "Clinical Stage (Prefix/Suffix) Descriptor" and will add a "y" to the TNM stage.

- Y Yes
- N No

Pathologic T: Enter the Pathologic Primary Tumor (T). Use ?? to obtain a list of choices.

Pathologic N: Enter the Pathologic Regional Lymph Nodes (N). Use ?? to obtain a list of choices.

Pathologic M: Enter the Pathologic Distant Metastasis (M). Use ?? to obtain a list of choices.

Staged By (Pathologic Stage): Identify the person who documented the pathologic AJCC staging elements and the stage group.

- 0 Not staged
- 1 Managing physician
- 2 Pathologist
- 3 Other physician
- 4 1, 2, or 3
- 5 Registrar
- 6 5 with 1, 2, or 3
- 7 Other
- 8 Staged, indiv unspecified
- 9 Unknown if staged

Other Stage: Enter Other Staging appropriate to Site. Use ?? to obtain a list of choices.

Type of Staging System (Pediatric): This prompt is automatically bypassed.

Pediatric Stage: This prompt is automatically bypassed.

Staged By (Pediatric): This prompt is automatically bypassed.

Date of 1st Positive Biopsy: Record the date of the first positive incisional or excisional biopsy. The biopsy may be taken from the primary or a secondary site. This data item refers to a tissue biopsy/positive histology only. The first positive biopsy may be at any time during the disease course. It may be non cancer-directed or cancer-directed surgery.

Note: If you are staging a Breast or Prostate tumor, the following data fields appear.

For Breast:

Biopsy Procedure: Record the biopsy procedure if the primary site is breast or prostate.

- 0 Not done, not a separate procedure
- 1 Biopsy, NOS
- 2 Fine needle aspiration (cytology)
- 3 Core biopsy (histology)
- 5 Excision of major duct
- 9 Unknown/death cert only

Guidance: Record the guidance if the primary site is breast or prostate.

- 0 Not guided, no biopsy
- 1 Guided, NOS

- 2 Radiographic NOS (no dye or dye unknown)
- 3 Mammographic, wire/needle localization
- 4 Stereotactic
- 5 Dye only
- 6 Dye plus (1-3)
- 7 Ultrasound
- 9 Unknown/death cert only

Palpability of Primary: Record the palpability of primary if the primary site is breast.

- 0 Not palpable
- 1 Palpable
- 9 Not stated/death cert only

First Detected By: Record how it was first detected if the primary site is breast.

- 0 Not a breast primary
- 1 Patient felt lump/nipple discharge
- 2 Physician felt lump
- 3 Mammography - routine
- 4 Occult, incidental finding
- 9 Unknown

For Prostate:

Biopsy Procedure: Select one of the following:

- 0 Not done, not separate proc
- 1 Incisional biopsy, NOS
- 2 Fine needle aspiration (cytology)
- 3 Needle core/biopsy gun (histology)
- 4 Sextant biopsy
- 9 Unknown/death cert only

Guidance: Select one of the following:

- 0 Not guided, no biopsy
- 1 Guided, NOS
- 2 Radiographic
- 3 Ultrasound
- 9 Unknown/death cert only

Approach for Biopsy of Primary: Record the approach.

- 0 No biopsy
- 1 Transrectal
- 2 Transperineal
- 3 Transurethral
- 4 Laparoscopic
- 5 Open (laparotomy)
- 9 Unknown/death cert only

Biopsy of Other than Primary: Select one of the following:

- 0 None
- 1 Seminal vesicle(s), NOS
- 2 Unilateral
- 3 Bilateral
- 4 Other than seminal vesicle
- 5 4 + 1
- 6 4 + 2
- 7 4 + 3
- 9 Unknown/death cert only

First Course of Treatment

(ROADS: 179-251)

Patient's Name SSN	First Course of Treatment	Site ICDO Topography
-----------------------	---------------------------	-------------------------

First course of treatment...:
Non cancer-directed surgery...:
Non ca-dir surg @facility...:
Surgery of primary site...:
Surg primary site @facility...:
Radiation...:
Radiation @facility...:
Radiation therapy to CNS...:
Chemotherapy...:
Chemotherapy @facility...:
Hormone therapy...:
Hormone therapy @facility...:
Immunotherapy...:
Immunotherapy @facility...:
Other treatment...:
Other treatment @facility...:

****NOTE** CLASS OF CASE: Note: Depending on the entry in the Class of Case field, this may or may not appear.**

NON CANCER-DIRECTED SURGERY

Non cancer-directed surgery...:
Non ca-dir surg @facility...:

Non Cancer-Directed Surgery

Non Cancer-Directed Surgery: Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are NON CANCER-DIRECTED SURGERY.

- 00 No surgical procedure
- 01 Incisional, needle, or aspiration biopsy of other than primary site
- 02 Incisional, needle, or aspiration biopsy of primary site
- 03 Exploratory ONLY (no biopsy)
- 04 Bypass surgery (no biopsy); -ostomy ONLY (no biopsy)
- 05 Exploratory ONLY and incisional or needle biopsy of primary or other sites
- 06 Bypass surgery or -ostomy ONLY and incisional or needle biopsy
- 07 Non-cancer-directed surgery, NOS
- 09 Unknown if surgery done

Non Cancer-Directed Surg Date: Enter the date of the surgery.

Non CA-Dir Surg @Facility: Record any non cancer directed surgery (diagnostic biopsies, etc.) done at your facility. Depending on the content in the Class of Case field, this field may be stuffed.

Non CA-Dir Surg @Facility Date: Record the date of the non cancer directed surgery done at your facility. Depending on the content in the Class of Case field, this field may be stuffed.

Date of No Treatment: If the physician decides not to treat the patient, record the date of this decision as the DATE OF NO TREATMENT. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

Number of Nodes Removed: Record the number of lymph nodes removed in the above procedure.

Scope of Ln Surgery @Facility: Record the extent of lymph node dissection performed at your facility. This field may duplicate the information recorded in the field above.

Scope of Ln Surg @Facility Dt: Record the date of the lymph node surgery done at your facility.

Num of Nodes Removed @Facility: Record the number of lymph nodes removed in the above procedure.

Surgery of Other Sites/Nodes: Enter the code for surgery of other regional site(s), distant site(s) or distant lymph node(s) in this field.

Surgery Oth Sites/Nodes Date: Enter the date the surgery was done. This prompt is bypassed if there was no surgery on other sites/nodes.

Surg Oth Site/Nodes @Facility: Enter any other procedure performed at your facility, this field may duplicate the information recorded above.

Surg Oth Sites/Nodes @Fac Date: Record the date of this procedure.

Reconstruction/Restoration: Select the type of reconstructive/restorative surgery done. Reconstructive surgery reconstructs, restores, or improves the shape and appearance or function of body structures that are missing, defective, damaged or misshapen by cancer or cancer-directed therapies.

Text-RX-Surgery: Enter any additional comments about the surgical treatment.

Reason for No Surgery: Record the reason for no cancer-directed surgery. Codes 1-9 are valid only when the field CANCER-DIRECTED SURGERY is code 00.

- 0 Surgery performed
- 1 Surgery not recommended
- 2 Contraindicated, autopsy-only cases
- 6 Reason unk
- 7 Pt refused surgery
- 8 Surgery recommended, unk if done
- 9 Unk if performed, death cert-only cases

Radiation

Patient's Name SSN	First Course of Treatment	Site ICDO Topography
RADIATION		

Radiation.....:		
Radiation hospital.....:		
Regional dose:cGy.....:		
Number of treatments.....:		
Radiation treatment volume..:		
Location of radiation.....:		
Intent of radiation.....:		
Regional treatment modality..:		
Radiation/surgery sequence..:		
Radiation completion status..:		
Radiation local control stat:		
Radiation auxiliary volume..:		
Radiation @facility.....:		
Reason for no radiation.....:		

Radiation: Record the type of radiation administered to the primary site or any metastatic site. Include all procedures that are part of the first course of treatment, whether delivered at the reporting institution or at other institutions.

- 0 None
- 1 Beam radiation
- 2 Radioactive implants
- 3 Radioisotopes
- 4 Beam rad w implants/radioisotopes
- 5 Radiation therapy, NOS
- 9 Unk if administered

Radiation Date: Enter the date the first course of radiation therapy was started.

Radiation Hospital: Record the hospital name/ACOS ID number of the facility treating this patient. If you wish to add a new facility, enter the assigned ACOS ID Number. If the new facility does not have an assigned ACOS ID Number, use the next available local ACOS ID Number.

Regional Dose:cGy: Code the dominant or most clinically significant dose delivered. This may be highly subjective and require assistance from the radiation oncologist for consistent coding.

Do not include boost doses.

Record the actual dose delivered.

Code 00000 if no radiation therapy was administered.

Code 99999 if radiation therapy was administered but dose is unknown.

Number of Treatments: Record the actual number of treatment sessions. A treatment session may include several treatment portals but they are delivered within a relatively confined interval of time, usually a few minutes, and should be counted as one session.
Code 00 if no radiation therapy was administered.
Code 99 if radiation therapy was administered but the number of treatments is unknown.

Radiation Treatment Volume: Provide a simple expression of the most common radiation volumes treated. In many cases, RADIATION TREATMENT VOLUME will be most appropriately coded by the radiation oncologist.

- 10 Chest/lung (NOS)
- 11 Lung (limited)
- 12 Esophagus
- 13 Stomach
- 14 Liver
- 15 Pancreas
- 16 Kidney
- 17 Abdomen (NOS)
- 18 Breast
- 19 Breast/lymph nodes
- 20 Chest wall
- 21 Chest wall/lymph nodes
- 22 Mantle
- 23 Lower extended field
- 24 Spine
- 25 Skull
- 26 Ribs
- 27 Hip
- 28 Pelvic bones
- 29 Pelvis (NOS)
- 30 Skin
- 31 Soft tissue
- 32 Hemibody
- 33 Whole body
- 34 Bladder and pelvis
- 35 Prostate and pelvis
- 36 Uterus
- 37 Shoulder
- 38 Extremities
- 39 Inverted Y
- 98 Other volume
- 99 Unknown volume
- 00 Consult only, no radiation, NA
- 01 Eye/orbit
- 02 Pituitary
- 03 Brain (NOS)
- 04 Brain (limited)
- 05 Head and neck (NOS)
- 06 Head and neck (limited)
- 07 Glottis
- 08 Sinuses

09 Parotid

Location of Radiation: Record the location where radiation treatment was administered.

- 0 No radiation
- 1 All radiation treatment here
- 2 Regional treatment here, boost elsewhere
- 3 Boost radiation here, regional elsewhere
- 4 All radiation treatment elsewhere
- 8 Other, NOS
- 9 Unknown

Intent of Radiation: Code the intent of radiation treatment. The responsible radiation oncologist is the best person to provide this information.

- 0 No radiation
- 1 Curative (primary)
- 2 Curative (adjuvant)
- 4 Palliative (pain control)
- 5 Palliative (other, cosmetic)
- 6 Prophylactic (no symptoms, preventive)
- 8 Other, NOS
- 9 Unknown

Regional Treatment Modality: Identify the dominant modality of therapy delivered to the primary volume of interest.

- 10 Neutrons (w or w/o X-Ray/electrons)
- 11 Megavoltage, NOS
- 12 Protons
- 13 Stereotactic radiosurgery
- 14 Brachytherapy (standard)
- 15 Brachytherapy, High-Dose-Rate (HDR)
- 16 Intraoperative radiation therapy (IORT)
- 98 Other, NOS
- 99 Unknown
- 00 No radiation
- 01 Orthovoltage
- 02 Cobalt 60, Cesium 137
- 03 X-Rays (2-5 MV)
- 04 X-Rays (6-10 MV)
- 05 X-Rays (11-19 MV)
- 06 X-Rays (>19 MV)
- 07 X-Rays (mixed energies)
- 08 Electrons
- 09 X-Rays and electrons (mixed)

Radiation Completion Status: Indicate whether the patient's radiation therapy was completed as outlined in the initial treatment plan. This information is generally available only in the radiation treatment chart.

- 0 No radiation
- 1 Treatment completed
- 2 Not complete, patient health
- 3 Not complete, patient expired
- 4 Not complete, patient choice
- 5 Not complete, family choice
- 6 Not complete, complications
- 7 Not complete, cytopenia
- 8 Not complete, other reason
- 9 Not complete, reason unknown

Radiation Local Control Status: Record the radiation treatment results in terms of disease control within the irradiated volume.

- 0 No radiation
- 1 Tumor control status not evaluable
- 2 Tumor/symptoms controlled
- 3 Tumor/symptoms returned
- 4 Tumor/symptoms never controlled
- 8 Other, NOS
- 9 Unknown

Radiation Auxiliary Volume: Provide a simple expression of the most common radiation auxiliary volumes treated.

- 10 Chest/lung (NOS)
- 11 Lung (limited)
- 12 Esophagus
- 13 Stomach
- 14 Liver
- 15 Pancreas
- 16 Kidney
- 17 Abdomen (NOS)
- 18 Breast
- 19 Breast/lymph nodes
- 20 Chest wall
- 21 Chest wall/lymph nodes
- 22 Mantle
- 23 Lower extended field
- 24 Spine
- 25 Skull
- 26 Ribs
- 27 Hip
- 28 Pelvic bones
- 29 Pelvis (NOS)
- 30 Skin
- 31 Soft tissue
- 32 Hemibody
- 33 Whole body
- 34 Bladder and pelvis
- 35 Prostate and pelvis

36	Uterus
37	Shoulder
38	Extremities
39	Inverted Y
98	Other volume
99	Unknown volume
00	Consult only, no radiation, NA
01	Eye/orbit
02	Pituitary
03	Brain (NOS)
04	Brain (limited)
05	Head and neck (NOS)
06	Head and neck (limited)
07	Glottis
08	Sinuses
09	Parotid

Radiation Auxiliary Date: If there was auxiliary radiation done, enter the date.

Radiation Auxiliary Text: Add any additional comments about the auxiliary radiation.

Radiation @Facility: Record the type of radiation given at your facility. This field may be a duplicate of the Radiation field above.

Radiation @Facility Date: Enter the date radiation was performed at your facility.

Radiation/Surgery Sequence: Define the order in which radiation therapy and cancer-directed surgery were delivered during first course of treatment. Code in the range of 2-6 ONLY if the patient had both cancer-directed surgery AND radiation therapy as first course of treatment. Surgery is limited to cancer-directed only (the field CANCER-DIRECTED SURGERY must be coded in the range of 10-90). Non cancer-directed surgery (biopsy, bypass, exploratory) does not qualify.

0	No rad and/or surg
2	Rad before surg
3	Rad after surg
4	Rad both before/after surg
5	Intraoperative rad
6	Intraoperative rad w rad before/after surg
9	Sequence unknown

Text-RX-Rad (Beam): Enter any additional comments concerning the radiation treatment.

Reason for No Radiation: Record the reason the patient did not receive radiation treatment.

0	Radiation performed
1	Radiation not recommended
2	Contraindicated, autopsy-only cases
6	Reason unk
7	Pt refused radiation

- 8 Radiation recommended, unk if performed
- 9 Unk if performed, death cert-only cases

Radiation Therapy to CNS: These data are being kept for historical purposes. Do not code for cases diagnosed as of January 1, 1996. Cases diagnosed on or after January 1, 1996 should be coded in the field RADIATION.

- 0 No radiation to CNS
- 1 Radiation
- 7 Patient refused radiation
- 8 Radiation recommended, unk if admin
- 9 Unknown/NA

Radiation Therapy to CNS Date: Record the date radiation therapy to the brain and CNS was initiated.

Chemotherapy

```
-----  
Patient's Name          First Course of Treatment          Site  
SSN                    ICDO Topography  
-----  
CHEMOTHERAPY  
-----  
Chemotherapy.....:  
Chemotherapy hospital.....:  
Chemotherapy @facility.....:  
Reason for no chemotherapy..:  
-----
```

Chemotherapy: Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. Refer to Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs, Third Edition, for drug categories.

- 0 None
- 1 Chemotherapy, NOS
- 2 Chemotherapy, single agent
- 3 Chemotherapy, multiple agents
- 9 Unknown if administered

Chemotherapy Date: Record the date the first course of chemotherapy was started.

Chemotherapy Hospital: Enter the hospital where the chemotherapy was given.

Chemotherapy @Facility: Record the type of chemotherapy given as a first course at your facility. This field may be a duplicate of the field above.

Chemotherapy @Facility Date: Enter the date of any chemotherapy given at your facility.

Text-RX-Chemo: Enter any additional comments about the chemotherapy.

Reason for No Chemotherapy: Record the reason the patient did not receive chemotherapy.

- 0 Chemo administered
- 1 Chemo not recommended
- 2 Contraindicated, autopsy-only cases
- 6 Reason unk
- 7 Pt refused chemo
- 8 Chemo recommended, unk if administered
- 9 Unk if administered, death cert-only cases

Hormone Therapy

Patient's Name SSN	First Course of Treatment	Site ICDO Topography
HORMONE THERAPY		

Hormone therapy.....:		
Hormone therapy hospital....:		
Hormone therapy @facility...:		
Reason for no hormone tpy...:		

Hormone Therapy: Record the type of Hormone Therapy the patient received as a part of first course of treatment at your institution and all other institutions.

Hormones can be used to alter the growth of cancer. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone responsive. Refer to Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs, Third Edition, for drug categories.

- 0 None
- 1 Hormone
- 2 Endocrine surgery and/or radiation
- 3 Comb of hormone/endocrine therapy
- 9 Unknown, death cert cases only

Hormone Therapy Date: Record the date Hormone Therapy was started.

Hormone Therapy Hospital: Enter the Hospital where Hormone Therapy was performed.

Hormone Therapy @Facility: Record the type of hormone therapy given at your facility.

Hormone Therapy @Facility Date: Enter the date hormone therapy was given at your facility.

Text-RX-Hormone: Enter any additional comments concerning the hormone therapy.

Reason for No Hormone Therapy: Enter the reason the patient did not receive hormone therapy.

- 0 HT administered
- 1 HT not recommended
- 2 Contraindicated, autopsy-only cases
- 6 Reason unk
- 7 Pt refused HT
- 8 HT recommended, unk if administered
- 9 Unk if administered, death cert-only cases

Immunotherapy

Patient's Name SSN	First Course of Treatment	Site ICDO Topography
IMMUNOTHERAPY		

Immunotherapy.....:		
Immunotherapy hospital.....:		
Immunotherapy @facility.....:		

Immunotherapy (BRM): Record the immunotherapy the patient received as a part of first course of treatment at the reporting institution and all other institutions. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells. Refer to Self-Instructional Manual for Tumor Registrars: Book 8 - Antineoplastic Drugs, Third Edition, for drug categories.

- 0 None
- 1 BRM
- 2 Bone marrow trans-autologous
- 3 Bone marrow trans-allogenic
- 4 Bone marrow trans, NOS
- 5 Stem cell trans
- 6 Combination 1 and 2,3,4 or 5
- 7 Patient refused
- 8 BRM recommended
- 9 Unknown

Immunotherapy Date: Enter the date of the immunotherapy.

Immunotherapy Hospital: Enter the hospital that gave the immunotherapy.

Immunotherapy @Facility: Record any immunotherapy treatment given at your facility as a first course of treatment. This field may be a duplicate of the above field.

Immunotherapy @Facility Date: Enter the date of the immunotherapy.

Text-RX-Immunotherapy: Enter any additional comments concerning the immunotherapy.

Other Treatment

Patient's Name SSN	First Course of Treatment	Site ICDO Topography
OTHER TREATMENT		

Other treatment.....:		
Other treatment hospital....:		
Other treatment @facility...:		

Other Treatment: Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions. Other treatment includes therapies designed to modify or control the cancer cells that are not defined in SURGERY, RADIATION, CHEMOTHERAPY or HORMONE THERAPY fields.

- 0 No other therapy
- 1 Other therapy
- 2 Experimental therapy
- 3 Double-blind clinical trial
- 6 Unproven therapy
- 7 Patient refused therapy
- 8 Other therapy rec, unk if admin
- 9 Unk if administered

Other Treatment Date: Enter the date of the other treatment.

Other Treatment Hospital: Enter the name of the other treatment hospital.

Other Treatment @Facility: Record any other treatment given at your facility as part of a first course of treatment.

Other Treatment @Facility Date: Enter the date other treatment was given.

Text-RX-Other: Enter any additional comments concerning the other treatment.

Protocol Eligibility/Participation

Patient's Name SSN	First Course of Treatment	Site ICDO Topography

PROTOCOL ELIGIBILITY/PARTICIPATION		

Protocol eligibility status.:		
Protocol participation.....:		
Year put on protocol.....:		

Protocol Eligibility Status: Record the eligibility status of the patient to be entered into a protocol.

- 0 Not available
- 1 On protocol
- 2 Ineligible (age,stage,etc.)
- 3 Ineligible (comorbidity, preexist cond)
- 4 Entered but withdrawn
- 6 Eligible, not entered
- 7 Eligible, refused
- 8 Not recommended
- 9 Unknown

Protocol Participation: Record whether the patient was enrolled in and treated on a protocol. A physician may treat a patient following the guidelines of an established protocol; however, the patient is not enrolled into the protocol. For these patients, use code 00 (Not on/NA).

- 00 Not on/NA
- 01 NSABP
- 02 GOG
- 03 RTOG
- 04 SWOG
- 05 ECOG
- 06 POG
- 07 CCG
- 08 CALGB
- 09 NCI
- 10 ACS
- 11 National protocol, NOS
- 12 Local protocol, NOS
- 99 Unknown

Year Put on Protocol: Record the year in which the patient was entered into a protocol.

Text-Remarks: Enter any additional comments.

Patient Care Evaluation

Refer to the Patient Care Evaluation study from the Commission on Cancer specific to the primary for information on what data is required. Due to the yearly changes on the requirements, Patient Care Evaluations are not covered in this manual.

Abstract Status only appears if you choose to edit All the primary information.

Abstract Status

```
-----  
Patient's Name          Abstract Status          Site  
SSN                    ICDO Topography  
-----
```

Abstracted by: }
Reporting Date: } These fields are completed for you.

Abstract Date: Enter the date the abstract is completed.

Abstract Status: Enter the status of the abstract data entry.

If any required fields are not filled in for this primary, the program gives you a list of those fields.

- 0 Incomplete
- 1 Minimal data
- 2 Partial
- 3 Complete

Reporting Date: This field is completed for you.

Abstracter: Record the name of the individual performing the abstracting.

Physician's Stage: Enter the physician's stage if it is different from AJCC staging.

Physician Staging: Enter the physician's name who did the staging.

Data OK?: If all the information is correct, enter YES at this prompt. Enter NO to return to:

```
-----  
Primary Sub-menu Options  
-----  
1. Patient Identification  
2. Cancer Identification  
3. Stage of Disease at Diagnosis  
4. First Course of Treatment  
5. Patient Care Evaluation  
A All - Complete Abstract  
  
Enter option: All//
```

Follow-up

If you want to do Follow-up on an existing primary and bypass all the background information in the abstract, enter NO at the "Edit patient data? YES/" and the "Continue with Patient History? Yes/" prompts to bring you to the following:

- E EDIT existing Primary
- A ADD another Primary
- F Follow-Up
- Q Quit Patient

EDIT/ADD primary for this patient: Edit// Follow-Up

Choose "F" to go directly to Follow-Up information.

*****DATE of LAST CONTACT*****

for PATIENT NAME

Date of Last Contact or Death: This date pertains to the date of the actual information and not the date the follow-up inquiry was forwarded or the date the follow-up report was received. If there is not new follow-up information, the entry is the same as that of the previous follow-up for this patient. If no follow-up information is ever received, code the latest date the patient was seen. This field pertains to the patient and not to the cancer. Thus, for a patient with more than one malignancy, all records for that patient should have the same date in this field.

This field allows multiple dates of contact. You may add a new date or edit a date already entered. If there are multiple dates in this field, and you want to edit one or more of them, enter ?? to get a list of those dates following the "Choose from:" direction, example:

Choose from:
04-01-1998
07-07-1998

Vital Status: Specify whether the patient was alive or dead at the last follow-up. This field pertains to the patient and not to the cancer. Thus, for a patient with more than one malignancy, all records for that patient should have the same code in this field.

0 Dead
1 Alive

Follow-Up Method: Code the source from which the latest follow-up information was obtained.

0 Reported Hospitalization (refers to a hospitalization at another hospital, NOT at your institution.)

- 1 Readmission (inpatient or outpatient) (refers to hospitalization or outpatient visit at your institution.)
- 2 Physician
- 3 Patient
- 4 Department of Motor Vehicles
- 5 Medicare/Medicaid file
- 7 Death certificate
- 8 Other (refers to a friend or relative.)
- 9 Unknown

Quality of Survival: Describe the patient's quality of survival.

- 0 Normal
- 1 Symptomatic & Ambulatory
- 2 More than 50% Ambulatory
- 3 Less than 50% Ambulatory
- 4 Bedridden
- 8 Not applicable, dead
- 9 Unknown or unspecified

Following Registry: Enter the registry or facility that will be following this patient.

Next Follow-Up Method: Select the type of follow-up recommended for the next follow-up sequence for the patient.

- 0 Chart requisition
- 1 Physician
- 2 Contact letter
- 3 Phone call
- 4 Other hospital contact
- 5 Other
- 8 Foreign residents (not allowed)
- 9 Not followed (refers to those cases that the registry may not routinely follow, for example, nonanalytic cases (class of case codes 3, 4, and 5), carcinoma in situ of the cervix, or cases of foreign residents.

Comments: Enter any comments you have on this follow-up.

A list of primary abstracts for this patient is displayed at this point showing the Accession/Sequence number, the Primary Site, the Last Tumor Status (No Evidence of..., Evidence of..., Unknown...), Date of Diagnosis, and Status of the abstract (Complete, Minimal Data, Partial, or Incomplete).

The program then displays the following for each primary (only those with a Diagnosis Date prior to the Date of Last Contact being edited) and asks for a Cancer Status on each:

Updating Primary Information for PRIMARY SITE ...

Cancer Status: Code the best available information concerning the cancer status of the patient at the date of last contact or death.

- 1 No evidence of this cancer
- 2 Evidence of this cancer
- 9 Unknown if this cancer present

It should be emphasized that official death certificates do not always indicate the presence of cancer, although the registry records may demonstrate that the patient had cancer immediately before death. Code the response according to registry or physician information. Consider such items as:

- How long before death was the last follow-up information obtained?
- Was the last follow-up information based on an actual medical examination?
- Are autopsy findings available to the registry?

The program then displays a summary of the statuses for each primary and the last follow-up and asks if the data is OK. If you answer NO, you are returned to the beginning Follow-up prompt.

When you finish, you may do Follow-up on another patient or exit the option.

Abstracting/Printing ...

Abstract Edit Primary

This option allows you to bypass the patient history information, etc. and go directly to editing information on the primary tumor. See Editing a New or an Existing Primary under Complete Abstract.

Abstracting/Printing ...

Print Abstract NOT Complete List

Use this option to print a list of records with Abstract Statuses of Incomplete, Minimal Data, and Partial. The report shows the accession/sequence number, patient name, SSN, ICDO-topography, and date of diagnosis. Records are sorted according to the Status and Patient Name.

Device: Enter the name of a printer or Q to queue your report.

Abstracting/Printing ...

Patient Summary

After selecting a patient and primary site (when more than one), the Patient Summary prints the following data to the screen. You may also send it to a printer for a hard copy.

Oncology Patient Name: Enter a patient name.

If the patient has more than one primary site, select the site you want covered in the report.

Medical Center	
Oncology Suspense Record	
Date	
Name:	SSN:
Sex:	DOB:
Race:	
Status:	Last Follow-up:
Autopsy Date/Time:	Autopsy #:
Cause of Death:	
Abstract Date:	Abstract Status:
Primary Sequence No.:	
Dx Date:	
Site:	
Topography:	
Morphology:	

You may PRINT a hardcopy

Device: Enter the name of a printer or Q to queue your report.

Abstracting/Printing ...

Print Abstract-Brief (80c)

Use this option to print an abstract for SEER reporting. It contains a summary of the patient's demographics, referral information, diagnosis date and facility, physicians, diagnostic information, staging data, and first course of treatment summary.

¹**Oncology Patient Name:** Enter the patient name or the site/group to obtain a list of records.
Select the record you want to print.

Device: Enter the printer name or Q to queue the report.

¹ Patch ONC*2.11*24 Prompt change.

Abstracting/Printing ...

Print Abstract-Extended (80c)

Use this option to print everything on file for the patient and primary site. You may also elect to print the Patient Care Evaluation if one is associated with the primary.

Oncology Patient Name: Enter a patient name.

If the patient has more than one primary site, select the site you want covered in the report.

Device: Enter the printer name or Q to queue the report.

Abstracting/Printing ...

Print Complete Abstract (132c)

Use this option to print a complete abstract capturing the extended data set. Choose a device that can print 132 columns.

Oncology Patient Name: Enter a patient name.

If the patient has more than one primary site, select the site you want covered in the report.

Device: Enter the printer name or Q to queue the report.

Abstracting/Printing ...

Print QA/Multiple Abstracts

Use this option to print more than one abstract.

First you select one of the following:

- 1 SEER Report
- 2 Extended 80c
- 3 Complete Abstract 132c/QA
- 4 Incidence Report
- 5 Print PCE Data

Then you select the abstracts you want to print:

- 1 One patient, all abstracts
- 2 All Abstracts one Primary
- 3 All abstracts one primary for one year
- 4 All abstracts one year
- 5 Abstracts by Diagnosis Date
- 6 QA-10% Completed Abstracts

Patient to Print: Enter a patient name.

Device: Enter the printer name or Q to queue the report.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Patient Information

Use this option to print the patient information (address, phone, marital status, exposure information, etc.) to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Family History

Use this option to print the patient's family history (family member and location of cancer) to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Physician Contact

Use this option to print the physician contacts for a patient to your computer screen. This report shows the patient's marital status at diagnosis, the patient address, and the primary payor including the physician contacts.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Cancer Information

Use this option to print the patient's cancer information to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Extent of Disease at Diagnosis

Use this option to print the patient's extent of disease at diagnosis to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Treatment - (First Course)

Use this option to print the patient's first course treatment to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Recurrence

Use this option to print recurring tumor information for a patient to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Subsequent Therapy

Use this option to print subsequent therapy information for a patient to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Follow-up

Use this option to print follow-up information for a patient to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...
Abstract Screens Menu (80c) ...

Complete Abstract

Use this option to print the patient's complete abstract to your computer screen.

Patient Name: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

If the patient has more than one site, you will be asked to select a site.

If it is possible that the site has PCE data, you will also be asked if you want to print the data.

Abstracting/Printing ...

¹Edit/print worksheet

Use this option to print out a worksheet (see [Worksheet](#)) or edit the worksheet.

Printing the worksheet:

Select one of the following:

E	Edit worksheet
P	Print worksheet

Action: **P**rint worksheet
DEVICE: (Enter a printer)

Editing the worksheet: It is strongly suggested that you use the screen editor if you want to make changes to the worksheet. The editors drop you in at the end of the document as can be seen in the example below. Once you answer Yes to edit, the beginning of the document is displayed.

Hints: Every line in the document is indented one space. This prevents problems with wrapping in the printed document.

Use the ↑ and ↓ arrows to move up and down in the editor. Use the ← and → arrows to move sideways.

Use <Ctrl>Q to exit without saving and <Ctrl>E to exit and save.

Using the Screen Editor:

Select one of the following:

E	Edit worksheet
P	Print worksheet

Action: **E**dit worksheet
MAIN FORM BODY: . . .

. . .
Date of Death: _____
Cause of Death: _____
ICD Cause of Death: _____
ICD Revision: _____
Place of Death: _____
Care Center at Death: _____
Autopsy: _____
Autopsy Date/Time: _____
Autopsy No: _____

Edit? NO// **YES**

==[WRAP]==[INSERT]=====< MAIN FORM BODY >=====[<PF1>H=Help]====

¹ Patch ONC*2.11*23 New option.

ONCOLOGY WORKSHEET

***** PATIENT IDENTIFICATION *****

Patient: _____ SSN: _____
Home Address: _____

 County: _____
Sex: _____ Race: _____ Ethnicity: _____
Date of Birth: _____ Age at DX: _____

***** CANCER IDENTIFICATION *****

Accession Number: _____ Accession Year: _____
Sequence Number: _____

<=====T=====T=====T=====T=====T=====T=====T>=====

VI. Follow-Up

An important cancer registry function is the systematic yearly follow-up of cancer patients. Follow-up is based on the date of last contact and is delinquent (lost) if no contact has been made within fifteen months after the date of last contact information. Cases that are lost (delinquent) should remain in follow-up until information is obtained.

A 90% follow-up rate of all living and deceased patients is required (See CANCER PROGRAM STANDARD, vol. 1", Standard 8.6.0).

Follow-up information must include: The date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, and site of histology(ies) of any subsequent primary(ies), the date of last contact and the status of the patient and the cancer.

Follow-up Functions Menu

PF	Post/Edit Follow-up
RF	Recurrence/Sub Tx Follow-up
FH	Patient Follow-up History
FA	Print Due Follow-up/Admission List
DF	Print Due Follow-up List by Month Due
TD	Print Due Follow-up List by 'Terminal Digit'
LF	Print Delinquent (LTF) List
SR	Follow-up Status Report by Patient (132c)
FP	Follow-up Procedures Menu ...
PI	Patient Follow-up Inquiry
AC	Add Patient Contact
AF	Attempt a Follow-up
PL	Print Follow-up Letter
EL	Add/Edit Follow-up Letter
FR	Individual Follow-up Report
UP	Update Contact File

- 5 Medicare/Medicaid file
- 7 Death certificate
- 8 Other
- 9 Unknown

If the Vital Status equals Dead (0), then the program skips the next prompts and asks for Death Information. See Posting a Follow-up with a Vital Status of Dead.

Quality of Survival: Enter the code that best describes the patient's quality of survival for this follow-up.

- 0 Normal
- 1 Symptomatic & Ambulatory
- 2 More than 50% Ambulatory
- 3 Less than 50% Ambulatory
- 4 Bedridden
- 8 Not applicable, dead
- 9 Unknown or unspecified

Following Registry: Record the six-digit institution identification number for the facility responsible for following the patient. Record 999999 if the FOLLOWING REGISTRY's identification number is unknown.

Next Follow-up Method: Enter the type of follow-up recommended for the next follow-up sequence for the patient.

- 0 Chart requisition
- 1 Physician
- 2 Contact letter
- 3 Phone call
- 4 Other hospital contact
- 5 Other
- 8 Foreign residents (not followed)
- 9 Not followed (Cases for which follow-up is not required, e.g., reportable by agreement cases)

Comments: This is an unlimited text field for recording any comments about this follow-up.

After entering comments, the status information is redisplayed and you are asked to update the Cancer status for **each** tumor.

This is an example:

¹ Acc/Sequence	Primary Site	Last Tumor Status	Date DX	Status
1998-00013/01	BREAST, UPPER-OUTER QU	No evid this CA	03/27/1998	Complete
1998-00013/02	CERVIX, ENDOCERVIX	Not stated	10/13/1998	Incomplete

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded.

Updating Primary Information for SITE ...

Cancer Status: Code the best available information concerning the cancer status of the patient at the date of last contact or death. Select one of the following:

- 1 No evidence of this cancer
- 2 Evidence of this cancer
- 9 Unknown if this cancer present

After entering the status for each site, the follow-up information is displayed and you are asked if the data is OK.

Posting a Follow-up with Vital Status of Dead

After entering the Date of Last Contact or Death, Vital Status and Follow-up Method, you are asked the following:

Comments: This is a word processing field to enter any information that might be pertinent to this posting.

The primary information is updated, the updated information is displayed and you are asked if it is OK.

The Death Information is displayed which you may edit.

Date@Time of Death: The default answer here is the date you entered for Date of Last Contact or Death or a previously entered date. You may edit this date and add a time if you need to.

Cause of Death/Cancer: Was the death related to the patient's cancer? Select one of the following:

- D Directly related
- I Indirectly related
- N Not related
- U Unknown

ICD Cause of Death: Enter the Diagnostic Code that was determined to be the cause of death.

Place of Death: Enter the state or country where the patient died.

Care Center at Death: Enter the hospital code or the name of the hospital that was covering the patient's care at the time of death.

Autopsy: Enter whether or not an autopsy performed.

Autopsy Date/Time: If an autopsy was performed, enter the date and time.

Autopsy #: If an autopsy was performed, enter the number (1-15 characters).

Path/Autopsy (Gross & Macro): This is a word processing field to enter the findings from the autopsy.

The Death Information is redisplayed and you are asked if the data is OK.

At this point you are asked for First Recurrence Information for each primary.

¹**Type of First Recurrence:** Select one of the following that best describes the recurrence.

- 10 Local
- 11 Trocar site
- 15 Comb of 10 and 11
- 16 Local recurrence following in situ lesion of same site
- 17 Comb of 16 with 10, 11, and/or 15
- 20 Regional, NOS
- 21 Regional tissue
- 22 Regional lymph nodes
- 25 Comb of 21 and 22
- 26 Regional recurrence following in situ lesion of same site
- 27 Comb of 26 w 21, 22 and/or 25
- 30 Any comb of 10, 11, and 20, 21, or 22
- 36 Any comb following in situ lesion same site w 10, 11, 20, 21, 22
- 40 Distant
- 46 Distant recurrence following in situ lesion of same site
- 70 Never disease-free
- 88 Recurred, site unknown, and/or stage at dx unknown
- 99 Unknown if recurred
- 00 None, disease-free
- 01 In situ
- 06 Recurrence following dx of in situ lesion of same site

Date of First Recurrence: Enter the date of recurrence.

The patient's contacts are displayed. You may delete them at this time or later using the Cleanup functionality in the option Update Contact File.

Example:

```
-----DELETE PATIENT'S CONTACTS-----  
  
AVAILABLE CONTACTS  
=====
```

Patient	EDEN, PATIENT
	708-786-1234

¹ Patch ONC*2.11*26 August 2000 Additional selections for Type of First Recurrence.

123 FORREST
ELMHURST,IL 60126

Next of Kin

HOME EVENINGS
DAVID EDEN
708-786-1234
123 FORREST
ELMHURST,IL 60126

Patient is dead - please delete contacts as soon as possible!
Deletion will affect this patient's contacts only!!

Delete Contacts?: Enter Yes or No. Only the above contacts will be deleted. If in the example above, David Eden is also the contact for another patient, it will not be deleted.

Follow-up Functions ...

Recurrence/Sub Tx Follow-up

Use this option to document recurrence and/or subsequent treatment. Recurrence is defined as the return or reappearance of the cancer after a disease-free interval or remission. Date of first recurrence is the date a medical practitioner diagnoses metastatic or recurrent cancer.

Patient: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

A screen displaying patient descriptors and a summary of the patient's primary sites appears and asks you to select the primary you want to edit for a recurrence.

¹**Type of First Recurrence:** Enter the appropriate code for this **first** recurrence for this primary. The term "recurrence" means the return or reappearance of the cancer after a disease-free intermission or remission.

Note: The cancer may recur in more than one site (i.e., both regional and distant metastases). Code regional in this data field and distant in "Other Type of Recurrence." If the patient has been disease-free since treatment, code 00.

- 10 Local
- 11 Trocar site
- 15 Comb of 10 and 11
- 16 Local recurrence following in situ lesion of same site
- 17 Comb of 16 with 10, 11, and/or 15
- 20 Regional, NOS
- 21 Regional tissue
- 22 Regional lymph nodes
- 25 Comb of 21 and 22
- 26 Regional recurrence following in situ lesion of same site
- 27 Comb of 26 w 21, 22 and/or 25
- 30 Any comb of 10, 11, and 20, 21, or 22
- 36 Any comb following in situ lesion same site w 10, 11, 20, 21, 22
- 40 Distant
- 46 Distant recurrence following in situ lesion of same site
- 70 Never disease-free
- 88 Recurred, site unknown, and/or stage at dx unknown
- 99 Unknown if recurred
- 00 None, disease-free
- 01 In situ
- 06 Recurrence following dx of in situ lesion of same site

¹ Patch ONC*2.11*26 August 2000 Additional selections for Type of First Recurrence.

If a Type of **First Recurrence** has already been entered, and you want to enter a new or subsequent recurrence, press the <ret> key until you reach the prompt, "Select DATE of SUBSEQUENT RECURRENCE".

Date of First Recurrence: Record the date of first recurrence based on the best available information.

¹Other Type of First Recurrence: Enter the appropriate code for any distant metastases in this field. If the patient has only one site of recurrence or has been disease-free since treatment, code 00.

- 10 Local
- 11 Trocar site
- 15 Comb of 10 and 11
- 16 Local recurrence following in situ lesion of same site
- 17 Comb of 16 with 10, 11, and/or 15
- 20 Regional, NOS
- 21 Regional tissue
- 22 Regional lymph nodes
- 25 Comb of 21 and 22
- 26 Regional recurrence following in situ lesion of same site
- 27 Comb of 26 w 21, 22 and/or 25
- 30 Any comb of 10, 11, and 20, 21, or 22
- 36 Any comb following in situ lesion same site w 10, 11, 20, 21, 22
- 40 Distant
- 46 Distant recurrence following in situ lesion of same site
- 70 Never disease-free
- 88 Recurred, site unknown, and/or stage at dx unknown
- 99 Unknown if recurred
- 00 None, disease-free
- 01 In situ
- 06 Recurrence following dx of in situ lesion of same site

Distant Site 1: Editing of this field is dependent upon the content of the Type of First Recurrence field.

Distant Site 2: Editing of this field is dependent upon the content of the Distant Site 1 field.

Distant Site 3: Editing of this field is dependent upon the content of the Distant Site 2 field.

Other T: Enter the appropriate code that evaluates the primary tumor and identifies the tumor size and/or extension.

Other N: Enter the code that classifies the regional lymph nodes and describes the absence or presence and the extent of node metastases.

¹ Patch ONC*2.11*26 August 2000 Additional selections for Other Type of First Recurrence.

Other M: Select the code that records the presence or absence of distant metastases.

The computed Recurrence Stage Grouping is displayed.

Staged By (Other Stage): Identify the person who documented the other AJCC staging elements and the stage group.

Date of Subsequent Recurrence: If the patient had another recurrence (following the first), document the date here or bypass this prompt to enter treatment for the **first** recurrence for this primary. If you enter a date here, you will also enter the subsequent recurrence type, the TNM, and who did the staging as shown above.

*****SUBSEQUENT COURSE OF TREATMENT*****

Remember, to bring up a list of selections, enter ?? at the prompt.

Initiation Date: For each recurrence for this primary, enter the date the treatment course began.

Surgery of Primary Site: If there was surgery to the primary site, enter the surgical code here.

Surgery of Primary Site Date: Enter the date the surgery was performed.

Scope of Lymph Node Surgery: If lymph node surgery was performed, record the scope of regional lymph node surgery.

Number of Nodes Removed: Enter the number of regional lymph nodes removed. If no nodes were removed, this prompt is bypassed.

Surgery of Other Sites/Nodes: Record the code for surgery of other regional site(s), distant site(s) or distant lymph node(s).

Recon/Restore - Delayed: Enter the code that best describes the surgical procedures done to improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. "Reconstruction/Restoration - Delayed" is limited to procedures started after the first course of cancer- directed therapy is complete or when it is unknown whether reconstruction was started during first or second course of therapy.

Recon/Restore - Delayed Date: If there was reconstructive surgery, enter the date here. If there was no reconstructive surgery, this prompt is bypassed.

Radiation: Enter the appropriate code for radiation therapy.

Radiation Date: Enter the date the radiation therapy was given or started.

Radiation Sequence: Enter the sequencing of the therapy in relation to the surgery.

Radiation Therapy to CNS: Enter the appropriate code for radiation therapy to the Central Nervous System.

Radiation Therapy to CNS Date: Enter the date radiation therapy to the CNS was initiated.

Chemotherapy: Enter the appropriate code for chemotherapy.

Chemotherapy Date: Enter the date on which chemotherapy was initiated.

Hormone/Steroid: Enter the appropriate code for hormone/steroid therapy.

Hormone/Steroid Date: If there was hormone/steroid therapy, enter the date it was initiated.

Immunotherapy (BRM): Enter the appropriate code for immunotherapy.

Immunotherapy Date: Enter the date immunotherapy was started.

Other Cancer Therapy: Enter a code indicating whether other cancer therapy was performed.

Other Cancer Therapy Date: Enter the date on which other cancer therapy was initiated.

Place: Enter the facility where the treatment was given.

Subsequent Therapy Comments: Enter any comments concerning this treatment or follow-up.

***** **POST/EDIT FOLLOW-UP** *****

At this point you can do a post/edit follow-up. See the chapter Post/Edit Follow-up under the Follow-up section for instruction.

Follow-up Functions ...

Patient Follow-up History

For a printout of the patient's follow-up history including when follow-up is next due, use this option by entering the patient's name and a device.

Follow-up Functions ...

Print Due Follow-up/Admission List

This option prints a list of follow-ups that are due for a selected date range. They are displayed by month due along with the record number, primary site, date of diagnosis, and the latest admission and discharge dates.

Your previous date range selection is displayed for you.

Start With Due Follow-up: Enter the beginning month and year for the date range.

Go To Due Follow-up: Enter the date for the end of the date range. This can be a day, month and year.

Device: Enter a printer.

Follow-up Functions ...

Print Due Follow-up List by Month Due

This option prints a list of follow-ups that are due for a selected date range. They are displayed by month due along with the record number, primary site, last date of contact, and date of diagnosis.

Your previous date range selection is displayed for you.

Start With Due Follow-up: Enter the beginning month and year for the date range.

Go To Due Follow-up: Enter the date for the end of the date range. This can be a day, month and year.

Device: Enter a printer.

Follow-up Functions ...

Print Due Follow-up List by 'Terminal Digit'

This option prints a list of follow-ups that are due for a selected date range. They are displayed by month due, sorted by the patient's SSN, and show the latest admission and discharge dates.

Your previous date range selection is displayed for you.

Start With Due Follow-up: Enter the beginning month and year for the date range.

Go To Due Follow-up: Enter the date for the end of the date range. This can be a day, month and year.

Device: Enter a printer.

Follow-up Functions ...

Print Delinquent (LTF) List

This option prints a list of all patients whose Due Follow-up date is over 3 months (have not been seen/contacted for over 15 months). These patients are considered to be Lost to Follow-up at that time. The report is sorted by the month and year the follow-up was due and prints the SSN, date of last contact, Site/Gp, and date of diagnosis.

Device: Enter a printer.

Follow-up Functions ...

Follow-up Status Report by Patient (132c)

This option prints a report sorted by one, two, or all follow-up statuses (Inactive, Active, and Lost to Follow-up). It shows the date of last contact, the vital status, the follow-up due date, site/gp, date of diagnosis, class category and acc/seq number. The report also displays a subcount by follow-up status and a total count of all cases in the report.

Start with Follow-up Status: FIRST: Select any one of the following statuses to sort by or press the <ret> key to accept the first status, Inactive:

- 0 INACTIVE
- 1 ACTIVE
- 8 (LTF)

Go to Follow-up Status: LAST: Enter a status or press the <ret> key to accept the last status, LTF). You may choose to print all the statuses, a single status by choosing it at both prompts, or two statuses (0 and 1 or 1 and 8).

Device: This requires a 132 column print.

Follow-up Functions ...

Follow-up Procedures Menu ...

This menu helps you manage follow-up by providing a list of contacts for the patient, follow-up letters, a summary report of the patient for inquiries by outside agencies, etc.

Follow-up Procedures Menu

- PI Patient Follow-up Inquiry
- AC Add Patient Contact
- AF Attempt a Follow-up
- PL Print Follow-up Letter
- EL Add/Edit Follow-up Letter
- FR Individual Follow-up Report
- UP Update Contact File

Follow-up Functions ...
Follow-up Procedures Menu ...

Patient Follow-up Inquiry

This option is most useful upon receipt of phone-calls by other Hospitals/Tumor registrars attempting follow-up of patients they may be treating or following. It provides basic summary information on the tumor status, diagnoses dates, and follow-up by entering a device. In this instance, it is appropriate to press the <ret> key at the device prompt to bring the report to the screen.

Follow-up Functions ... Follow-up Procedures Menu ...

Add Patient Contact

Use this option to enter contacts (names, addresses, phone numbers) for specific patients. This option also provides a mechanism to document that a contact was attempted or made and the results of the contact.

Note: If the patient's Vital Status is DEAD, contacts entered through this option will be deleted when you use the Cleanup action under the option Update Contact File or the Delete Patient's Contacts functionality that comes up when a Patient's Vital Status is changed to DEAD. It is suggested that you use this option to enter contacts that will only be used by a single patient.

Patient: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

A list of available contacts for the patient is displayed.

Type of Follow-up Contact: Enter the type of contact from the list below. To enter two different contacts of the same type, enter the second with quotes (e.g., the second MD would be entered as "MD"). If you select PT (Patient), you will be able to edit the patient's address and phone number. Note: Use UPPER CASE.

PT	Patient
MD	Physician
NOK	Next of Kin
KIN	Other Kin
GR	Guardian
SO	Significant Other
FR	Friend
HOSP	Hospital
NH	Nursing Home
HP	Hospice
TR	Tumor Registrar
INST	Institution
OTH	Other

Contact Name: Enter the name of the individual. This is a free text field. Note: It is suggested that you always enter a person's name in either one of two ways: LAST,FIRST or FIRST LAST. If you get in the habit of always doing it one way, then finding and selecting a contact when doing a follow-up will be easier.

Oncology Contact Type: Is this person the patient, a physician, a person, institution, government agency or other? This prompt only appears when entering a new contact. Select one of the following:

- 1 PATIENT
- 2 PHYSICIAN
- 3 CONTACT PERSON
- 4 INSTITUTION
- 5 OTHER
- 6 GOVERNMENT AGENCY

Street Address 1: Enter the street address at this and, if needed, the following two prompts.

Street Address 2:

Street Address 3:

Zip Code: Enter the Zip Code which will also grab the city and state for you.

Phone: Enter the telephone number with the area code if needed using either hyphens or parentheses.

Title: Enter the person's title such as: MR., MRS., MISS, etc.

Comments: Enter short comments concerning this contact, such as: home evenings, this address no longer valid for this patient, etc.

At this point you may do any of the following:

- 1 Display Contacts
- 2 Edit Contact
- 3 Attempt a Follow-up
- 4 Another Patient
- 5 Exit Option

1. Display Contacts shows all the contacts with their addresses and phone numbers for the patient. After displaying the contacts, it automatically drops into the Add/Edit Contacts functionality as shown above.
2. Edit Contact takes you through the same functionality as shown above.
3. Attempt a Follow-up functionality is described in the next chapter.
4. Another Patient allows you to add or edit contacts for different patient.

Follow-up Functions ... Follow-up Procedures Menu ...

Attempt a Follow-up

This option is used to document follow-up attempts, successful or non-successful. If the follow-up is done by letter, you can also print the letter using this option. Successful contacts lead into posting of the follow-up. This process then allows for not only tracking the follow-up history, but the attempt history as well. For instruction on posting the follow-up, see chapter, Post/Edit Follow-Up.

Patient: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

Follow-up Attempt Date: Enter the date of the attempted follow-up.

Type: Indicate how the follow-up information will be obtained.

- 1 Chart Review
- 2 Phone Contact
- 3 Letter Contact
- 8 Other

If you select Chart Review, the program skips to the prompt Result.

The Contact: Enter the name of the person or facility you contacted, attempted to contact, or in the case of a letter, plan to contact. Note: You can enter a new contact at this prompt, however, you will not be asked the address and phone information for the new contact. This information can be entered using the option Update Contact File, the Add/Edit functionality, or, if you want this contact only for this patient, the Add Patient Contact option.

Oncology Contact Type: If you entered a new contact, this prompt will appear. Select one of the following:

- 1 PATIENT
- 2 PHYSICIAN
- 3 CONTACT PERSON
- 4 INSTITUTION
- 5 OTHER
- 6 GOVERNMENT AGENCY

Result: Indicate the success of the follow-up. If letter was selected above, this will default to Pending.

- 1 Successful
- 2 Unsuccessful

- 8 Pending
- 9 Unknown

Remarks: Enter short comments concerning this attempted follow-up.

Select one of the following:

- 1 Display Contacts
- 2 Edit Contact
- 3 Attempt a Follow-up
- 4 Another Patient
- 5 Exit Option

If this was not a contact by letter, you may choose to do any of the above.

1. Display Contacts shows all the contacts with their addresses and phone numbers for the patient. After displaying the contacts, it automatically drops into the Add/Edit Contacts functionality as shown in the chapter for the option Add Patient Contact.
2. Edit Contact takes you through the same functionality as in the option Add Patient Contact.
3. Attempt a Follow-up functionality returns you to the functionality described in this chapter.
4. Another Patient allows you to add or edit contacts for different patient.

If the contact is by letter, you can generate the letter at this point. However, if you added a new contact at The Contact prompt, there will be no address on the letter. See instructions for printing a follow-up letter in the chapter, Print Follow-up Letter.

Note: When the contact returns a letter with the requested information, the Result field should be changed to Successful. It should be changed to Unsuccessful if the letter is returned by the post office indicating that the letter could not be delivered. This will allow you to accurately track the status of your follow-up letters.

Follow-up Functions ...
Follow-up Procedures Menu ...

Print Follow-up Letter

This option prints a follow-up letter. This functionality is available in other options also.

Patient: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

Last Follow-up Contact: This defaults to the last person contacted. You may enter a different contact or a new contact at this prompt. However, if you are adding a new contact, it is advisable to use the Add Patient Contact (when it is a contact for this patient only) or the Update Contact File (a contact used by multiple patients) option first so address and phone information can be entered also. Then use this option to print the follow-up letter.

Specify TYPE Contact letter: The program looks at the Oncology Contact Type to determine which letters are selectable at this prompt.

Device: Enter a printer.

Follow-up Functions ... Follow-up Procedures Menu ...

Add/Edit Follow-up Letter

This option allows you to add follow-up form letters and edit existing letters.

Adding a New Letter

Select Letter to Add/Edit: Enter the name of a new letter. The use of *s in the name is a good way to prevent the letter from being overwritten in a future update to the program (e.g., PATIENT *SITE LETTER*).

Form Type: Select the form type from the following list. This controls the letters that appear for selection when you choose to print a letter (e.g., If it is a patient that is the contact person, then the letters listed for selection are those written for patients. If it is a physician contact, the letters listed will be those written for physicians, and so on.).

- 1 PATIENT
- 2 PHYSICIAN
- 3 NEXT OF KIN
- 4 INSTITUTION
- 5 TUMOR REGISTRAR
- 6 DEATH INQUIRY

Description: This is a word processing field to enter information about the letter or a description of it.

Main Form Body: To replicate the functionality of the letters that automatically adds the date, the contact name and address, a salutation to the contact, etc., use one of the same Form Type letters as an example and apply the same spacing and the same content between the || to your new letter. You will want to test the letter after creating it to make sure all the automatic functionality has been carried over correctly to the new letter.

The appearance of the letter content depends on the editor you are using, either Screen Editor or Line Editor. It is advisable to use the Screen Editor for editing the individual letters. (This can be changed through the option Edit User Characteristics, generally found in a secondary menu when you log onto the computer.)

For questions regarding the use of your editor (editing, saving, exiting without saving, etc., please see your IRM staff.

Editing a Letter

Select Letter to Add/Edit: Select the letter you want to edit.

Name: If you choose to edit a letter, it is strongly suggested that you also change the name of the letter at this prompt. That will prevent the letter from being overwritten in a future update to the program. The use of *s in the name as shown in the example is a good way to prevent this from happening.

Example:

```
NAME: PATIENT LASER PRINTER  Replace ... With PATIENT *SITE LETTER*  
Replace <ret>
```

Form Type: You can change the form type here. Select the form type from the following list. This controls the letters that appear for selection when you choose to print a letter (e.g., If it is a patient that is the contact person, then the letters listed for selection are those written for patients. If it is a physician contact, the letters listed will be those written for physicians, and so on.).

- 1 PATIENT
- 2 PHYSICIAN
- 3 NEXT OF KIN
- 4 INSTITUTION
- 5 TUMOR REGISTRAR
- 6 DEATH INQUIRY

Description: This is a word processing field to enter information about the letter or a description of it.

Main Form Body: The appearance of the letter content depends on the editor you are using, either Screen Editor or Line Editor. It is advisable to use the Screen Editor for editing the individual letters. (This can be changed through the option Edit User Characteristics, generally found in a secondary menu when you log onto the computer.) The body of the letter can easily be changed but the portions of the letters that bring in information from other parts of the program should not be altered. This would be information with the straight brackets around them ie: |LOWERCASE(LAST NAME)| or |SSN|

For questions regarding the use of your editor (editing, saving, exiting without saving, etc., please see your IRM staff.

Follow-up Functions ...
Follow-up Procedures Menu ...

Individual Follow-up Report

This option prints the complete follow-up report including the last contact, pending contacts, and contact history.

Patient: Enter the patient's name: LAST,FIRST or first initial last name plus last 4 digits of the SSN.

Device: Enter a printer name.

Follow-up Functions ...

Follow-up Procedures Menu ...

Update Contact File

This option allows for maintenance of the Oncology Contact file (#165). You can add new contacts or edit contacts, delete them, print them, or clean out contacts for patients who are deceased. It is recommended that you enter contacts here that may be used for following up many patients, such as institutions, doctors, etc. If you want to enter a contact that should be deleted when the patient expires, such as family members, use the option Add Patient Contact.

Select one of the following:

- | | |
|---|----------|
| 1 | Add/Edit |
| 2 | Delete |
| 3 | Print |
| 4 | Cleanup |
| 5 | Exit |

Select function:

Add/Edit Contact

Oncology Contact: Enter a new contact here or select a contact to edit.

Oncology Contact Type: This appears when you add a new contact.

Or

Type: This appears when you select a contact to edit.

Select the type of contact.

- | | |
|---|-------------------|
| 1 | PATIENT |
| 2 | PHYSICIAN |
| 3 | CONTACT PERSON |
| 4 | INSTITUTION |
| 5 | OTHER |
| 6 | GOVERNMENT AGENCY |

Street Address 1: Enter the street address at this and, if needed, the following two prompts.

Street Address 2:

Street Address 3:

Zip Code: Enter the Zip Code which will also grab the city and state for you.

Phone: Enter the telephone number with the area code, if needed, using either hyphens or parentheses.

Title: Enter the person's title such as: MR., MRS., DR. etc. if this is a person.

Comments: Enter short comments concerning this contact, such as: Call after 9 am.

Delete Contact

This option will not let you delete entries that are being used by other files. If a patient record contains a contact you want to delete, it will not be deleted. If the patient is deceased, it is recommended you use the option to Cleanup the file to remove contacts no longer used.

Oncology Contact: Select the contact you want to delete. If no file is using (pointing to) it, the program deletes the entry. There is no second guessing, so be sure it is the contact you want to delete before entering it.

Print

Select how you want the contact information sorted, alphabetically or by type. If you select alphabetically, you must enter a free text contact name at the "Start with" and "Go to" prompts or press the <ret> key to accept all contacts. If you select to sort by type, you are asked the following:

Start with Type: FIRST: Press the <ret> key here to begin the sort with Patient or enter the type you want.

- 1 PATIENT
- 2 PHYSICIAN
- 3 CONTACT PERSON
- 4 INSTITUTION
- 5 OTHER
- 6 GOVERNMENT AGENCY

Go to Type: LAST: Press the <ret> key to accept Government or enter the type you want.

Device: Enter a printer name.

Cleanup

By selecting Cleanup, the program automatically removes contact data for patients who are deceased (Vital Status = DEAD) if another record is not using the contact. This is the contact data shown for a patient when using the functionality Display Contacts.

VII. Registry Lists

This is a menu of registry listings containing various accession registers, patient and site reports.

Any report with (132c) following the name requires a printer that will print 132 columns.

Registry Lists

AA	Accession Register-ACOS (80c)
AS	Accession Register-Site (80c)
AE	Accession Register-EOVA (132c)
PA	Patient Index-ACOS (132c)
PS	Patient Index-Site (80c)
PE	Patient Index-EOVA (132c)
IN	Primary ICDO Listing (80c)
SG	Primary Site/GP Listing (80c)
IW	Primary ICDO Listing (132c)

Registry Lists ...

Accession Register-ACOS (80c)

This is the ACOS required Accession Register data items.

¹To get all records, simply press the <ret> key at the "Start with" prompt.

```
For a complete register:  
START WITH ACC/SEQ NUMBER: FIRST// <Enter>
```

To get all records beginning with the same year:

```
For a single accession year (e.g. 1999):  
START WITH ACC/SEQ NUMBER: FIRST// 1999-00000  
GO TO ACC/SEQ NUMBER: LAST// 1999-99999
```

To get a single record:

```
For a single patient (e.g. 1999-00001):  
START WITH ACC/SEQ NUMBER: FIRST// 1999-00001/00  
GO TO ACC/SEQ NUMBER: LAST// 1999-00001/99
```

ACCESSION LIST (ACOS) complete		MAR 24,1999 14:38		PAGE 1	
ACC/SEQ#	PATIENT NAME	ICDO	TOPOGRAPHY	DATE DX	YEAR
1999-00001/00	NAME,PATIENT	C50.5	BREAST, LOWER-OUTER	04/25/1998	1998
...					

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded.

Registry Lists ...

Accession Register-Site (80c)

This prints the Accession Register listing the Primary Site/GP (not ACOS required).

¹To get all records, simply press the <ret> key at the "Start with" prompt.

For a complete register:
START WITH ACC/SEQ NUMBER: FIRST// <Enter>

To get all records beginning with the same year:

For a single accession year (e.g. 1999):
START WITH ACC/SEQ NUMBER: FIRST// 1999-00000
GO TO ACC/SEQ NUMBER: LAST// 1999-99999

To get a single record:

For a single patient (e.g. 1999-00001):
START WITH ACC/SEQ NUMBER: FIRST// 1999-00001/00
GO TO ACC/SEQ NUMBER: LAST// 1999-00001/99

ACCESSION REGISTER - SITE/GP complete			MAR 24,1999 14:44	PAGE 1	
ACC/SEQ#	PATIENT NAME	MED REC#	PRIMARY SITE/GP	DATE DX	YEAR
1999-00001/00	NAME,PATIENT	462-56-2341	BREAST	04/25/1998	1998

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded.

Registry Lists ...

Accession Register-EOVA (132c)

This prints the Accession Register as required by East Orange VAMC.

¹To get all records, simply press the <ret> key at the "Start with" prompt.

```
For a complete register:  
START WITH ACC/SEQ NUMBER: FIRST// <Enter>
```

To get all records beginning with the same year:

```
For a single accession year (e.g. 1999):  
START WITH ACC/SEQ NUMBER: FIRST// 1999-00000  
GO TO ACC/SEQ NUMBER: LAST// 1999-99999
```

To get a single record:

```
For a single patient (e.g. 1999-00001):  
START WITH ACC/SEQ NUMBER: FIRST// 1999-00001/00  
GO TO ACC/SEQ NUMBER: LAST// 1999-00001/99
```

ACCESSION REGISTER										MAR 24,1999
15:03	PAGE 1									
ACC/SEQ NO.	SITE/GP	PATIENT NAME	DX DATE	AGE AT DX	CLASS CATEGORY	SSN	RACE	SX	STATUS	
1999-00001/00	BREAST	NAME,PATIENT	04/25/98	60	Analytic	462-56-2341	White	Fe	Alive	

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded.

Registry Lists ...

Patient Index-ACOS (132c)

This prints the Patient Index which contains all elements required by the ACOS Cancer Program Manual.

Device: Enter a printer name.

ACOS PATIENT INDEX: ROBERT ANDERSON			HINES DEVELOPMENT			MAR 24,1999 15:05		PAGE: 1	
PATIENT NAME	MED RECORD#	S	DT-BIRTH	DT-DEATH	ACC/SEQ-NO	DATE DX	ICDO - TOPOGRAPHY	L	ICDO - MORPHOLOGY

PATIENT NAME:									
NAME,PATIENT	353-16-5627	N	04/11/1916		1998-00015/00	07/30/1998	C44.8 SKIN OVERLAP	0	8140/3 ADENOCARCINOMA N

Registry Lists ...

Patient Index-Site (80c)

This prints the Patient Index listing the Primary site.

Start with Name: FIRST: Press the <ret> key to get all the patients. When selecting a single patient, enter the last name in UPPER CASE.

Go to Name: LAST: This prompt only appears if you made an entry at the "Start with" prompt. When selecting a single patient, enter the last name in UPPER CASE and append a Z at the end, e.g., enter SMITH as SMITHZ.

Device: Enter a printer name.

ONCOLOGY PATIENT LIST		MAR 24, 1999 14:48		PAGE 1	
NAME	SSN	SX ACC/SEQ #	PRIMARY SITE/GP	DATE DX	

NAME, PATIENT	353-16-5627	N 1998-00015/00	SKIN	07/30/1998	

Registry Lists ...

Patient Index-EOVA (132c)

This is the Patient Index Register for East Orange requirements.

Start with Name: FIRST: Press the <ret> key to get all the patients. When selecting a single patient, enter the last name in UPPER CASE.

Go to Name: LAST: This prompt only appears if you made an entry at the "Start with" prompt. When selecting a single patient, enter the last name in UPPER CASE and append a Z at the end, e.g., enter SMITH as SMITHZ.

Device: Enter a printer name.

ONCOLOGY PATIENT LIST							MAR 24,1999	15:08	PAGE 1
NAME	SSN	DOB	RACE	ABTRACTER	ACC #	SITE/GP	DX DATE	STATUS	
NAME,PATIENT	353-16-5627	04/11/1916	White		980015	SKIN	07/30/1998	Alive	

Registry Lists ...

Primary ICDO Listing (80c)

This is a Primary Site listing using ICDO Topography as the sort.

Device: Enter a printer name.

¹

ICDO-SITE: C00-LIP		MAR 24, 1999		PAGE 1	
PATIENT NAME	SSN	YR	ACC/SEQ #	TOPOGRAPHY	DATE DX
ICDO CODE: C00.0					
NAME, PATIENT	579-20-9513	1998	1998-0005/03	LIP, EXTERNAL U	05/29/1997

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded plus report header changes.

Registry Lists ...

Primary Site/GP Listing (80c)

This is a Primary Site listing, sorted by Primary SITE/GP, then by name, by date of diagnosis. The ICDO Topography code is printed.

Example:

```
START WITH SITE/GP: FIRST// BONE
GO TO SITE/GP: LAST// BONE
  * Previous selection: ICDO TOPOGRAPHY-CODE not null
  START WITH ICDO CODE: FIRST// C41.9
  GO TO ICDO CODE: LAST// C41.9
DEVICE: (Enter a printer name)
```

1

SITE/GP: BONE			MAR 25,1999		PAGE 1
PATIENT NAME	SSN	YR	ACC/SEQ #	TOPOGRAPHY	DATE DX

ICDO CODE: C41.9					
NAME, PATIENT	406-24-6662	1998	98-0008/02	BONES NOS	05/05/1991
NAME, PATIENT	333-12-4444	1995	93-0002/02	BONES NOS	11/18/1998

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded plus report header changes.

Registry Lists ...

Primary ICDO Listing (132c)

This is a Primary Site listing using ICDO Topography as the sort.

Device: Enter a printer name.

1

PRIMARY ICDO:		HINES DEVELOPMENT			MAR 24,1999 15:10		PAGE		1
PATIENT NAME	SSN	DOB	DOD	YEAR	ACC/SEQ #	DATE DX	TOPOGRAPHY	MORPHOLOGY	

NAME,PATIENT	579-20-9513			1998	1998-00005/03	05/29/1997	C00.0 LIP, EXTERNAL U	8070/2 SQUAMOUS CELL	

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded plus report header changes.

VIII. Annual Reporting

This menu contains annual reports.

Any report with (132c) following the name requires a printer that will print 132 columns.

Annual Reports

AAR	Annual ACOS Accession Register (80c)
API	Annual ACOS Patient Index (132c)
ASL	Annual Primary Site/GP Listing (132c)
ACL	Annual Patient List by Class of Case (80c)
SST	Annual Primary Site/Stage/Tx (132c)
TST	Annual ICDO Topography/Stage/Tx (132c)
SDX	Annual Status/Site/Dx-Age (132c)
HIS	Annual Histology/Site/Topography (80c)
AST	Annual Site/ICDO Topography/Histology (80c)
ACT	Annual Cross Tabs (80c)
CPR	Print Custom Reports

Annual Reporting ...

Annual ACOS Accession Register (80c)

This is the Annual Accession Register required by ACOS. It is sorted by accession year and prints a count of records at the end.

Year for Annual Report: Enter a four digit year.

Device: Enter a printer name.

ACCESSION REGISTER - 1998		HINES DEVELOPMENT		MAR 25,1999 PAGE 1	
ACC/SEQ-No	Patient Name	ICDO - Topography		Date Dx	C L

1989-00001/05	NAME,PATIENT	C15.9	ESOPHAGUS NOS	08/18/1998	1 0

Annual Reporting ...

Annual ACOS Patient Index (132c)

This option prints the Annual Patient Index ACOS required items for an accession year. It also provides a count of the records.

Year for Annual Report: Enter a four digit year.

Device: Enter a printer name.

```
*****
ACOS ANNUAL PATIENT INDEX - 1995                HINES ISC                SEP 23,1996 13:23                PAGE 1
PATIENT NAME      MED RECORD# S DT-BIRTH DT-DEATH ACC/SEQ-NO    DATE DX  ICDO - TOPOGRAPHY      ICDO - MORPHOLOGY      L
*****
NAME,PATIENT      012-12-909  M 01/01/23  05/08/96  1996-00006/06  05/21/96  C34.3 LUNG, LOWER LOBE  8070/3 SQUAMOUS CELL CARC  1
*****
```

Annual Reporting ...

Annual Primary Site/GP Listing (132c)

This is an annual report sorted first by accession year and then by the primary site/group which is independent of the IDCO codes.

Note: Enter the Site/Gp in UPPERCASE.

Example:

```
START WITH ACCESSION YEAR: FIRST// 1998
GO TO ACCESSION YEAR: LAST// 1998
  * Previous selection: SITE/GP equals PROSTATE
START WITH SITE/GP: FIRST// LUNG
GO TO SITE/GP: LAST// LUNG
```

Device: (Enter a printer name)

ACOS SITE/GP INDEX - 1998: LUNG				HINES ISC		SEP 24,1996 09:09		PAGE 1	
PATIENT NAME		MED RECORD#	S	DT-BIRTH	DT-DEATH	ACC/SEQ-NO	DATE DX	ICDO - TOPOGRAPHY	ICDO - MORPHOLOGY

NAME,PATIENT		012-12-909	M	01/01/23	05/08/96	1996-00006/06	05/21/96	C34.3 LUNG, LOWER LOBE	8070/3 SQUAMOUS CELL CARC

Annual Reporting ...

Annual Patient List by Class of Case (80c)

This option prints an Oncology patient list for a selected accession year, sorted first by class category, then by class of case. It provides a subcount for each class of case and a total count at the end.

Year for Annual Report: Enter a four digit year.

Device: Enter a printer name.

```
*****
1998 - NonAnalytic          HINES DEVELOPMENT          MAR 25,1999          PAGE:  1
Patient Name                Med Rec#   Sx Acc/Seq#           Site/Group           Date Dx
*****
CLASS OF CASE: Dx ew, 1st rx ew
NAME,PATIENT                029-88-2389 M 1998-00018/01        PROSTATE             09/09/1998
NAME,PATIENT                029-88-2389 M 1998-00018/02        COLON                11/23/1998
NAME,PATIENT                029-88-2389 M 1998-00018/03        SKIN                 12/02/1998
NAME,PATIENT                406-24-6662 M 1998-00008/05        COLON
-----
SUBCOUNT                    4
CLASS OF CASE: Dx at autopsy
```

Annual Reporting ...

Annual Primary Site/Stage/Tx (132c)

This option prints a report of four kinds of treatment. It is sorted by primary site/group, AJCC summary stage group, and treatment and counts the number in stage group and the number in treatment.

Note: Enter the Site/Gp in UPPERCASE.

Example:

```
START WITH ACCESSION YEAR: FIRST// 1998
GO TO ACCESSION YEAR: LAST// 1998
  * Previous selection: SITE/GP equals PROSTATE
  START WITH SITE/GP: FIRST// PROSTATE
  GO TO SITE/GP: LAST// PROSTATE
DEVICE: (Enter a printer name)
```

ANNUAL PRIMARY SITE/STAGE/TOPOGRAPHY INDEX				HINES DEVELOPMENT			MAR 30, 1999 14:17		PAGE		1
PT ID TX	TREATMENT	SURG DATE	SURGERY	RAD DATE	RADIATION	CHEMO DT	CHEMOTHERAPY	HT DATE	HORMONE	TPY	

SITE/GP: PROSTATE											
STAGE GROUPING-AJCC: III											
E6662 C61.9	BRM/CMX	12/23/1998	02 Incisional, nee	12/23/1998	Radioactive im	12/23/1998	Chemotherapy,	12/23/1998	Comb of		
hor	-----										
SUBCOUNT	1										
S0415 C61.9	SUR/XRT	03/18/1998	02 Incisional, nee	04/01/1998	Beam radiation	00/00/0000	None	00/00/0000	None		
W0192 C61.9	SUR/XRT	05/30/1998	02 Incisional, nee	06/10/1998	Beam radiation	00/00/0000	None	00/00/0000	None		

SUBCOUNT	2										

SUBCOUNT	3										

Annual Reporting ...

Annual ICDO Topography/Stage/Tx (132c)

This option prints a cancer case list sorted first by ICDO Topography, then by stage of disease, and finally by sequence of treatment (or none).

Example:

```
* Previous selection: ACCESSION YEAR equals 1998
START WITH ACCESSION YEAR: FIRST// 1998
GO TO ACCESSION YEAR: LAST// 1998
  * Previous selection: ICDO-SITE CODE not null
  START WITH ICDO-SITE CODE: FIRST// C50
  GO TO ICDO-SITE CODE: LAST// C50
DEVICE: (Enter a printer name)
```

PRIMARY SITE/GP by STAGE by TREATMENT				MAR 25, 1999 14:57 PAGE 1		
				ICDO-SITE CODE: C50		
				STAGE GROUPING-AJCC: 0		
E5915	C50.4	SUR	03/27/1998 40 Total (simple	00/00/0000 None	00/00/0000 None	00/00/0000 None

SUBCOUNT	1					

SUBCOUNT	1					
				STAGE GROUPING-AJCC: I		

Annual Reporting ...

Annual Status/Site/Dx-Age (132c)

This is an annual report that sorts first by accession year, then class category, status, site/gp, and diagnosis age group. It gives subcounts for accession year, site/gp and dx age group for the field of accession/Sequence number.

For Class Category, enter A for Analytic or press <ret> to accept all.

```
* Previous selection: ACCESSION YEAR from 1996
START WITH ACCESSION YEAR: FIRST// 1998
GO TO ACCESSION YEAR: LAST// 1998
  * Previous selection: CLASS CATEGORY not null
  START WITH CLASS CATEGORY: FIRST// Analytic    USES INTERNAL CODE: 1
  GO TO CLASS CATEGORY: LAST// Analytic
DEVICE: (Enter a printer)
```

PRIMARY LIST		MAR 25,1999 15:07		PAGE 1	
ACCESSION YEAR: 1998					
CLASS CATEGORY: Analytic					
STATUS: Alive					
SITE/GP: BREAST					
DX AGE-GP: 30-39					
NAME,PATIENT	261-44-2073	98-0007/00	03/10/1998	BREAST, AXILLARY TAI	DUCT CARCINOMA, INFI T1 NO M0 I SUR

SUBCOUNT	1				

Annual Reporting ...

Annual Histology/Site/Topography (80c)

This is an annual report that sorts by accession year and histology. Within histology, it sorts by site and then by IDCO topography. It also provides subcounts by histology and a total count of records.

Start with Accession Year: FIRST: Enter a four digit year or press the <ret> key to accept all years.

Go to Accession Year: LAST: Enter a four digit year. This prompt only appears if you made an entry at the "Start with" prompt.

Start with Histology: FIRST: Enter a Histology or press the <ret> key to accept all Histologies for the year(s) selected.

Got to Histology: LAST: Enter a Histology. This prompt only appears if you made an entry at the "Start with" prompt.

Device: Enter a printer name.

Note: Use UPPERCASE when entering a Histology. You must enter exactly what you want at the "Start with" and "Go to" prompts to get only a single type histology (e.g., ADENOCARCINOMA NOS) or make it not exact by using the Z to get all histologies beginning with whatever you enter as shown in the example below.

Example:

```
* Previous selection: ACCESSION YEAR not null
START WITH ACCESSION YEAR: FIRST// <ret>
  * Previous selection: HISTOLOGY from ADENOCARCINOMA
  START WITH HISTOLOGY: FIRST// ADENO
  GO TO HISTOLOGY: LAST// ADENOZ
DEVICE: (Enter a printer name)
```

```
*****
1998 - Analytic           HINES DEVELOPMENT           MAR 25,1999           PAGE: 1
Patient Name           Med Rec#           Sx Acc/Seq#           ICDO-Topography           Date Dx
*****
                HISTOLOGY: ADENOCARCINOMA NOS
                SITE/GP: BREAST
                ICDO-SITE CODE: C50
                PATIENT NAME:
NAME,PATIENT           476-23-5719 M 1989-00003/01  BREAST, UPPER-OUTER           04/01/1989
                -----
SUBCOUNT                1
                SITE/GP: COLON
                ICDO-SITE CODE: C18
                PATIENT NAME:
```

Annual Reporting ...

Annual Site/ICDO Topography/Histology (80c)

This is a report of analytic cases sorted by accession year, site/gp, ICDO-topography and IDCO-histology. It shows treatment and counts.

Year for Annual Report: Enter a four digit year.

Device: Enter a printer name.

1

PRIMARY STATISTICS		MAR 25,1999 10:37		PAGE 20
ACC/SEQ	NON			AGE
NUMBER	CANCER-DIRECTED			AT
	SURGERY	RADIATION	CHEMOTHERAPY	DX

	SITE/GP: PROSTATE			
	ICDO-TOPOGRAPHY: PROSTATE			
	HISTOLOGY: ADENOCARCINOMA NOS			
1998-00002/00	02	Incisional, needl		49
1998-00003/01	02	Incisional, needl	Beam radiation	39
1998-00009/02	02	Incisional, needl	Beam radiation	42
1998-00011/00	02	Incisional, needl	Beam radiation	56
1998-00016/01	00	No surgical proce	None	44
1998-00008/03	02	Incisional, needl	Radioactive implants	32

SUBCOUNT		6		

¹ Patch ONC*2.11*25 April 2000 Accession Number expanded plus report header changes.

Annual Reporting ...

Annual Cross Tabs (80c)

This is a cross tabs report for a selected reporting year covering a selected range of years for the complete registry.

Note: This is a lengthy report and should be queued to print during off hours. Assure that the printer it is sent to is well stocked with paper prior to starting.

The following is an example only:

```
CROSS TABS for ANNUAL Reports
      requires definition of
      YEAR and Row for all TABLES

Select YEAR for Cross Tab Reports:  (1989-1999): 1998// <ret>

Specify Time Frame for Total Registry:  (1989-1999): 1998

      Year for Annual Report is: 1998

      Complete Registry is 1998 to 1998

Definitions OK? Y// <ret>ES

Select one of the following:

      1      PRIMARY SITE/GP
      2      ICDO-SITE
      3      ICDO-TOPOGRAPHY
      4      SELECTED SITES
      5      SYSTEMS

Select Row: 1  PRIMARY SITE/GP

Percentages? ??

Enter either 'Y' or 'N'.

Percentages? y  YES

      -QUE ('Q') to run this report at night.
      -Ask your IRM for the appropriate time.

Select Device to Print Annual Cross Tabs: HOME// (Enter 'Q' and a printer
name)

FILE: ONCOLOGY PRIMARY
SEARCH TEMPLATE: ONCOS RANGE-ALLCASES

Two-Way Table with PRIMARY SITE/GP Values for Rows
```

and CLASS CATEGORY Values for Columns
For Entries in Search Template ONCOS RANGE-ALLCASES.

PRIMARY Template ONCOS RANGE-ALLCASES Cross TabsMAR 25,1999 10:46 Page 1				
PRIMARY SITE/GP:	CLASS CATEGORY			Total
	NonAnaly	Analytic	?	
BONE	0	1	0	1
	0.0	2.3	0.0	2.3
BRAIN	0	1	0	1
	0.0	2.3	0.0	2.3

Annual Reporting ...

Print Custom Reports

This option allows you to create custom reports using VA FileMan. A simple report is created by specifying which file (Oncology Primary (#165.5), Oncology Patient (#160), and Oncology Contact (#165)) the information is coming from, the fields that contain the data, how you want the data separated/sorted, and what information you need printed. See the VA FileMan User Guide for a more detailed explanation of sorting, searching, and printing using VA FileMan.

Oncology Primary file #165.5 contains the cancer case data which is everything about the primary, including accession number, status, diagnosis, physicians, treatment, staging, etc.

Oncology Patient file #160 contains all the patients with their demographic data (address, phone, marital status, etc.), history (tobacco and alcohol use, occupation, family history of CA, etc.), and follow-up history (dates of contacts and attempts, cancer status, quality of survival, etc.).

Oncology Contact file #165 contains contact names, addresses, phone numbers, etc.

Since the Oncology Primary file is generally the file to choose when looking to compile data on the cancer cases at your facility, we will use that in the following example. It is a report based on the year 1995 and the Site/Gp of Lung. You can change this report by entering a different year, or accepting all years, by entering a Site/Gp other than Lung, or by choosing to print fields other than those shown here:

You may customize your own reports using this option
See the FileManager Manual for detailed instructions

Select one of the following:

1	PRIMARY
2	PATIENT
3	CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

```
SORT BY: NUMBER// ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1995
GO TO ACCESSION YEAR: LAST// 1995
  WITHIN ACCESSION YEAR, SORT BY: SITE/GP
    START WITH SITE/GP: FIRST// LUNG
      GO TO SITE/GP: LAST// LUNG
        WITHIN SITE/GP, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: ACCESSION YEAR
THEN PRINT FIELD: PATIENT NAME
THEN PRINT FIELD: DATE DX
THEN PRINT FIELD: ICDO-TOPOGRAPHY
THEN PRINT FIELD: HISTOLOGY
THEN PRINT FIELD: <ret>
```

 Heading (S/C): ONCOLOGY PRIMARY LIST Replace ... With **1995 LUNG CASES**
 Replace <ret> 1995 LUNG CASES
 STORE PRINT LOGIC IN TEMPLATE: <ret>
 START AT PAGE: 1// <ret>
 DEVICE: (Enter a printer name)

1995 LUNG CASES		MAR 25,1999 12:32	PAGE 1
ACCESSION			
YEAR	PATIENT NAME	DATE DX	
ICDO-TOPOGRAPHY	HISTOLOGY		

	SITE/GP: LUNG		
1995	NAME,PATIENT	01/01/1993	
LUNG, UPPER LOBE	CARCINOMA, ANAPLASTIC NOS IN SITU		

Note: For additional help in creating your own sorts, see Appendix IV: VA FileMan Sorts and Searches to Go! and Appendix III: Oncology files (#160, #165, #165.5).

IX. Statistical Reporting

Statistics is a branch of mathematics dealing with a collection, summarization, analysis, interpretation, and presentation of masses of **numerical** data. Statistics represents **counts** or **measurements** of disease factors in cancer patients. Statistical analysis is a means of summarizing the essential features and relationships of the data. From that, one can generalize to reveal the major characteristics of the patient group in order to determine broad patterns of behavior or tendencies.

Data can be prepared for presentation in the form of tables or graphs.

This system is set up to search for user defined criteria. Multiple cross tabulations (Cross Tabs) can easily be produced either with or without percentages provided. Options included will provide survival curves using the actuarial life table for site, treatment and stage.

Statistical Reports

- CI Cross Tabs (ICDO-Site) - Total Registry
- CR Cross Tabs (User Selectable) - Total Registry
- TS Treatment by Stage - Cross tabs

Note: Before using the following menu options, you will have to create your own search templates to use in the Survival reports. See the option Define Search Criteria to do this.

- CT Cross Tab Routines
- SP Survival by Site
- SS Survival by Stage
- TX Survival by Treatment
- SU Survival Routines
- DS Define Search Criteria

Statistical Reports ...

Cross Tabs (ICDO-Site) - Total Registry

Use this option to create cross-tab reports with the ICDO-Site pre-defined as the row. The remaining variables are chosen from a series of lists as shown in the following example.

Example:

```
CROSS TABS for Total Registry

Select one of the following:

1      All years
2      Range of years
3      Particular year

Select time frame: 3 Particular year

Select YEAR for Annual Reports: (1995-1999): 1995// <RET>

Select one of the following:

N      Non-Analytic
A      Analytic
T      All Cases

Select CLASS Category: T All Cases

Using ICDO-SITE for Rows...Select column:

Select one of the following:

0      ACCESSION YEAR
1      CLASS OF CASE
2      STATUS
3      SEX
4      RACE
5      RACE-SEX
6      DX AGE-GP
7      PLACE OF BIRTH
8      MARITAL STATUS AT DX
9      STATE
10     ST-COUNTY
11     CLASS CATEGORY
12     ALL of the ABOVE
```

Note: If you select Analytic for the Class Category, choices beginning with 11 are the following:

```
11     STAGE GROUPING-AJCC
12     1TREATMENT PLAN
13     SUMMARY STAGE
14     HISTOLOGY
15     ALL of the ABOVE
```

¹ Patch Onc*2.11*24 Changed from Treatment field to Treatment Plan field.

Select Column: 5 RACE-SEX

Percentages? **YES**

CROSS TABS: ICDO-SITE vs RACE-SEX

TOTAL: All Cases in Registry

Years: 1995

Conditions OK? Yes// **<RET>** YES

QUE ('Q') report unless to 'home' device

Select Device to Print Cross Tabs: (Enter a printer name)

The following table is then displayed.

Two-Way Table with ICDO-SITE Values for Rows
and RACE-SEX Values for Columns
For Entries in Search Template ONCOS ANNUAL-ALLCASES
...EXCUSE ME, JUST A MOMENT PLEASE...
.

PRIMARY Template ONCOS ANNUAL-ALLCASES Cross Tabs SEP 25,1996 15:36 Page 1						
ICDO-SITE:	RACE-SEX					Total
	Other-	Other-F	Other-M	White-F	White-M	
LUNG/BRONCHUS	0 0.0	0 0.0	0 0.0	1 7.7	1 7.7	2 15.4
SKIN	1 7.7	0 0.0	0 0.0	0 0.0	0 0.0	1 7.7
BLADDER	0 0.0	1 7.7	5 38.5	2 15.4	1 7.7	9 69.2
?	0 0.0	0 0.0	0 0.0	1 7.7	0 0.0	1 7.7
Total	1	1	5	4	2	13
%	7.7	7.7	38.5	30.8	15.4	100.0

Statistical Reports ...

Cross Tabs (User Selectable) - Total Registry

Use this option to create cross-tab reports which allow the choice of a row and column as well as a time frame. Your selections determine the elements in the count.

Example:

```
CROSS TABS for Total Registry

Select one of the following:

1      All years
2      Range of years
3      Particular year

Select time frame: 2 Range of years

Select range of years (from year to year)
from which to SEARCH DATA for study

Select Range years: (1989-1999): 1997-1999

RANGE is 1997 to 1999

Range OK? Y// <ret>ES

Select one of the following:

N      Non-Analytic
A      Analytic
T      All Cases

Select CLASS Category: t All Cases

Select one of the following:

1      PRIMARY SITE/GP
2      ICDO-SITE
3      ICDO-TOPOGRAPHY
4      SELECTED SITES
5      SYSTEMS
6      HISTOLOGY

Select Row: 1 PRIMARY SITE/GP

Select one of the following:

0      ACCESSION YEAR
1      CLASS OF CASE
2      STATUS
3      SEX
4      RACE
5      RACE-SEX
6      DX AGE-GP
7      PLACE OF BIRTH
8      MARITAL STATUS AT DX
```

9 STATE
10 ST-COUNTY
11 CLASS CATEGORY
12 ALL of the ABOVE

Select Column: 2 STATUS

Percentages? y YES

CROSS TABS: PRIMARY SITE/GP vs STATUS

TOTAL: All Cases in Registry

Years: 1997-1999

Conditions OK? Yes// <ret> YES

QUE ('Q') report unless to 'home' device

Select Device to Print Cross Tabs: HOME// (Enter a printer name)

Two-Way Table with PRIMARY SITE/GP Values for Rows
and STATUS Values for Columns
For Entries in Search Template ONCOS RANGE-ALLCASES
...HMMM, JUST A MOMENT PLEASE...
.

PRIMARY SITE/GP:	STATUS		
	Alive	Dead	Total
BONE	1 1.9	1 1.9	2 3.8
BRAIN	1 1.9	0 0.0	2 3.8
BREAST	8 15.1	0 0.0	8 15.1
CERVIX	1 1.9	0 0.0	1 1.9
COLON	3 5.7	1 1.9	4 7.5

...

PRIMARY SITE/GP:	STATUS		
	Alive	Dead	Total
Total	37	15	52
%	71.2	28.8	100.0

Statistical Reports ...

Treatment by Stage - Cross Tabs

Use this option to produce four cross-tabs reports for Treatment by Stage groups I, II, III, IV.

Example:

```

This option will print cross-tabs for ALL ANALYTIC
cases for TREATMENT by STAGE groups (I,II,III,IV)

Select one of the following:

1          All years
2          Range of years
3          Particular year

Select time frame: 2 Range of years

Select range of years (from year to year)
from which to SEARCH DATA for study

Select Range years: (1989-1999): 1997-1999

RANGE is 1997 to 1999

Range OK? Y// <ret>ES

Select one of the following:

1          PRIMARY SITE/GP
2          ICDO-SITE
3          ICDO-TOPOGRAPHY
4          SELECTED SITES
5          SYSTEMS
6          HISTOLOGY

Select Row: 1 PRIMARY SITE/GP

Percentages? y YES

DEVICE: HOME// (Enter a printer name)

SEARCH TEMPLATE: ONCOS ANALYTIC

Two-Way Table with PRIMARY SITE/GP Values for Rows
and GP-I AJCC SUMMARY STAGE Values for Columns
For Entries in Search Template Years: 1997-1999
.
```

PRIMARY Template Years: 1997-1999 Cross TabsMAR 26,1999 12:20 Page 1

PRIMARY SITE/GP:	GP-I AJCC SUMMARY STAGE			Total
	I	IB	?	
BONE	2	0	0	2
	5.0	0.0	0.0	5.0
BRAIN	1	0	0	1
	2.5	0.0	0.0	2.5

...

PRIMARY Template Years: 1997-1999 Cross TabsAPR 5,1999 09:12 Page 4

PRIMARY SITE/GP:	GP-I AJCC SUMMARY STAGE			Total
	I	IB	?	
Total	38	1	0	39
%	97.4	2.6	0.0	100.0

...

Two-Way Table with PRIMARY SITE/GP Values for Rows
 and GP-II AJCC SUMMARY STAGE Values for Columns
 For Entries in Search Template Years: 1997-1999

.
 ...

Statistical Reports ...

Cross Tabs Routines

Use this option to create your own cross-tab reports by defining your search criteria using data from the three main Oncology files:

Oncology Primary file #165.5 contains the cancer case data which is everything about the primary, including accession number, status, diagnosis, physicians, treatment, staging, etc.

Oncology Patient file #160 contains all the patients with their demographic data (address, phone, marital status, etc.), history (tobacco and alcohol use, occupation, family history of CA, etc.), and follow-up history (dates of contacts and attempts, cancer status, quality of survival, etc.).

Oncology Contact file #165 contains contact names, addresses, phone numbers, etc.

You begin by determining the data you want in your report, then select the file that contains that data. If your report is patient centered, you would select the Oncology Patient file. If your report is centered around the cancer data, then you would select the Oncology Primary file. The Oncology Contact file does not lend itself well to cross tabs reports. It is mostly a multiple listing of contacts. **Cross tabs reports are a means of counting** records, cases, primaries, treatments, etc.

Choose the field that contains the most entries for the row selection to make your report easier to read either on the screen or in printed format. For example, if you were doing a report of the patient status versus the primary, there are more primaries than there are statuses. The primaries would be the row selection and the statuses the column selection as shown here:

	Alive	Dead	Totals
Primary 1 %	Total alive % alive	Total dead % dead	
Primary 2 %			
Primary 3 %			
Primary 4 %			
...			

To obtain a list of fields for selection, type two ?? at the Row and Column prompts.

Example: Oncology Patient file. We want to know **how many autopsies** were performed on the patients that **died from their cancer**. We created a template to search for all patients with a Status of "Dead", whose Cause of Death/Cancer does not equal "Not related" (See Define Search Criteria). We will use that template for this report:

CROSS TAB ROUTINES

CREATE your own Cross-Tab Reports!!

- 1 - Select File (usually Primary)
- 2 - Select a field for the ROW
- 3 - Select a field for the Column
- 4 - Optional: choose Column cutpoints
- 5 - Choose a SEARCH template to select cases

REMEMBER - type a '?' for HELP!!

Select one of the following:

- | | |
|---|---------|
| 1 | PRIMARY |
| 2 | PATIENT |
| 3 | CONTACT |

Select File to Search: 1// **2** PATIENT

We will build Crosstabs on entries in ONCOLOGY PATIENT file...

Select Search template to filter cases? Yes// **<ret>** YES

Select Search Template (Type ONCOS for list): **ONCOZ DEAD FROM CA** ONCOZ DEAD FROM CA

(Apr 12, 1999@09:42) User #4570 File #160

REMINDER: Run Define Search Criteria option
to be sure selected entries are up-to-date!!

Continue ? Y// **<ret>**ES

Select COLUMN field: **CAUSE OF DEATH/CANCER**

Select ROW field: **AUTOPSY**

- | | |
|---|-------------------|
| 1 | AUTOPSY |
| 2 | AUTOPSY # |
| 3 | AUTOPSY DATE/TIME |

CHOOSE 1-3: **1** AUTOPSY

Print Percents? No// **YES**

Two-Way Table with AUTOPSY Values for Rows
and CAUSE OF DEATH/CANCER Values for Columns
For Entries in Search Template ONCOZ DEAD FROM CA
OK? Yes// **<ret>** (Yes)

Select device to Print Cross Tabs: HOME// (Enter a printer name or press <ret> to bring the report to your screen.)

...EXCUSE ME, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

.

AUTOPSY:	CAUSE OF DEATH/CANCER	
	Directly	Total
No autopsy	10 33.3	10 33.3
Autopsy performed	20 66.7	20 66.7
Total	30	30
%	100.0	100.0

Example: Oncology Primary file. We want to know **how many** patients fall into each **diagnostic age group by primary**.

CROSS TAB ROUTINES

CREATE your own Cross-Tab Reports!!

- 1 - Select File (usually Primary)
- 2 - Select a field for the ROW
- 3 - Select a field for the Column
- 4 - Optional: choose Column cutpoints
- 5 - Choose a SEARCH template to select cases

REMEMBER - type a '?' for HELP!!

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1// <ret> PRIMARY

We will build Crosstabs on entries in ONCOLOGY PRIMARY file...

Select Search template to filter cases? Yes// NO

Cases will cover entire registry - OK? No// YES

Select COLUMN field: 4.1 DX AGE-GP

Select ROW field: PRIMARY SITE/GP

Print Percents? No// YES

Two-Way Table with PRIMARY SITE/GP Values for Rows
and DX AGE-GP Values for Columns

For ALL Cases

OK? Yes// <ret> (Yes)

Select device to Print Cross Tabs: HOME// (Enter a printer name or press the <ret> key to bring the report to your screen.)

...EXCUSE ME, LET ME THINK ABOUT THAT A MOMENT...

PRIMARY Cross Tabs		APR 12,1999 09:58			Page 1

PRIMARY SITE/GP:	DX AGE-GP				Total
	20-29	30-39	40-49	50-59	
BLADDER	0 0.0	1 1.3	0 0.0	0 0.0	1 1.3

BONE	1 1.3	0 0.0	1 1.3	2 2.6	5 6.5

BRAIN	0 0.0	0 0.0	1 1.3	0 0.0	3 3.9

BREAST	0 0.0	2 2.6	1 1.3	1 1.3	9 11.7

...					

PRIMARY SITE/GP:	DX AGE-GP			Total
	60-69	70-79	80-99	
BLADDER	0 0.0	0 0.0	0 0.0	1 1.3

BONE	0 0.0	0 0.0	1 1.3	5 6.5

BRAIN	1 1.3	0 0.0	1 1.3	3 3.9

BREAST	1 1.3	3 3.9	1 1.3	9 11.7

...				

Statistical Reports ...

Survival by Site

This option checks for the Status of Dead in the Status field of the Oncology Primary file and uses it along with the search template you choose to report survival by site. To use this option, select one of the predefined search templates. If data is available (5 year minimum) a life table and survival curves can be produced.

Example: Try printing this report using the search template ONCOS RANGE-ALLCASES or ONCOS ANALYTIC to see what this report can do.

Enter a package template name (beginning with ONCO) or your own template name below.

Search template names begin with ONCOS. All other ONCO templates are sort templates.

If you select a sort template here, you will be prompted for a search template later.

```
Select Template: ONCOS RANGE-ALLCASES
                  (Mar 25, 1999)          File #165.5  ONCOS RANGE-ALLCASES
```

```
REMINDER: Run Define Search Criteria option
to be sure selected entries are up-to-date!!
```

```
Continue ? Y// <ret>ES
SEARCH TEMPLATE: ONCOS RANGE-ALLCASES
DURATION field: SURVIVAL MONTHS
STATUS expression: STATUS="Dead"

DEVICE: HOME// (Enter a printer name)
```

Statistical Reports ...

Survival by Stage

If the data is available and on line, this option prints the life tables and survival curves for the whole registry, divided into four stage groups (I, II, III, and IV). Curves produced show stages I and II with much better survival rates than those diseases in stages III and IV.

Example: Try printing this report using the search template ONCOS RANGE-ALLCASES or ONCOS ANALYTIC to see what this report can do.

```

SURVIVAL by Stage of Disease (All)
Select Template:   ONCOS RANGE-ALLCASES
                  (Mar 25, 1999)           File #165.5  ONCOS RANGE-ALLCASES

REMINDER: Run Define Search Criteria option
to be sure selected entries are up-to-date!!

Continue ? Y// <ret>ES
SEARCH TEMPLATE: ONCOS RANGE-ALLCASES
DURATION field: SURVIVAL MONTHS
STATUS expression: STATUS="Dead"

DEVICE: HOME// (Enter a printer name)
```

Statistical Reports ...

Survival by Treatment

If there is sufficient data, this option prints life tables and survival curves using Treatment or Sequence of Treatment as a variable. Treatment groups are defined using a search template.

Example: Try printing this report using the search template ONCOS RANGE-ALLCASES or ONCOS ANALYTIC to see what this report can do.

```
Select Template:   ONCOS RANGE-ALLCASES
                  (Mar 25, 1999)                File #165.5  ONCOS RANGE-ALLCASES
```

```
REMINDER: Run Define Search Criteria option
to be sure selected entries are up-to-date!!
```

```
Continue ? Y// <ret>ES
SEARCH TEMPLATE: ONCOS RANGE-ALLCASES
DURATION field: SURVIVAL MONTHS
STATUS expression: STATUS="Dead"

DEVICE: HOME// (Enter a printer name)
```

Statistical Reports ...

Survival Routines

This option tabulates survival data and produces a survival curves graph.

To use this option, select the Oncology file (Oncology Primary file #165.5 or Oncology Patient file #160) from which to extract data. Then, sort through the data by using a search template. To see what templates are already available, type "ONCOS" at the "Select SEARCH TEMPLATE" prompt. Note: Not all ONCOS templates are search templates. If you choose one that isn't the program will tell you with the following expression:

```
Sorry, TEMPLATE NAME must be a SEARCH template
```

You can run the option without using a template. The results are the same, but the process takes longer.

Survival curves are plotted over a one year period. You normally use "YR" for Duration unit, and "YR" for interval unit. For the Survival Duration prompt, enter a field that either tracks time such as Survival Months or from which time can be determined such as Date Last Contact.

The number of sub-groups determines the number of survival curves to be run simultaneously. Up to four sub-groups may be selected. However, each additional sub-group adds search criteria which must be met to make the data true and makes reading the curves more difficult.

Example:

```
Select FILE: 160  ONCOLOGY PATIENT
FILE: 160

Restrict cases with a SEARCH TEMPLATE? Yes// <ret>  YES
Select SEARCH TEMPLATE:  ONCOS ANALYTIC

REMINDER: Run Define Search Criteria Option
to be sure selected entries are up-to-date!!

Select survival DURATION field:  DATE LAST CONTACT
DURATION unit (Day, Wk, Mo, Yr):  YR
INTERVAL unit (Mo, Yr):  Yr//  YR
Enter survival STATUS expression:  STATUS=0
Number of sub-groups: 1// <ret>
Do you want curves plotted? No//  Y  (Yes)

Survival analysis for template ONCOS ANALYTIC - OK? Yes// <ret>  (Yes)

DEVICE: HOME// (Enter a printer name)
```

Statistical Reports ...

Define Search Criteria

This option allows you to create templates that apply search criteria to the main Oncology files (Oncology Primary, Oncology Patient, and Oncology Contact) and manipulate the printing of that data for use in the survival statistics options (Survival by Site, Stage, and Treatment and Survival Routines) and other presentation graphics.

Note: Refer to Appendix IV: VA FileMan Sorts and Searches to Go! for examples other than those shown in this chapter.

There are a number of search templates already defined and available to you within the program. These are namespaced (ONC) and begin with ONCOS. Any templates that you define here and want to save for reuse later should be named beginning with ONCOZ. The rest of the name should reflect the general content of the data it will find. It is also wise to define exactly what the search does or when you would use it in the description field when you create your template.

Prior to initiating the search, it is necessary to know specifically what information you want in the report and where (in which file) that data resides. One of the best ways for determining the data you need is by designing a report by hand showing the data you want displayed and then searching each file to discover where the data lives. Write out your definition of the report. If you define what the report will do, you generally have the basis for what you need to define in your search template.

In some of the following examples, we added template names (Sort/Search and Print) to demonstrate how this is done. You do not need to name every template you create, only those that you will use often.

Report Definition #1: Find all records with a Patient (Oncology Patient file) Status of "Dead" (Status field), whose Cause of Death (Cause of Death/Cancer field) was not "Not Related". Then print the ICD Cause of Death, Patient Name, Date of Death and SSN.

Note that the data for Status and Cause of Death/Cancer are entered in Upper and lower case as they are in their respective fields. Search criteria is often case sensitive.

```
This option allows you to create 'SEARCH TEMPLATES'  
which are used in Cross-Tabs and Survival Analysis
```

```
REMEMBER to name templates beginning with  
ONCOZ for USER defined templates  
verses Package distributed (ONCOS).
```

```
To 'RUN' Existing Templates enter '[ONCOS' to begin,  
to bring up pre-defined templates for use with Cross-tabs.
```

```
Select one of the following:
```

```
1          PRIMARY  
2          PATIENT
```

Select File to Search: 2 PATIENT

We will search entries in PATIENT file...

-A- SEARCH FOR ONCOLOGY PATIENT FIELD: STATUS
-A- CONDITION: EQUALS
-A- EQUALS: Dead

Our first field definition is for the *Status* field. The status should *equal Dead*. Note: Searching a template can be case sensitive particularly when we use the condition of *Equals*, so we entered Dead in Upper and lower case because that's the way it appears in the file.

-B- SEARCH FOR ONCOLOGY PATIENT FIELD: CAUSE OF DEATH/CANCER
-B- CONDITION: EQUALS
-B- NOT EQUALS: Not related

-C- SEARCH FOR ONCOLOGY PATIENT FIELD: <ret>

The last field we search is *Cause of Death/Cancer*. It should *not* (') *equal Not related*.

Both conditions (A and B) must be present so we use the ampersand with them following the If statement: A&B.

IF: A&B STATUS EQUALS 0 (Dead)
and CAUSE OF DEATH/CANCER NOT EQUALS "N" (Not related)
OR: <ret>

We'll call this template ONCOZ DEAD FROM CA.

STORE RESULTS OF SEARCH IN TEMPLATE: ONCOZ DEAD FROM CA
(Apr 12, 1999@09:33) User #4570 File #160
Are you adding 'ONCOZ DEAD FROM CA' as a new SORT TEMPLATE? No// Y (Yes)

DESCRIPTION:
This template grabs all patients that either died from their CA or there was a possibility that their death was attributable to their CA.

Edit? NO// <ret>

SORT BY: NUMBER// ICD CAUSE OF DEATH
START WITH ICD CAUSE OF DEATH: FIRST// <ret>
WITHIN ICD CAUSE OF DEATH, SORT BY: <ret>
FIRST PRINT FIELD: NAME
THEN PRINT FIELD: DATE
1 DATE ENTERED
2 DATE LAST CONTACT
3 DATE@TIME OF DEATH
CHOOSE 1-3: 3 DATE@TIME OF DEATH
THEN PRINT FIELD: SSN
THEN PRINT FIELD: <ret>

 Heading (S/C): ONCOLOGY PATIENT SEARCH Replace <ret>
 DEVICE: (Enter a printer name)
 ...HMMM, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

ONCOLOGY PATIENT SEARCH	APR 12,1999 09:43	PAGE 1
NAME	DATE@TIME OF DEATH	SSN
ICD CAUSE OF DEATH: 162.9		
ESTRADA,ERIC	12/16/1998	406-24-6662
ICD CAUSE OF DEATH: 188.9		
TEST,A	10/21/1993	111-11-1111
ICD CAUSE OF DEATH: 456.0		
TEST,G	04/05/1999	777-77-7777

Report Definition #2: Find all records of Cancer (Oncology Primary file) of the Breast (Site/Gp equals Breast) diagnosed (Date Dx) in 1998.

This option allows you to create 'SEARCH TEMPLATES' which are used in Cross-Tabs and Survival Analysis

REMEMBER to name templates beginning with ONCOZ for USER defined templates verses Package distributed (ONCOS).

To 'RUN' Existing Templates enter '[ONCOS' to begin, to bring up pre-defined templates for use with Cross-tabs.

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

For this search, we need to use the Oncology Primary file because we are looking for cancer data and Site/Gp is a required entry for each record in that file.

We will search entries in PRIMARY file...

-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: **SITE/GP**
-A- CONDITION: **??**

Choose from:

- 1 NULL
- 2 CONTAINS
- 3 MATCHES
- 4 LESS THAN
- 5 EQUALS
- 6 GREATER THAN

YOU CAN NEGATE ANY OF THESE CONDITIONS BY PRECEDING THEM WITH "'" OR "-" SO THAT "'NULL'" MEANS "NOT NULL"

-A- CONDITION: **CONTAINS**
-A- CONTAINS: **BREAST**

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: **DATE DX**
-B- CONDITION: **GREATER THAN**
-B- GREATER THAN DATE: **123197** (DEC 31, 1997)

-C- SEARCH FOR ONCOLOGY PRIMARY FIELD: **DATE DX**
-C- CONDITION: **LESS THAN**
-C- LESS THAN DATE: **010199** (JAN 01, 1999)

-D- SEARCH FOR ONCOLOGY PRIMARY FIELD: **<ret>**

For the first search criteria, we need to limit the search to just those records with a Site/Gp of Breast.

Field: We choose *SITE/GP* in the Oncology Primary file because that field groups all the breast cancers under one category, **BREAST**. Each record in the file must have a Site/Gp defined and a patient name for that Site/Gp.

Condition: The record must *CONTAIN* a specific Site/Gp. Note: We could have used Equals here also.

Contains: It must contain the Site/Gp *BREAST*.

We determined from our report definition and from looking at the Oncology Primary file that the Date Dx will give us when each case was diagnosed. We want every record of breast cancer that was diagnosed in 1998.

For the second search criteria we need to define the date the search should begin using the *DATE DX* field.

Our Condition has to be *GREATER THAN* because there is no condition of greater than and equal to. The Date, therefore must be the day before 1/1/98.

For the third search criteria, we define the ending date for the search using the *DATE DX* field and the *LESS THAN* condition.

That finishes our conditions.

```

IF: A&B&C   SITE/GP CONTAINS "BREAST"
           and DATE DX GREATER THAN DEC 31,1997 (123197)
           and DATE DX LESS THAN JAN 1,1999 (010199)
OR: <ret>

```

Now we need to tell the search that each of these conditions must be present for the record to be part of our report.

```

STORE RESULTS OF SEARCH IN TEMPLATE: ONCOZ BREAST 1998
Are you adding 'ONCOZ BREAST 1998' as a new SORT TEMPLATE? No// Y (Yes)
DESCRIPTION:
  No existing text
  Edit? NO// <ret>YES

```

```

==[ WRAP ]==[ INSERT ]=====< DESCRIPTION >===== [ <PF1>H=Help ]=====
This template finds all cases diagnosed in 1998 with a Site/Gp of Breast.

```

```

<=====T=====T=====T=====T=====T=====T=====T=====T=====T=====T>=====T

```

```

SORT BY: NUMBER// ICDO-TOPOGRAPHY;"";S2
START WITH ICDO-TOPOGRAPHY: FIRST// <ret>
WITHIN ICDO-TOPOGRAPHY, SORT BY: <ret>

```

Our sort will be by the ICDO-Topography field. We will suppress printing the subheader caption ("") and skip two lines between each new ICDO-topography. Since our search criteria is limiting all records to those for Breast, we do not have to select Start and End with data.

```

FIRST PRINT FIELD: !PID#;S1;C1

```

We want to count the number of records (!). We'll print the patient's ID, skip a line between each record (S1), and start printing in the first column (C1).

```

THEN PRINT FIELD: HISTOLOGY;L28

```

We'll print Histology within 28 characters.

```

THEN PRINT FIELD: TNM
THEN PRINT FIELD: AJCC STAGE;"STAGE"

```

We'll shorten the column name of AJCC STAGE to just STAGE.

```

THEN PRINT FIELD: TREATMENT
THEN PRINT FIELD: STATUS

```

We'll shorten the name of SURVIVAL MONTHS to SURV MON.

```

THEN PRINT FIELD: SURVIVAL MONTHS;"SURV MON"
THEN PRINT FIELD: <ret>

```

We'll give the report a heading that means something. And we will give the print template the same name as the as the search template. Because the print template could be used for different Primary statistics, you could name it something more generic.

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **CA BREAST DX 1998**
 Replace <ret>
 CA BREAST DX 1998

STORE PRINT LOGIC IN TEMPLATE: **ONCOZ BREAST 1998**

Are you adding 'ONCOZ BREAST 1998' as a new PRINT TEMPLATE? No// **Y** (Yes)
 DEVICE: (Enter a printer name)

...HMMM, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

CA BREAST DX 1998		APR 7,1999 08:13		PAGE 1
PID#	HISTOLOGY	TNM	STAGE	
TREATMENT		STATUS	SURV MON	

BREAST, AXILLARY TAIL				
S2073	DUCT CARCINOMA, INFILTRATING	T1 N0 M0		I
SUR		Alive	1.5	
BREAST, LOWER-INNER QUADRANT				
F4374	INTRADUCTAL CA/LOBULAR CIS	T1A N0 M0		I
SUR		Alive	0.9	

...

CA BREAST DX 1998		APR 7,1999 08:13		PAGE 3
PID#	HISTOLOGY	TNM	STAGE	
TREATMENT		STATUS	SURV MON	

BREAST, UPPER-OUTER QUADRANT				
E5915	LOBULAR CARCINOMA IN SITU	T1A N0 M0		0
SUR		Alive	11.5	
SKIN, TRUNK				
G9201	BOWEN'S DISEASE			
NTX		Alive	0.0	

COUNT	7			

At this point you will need to check the data from your two search templates. Are the reports capturing every case that you intended? If not, adjust the search criteria. You can create another search and name it the same to replace the one that is not capturing the data you wanted.

*NOTE: Remember the names of the templates you create in each of the searches. These template names can be used when running the Survival options for Site, Stage, Treatment and Options. Or, if you want to use this option to run the report you designed, enter the search template name within an open bracket '[' at the first search field as in this example:

```
-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: [ONCOZ BREAST 1998
```

Enter the print template at the first print field as in this example:

```
FIRST PRINT FIELD: [ONCOZ BREAST 1998
```

Now that you have created two search templates, you can use similar criteria to create other templates:

1. Make templates for each of the Site/Gp types. The print template can be used for all of them.
2. Make templates that will grab all records for a particular Site/Gp. Hint: Don't enter the date range conditions.
3. Make templates that only grab analytic records for each Site/Gp. And those that only grab non-analytic.
4. Make a template that only looks at patients with a status of Alive.

X. Utility Options

The Utility Options menu is used to manage your Oncology database by allowing you to correct errors, delete records, and create data disks to send to national and state databases.

¹Utility Options

PI	Patient/Primary Inquiry
RD	Print Oncology Patient Record
RS	Registry Summary Reports
DP	Delete Oncology Patient
DS	Delete Primary Site/GP Record
EA	Edit Site/AccSeq# Data
LG	List Topographic Site Groups
LT	List Topography Codes by Site Group
ER	Report of accessions requiring additional input
AR	Create a report to preview ACOS output
CT	Create ACOS Data Disk
CC	Create State Data Disk
SR	Create a report to preview State output
TR	Define Tumor Registry Parameters
AC	Enter/Edit Facility file

¹ Patch ONC*2.11*22 Removed option Edit Surgery Codes.

Utility Options ...

Patient/Primary Inquiry

To quickly check to see if a person is in the Oncology Patient file, use this option and enter the person's name at the "Oncology Patient Name" prompt (LAST,FIRST). If it is an Oncology Patient, patient information is displayed along with the patient's primaries that have been defined. If the person is not in the file, you are returned to the "Oncology Patient Name" prompt.

Example:

```
???????? ONCOLOGY PATIENT INQUIRY ??????????
```

```
Select ONCOLOGY PATIENT NAME:   DOE,JANE
```

```
      Patient information:
```

```
Name:  DOE,JANE                Date Last Contact: 03/11/1999
SSN:   218-34-5915             Vital Status:       Alive
DOB:   04/01/1938              Cancer Status:     Unknown
```

```
      DOE,JANE has following Primaries defined:
```

Acc/Seq#	Primary Site	Last Tumor Status	Date DX	Abst Status
1998-00013/01	BREAST, UPPER-OUTER QU	No evid this CA	03/27/1998	Complete
1998-00013/02	CERVIX, ENDOCERVIX	Evidence this CA	10/13/1998	Incomplete
1998-00013/03	LUNG, UPPER LOBE	Evidence this CA	01/11/1998	Incomplete

```
Select ONCOLOGY PATIENT NAME: WHATEVER,LEWIS
```

```
      Searching for a VA Patient
```

```
      Searching for a Non-VA or Ambiguous Patient
```

```
Select ONCOLOGY PATIENT NAME:
```

Utility Options ...

Print Oncology Patient Record

This option displays all information regarding a patient contained in both the Oncology Patient file and Oncology Primary file. This option might be useful prior to deleting patients (option: Delete Oncology Patient), etc.

Example:

```
Select patient for record DUMP:    DOE, JANE
```

```
DEVICE: HOME// (Enter a printer name or press the <ret> key to bring the report to  
your screen)
```

```
***** Information from Oncology Patient File
```

```
NAME: EDEN, BARBARA                PLACE OF BIRTH: Massachusetts  
RACE: White  
SPANISH ORIGIN: Non-Spanish, non-Hispanic  
SEX: Female                        AGENT ORANGE EXPOSURE: No  
IONIZING RADIATION EXPOSURE: No    PERSIAN GULF SERVICE: No  
CHEMICAL EXPOSURE: No              ASBESTOS EXPOSURE: No
```

```
...  
...  
...
```

```
***** END of RECORD *****
```

Utility Options ...

Registry Summary Reports

These reports provide a count of the total registry, both analytic and non-analytic.

Example when selecting Today:

Registry Summary Report - Current Status

Select one of the following:

T	Today
A	Annual
F	Followup

Select time: Today// <ret>

DEVICE: HOME// (Enter a printer name or press the <ret> key to print to your screen)

...HMMM, HOLD ON...

HINES DEVELOPMENT
BUILDING 37
HINES, IL 60141

01/01/80 - 03/31/99

Tumor Registrar
Gary Baldwin
708-786-5900

Analytical:	61
Non-Analytical:	14

Total:	75

WORKLOAD STATISTICS

Suspense:	20	Incomplete:	27	Minimal:	1	Partial:	1	Complete:	47
-----------	----	-------------	----	----------	---	----------	---	-----------	----

Example of Annual:

Select one of the following:

T	Today
A	Annual
F	Followup

Select time: Today// **Annual**

Select YEAR for Summary: (1989-1999): 1998// **1999**

DEVICE: HOME// (Enter a printer name that will print 132 columns.)

...EXCUSE ME, HOLD ON...

ANNUAL SUMMARY REPORT: 1999 APR 27, 1999@10:43:29

SITE:	TOT#	ANAL	NON		W-M	W-F	B-M	B-F	O-M	O-F		0	I	II	III	IV	U	NA	INC	
COLON	12	12			6		1		5			1	2	1						8

Example of Followup:

Registry Summary Report - Current Status

Select one of the following:

T	Today
A	Annual
F	Followup

Select time: Today// **f** Followup

DEVICE: HOME// (Enter a printer name or press the <ret> key to print to your screen)

...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

MAR 31,1999@11:19:04

FOLLOW-UP RATE FOR ALL PATIENTS (LIVING AND DEAD)	NUMBER	PERCENT
Total cases in registry since reference date	75	100%
1. Less benign/borderline (behavior code 0/1)	- 0	
2. Less Carcinoma in situ CERVIX cases	- 0	
3. Less cases of in situ/localized basal and squamous cell carcinoma of skin	- 0	
4. Less foreign residents	- 0	
5. Less nonanalytic (includes recurrent cases class of case 3,4,5, 8 & 9)	- 13	
SUBTOTAL CASES = ANALYTIC CASES (A)	62	100%
(class of case 0, 1, 2)		
1. Less number dead (B)	15	24%
SUBTOTAL CASES (NUMBER LIVING) (C)	47	76%
1. Less number current (known to be alive in the last 15 months) (D)	28	45%
TOTAL (LOST TO FOLLOW UP OR NOT CURRENT) (E)	19 *	31%
(* should be less than 10%)		

=====

FOLLOW UP RATE FOR LIVING PATIENTS ONLY	NUMBER	PERCENT
Enter the total number from Line C	47	100%
Subtract the total number from Line D -	28	60%
Total lost/not current of living patients -	19	40%

Utility Options ...

Delete Oncology Patient

Use this option to delete an Oncology patient from the Oncology Patient file (#160). This will also delete any associated records in the Oncology Primary file (#165.5). Use the option Print Oncology Patient Record to see the data you will be deleting when you delete the patient.

Example:

```

_____DELETE ONCOLOGY PATIENT_____

Select ONCOLOGY patient name:      TEST, SALLY

      SSN:FROM DUBOIS HOSPITAL      Race: Unknown
      DOB: FEB  3,1945              Sex: Female

has the following in the Primary file:

Acc/Seq#      Primary Site      Last Tumor Status  Date DX      Abst Status
1999-00004/00  UTERUS, NOS      Evidence this CA  01/21/1999  Incomplete

DELETING a Patient will also DELETE any Primaries

Are your SURE you want to DELETE Oncology Patient? NO// y YES
      Deleting primary...

      DELETED!!!

...SORRY, I'M WORKING AS FAST AS I CAN...

      Deleting Patient...

      DELETED
```

Utility Options ...

Delete Primary Site/Gp Record

Use this option to delete a selected Primary record for a specific Oncology patient.

Example:

```
-----DELETE PRIMARY RECORD-----

Select ONCOLOGY patient name:
Select ONCOLOGY patient name: test,george TEST,GEORGE      07-04-61
777777777
PILL
...OK? Yes// <ret> (Yes)

SSN: 777-77-7777      Race: White
DOB: JUL 4,1961      Sex: Male

TEST,GEORGE          has following Primaries

Acc/Seq#      Primary Site      Last Tumor Status  Date DX      Abst Status
1992-00001/00 STOMACH, CARDIA   No evid this CA   02/02/1992   Complete
1992-00001/03 TRACHEA           No evid this CA   09/09/1998   Incomplete
1992-00001/04 LIVER             Unknown           06/01/1998   Incomplete

Select primary to DELETE

1  15  STOMACH      STOMACH, CARDIA      TEST,GEORGE
2  15  LUNG        TRACHEA              TEST,GEORGE
3  15  LIVER        LIVER                TEST,GEORGE
CHOOSE 1-3: 3  LIVER      LIVER                TEST,GEORGE

TEST,GEORGE          LIVER

Are you SURE you want to DELETE primary? NO// y YES

OK then,
      Deleting primary...

DELETED!!!

Acc/Seq#      Primary Site      Last Tumor Status  Date DX      Abst Status
1992-00001/00 STOMACH, CARDIA   No evid this CA   02/02/1992   Complete
1992-00001/03 TRACHEA           No evid this CA   09/09/1998   Incomplete
```

Utility Options ...

Edit Site/AccSeq# Data

This option allows you to edit/correct accession numbers, sequence numbers, diagnosis dates, etc. when they have been found to be incorrect.

Oncology Patient Name: Enter the patient name: LAST,FIRST or First initial last name plus last four digits of the SSN.

The patient's SSN, race, DOB and sex are shown along with the patient's primaries. If more than one, you are asked to select the primary you want to edit. Then you may edit any of the following pieces of data:

Site/Gp: Press the <ret> key to accept the default answer or change the Site/Gp.

ICDO-Topography: Press the <ret> key to accept the default answer or change the ICDO-topography.

Accession Year: Press the <ret> key to accept the default answer or change the Accession Year.

Accession No.: Press the <ret> key to accept the default answer or change the Accession Number.

Sequence No.: Press the <ret> key to accept the default answer or change the Sequence Number.

Class of Case: Press the <ret> key to accept the default answer or change the Class of Case.

Date Dx: Press the <ret> key to accept the default answer or change the Date of Diagnosis.

Histology: Press the <ret> key to accept the default answer or change the Histology.

You are asked if the data is Okay. If it is, you may enter another patient to edit and exit the program. If it is not, you are asked to select a primary to edit.

Utility Options ...

List Topography Site Groups

This option lists the topographic (non-histologic) site groups from the Site-Group for Oncology file (#164.2).

Device: Enter a printer name or press the <ret> key to print to your screen.

Example:

DEVICE: (Enter a printer name)

TOPOGRAPHIC SITE GROUPS		MAR 31,1999	14:22	PAGE 1
Description				
1	LIP			
9	ORAL CAVITY			
13	PHARYNX			
14	ESOPHAGUS			
15	STOMACH			
17	COLON			
18	RECTUM/ANUS			
20	LIVER			
21	GALLBLADDER			
23	PANCREAS , EXOCRINE			
...				
...				
...				

Utility Options ...

List Topography Codes by Site Group

This option provides a reporting method for the registrar to list topography codes by site group.

Device: Enter a printer name or press the <ret> key to print to your screen.

Example:

DEVICE: (Enter a printer name)

ICDO TOPOGRAPHY LIST BY SITE GROUP		MAR 31, 1999	14:24	PAGE 1
Description	ICDO-2	Topography Code		

LIP	C00.0	LIP, EXTERNAL UPPER		
	C00.1	LIP, EXTERNAL LOWER		
	C00.2	LIP, EXTERNAL NOS		
	C00.3	LIP, UPPER MUCOSA		
...				
...				
...				

Utility Options ...

Report of Accessions Requiring Additional Input

Use this report to examine the specified accession of tumors for completeness in terms of ACOS required fields. Only accessions which have no data in the required field set will be listed with the fields which have the discrepancy.

Example:

```
DISPLAY/PRINT on-line instructions for Help? Yes// <ret> YES
```

```
This report displays incomplete records for data to be
transmitted to the ACOS, for a time period specified. The
report does not specify exactly where in the database to fix
problems. It is intended only as an aid.
```

```
Select Accession Year: (1980-2000): 1998// <ret>
Abstract Completed Date, Start: Jan 1, 1998// <ret> JAN 1,1998
Abstract Completed Date, End: Dec 31, 1998// <ret> DEC 31,1998
ACOS Number: 330250// <ret>
```

```
ACOS Number is 330250
Accession Year for State data is 1998
Abstract Completed Date, Start is JAN 1,1998
Abstract Completed Date, End is DEC 31,1998
```

```
Definitions OK? Yes// <ret> YES
DEVICE: HOME// (Enter a printer name)
```

Pg. 1	Oncology ACOS Report
Oncology ACOS Required data Report	

Patient ID	S0415
Primary Site	C619
RX summary-biological response modifier	*****

Utility Options ...

Create a Report to Preview ACOS Output

This report allows the tumor registrar to preview the contents of the specified accessions intended for output to the ACOS disk. This option is independent of the disk capture function but uses the precise database selection criteria. If you have never created a disk or need a refresher, respond Yes to display/print the on-line help before sending this to a printer.

Note: If you choose to "display/print the on-line instructions", you must keep pressing the <ret> key to move to the next screen until you reach the Device prompt.

Utility Options ...

Create ACOS Data Disk

This option will allow for the creation of a disk to be submitted to the American College of Surgeons (ACOS) in response to the annual call for data. FOR USE BY IRM ONLY.

Example:

```
DISPLAY/PRINT on-line instructions for Help? Yes// n NO
      Enter the Hospital ACoS Number.
      ACOS Number: 330250// <ret>
```

```
      Enter the accession year to be used by the extract.
      Accession year: 1999// <ret>
      These are your current settings:
```

```
      Hospital ACoS Number: 330250
      Year: 1999
```

```
Are these definitions correct: ? YES// <ret>
```

```
-----
| Please activate your PC capture program. The data will be sent |
|           in 30 seconds or when you press the return key.     |
-----
```

Utility Options ...

Create State Data Disk

This option allows you to create a disk for transmission of cancer registry information including confidential patient identity data to the State collecting agencies. The length of the strings gathered here are 1150 characters as opposed to the 850 character ACOS data strings.

You may print on-line instructions. Remember to press the <ret> key to move to the next screen until you reach the "Select the NAACCR Record layout to use" prompt.

You must know which version of the NAACCR should be used before running this program. The following is only an example:

```
DISPLAY/PRINT on-line instructions for Help? Yes// n NO
Select the NAACCR Record layout to use:
  1) Version 5.1 of the VAACCR 5966 Characters (VA Registry)
  2) Version 6.0 of the NAACCR 5966 Characters
  3) Version 5.1 of the NAACCR 5966 Characters
  4) Version 5.0 of the NAACCR 5300 Characters
  5) Version 4.0 of the NAACCR 5300 Characters

Select Layout: 1 V5.1 VA 5966 Characters
              Enter the Hospital ACoS Number.
              ACOS Number: 330250// <ret>

Enter the accession year to be used by the extract.
              Accession year: 1999// <ret>
Select Abstract Start Date: Jan 01, 1999// (JAN 01, 1999)
Select Abstract End Date: Dec 31, 1999// (DEC 31, 1999)
These are your current settings:

              Hospital ACoS Number: 330250
              Year: 1999
              Abstract Starting from: 1/1/99 To: 12/31/99

Are these definitions correct: ? YES// <ret>
```

```
-----
|Please activate your PC capture program. The data will be sent|
|           in 30 seconds or when you press the return key.   |
|-----
```

Utility Options ...

Create a Report to Preview State Output

Use this option to print out the state extract data in a report format.

Example:

```
DISPLAY/PRINT on-line instructions for Help? Yes// n NO
Select the NAACCR Record layout to use:
  1) Version 5.1 of the VAACCR 5966 Characters (VA Registry)
  2) Version 6.0 of the NAACCR 5966 Characters
  3) Version 5.1 of the NAACCR 5966 Characters
  4) Version 5.0 of the NAACCR 5300 Characters
  5) Version 4.0 of the NAACCR 5300 Characters

Select Layout: 1 V5.1 VA 5966 Characters
              Enter the Hospital ACoS Number.
              ACOS Number: 330250// <ret>

Enter the accession year to be used by the extract.
              Accession year: 1999// <ret>
Select Abstract Start Date: Jan 01, 1999// (JAN 01, 1999)
Select Abstract End Date: Dec 31, 1999// (DEC 31, 1999)
These are your current settings:

              Hospital ACoS Number: 330250
              Year: 1999
              Abstract Starting from: 1/1/99 To: 12/31/99

Are these definitions correct: ? YES// <ret>
DEVICE: HOME// (Enter a printer name)
```

NAACCR VACCR EXTRACT V5.1	Page: 1
Patient: TEST,TUMOR	SSN: 473-17-3618
Data Element:	Data Value
=====	=====
Record Type.....	A
Patient ID Number.....	00000000
Registry Type.....	3
Registry ID.....	63302500
NAACCR Record Number.....	5
...	
...	
...	

Utility Options ...

Define Tumor Registry Parameters

This is the first option to be used in setting up the package. It is necessary to make several of the follow-up options work. See the chapter on Package Implementation.

XI. Glossary

Abstract	A summary of pertinent information about the patient, the cancer, the treatment, and outcome. To compile the essential data on a case.
Accession Register	An annual, sequential listing of all cases entered into the registry.
Accession number	A number unique to the patient which identifies the patient by the year diagnosed and in the order he was identified by the registry.
Accession Year	The year in which the patient was first seen at the reporting institution for the primary.
ACoS	American College of Surgeons.
ACoS number	A number assigned to facilities by the American College of Surgeons.
ADPAC	Designated individual responsible for user-level management and maintenance of an application package such as Oncology.
AJCC	American Joint Commission on Cancer.
Analytic case	A case which was diagnosed at your facility or cases in which all or part of the first course of therapy was given at your facility after your reference date.
Automatic case finding	The electronic capture of cases meeting the defined criteria.
BRM	Biological Response Modifier. This is a generic term given to all chemical or biological agents which alter the immune system or the defense mechanism.
Case finding	A systematic method of locating all eligible cases.
Central Registry Number	The registry number assigned by the state central registry where applicable.
Device	As used in this document, a printer or computer screen to which a display/report is sent.
ERA	Estrogen Receptor Assay is a tumor marker for breast cancer.
Gleason's Grade	A system for assigning differentiation scores to prostate tissue

specimens. The higher the pattern score, the worse the prognosis.

ICD-O	International Classification of Diseases for Oncology.
ICD-9 CM	International Classification of Diseases, Clinical Modification, 9 th Revision. Used to code death information.
Institution ID Number	The registry number assigned by the American College of Surgeons. It is used to define the registry in the ACoS Call for Data.
LTF	Lost to Follow-up. This condition occurs when no contact has been made in over 15 months.
Non-Analytic case	A case involving a patient who was diagnosed elsewhere and treated elsewhere, or was diagnosed and treated prior to the reference date at your facility. These patients are excluded from the survival statistics.
PRA	Progesterone Receptor Assay is a tumor marker for breast cancer.
Primary	Refers to a specific anatomical site with malignancy.
PTF	Patient Treatment File.
Reference date	Starting date after which all cases are entered into the registry. It is established as January 1 of a given year.
SEER	Surveillance, Epidemiology and End Results Program.
Sequence number	A number which relates to the independent primary malignancies that occur in the same individual.
State Hospital Number	The number assigned by the state to your medical center.
Template	A computerized filter created to screen information and later print the information in a specific format.
Tumor marker	Medical laboratory examinations of material that may be indicative of presence of malignancy.
VA FileMan	The VA file management program used to maintain, access, and manipulate data in a file.
Suspense, being in	Having a date in the Suspense Date field in the Oncology Patient file #160. Cases remain in suspense until they are accessioned for abstracting or manually deleted.

VISTA

Veterans Health Information Systems and Technology Architecture.

XII. Index

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***** **CANCER REGISTRY ABSTRACT** *****

Patient Name: _____ SSN: _____

Home Address: _____

County: _____

Sex: _____ Race: _____ Ethnicity: _____

Date of Birth: _____ Age at DX: _____

***** **CANCER IDENTIFICATION** *****

Accession Number: _____ Accession Year: _____ Sequence Number: _____

Date Dx: _____ Dx Facility: _____

Admission Date: _____ Discharge Date: _____

Class of Case: _____ Type of Reporting Source: _____

IP/OP Status: _____ Site/Group: _____

ICDO-Site: _____

Text-Primary Site: _____

Laterality: _____ Histology: _____

Text-Histology: _____

Grade: _____ Diagnostic Confirmation: _____

Tumor Marker 1: _____

Tumor Marker 2: _____

Tumor Marker 3: _____

Referring Facility: _____ Transfer Facility: _____

Presentation at Cancer Conference: _____ Date of Cancer Conference: _____

Screening Date: _____ Screening Result: _____

***** **EXTENT OF DISEASE AT DIAGNOSIS** *****

Clinical TNM: _____ Pathologic TNM: _____
Clinical T: _____ Pathologic T: _____
Clinical N: _____ Pathologic N: _____
Clinical M: _____ Pathologic M: _____

Clinical Stage Group: _____ Pathologic Stage Group: _____
Staged By (Clin): _____ Staged By (Path): _____
Other Stage: _____
Type of Staging System (Pediatric): _____
Pediatric Stage Group: _____ Staged By (Pediatric): _____

Physician's Stage: _____ Physician Staging: _____

Date of 1st Positive Biopsy: _____

Size of Tumor (mm): _____

Extension: _____

Pathologic Extension for Prostate: _____

Lymph Nodes: _____ Nodes Examined (Regional): _____ Nodes Positive (Regional): _____

Metastasis 1: _____

Metastasis 2: _____

Metastasis 3: _____

General Summary Stage: _____

Peripheral Blood Involvement: _____

Associated With HIV: _____

Referred to Support Services: _____

***** **FIRST COURSE OF TREATMENT** *****

Non Cancer-Directed Surgery: _____
Non Cancer-Directed Surgery Date: _____

Non Cancer-Directed Surgery @Facility: _____
Non Cancer-Directed Surgery @Facility Date: _____

Date of no treatment: _____

Surgery of Primary Site: _____
Surgery of Primary Site Date: _____
Surgery of Primary Site @Facility: _____
Surgery of Primary Site @Facility Date: _____
Surgery Hospital: _____
Surgical Approach: _____
Surgical Margins: _____
Reconstruction/Restoration: _____
Reason for no Surgery: _____

Text Rx-Surgery: _____

Radiation: _____
Radiation Start Date: _____
Radiation Hospital: _____
Radiation @Facility: _____
Radiation @Facility Date: _____
Regional Dose: _____
Number of Treatments: _____
Radiation Treatment Volume: _____
Location of Radiation Treatment: _____
Intent of Treatment: _____
Regional Treatment Modality: _____
Radiation Treatment Completion Status: _____
Radiation Local Control Status: _____
Reason for No Radiation: _____
Radiation/Surgery Sequence: _____
Radiation Auxiliary Volume: _____
Radiation Auxiliary Date: _____
Radiation Auxiliary Text: _____

Text Rx-Rad (BEAM): _____

Text Rx-Rad-Other: _____

Radiation Therapy to CNS: _____
Prophylactic Radiation Date: _____
Radiation Therapy to CNS Hospital: _____

Chemotherapy: _____
Chemotherapy Start Date: _____
Chemotherapy Hospital: _____
Chemotherapy @Facility: _____
Chemotherapy @Facility Date: _____
Reason for No Chemotherapy: _____

Text Rx-Chemo: _____

Hormone Therapy: _____
Hormone Therapy Start Date: _____
Hormone Therapy Hospital: _____
Hormone Therapy @Facility: _____
Hormone Therapy @Facility Date: _____
Reason for No Hormone Therapy: _____

Text Rx-Hormone: _____

Immunotherapy: _____
Immunotherapy Start Date: _____
Immunotherapy Hospital: _____
Immunotherapy @Facility: _____
Immunotherapy @Facility Date: _____

Text Rx-Immunotherapy: _____

Other Treatment: _____
Other Treatment Date: _____
Other Treatment Hospital: _____
Other Treatment @Facility: _____
Other Treatment @Facility Date: _____

Text Rx-Other Cancer-Directed Surgery: _____

Protocol Eligibility Status: _____
Year Put on Protocol: _____
Protocol Participation: _____

Text-Remarks: _____

Text Dx Proc-Phys.Exam: _____

Text Dx Proc-Xray/Scan: _____

Text Dx Proc-Operations: _____

Text Dx Proc-Lab Tests: _____

Text Dx Proc-Endoscopy: _____

Text Dx Proc-Path/Cyto: _____

***** **RECURRENCES** *****

Date of First Recurrence: _____ Type of First Recurrence: _____
Distant Site 1: _____
Distant Site 2: _____
Distant Site 3: _____

***** **SUBSEQUENT COURSE OF THERAPY** *****

Initiation Date: _____
Surgery Code: _____ Date: _____
Radiation Code: _____ Date: _____
Radiation Sequence: _____
Radiation to Brain/CNS: _____ Date: _____
Chemotherapy: _____ Date: _____
Hormone Therapy: _____ Date: _____
Immunotherapy (BRM): _____ Date: _____
Other Cancer Therapy: _____ Date: _____
Place: _____

***** **OTHER PRIMARY SITES** *****

***** PERSONAL DATA *****

Address at DX: _____

City/Town: _____

State at DX: _____

Postal Code at DX: _____

County at DX: _____

Birthplace: _____

Religion: _____

Marital Status: _____

Primary Payor at DX: _____

Home Telephone: _____

Next of Kin: _____

Abstract Status: _____ Abstract Date: _____ Abstracted by: _____

Agent Orange Exposure: _____

Ionizing Radiation Exposure: _____

Persian Gulf Service: _____

Chemical Exposure: _____

Asbestos Exposure: _____

***** EMPLOYMENT HISTORY *****

Occupation: _____ Number of Years: _____ Last Date: _____

Industry/Address: _____

***** TOBACCO AND ALCOHOL USAGE *****

Tobacco History: _____

Alcohol History: _____

***** **CANCER FAMILY HISTORY** *****

Family Member: _____ Location of Cancer: _____

***** **PHYSICIAN CONTACTS** *****

Primary Surgeon: _____
Managing Physician: _____
Following Physician: _____
Other Physician (3): _____
Other Physician (4): _____

QA Selected: _____ QA Date: _____ QA Review: _____

***** **FOLLOW-UP HISTORY** *****

Last Contact: _____
Follow-up Method: _____
Vital Status: _____
Next Follow-up Method: _____
Quality of Survival: _____
Unusual Follow-up Method: _____
Following Registry: _____
Last Tumor Status: _____

Date of Death: _____
Cause of Death: _____
ICD Cause of Death: _____
ICD Revision: _____
Place of Death: _____
Care Center at Death: _____
Autopsy: _____
Autopsy Date/Time: _____
Autopsy No. _____

XIV. Appendix I: VA FileMan Word Processing Editor

When editing word processing data in VA FileMan, you are automatically dropped into a special line-oriented text editor. If no data is in a field, you will see the field name followed by "1>":

```
TEXT:  
1>
```

At this point, you can type a line of text that will become Line 1 of your document. You can also press return at the "1>" prompt to drop out of word processing, if no text needs to be inserted at this time.

After inserting text in line 1, line 2 will appear with its own prompt, line 3, and so on. When you are through typing, enter a carriage return at a line prompt. The "Edit Option:" prompt then appears:

```
EDIT Option:
```

Here, press return to leave text editing for this field. If you made a typing error, enter the line number containing the error. The line is displayed, and you can enter changes at this point.

This example shows entering diagnosis history for a patient:

```
HISTORY:  
1>Owing to extreme poverty in early youth, patient seems not to  
2>have had a proper diet. Since achieving economic success,  
3>his diet has been adequate, but traces of original deficiency remain.  
4> <ret>  
EDIT Option: <ret>
```

Note: Enter a carriage return after each line that you type in order to get to the next line number. The "EDIT Option:" prompt can be responded to with a line number or with one of the line numbers described below. If a line number is entered, the text of the line is edited, and VA FileMan will prompt with "EDIT line:".

Editing Options

If you have entered text, and press the return key at the next text line prompt, VA FileMan responds with the "EDIT Option:" prompt. Either press the return key to exit the editor, or enter an edit option command.

Enter "??" at the "EDIT Option:" prompt to see the following list of commands:

- A ADD more lines to the end of the text
- B BREAK a line into two lines

- C CHANGE occurrences of a string of text to another string
- D DELETE a range of lines
- E EDIT a line (Using the Replace... With... dialogue)
- I INSERT one or more lines after an existing line (or line 0)
- J JOIN two lines into one
- L LIST a range of lines
- M MOVE a group of lines within the text
- P PRINT a range of lines as formatted output (with wraparound, etc.)
- R REPEAT a group of lines elsewhere in the text
- S SEARCH for occurrences of a string of text
- T TRANSFER text in from a different word processing designated field
- U UTILITY Submenu consisting of three utility commands:
 1. Editor Change
 2. File Transfer from Foreign CPU
 3. Text-Terminator-String Change

When you exit from one of these functions, you return to the "EDIT Option:" prompt.

Editing Existing Text

When you are editing any word processing text that has already been entered, VA FileMan will display the existing lines (or the last nine lines, if the text is too long). You are then asked to choose an edit option. Whenever any of the edit options cause lines to be inserted between existing lines, the lines are renumbered, so that the lines are always sequentially numbered.

Line Numbers and Word Wrapping in the Word Processing Editor

Note that the line numbers are meaningful only in editing. Word processing data is usually printed in a wrap-around mode. What is internally line 3 might be printed as lines 5 and 6.

To force a line to be printed as it stands, without wrap-around, set a tab at the end of the line. (Lines consisting only of punctuation - for example a single space - will also be printed as they stand.) Lines that begin with a space will start on the output line.

Tabs in the Word Processing Editor

Tabs can be meaningful whenever they occur in a line. NOTE: If you insert a tab by typing the special tab key on the keyboard (or control I, if you have no tab key), a |TAB| will be inserted in the text. When editing, a tab is recognized as |TAB|, not as five blank lines.

Use of Window or Frames | | in the Word Processing Editor

In general, all special format control functions embedded within the text of a word processing field must appear within windows that are framed by the vertical-bar character (|). If your keyboard does not have the "|" key, some keyboards will allow you to substitute the tab key for the "|" key.

The following are some of the special word processing functions that can appear within any VA FileMan word processing text (n refers to the user specified number):

RIGHT-JUSTIFY	Causes following text to be padded with spaces between words, so the right margin is even.
DOUBLE-SPACE	Causes following text to be printed with blank lines inserted every other line.
SINGLE-SPACE	Turns off double-spacing for following text.
TOP	Causes a page break to occur at this point.
PAGEFEED	Causes page breaks to occur in the following text, whenever fewer than user specified number lines remain on the current page.
PAGESTART	Causes text on following pages to begin at line# specified by the user.
SETPAGE	Resets page numbering, so that the following page number will be n+1 (n being the number specified by the user).
BLANK	Causes n number of blank lines to be inserted at this point in the text.
INDENT	Causes following text to be indented n number of spaces from left margin.
SETTAB	Sets tab positions for the following text. In subsequent text, the first TAB encountered will cause indentation to column position n1 from the left margin. The second TAB encountered will cause indentation to column n2 and so on. In default of any SETTAB functions, the tab settings are 5, 10, 15, 20... column positions from the left margin. If any SETTAB argument is negative, it means that any text following the corresponding TAB will be right-justified so that the rightmost column of that text will fall in the column number that is the absolute value of the SETTAB argument. If a SETTAB argument

is the literal "C" (type the quotes), the text following the corresponding tab setting (e.g., |SETTAB("C")) will be centered.

- |TAB n| Overrides any SETTAB specification and causes tabbing to the nth column over from the left margin. Output is right-justified on the nth column if n is negative.
- |WIDTH| Specifies that the following text will always be printed in a column n characters wide. Note that, in the absence of a WIDTH specification, the output column width is determined by the user (or defaulted by the system) at print time.
- |NOWRAP| Causes following text to be printed line for line (without wrap-around). This eliminated the need to end each line with a tab, start the line with a tab, or start the line with a space to force the line to be printed as it stands.
- |WRAP| Causes following text to be printed in word-wrap mode.
- |_ | Starts underlining. Underlining continues until a second |_| is encountered. This only works on printers that underline. This command will not work on a dot matrix printer, but some dot matrix printers will let you back up and then use the underscore. Your CRT or a C-ITOH will simply ignore this command.

XV. Appendix II: VA FileMan Options

The Oncology package uses VA FileMan to manipulate the data and produce reports. These functions are built into the package and are selectable from menu options. If you have access to VA FileMan, you can also run customized reports. This Appendix illustrates the use of VA FileMan Inquire and Print options, which allow you to quickly display data and to develop customized reports. The following topics are discussed:

- Inquire to File Entries Option
- Specifying a Sort Order
- Format Controls on Sort Fields
- Print File Entries Option
- Format Controls on Print Fields
- Templates
- Specifying Search Criteria

For a more complete discussion, see the *VA FileMan User Manual*.

Inquire to File Entries Option

The quickest way to see a display of all data for a given file entry or for a small number of entries, is to use the Inquire to File Entries option. After selecting the Inquire to File Entries option, you will see the following prompts:

Prompt	Response
OUTPUT FROM WHAT FILE:	Enter file for inquiry.
Select PATIENT:	Enter patient name.
ANOTHER ONE:	Enter patient name. If many entries are made, the prompt "STORE THESE ENTRY IDS IN A TEMPLATE" appears. Enter a template name to save the entries in this manner.
STANDARD CAPTIONED OUTPUT? YES//	Enter a carriage return to have all selected entries made in the format label:data.
DISPLAY COMPUTED FIELDS? NO//	Enter "Yes" to have computed fields displayed after non-computed fields

are displayed. The computed field format is label(c):computed value.

DISPLAY AUDIT TRAIL? NO//

Enter "Yes" to have audited fields displayed after non-audited fields. The audit report displays the old and new values of the audited field.

An example of a generated display appears below:

NAME: DAYSTROM, RICHARD SEX: MALE
DATE OF BIRTH: JAN 3, 1945 DIAGNOSIS: B-12 DEFICIENCY
HISTORY: Patient received inadequate nutrition during youth. Although diet has recently improved, traces of the deficiency remain.
DIAGNOSIS: ANGINA PECTORIS AGE AT ONSET: 34
PROVIDER: MCCOY, R.L. SSN: 999999999
CURRENT AGE: (c):46

In the above example, the patient has two diagnoses on file, one of which has an associated History text. Note that if the field has no value, it will not be displayed. For example, no religion information was entered on the patient, so the "Religion" field is not displayed. Computed fields which evaluate to null are not displayed.

Specifying a Sort Order

Prompt	Response/Result
OUTPUT FROM WHAT FILE:	Enter the name of the file for display.
SORT BY: NAME//DIAGNOSIS	Enter a carriage return to sort by the default, or enter a different sort field after the double slashes.
DIAGNOSIS SUB-FIELD: DIAGNOSIS	Enter a diagnosis sub-field.
START WITH DIAGNOSIS: FIRST//	Enter a carriage return to begin with the first diagnosis. To enter a range of diagnoses, enter the first diagnosis at the second prompt.
WITHIN DIAGNOSIS,SORT BY: NAME	Sort within each diagnosis by the patient name.
START WITH NAME: FIRST//	Enter a carriage return to begin with the first name.

WITHIN NAME, SORT BY:

FIRST PRINT FIELD: NAME

Enter the name of field.

THEN PRINT FIELD: DIAGNOSIS

THEN PRINT DIAGNOSIS SUB-FIELD:

Enter a sub-field.

THEN PRINT DIAGNOSIS SUB-FIELD:

THEN PRINT FIELD:

Enter a carriage return if no more fields are required.

HEADING: PATIENT LIST//

Enter a carriage return to accept the default, or enter a different heading name after the double slashes.

The following report would then be generated:

PATIENT LIST	NOV 28, 1991	11:36	PAGE 1
NAME	HISTORY		

DIAGNOSIS: ANGINA

ADAMS, JOHN	Episodes have been more frequent in recent months.
BROWN, JOSIE	Mild case in early stages.
LEWIS, ROLLIE	

DIAGNOSIS: B-12 DEFICIENCY

DAYSTROM, RICHARD	Patient received inadequate nutrition during youth. Although diet has subsequently improved, traces of the deficiency remain.
LEWIS, ROLLIE	Deficiency due to undetermined cause.

Format Controls on Sort Fields

The "SORT BY:" prompt in the Print File Entries option is used for sorting file data. Sort codes for a field can be entered at the "SORT BY:" prompt.

Sort Type	Code
Separate page for each field	Precede name of the field with a pound sign (#).
Reverse order for sorting	Precede name of field with a minus sign. For dates, the sort goes from latest to earliest date. For numbers, sort goes from

	largest to smallest.
Sub-total within a SORT-BY field	Precede name of field with a plus sign.
Print sequential ranking numbers	Precede name of field with an exclamation point.
Suppress the printing of a	Precede the name of the field with the @ sign.
SORT sub-header	
Skip n lines before sub-header	Follow field name with ;Sn.
Begin sub-header at column n	Follow field name with ;Cn.
Force the sorting to take n characters of data as sort value	Follow field with ;Ln.
Replace the caption in sub-header	Follow field with ;"replacement caption" (replacement caption in quotes) and sort dialogue. To print no caption, enter ;""
	This caption will be used in place of the field label in the sort prompts.
Replace caption in sort dialogue	Follow field with ;"text","text" being replacement caption in quotes.
Restrict output to a range of values	Precede name of field with apostrophe (').
Sub-header in a report	Sort by a field that is not one of the fields which has been specified as a print field.
Automatic prompting of the STORE THIS IN A SORT TEMPLATE	Sort by more than two fields, or answer the second "GOTO:" prompt or the last "SORT BY:" question with a "J".

Print File Entries Option

Use this option to display all data from a single file in a format of rows and columns.

Prompt	Response
OUTPUT FROM WHAT FILE:	Enter the name of the file for display.
SORT BY: NAME//	Enter a carriage return to sort by the

default, or enter a different sort field after the slashes.

START WITH NAME: FIRST//
GO TO NAME: LAST//

Enter a carriage return to begin with the first name. In this case, the second prompt is not displayed. To specify a range of names, enter the beginning name at the first prompt, the ending name at the second prompt.

FIRST PRINT FIELD:

Enter the name of the field.

THEN PRINT FIELD:

Enter a carriage return if no more fields are required.

HEADING: PATIENT LIST//

Enter a carriage return to accept the default, or enter a different heading name after the double slashes.

In this example, the Patient file was selected, the sort is by name, and the printed fields are name and sex:

PATIENT LIST NAME	NOV 28,1991 11:36 SEX	PAGE 1

ADAMS, JOHN	MALE	
BROWN, JOSIE	FEMALE	
LEWIS, ROLLIE	MALE	
LORTON, GEORGE	MALE	

Different formats are easily produced using the same entry prompts. For example, if we chose a sort field of sex, and selected name and date of birth as print fields, we would obtain:

PATIENT LIST NAME	NOV 28,1991 11:36 DATE OF BIRTH	PAGE 1

SEX: MALE		
ADAMS, JOHN	NOV 3, 1943	
LEWIS, ROLLIE	DEC 13, 1920	
LORTON, GEORGE	JUL 1, 1941	
SEX: FEMALE		
BROWN, JOSIE	JAN 11, 1933	

A sort field could also be a multiple field, that is, a field with sub-fields.

Format Controls on Print Fields

For each field on your list, you can indicate exactly how long the field window should be; the columnar position at which the field should start; lines to skip before printing the field; the column title for the field; totals and maximum/minimum values; the number of decimal digits and interval range for calculation; and literal strings.

Enter the code for the output at the "PRINT FIELD:" prompt:

Output	Code
Total	Precede field label with ampersand (&).
Count	Precede field label with exclamation point.
Total, count, and mean	Precede field label with plus sign.
Total, count, mean min/max, standard deviation	Precede field label with pound sign (#).
Left justify	Follow field label with ;Ln, n being the number of spaces from left margin. Data may be truncated.
Right justify	Follow field label with ;Rn, n being the number of spaces from right margin. Data may be truncated.
Column position	Follow field label with ;Cn, n, or -n being the column number (negative numbers start from right margin).
Row position	Follow field label with ;Yn, n, or -n being the row number (negative numbers start from bottom margin).
Skip line	Follow field label with ;S for a single line, ;Sn for a number of lines.
Special header	Follow field label with ;"text", "text" being the new header text, enclosed in quotes.
Title as header	Follow field label with ;T. T is the title of the field.
Decimal precision	Follow field label with ;Dn. D is the number of digits.
Wrap-around	Follow field label with ;W or ;Wn where n is the number of letters per line.

Suppress inter-column Follow field specification with ;X.

Literal insertion Type the literal within quotes at the PRINT FIELD:
prompt.

Suppress duplicate Follow the field label with ;N.
values of the field in
successive columns

Several of the format codes can be strung together, as in:

```
THEN PRINT FIELD: +AGENCY;S1;C3;L13;"Agency Code"
```

Here, the format represents total of all values (+), skip one line (S1), start printing in column three (C3), truncate to 18 characters (L18), make "Agency Code" the special header for the column ("Agency Code").

NOTE: If all the fields for printing are preceded by the numeric specifiers (& for total, ! for count, + for total, count, and mean, # for max/min, standard deviation, total, count, and mean), the individual fields will not be printed.

Templates

If you have chosen five or more print fields, you may conveniently store these fields in a print template. VA FileMan will automatically prompt you, if you do select five fields, for whether a print template should be created:

```
STORE PRINT LOGIC IN TEMPLATE:
```

At this prompt, you can enter a 2-30 character name (don't use a bracket as the first character) for a new template, or enter a carriage return to skip creating a template.

You can also create a print template as you enter your fields at the "PRINT FIELD:" prompt. For this, enter "]" at the first "PRINT FIELD:" prompt. Then, enter your fields as usual. Even if fewer than five fields are entered, you will be able to store them in a print template:

```
PRINT FIELD: ]  
PRINT FIELD: NAME  
THAN PRINT FIELD: SEX  
THEN PRINT FIELD: <ret>  
HEADING: <ret>  
STORE PRINT LOGIC IN TEMPLATE: ONCOZ TEMPLATE
```

To use this template later, enter the template name, enclosed within brackets, at the "PRINT FIELD:" prompt:

PRINT FIELD: [ONCOZ TEMPLATE]

To see a list of all templates, enter [?]:

PRINT FIELD: [?]

VA FileMan includes a captioned print template for output, in the format used in the Inquire to File Entries option. In this template, computed fields followed by (C): are listed after the non-computed fields. The computed fields are not displayed if they evaluate to null.

When you save a template (print, sort, or input), it gets protected with the access code of its creator. You are the only person who can edit the template.

To edit the template, enter the template name at the "PRINT FIELD:" prompt. You then have a chance to edit it:

```
WANT TO EDIT 'EXAMPLE' TEMPLATE? NO// Y (YES)
```

```
NAME: EXAMPLE// <ret>
READ ACCESS: <ret>
WRITE ACCESS: <ret>
FIRST PRINT FIELD: FIELD1// <ret>
THEN PRINT FIELD: FIELD2// <ret>
THEN PRINT FIELD: FIELD4//^FIELD3
THEN PRINT FIELD: FIELD4// <ret>
```

In this example, FIELD3 was inserted before FIELD4 in the template order. The addition can be seen when the template is called up again. The read and write access for the template can also be edited.

Specifying Search Criteria

A VA FileMan search provides a way of selecting file entries that meet predefined criteria.

Prompt	Response/Result
OUTPUT FROM WHAT FILE	Enter name of file to be searched.
-A- SEARCH FOR FIELD	Enter name of first field to be checked.
-A- CONDITION	Enter the comparison criteria Choices are: NULL (no data) CONTAINS or [("x" is contained in the field) MATCHES (FileMan pattern match) LESS THAN or < (use for dates and numerical data) EQUALS or = (must be exact match)

GREATER THAN or > use for dates and numerical data)

-A- ()

Enter the specific information to be checked (e.g., CONTAINS: Lung; LESS THAN: 65; EQUALS: 65).

-B- SEARCH FOR FIELD

Enter a second field for comparison This could be the same field as A or another field. You will be given the opportunity to search fields until you enter <ret> at this prompt.

-B- CONDITION

Enter the same or different comparison criteria

-B- ()

Sample:

```
-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: .0101 PRIMARY SITE/GP
-A- CONDITION: CONTAINS
-A- CONTAINS: BREAST

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: 4 AGE AT DX
-B- CONDITION: GREATER THAN
-B- GREATER THAN: 60
-C- SEARCH FOR ONCOLOGY PRIMARY FIELD: 4 AGE AT DX
-C- CONDITION: LESS THAN
-C- LESS THAN: 95

-D- SEARCH FOR ONCOLOGY PRIMARY FIELD: .0101 PRIMARY SITE/GP
-D- CONDITION: CONTAINS
-D- CONTAINS: LUNG

-E- SEARCH FOR ONCOLOGY PRIMARY FIELD: <ret>
```

You will then specify how these criteria should be combined. Several examples based on the sample are shown below.

IF: ABC

PRIMARY SITE/GP CONTAINS "BREAST"
and AGE AT DX GREATER THAN 60
and AGE AT DX LESS THAN 95

OR: BCD

Or AGE AT DX GREATER THAN 60 and
AGE AT DX LESS THAN 95 and
PRIMARY SITE/GP CONTAINS "LUNG"

OR: <ret>

This search will find records of patients aged 61-94 with a PRIMARY SITE/GP of Breast and also patients aged 61-94 with a PRIMARY SITE/GP of Lung.

IF: ABCD

PRIMARY SITE/GP CONTAINS
"BREAST" and AGE AT DX GREATER
THAN 60 and AGE AT DX LESS THAN 95
and PRIMARY SITE/GP CONTAINS
"LUNG"

OR: <ret>

This search finds records of patients aged 61-94 whose PRIMARY SITE/GP contains both Breast and Lung.

IF: AD

PRIMARY SITE/GP CONTAINS
"BREAST" and PRIMARY SITE/GP
CONTAINS "LUNG"

OR: BD

Or AGE AT DX GREATER THAN 60 and
PRIMARY SITE/GP CONTAINS "LUNG"

OR: <ret>

This search produces a list of those records in which the PRIMARY SITE/GP contains both Breast and Lung, and also those records of patients over age 60 with a PRIMARY SITE/GP of Lung.

The search criteria may then be saved in a template. Begin your template name with ONCOZ.

FileManager Functions

Print Qualifiers	Sort Qualifiers	Operators
<p>Prefixes</p> <p>&field Total !field Count +field Total Count and Mean #field Count, Mean, Minimum, Maximum and Standard Deviation</p> <p>Suffixes</p> <p>;Ln Left Justify over n characters ;Rn Right-Justify over n characters ;Cn Start the output at column n ;Yn Start the output at row (line) n ;C-n Start the output n columns from the right margin ;Y-n Start the output n lines from the bottom margin ;Dn Output a numeric value with n decimal places ;Sn Skip n lines before printing ;Wn Wrap around over n columns ;N Do not print duplicated fields ;T Use the field TITLE as the column header header ;X Omit spaces between print fields & suppress column header ;" " Suppress the column header ;"xxx" Use xxx as the column header</p>	<p>Prefixes</p> <p>+field Totaled fields (those prefixed with !,&,+and # in the print by:) will be subtotaled -field Reverse sort (numeric/date valued fields only) !field Print ranking or sequence number @field Suppress the subheader if the Sort By field is not printed 'field Specify a range without sorting the output #field Start a new page every time the sort value changes</p> <p>Suffixes</p> <p>;Sn Skip n lines when the sort field value changes ;Ln Use the first n characters for sorting ;Cn Start the sub-header caption at column n ;"'" Suppress the sub-header caption but print the value ;"xxx" Use xxx as the sub-header caption</p> <p>Input Qualifiers</p> <p>;T Use the Title as the input caption ;"xxx" Use xxx as the input caption ;dup Allow space bar to recall previous selection ;req Make the field required for this input session</p>	<p>Arithmetic Unary (Single Valued Operators)</p> <p>+ Take the numeric interpretation - Negate the numeric interpretation</p> <p>Arithmetic Binary Operators</p> <p>+ Addition - Subtraction * Multiplication / Full Division \ Integer Division</p> <p>Relational Or Boolean Operators</p> <p>= Equals > Greater than < Less than [Contains] Follows ! Or & And ' Not (an apostrophe to negate any of the above boolean operations) '>' means not greater than</p> <p>String Operators</p> <p>_ The underscore character means concatenate or join together. "ABC"_"DE" yields ABCDE ? Pattern Match</p>

COUNT(fname)	Counts the number of entries in a file or in a multiple	COUNT(APPOINTMENT DATE/TIME)	Counts number of appt/date/times for a patient
DATE(datexp)	Returns the date portion of a date/time expression	DATE(LOGIN DATE/TIME) = JAN 01,1994	LOGIN DATE/TIME = 010194@1400
DAYOFWEEK(datexp)	Returns the day of the week of the date in datexp	DAYOFWEEK(DATE OF BIRTH) = Tuesday	DATE OF BIRTH = APRIL 26, 1994
DUP(string.n)	Returns a string n characters long	DUP(" ",80) = ***** (80 wide)	
INTERNAL(field)	Returns internal value of field	INTERNAL(PROVIDER) = 147	
LAST(fname)	Returns the last entry in multiple or file	LAST(DIAGNOSIS) = SEPSIS	
LOWERCASE(field)	Changes uppercase char in string to lowercase except 1st char and 1st char after punctuation	LOWERCASE(NAME) = Smith,John J	NAME = SMITH,JOHN J
MAXIMUM(fname)	Returns the largest value from the .01 field of the file or multiple identified by fname	MAXIMUM(PATIENT:AGE) = 99	
MONTH(datexp)	Returns the month and year from a date/time valued expression	MONTH(DATE OF BIRTH) = JUL 1969	DATE OF BIRTH = JULY 7, 1969
MONTHNAME(n)	Returns the full name of the month corresponding to n	MONTHNAME(4) = APRIL MONTHNAME(+\$E(DATE OF BIRTH)) = APRIL	
NUMDATE(datexp)	Returns the date in datexp in	NUMDATE(DATE OF BIRTH) = 07/07/69	DATE OF BIRTH = JULY 7,
NUMDAY(datexp)	Returns the day of the month in datexp as a number	NUMDAY(DATE OF BIRTH) = 7	DATE OF BIRTH = JULY 7, 1969
NUMMONTH(datexp)	Returns the month in datexp as a number	NUMMONTH(DATE OF BIRTH) = 7	DATE OF BIRTH = JULY 7, 1969
NUMYEAR(datexp)	Returns the last 2 digits of the year in datexp as a number	NUMYEAR(DATE OF BIRTH) = 69	DATE OF BIRTH = JULY 7, 1969
REVERSE(string)	Returns the characters in string in reverse order	REVERSE(NAME) = EOJ	NAME = JOE
TIME(datexp)	Returns time from datexp in 12 hour format with am/pm	TIME(NOW) = 1:15 PM	
TOTAL(fname)	Totals the values of the .01 field of a multiple or file.	"\$_TOTAL(VISIT COST) = \$569.32	VISIT COST is a multiple
YEAR(datexp)	Returns the year from datexp	YEAR(DOB) = 1969	DOB = JULY 7, 1969

XVI. Appendix III: Oncology Files (#160, #165, #165.5)

Oncology Patient File (#160)

NUMBER	LABEL
.01	NAME
.011	LAST NAME
.012	FIRST-LAST
.013	C'LASTNAME
.014	SALUTATION
.015	MIDDLE NAME/INITIAL
.111	STREET ADDRESS 1
.112	STREET ADDRESS 2
.113	STREET ADDRESS 3
.115	STATE
.116	ZIP CODE
.117	COUNTY
.118	ZIP-COUNTY
.119	ADDRESS
.12	CTY
.131	PHONE
.2	CONTACTS
.21	NOK-INFO
.211	NOK2-INFO
.212	RELATIVE
.213	RELATIVE-2
.214	NOK
1	ALIAS
2	SSN
2.1	CSSN
3	DOB
3.1	DOB1
4	MEDICAL RECORD NUMBER
4.1	TERMINAL DIGIT
5	REGIONAL NO.
6	CENTRAL NO.
7	PLACE OF BIRTH
8	RACE
9	SPANISH ORIGIN
10	SEX
11	LRDFN
12	CURRENT OCCUPATION
13	RELIGION
14	MARITAL STATUS
15	STATUS
15.1	LAST FOLLOW-UP CONTACT
15.2	FOLLOW-UP STATUS
16	DATE LAST CONTACT
18.9	CAUSE OF DEATH/CANCER
19	CAUSE OF DEATH
19.1	STATE DEATH CERT
20	ICD REVISION
21	PLACE OF DEATH
22	*SURVIVAL MONTHS
22.9	AUTOPSY
23	AUTOPSY DATE/TIME
24	AUTOPSY #
24.5	CARE CENTER AT DEATH
27	DUE FOLLOW-UP
29	DATE@TIME OF DEATH

29.1	DOD
31	PATH/AUTOPSY (GROSS & MICRO)
32	DESC
33.1	SUSPENSE ADMIT DATE
33.2	SUSPENSE DISCHARGE DATE
33.3	SUSPENSE EPISODE OF CARE
33.4	SUSPENSE MONTH
33.6	PRIORITY
34	LAST EPISODE of CARE
34.1	LAST ADMIT DATE
34.2	LAST DISCHARGE DATE
35	SITE/GP-DTDX
36	LOST TO FOLLOWUP
37	MONTHS DELINQUENT
38	TOBACCO HISTORY
39	ALCOHOL HISTORY
40	TOBACCO USAGE
41	ALCOHOL USAGE
42	OCCUPATION
43	FAMILY HISTORY OF CANCER
44	FAMILY MEMBER WITH CANCER
45	TODAY'S DATE
46	HISTORY-FOLLOWUP
47	EMPLOYMENT STATUS
48	AGENT ORANGE EXPOSURE
49	ICD0-TOPOGRAPHY LIST
50	IONIZING RADIATION EXPOSURE
51	PERSIAN GULF SERVICE
52	CHEMICAL EXPOSURE
53	LAB CASEFINDING REPORT
54	PTF CASEFINDING REPORT
58	RADIOLOGY CASEFINDING REPORT
59	NO PRIMARY
60	PID#
61	ASBESTOS EXPOSURE
70	MULTIPLE TUMOR STATUS (DEATH)
75	¹ SUSPENSE
100	SITE & DATE DX
300	DOCUMENT
400	FOLLOW-UP
410	FOLLOW-UP ATTEMPTS
420	FOLLOW-UP CONTACT
1000	HOSPITAL NAME
1000.1	C. HOSPITAL NAME
1001	HOSPITAL STREET ADDRESS
1001.1	C. HOSPITAL STREET ADDRESS
1002	HOSPITAL CITY,ST ZIP
1002.1	C. HOSPITAL CITY,ST ZIP
1003	STATE HOSPITAL NUMBER
1004	Tumor Registrar
1004.5	TR PHONE NUMBER
1005	CONVERTED

Oncology Contact File (#165)

NUMBER	LABEL
.01	CONTACT

¹ Patch ONC*2.11*26 August 2000 Suspense converted to a multiple containing: Date Entered, Source, Lab Morphology, Division, Suspense Date, Organ/Tissue, PTF Discharge, Radiological Procedure, ICD9, PTF Code, ICDO Morphology Code, and Test Time.

.011	FIRST-LAST
.111	STREET ADDRESS 1
.112	STREET ADDRESS 2
.113	STREET ADDRESS 3
.119	ZIP CODE
.1211	TEMPORARY ADDRESS 1
.1212	TEMPORARY ADDRESS 2
.1213	TEMPORARY ADDRESS 3
.1217	START DATE OF TEMP ADDRESS
.1218	END DATE OF TEMP ADDRESS
.1219	TEMPORARY ZIP CODE
.131	PHONE
.132	OFFICE PHONE
.133	PHONE #3
.134	PHONE #4
1	TYPE
2	TITLE
3	COMMENTS
99	VA HOSPITAL #
100	VA PROVIDER #

Oncology Primary File (#165.5)

NUMBER	LABEL

.01	SITE/GP
.0101	PRIMARY SITE/GP
.015	SELECTED SITES
.016	MAJOR ICDO-SITES
.017	SYSTEMS
.02	PATIENT NAME
.022	ICDO-SITE
.023	ICDO-SITE CODE
.025	PATIENT ID
.03	REPORTING HOSPITAL
.04	CLASS OF CASE
.041	CLASS NO.
.042	CLASS CATEGORY
.043	CASE CLASS
.045	*YEAR OF ACCESSION NUMBER
.05	ACCESSION NUMBER
.06	SEQUENCE NO.
.061	ACC/SEQ NO.
.07	ACCESSION YEAR
.08	MEDICAL RECORD NUMBER
.09	SSN
.091	STATUS
.093	PLACE OF BIRTH (STATE)
.1	SEX
.115	STATE
.1157	ST-COUNTY
.117	COUNTY
.12	RACE
.13	RACE-SEX
.14	SEX-RACE
1	FIRST ADMIT DATE
1.1	DISCHARGE DATE
1.2	TYPE OF REPORTING SOURCE
2	PRIMARY SURGEON
2.1	FOLLOWING PHYSICIAN
2.2	MANAGING PHYSICIAN
2.3	OTHER PHYSICIAN (3)
2.4	OTHER PHYSICIAN (4)

3 DATE DX
3.1 DIAGNOSIS EPISODE CARE
3.5 YEAR DX
4 AGE AT DX
4.1 DX AGE-GP
5 DX FACILITY
6 REFERRING FACILITY
7 TRANSFER FACILITY
8 PATIENT ADDRESS AT DX
8.1 CITY/TOWN AT DX
9 POSTAL CODE AT DX
10 COUNTY AT DX
11 MARITAL STATUS AT DX
12 *OCCUPATION/INDUSTRY
13 *OCCUPATION CODE
14 *INDUSTRY CODE
15 *OCC/IND CODING SCHEME
16 STATE AT DX
17 SUSPENSE DATE
18 PRIMARY PAYOR AT DX
19 STAGED BY (CLINICAL STAGE)
20 ICDO-TOPOGRAPHY
20.1 ICDO TOPOGRAPHY-CODE
21 *TOPOGRAPHY-SNOMED
21.5 INFRA/SUPRA
21.51 IRIS/CILIARY BODY
21.52 UPPER/LOWER
22 HISTOLOGY
22.1 ICDO HISTOLOGY-CODE
22.2 PAPILLARY/FOLLICULAR
23 RECONSTRUCTION/RESTORATION
24 GRADE/DIFFERENTIATION
25 *GRADE ABBREVIATION
25.1 TUMOR MARKER 1
25.2 TUMOR MARKER 2
25.3 TUMOR MARKER 3
26 DIAGNOSTIC CONFIRMATION
27 HISTO-MORPHOLOGY
28 LATERALITY
29 SIZE OF TUMOR
29.9 EXTENSION LIST USED
30 EXTENSION
30.1 PATHOLOGIC EXTENSION
30.5 PERIPHERAL BLOOD INVOLVEMENT
30.9 LYMPH NODE LIST USED
31 LYMPH NODES
32 NODES POSITIVE (REGIONAL)
33 NODES EXAMINED (REGIONAL)
33.1 #NODES EXAMINED
34 METASTASIS 1
34.1 METASTASIS 2
34.2 METASTASIS 3
35 SUMMARY STAGE
35.1 GEN SUM STG
36 AJCC STAGING BASIS
37 CLINICAL TNM
37.1 CLINICAL T
37.15 T-Encoding
37.2 CLINICAL N
37.25 N-Encoding
37.3 CLINICAL M
37.35 M-Encoding
37.9 AUTOMATIC STAGING OVERRIDDEN
38 CLINICAL STAGE GROUP
38.1 GP-I AJCC SUMMARY STAGE
38.2 GP-II AJCC SUMMARY STAGE

38.3 GP-III AJCC SUMMARY STAGE
38.4 GP-IV AJCC SUMMARY STAGE
38.5 STAGE GROUPING-AJCC
39 OTHER STAGE
40 AJCC STAGE
40.1 TNM
40.2 STAGED BY
41 ASSOCIATED WITH HIV
42 ¹TREATMENT PLAN
43 TREATMENT
44 T-CODE
45 PERFORMANCE STATUS
46 N-CODE
47 M-CODE
48 OTHER PRIMARY SITES
49 FIRST COURSE OF TREATMENT DATE
50 SURGERY OF PRIMARY SITE DATE
50.1 SURGERY HOSPITAL
50.2 SURG PRIMARY SITE @FACILITY
50.3 SURG PRIMARY SITE @FACILITY DT
51 RADIATION DATE
51.1 RADIATION HOSPITAL
51.2 RADIATION
51.3 RADIATION/SURGERY SEQUENCE
51.4 RADIATION @FACILITY
51.5 RADIATION @FACILITY DATE
52 RADIATION THERAPY TO CNS DATE
52.1 RADIATION THERAPY TO CNS HOSP
52.2 RADIATION THERAPY TO CNS
53 CHEMOTHERAPY DATE
53.1 CHEMOTHERAPY HOSPITAL
53.2 CHEMOTHERAPY
53.3 CHEMOTHERAPY @FACILITY
53.4 CHEMOTHERAPY @FACILITY DATE
54 HORMONE THERAPY DATE
54.1 HORMONE THERAPY HOSPITAL
54.2 HORMONE THERAPY
54.3 HORMONE THERAPY @FACILITY
54.4 HORMONE THERAPY @FACILITY DATE
55 IMMUNOTHERAPY DATE
55.1 IMMUNOTHERAPY HOSPITAL
55.2 IMMUNOTHERAPY (BRM)
55.3 IMMUNOTHERAPY @FACILITY
55.4 IMMUNOTHERAPY @FACILITY DATE
56 NUMBER OF TREATMENTS
57 OTHER TREATMENT DATE
57.1 OTHER TREATMENT HOSPITAL
57.2 OTHER TREATMENT
57.3 OTHER TREATMENT @FACILITY
57.4 OTHER TREATMENT @FACILITY DATE
58 REASON FOR NO SURGERY
58.1 NON CANCER-DIRECTED SURGERY
58.2 SURGERY OF PRIMARY SITE
58.3 NON CANCER-DIRECTED SURG DATE
58.4 NON CA-DIR SURG @FACILITY
58.5 NON CA-DIR SURG @FACILITY DATE
59 SURGICAL MARGINS
60 SUBSEQUENT COURSE OF TREATMENT
61 PID#
62 QA SELECTED
63 QA REVIEW
64 QA DATE
65 PHYSICIAN'S STAGE
66 PHYSICIAN STAGING

¹ Patch ONC*2.11*24 Field name change from TX SEQ to Treatment Plan.

67 ACOS #
68 STATE HOSPITAL #:
69 MULTIPLE TUMORS
69.1 FAMILY HISTORY
69.2 DIFFUSE RETINAL INVOLVEMENT
69.3 MULTIMODALITY THERAPY (CLIN)
69.4 MULTIMODALITY THERAPY (PATH)
70 DATE OF FIRST RECURRENCE
71 TYPE OF FIRST RECURRENCE
71.1 DISTANT SITE 1
71.2 DISTANT SITE 2
71.3 DISTANT SITE 3
71.4 OTHER TYPE OF FIRST RECURRENCE
72 SUBSEQUENT RECURRENCES
73 TUMOR STATUS
74 SURGICAL APPROACH
75 REASON FOR NO RADIATION
76 REASON FOR NO CHEMOTHERAPY
77 REASON FOR NO HORMONE THERAPY
78 CONVERTED
79 SCREENING DATE
80 RADIATION TREATMENT
81 COMPLETED BY
¹82 REVIEWED BY CANCER COMMITTEE
84 PCE INDICATOR
85 PATHOLOGIC T
86 PATHOLOGIC N
87 PATHOLOGIC M
88 PATHOLOGIC STAGE GROUP
89 STAGED BY (PATHOLOGIC STAGE)
89.1 PATHOLOGIC TNM
90 ABSTRACT DATE
91 ABSTRACT STATUS
92 ABTRACTER
93 OTHER T
94 REPORTING DATE
95 LAST TUMOR STATUS
95.1 V.STATUS/TUMOR STATUS
96 *ENTERED BY
97 ABSTRACT INCOMPLETE
98 OTHER N
99 OTHER M
100 TEXT-PRIMARY SITE
101 TEXT-HISTOLOGY
102 *TEXT-OCCUPATION/INDUSTRY
103 TEXT-DX PROC-OP
104 TEXT-DX PROC-PE
105 TEXT-DX PROC-X-RAY/SCAN
106 TEXT-DX PROC-SCOPES
107 TEXT-DX PROC-PATH
108 TEXT-RX-SURGERY
109 TEXT-RX-RAD (BEAM)
110 TEXT-RX-RAD/CNS
111 TEXT-RX-CHEMO
112 TEXT-RX-HORMONE
113 TEXT-REMARKS
114 TEXT-RX-IMMUNOTHERAPY
115 TEXT-RX-OTHER
116 TEXT-DX-LAB TESTS
117 OTHER STAGE GROUP
118 STAGED BY (OTHER STAGE)
119 SCREENING RESULT
120 PRESENTATION AT CANCER CONF
121 DATE OF CANCER CONF

¹ Patch ONC*2.11*24 Autopsy field #83 deleted.

122 REFERRAL TO SUPPORT SERVICES
123 INPATIENT/OUTPATIENT STATUS
124 DATE OF NO TREATMENT
125 RADIATION TREATMENT VOLUME
126 LOCATION OF RADIATION
127 INTENT OF RADIATION
128 RADIATION COMPLETION STATUS
129 RADIATION AUXILIARY VOLUME
130 RADIATION AUXILIARY DATE
131 RADIATION AUXILIARY TEXT
132 RADIATION LOCAL CONTROL STATUS
133 YEAR PUT ON PROTOCOL
134 CLINICAL RISK FACTORS
135 PATHOLOGIC RISK FACTORS
136 SERUM TUMOR MARKERS
137 DATE OF 1ST POSITIVE BIOPSY
138 SCOPE OF LYMPH NODE SURGERY
138.1 SCOPE OF LN SURG @FACILITY
138.2 SCOPE OF LYMPH NODE SURG DATE
138.3 SCOPE OF LN SURG @FACILITY DT
139 SURGERY OF OTHER SITES/NODES
139.1 SURG OTH SITE/NODE @FACILITY
139.2 SURGERY OTH SITES/NODES DATE
139.3 SURG OTH SITE/NODE @FAC DATE
140 NUMBER OF NODES REMOVED
140.1 NUM NODES REMOVED @FACILITY
141 BIOPSY PROCEDURE
142 GUIDANCE
143 PALPABILITY OF PRIMARY
144 FIRST DETECTED BY
145 APPROACH FOR BIOPSY OF PRIMARY
146 BIOPSY OF OTHER THAN PRIMARY
147 CENSUS TRACT
150 FOLLOW-UP HISTORY
200 DATE LAST CONTACT
201 SURVIVAL DAYS
202 SURVIVAL MONTHS
203 SURVIVAL (YEARS)
204 WEEKS OF FOLLOW-UP
220 ICDO-1 TOPOGRAPHY
221 ICDO-1 MORPHOLOGY
300 PATIENT REFERRED FOR TREATMENT
301 LENGTH OF STAY
302 HISTORY OF CERVIX CA (PT)
303 HISTORY OF COLON CA (PT)
304 HISTORY OF BLADDER CA (PT)
305 HISTORY OF HEAD & NECK CA (PT)
306 HISTORY OF KIDNEY CA (PT)
307 HISTORY OF PROSTATE CA (PT)
308 HISTORY OF OTHER CA (PT)
309 HISTORY OF BLADDER CA (FAM)
310 HISTORY OF COLON CA (FAM)
311 HISTORY OF LUNG CA (FAM)
312 HISTORY OF PROSTATE CA (FAM)
313 HISTORY OF OTHER CA (FAM)
314 SMOKING HISTORY
315 DURATION OF SMOKING HISTORY
316 DURATION OF SMOKE FREE HISTORY
317 GROSS HEMATURIA
318 MICROSCOPIC HEMATURIA
319 URINARY FREQUENCY
320 BLADDER IRRITABILITY
321 DYSURIA
322 OTHER CLINICAL DETECTIONS
323 ONSET OF SYMPTOMS
324 DURATION OF GROSS HEMATURIA

325 DURATION OF DYSURIA
326 BIMANUAL EXAM OF BLADDER
327 CYSTOSCOPY WITH BIOPSY
328 CYSTOSCOPY WITHOUT BIOPSY
329 FLOW CYTOMETRY
330 INTRAVENOUS PYELOGRAM (BLA)
331 URINE CYTOLOGY
332 URINALYSIS
333 OTHER DIAGNOSTIC PROCEDURES
334 SPECIALTY MAKING DIAGNOSIS
335 ABDOMINAL ULTRASOUND
336 BONE IMAGING
337 CHEST X-RAY (BLADDER)
338 CT CHEST/LUNG
339 CT ABDOMEN/PELVIS
340 CT OTHER
341 MRI PELVIS/ABDOMEN
342 MRI OTHER
343 OTHER STAGING PROCEDURES
344 PRESENCE OF HYDRONEPHROSIS
345 PRESENCE OF MULTIPLE TUMORS
346 PROTOCOL ELIGIBILITY STATUS
347 MANAGING PHYSICIAN (PRIMARY)
348 MANAGING PHYSICIAN (SECONDARY)
349 TUMOR RESECTION DURING TURB
350 TYPE OF URINARY DIVERSION
351 PELVIC LYMPH NODE DISSECT (BL)
352 BLEEDING REQUIRING TRANSFUSION
353 DEEP VEIN THROMBOSIS
354 MYOCARDIAL INFARCTION
355 PELVIC ABSCESS
356 PNEUMONIA REQ ANTIBIOTICS
357 POST-OPERATIVE DEATH
358 PULMONARY EMBOLISM/THROMBOSIS
359 REOPERATION
360 OTHER SURGICAL COMPLICATIONS
361 DATE RADIATION THERAPY ENDED
362 TOTAL RAD (cGy/rad) DOSE
363 REGIONAL TREATMENT MODALITY
364 URINARY INCONTINENCE
365 HEMATURIA
366 RADIATION BOWEL INJURY
367 DATE CHEMOTHERAPY ENDED
368 ROUTE CHEMOTHERAPY ADMIN
369 ADRIAMYCIN
370 CARBOPLATINUM
371 CISPLATIN
372 CYCLOPHOSPHAMIDE (BLA)
373 5-FLUOROURACIL
374 GALLIUM NITRATE
375 IFOSFAMIDE
376 METHOTREXATE
377 TAXOL
378 THIOTEPA
379 VINBLASTINE
380 OTHER CHEMOTHERAPY AGENTS
381 INDICATION FOR ADMIN OF AGENTS
382 REASON CHEMOTHERAPY STOPPED
383 BCG
384 INTERFERON
385 INTERLEUKIN-2
386 OTHER TYPE OF IMMUNOTHERAPY
387 TYPE OF 1ST RECURRENCE/BLADDER
400 HISTORY OF THYROID CA (FAM)
401 HISTORY OF LYMPHOMA (PT)
402 HISTORY OF CHILDHOOD MALIG

403 PRIOR EXPOSURE TO RADIATION
404 HISTORY OF GOITER (PT)
405 HISTORY OF GOITER (FAM)
406 HISTORY OF GRAVES DISEASE (PT)
407 HISTORY OF THYROIDITIS (PT)
408 DYSPHAGIA
409 HOARSENESS OR VOICE CHANGE
410 NECK NODAL MASS
411 PAIN, BONE
412 PAIN, NECK
413 PATHOLOGIC FRACTURE
414 STRIDOR/DIFFICULTY BREATHING
415 THYROID MASS
416 WEIGHT LOSS
417 OTHER SIGNS/SYMPTOMS
418 BONE SCAN (THYROID)
419 CHEST X-RAY (THYROID)
420 CT SCAN OF NECK (THYROID)
421 CT SCAN OF CHEST
422 INCISIONAL BIOPSY OF THYROID
423 LARYNGOSCOPY
424 NECK X-RAY (AP & LATERAL)
425 NEEDLE ASPIRATION OF NECK NODE
426 NEEDLE ASPIRATION OF THYROID
427 MRI OF NECK
428 THYROID SCAN
429 ULTRASOUND OF THYROID
430 OTHER DIAGNOSTIC/SURGICAL TEST
431 BLOOD VESSEL INVASION
432 EXTRA-THYROIDAL EXTENSION
433 MULTIFOCAL
434 LOCATION OF POSITIVE NODES
435 DATE OF DISCHARGE AFTER SURG
436 AIRWAY PROBLEM
437 BLEEDING/HEMATOMA
438 HYPOCALCEMIA
439 RECURRENT NERVE INJURY
440 WOUND INFECTION
441 POSTOPERATIVE DEATH
442 REGIONAL DOSE:cGy
443 BOOST DOSAGE
444 INITIAL DOSE OF RADIOIODINE
445 SECOND DOSE OF RADIOIODINE
446 ADJUVANT CHEMOTHERAPY (THY)
500 HISTORY OF SOFT TIS SARC (FAM)
501 HISTORY OF ANY CANCER (PT)
502 ANGIOGRAM OF PRIMARY
503 BONE MARROW ASPIRATE OR BIOPSY
504 BONE SCAN (SOFT TIS SARCOMA)
505 CHEST X-RAY (STS/NHL)
506 CT SCAN OF CHEST (STS)
507 CT SCAN OF PRIMARY
508 LIVER FUNCTION STUDIES (STS)
509 LYMPHANGIOGRAM
510 MRI OF PRIMARY
511 MRI OF OTHER
512 SKELETAL X-RAY
513 SONOGRAM
514 CYTOGENETICS
515 ELECTRON MICROSCOPY
516 IMMUNOHISTOCHEMISTRY
517 IN SITU HYBRIDIZATION
518 OUTSIDE CONFIRMATION REQUESTED
519 SUBSITE
520 TYPE OF ADDITIONAL CODING SYS
521 VALUE OF ADDITIONAL CODING SYS

522 PATHOLOGIC SIZE OF TUMOR
523 DEPTH OF TUMOR
524 CONSULTATIONS (MED ONCOLOGIST)
525 CONSULTATIONS (RAD ONCOLOGIST)
526 TREATING SURGEON
527 ASA CLASS
528 FINE NEEDLE ASPIRATION
529 CORE NEEDLE BIOPSY
530 INCISIONAL BIOPSY (STS PCE)
531 EXCISIONAL BIOPSY
532 EXTERNAL BEAM RADIATION
533 EXTERNAL BEAM RAD FRACTIONS
534 EXTERNAL BEAM RADIATION ENERGY
535 INTRAOPERATIVE RADIATION
536 INTRAOPERATIVE RADIATION DOSE
537 INTRAOPERATIVE RADIATION ENER
538 BRACHYTHERAPY
539 BRACHYTHERAPY DAYS
540 BRACHYTHERAPY RADIATION DOSE
541 DATE BRACHYTHERAPY STARTED
542 DATE BRACHYTHERAPY ENDED
543 CYTOXAN
544 DTIC
545 DOXORUBICIN (STS)
546 ETOPOSIDE
547 CISPLATIN METHOD OF DELIVERY
548 CYTOXAN METHOD OF DELIVERY
549 DTIC METHOD OF DELIVERY
550 DOXORUBICIN METHOD OF DELIVERY
551 ETOPOSIDE METHOD OF DELIVERY
552 IFOSFAMIDE METHOD OF DELIVERY
553 CISPLATIN LOCATION
554 CYTOXAN LOCATION
555 DTIC LOCATION
556 DOXORUBICIN LOCATION
557 ETOPOSIDE LOCATION
558 IFOSFAMIDE LOCATION
559 COLONY STIMULATING FACTORS
560 PROTOCOL PARTICIPATION
561 OTHER PROTOCOL
562 REFERRED TO REHAB SERVICES
563 PHYSICAL THERAPY/REHABILITATION
564 TRANSFERRED TO REHABILITATION
565 NUMBER OF HOSPITALIZATIONS
566 TOTAL LENGTH OF STAYS
567 DATE EXT BEAM RAD STARTED
600 CLINICAL DX WITH BONE LESION
601 CLINICAL DX BY RECTAL EXAM
602 CYTOLOGY
603 INCIDENTAL FINDING IN TURP
604 NEEDLE ASPIRATION BIOPSY
605 NEEDLE BIOPSY, NOS
606 PERINEAL BIOPSY
607 TRANSRECTAL BIOPSY
608 TRUS
609 TRANSURETHRAL RESECTION
610 OTHER METHOD OF DX (PROSTATE)
611 BONE MARROW ASPIRATION
612 BONE SCAN (PROSTATE)
613 BONE X-RAY
614 CHEST X-RAY (PROSTATE)
615 CT SCAN OF PRIMARY SITE
616 INTRAVENOUS PYELOGRAM (PRO)
617 LIVER SCAN
618 MRI (PRO)
619 PELVIC LYMPH NODE DISSECT (PR)

620 PROSTATIC ACID PHOSPHATASE
621 PROSTATE SPECIFIC ANTIGEN
622 OTHER DIAGNOSTIC INFORMATION
623 GLEASON'S SCORE (02-40)
623.1 PREDOMINANT PATTERN (02-40)
623.2 LESSER PATTERN (02-40)
623.3 GLEASON'S SCORE (50-70)
623.4 PREDOMINANT PATTERN (50-70)
623.5 LESSER PATTERN (50-70)
624 RESEARCH PROTOCOL
625 RAD THERAPY PLANNED/GIVEN
626 INTERSTITIAL RAD PLANNED/GIVEN
627 IODINE 125
628 GOLD 198
629 PALLADIUM 103
630 IRIDIUM 192
631 OTHER INTERSTITIAL, NOS
632 EXTERNAL RAD PLANNED/GIVEN
633 PROSTATE REGION ONLY
634 PROSTATE AND PELVIC NODES
635 PROSTATE & PELVIC PARA-AORTIC
636 DISTANT METASTATIC SITES
637 OTHER EXTERNAL SITES, NOS
638 TOTAL RAD DOSE (PROSTATE)
639 TOTAL RAD DOSE (PELVIC NODES)
640 TOTAL RAD DOSE (PARA-AORTIC)
641 RESEARCH PROTOCOL (RADIATION)
642 HORMONE THERAPY PLANNED/GIVEN
643 ESTROGENS
644 ANTIANDROGENS
645 PROGESTATIONAL AGENTS
646 LUTEINIZING HORMONES
647 ORCHIECTOMY
648 OTHER EXOGENOUS HORMONE AGENTS
649 BACKACHE (1ST RECURRENCE)
650 BONE SCAN (1ST RECURRENCE)
651 LETHARGY
652 RECTAL EXAM (1ST RECURRENCE)
653 TUMOR MARKER (1ST RECURRENCE)
654 WEIGHT LOSS (1ST RECURRENCE)
655 OTHER METHODS (1ST RECURRENCE)
656 REASON FOR 2ND COURSE
657 FAM HIST OF PROSTATE CA (PR98)
658 HEMATURIA (PR98)
659 LOWER BACK PAIN (PR98)
660 TROUBLE URINATING (PR98)
661 CLIN DX W/ BONE LESION (PR98)
662 CLIN DX BY RECTAL EXAM (PR98)
663 CYTOLOGY (PR98)
664 DIGITAL TRANSRECTAL BIO (PR98)
665 INCIDENTAL FIND IN TURP (PR98)
666 NEEDLE BIOPSY, NOS (PR98)
667 PERINEAL BIOPSY (PR98)
668 PSA METHOD OF DIAGNOSIS (PR98)
669 TRANSRECTAL BIOPSY (PR98)
670 TRANSURETHRAL RESECTION (PR98)
671 BONE MARROW ASPIRATION (PR98)
672 BONE SCAN (PR98)
673 BONE X-RAY (PR98)
674 CHEST X-RAY (PR98)
675 CT SCAN OF ABDOMEN (PR98)
676 CT SCAN OF PELVIS (PR98)
677 INTRAVENOUS PYELOGRAM (PR98)
678 MRI (PR98)
679 PELVIC LYMPH ND DISSECT (PR98)
680 POLYMERASE CHAIN REACT (PR98)

681 PROSTATIC ACID PHOSPH (PR98)
682 PSA DIAGNOSTIC EVAL (PR98)
683 ULTRASOUND OF ABDOMEN (PR98)
684 RESULTS OF PSA TEST (PR98)
685 WATCHFUL WAITING (PR98)
686 LENGTH OF STAY (PR98)
687 LAPAROSCOPIC (PR98)
688 OPEN (PR98)
689 PERMANENT RECTAL INJURY (PR98)
690 THROMBOEMBOLISM (PR98)
691 URETHRAL STRICTURE (PR98)
692 RADIATION FACILITY
693 ROUTE OF INTERSTITIAL RAD
694 TYPE OF RADIATION ADMIN
695 GASTROINTESTINAL COMPLICATIONS
696 GASTROURINARY COMPLICATIONS
697 ANORECTAL COMPLICATIONS
698 CHRONIC COMPLICATIONS
699 URETHRAL/BLADDER COMPLICATIONS
699 .1 DATE OF ORCHIECTOMY
700 HISTORY OF COLORECTAL CA (FAM)
701 HISTORY OF COLORECTAL CA (PT)
702 MULTIPLE COLORECTAL PRIMARIES
703 HISTORY OF BREAST CA (PT)
704 HISTORY OF LUNG CA (PT)
705 HISTORY OF OVARIAN CA (PT)
706 HISTORY OF OVARIAN CARCINOMA
707 HISTORY OF STOMACH CA (PT)
708 HISTORY OF THYROID CA (PT)
709 HISTORY OF UTERUS CA (PT)
710 PREVIOUS TAH/BSO
711 PRIOR FAP
712 PRIOR HNPCC
713 PRIOR IBD
714 PRIOR POLYPS
715 POLYPS
716 DURATION OF ANEMIA
717 DURATION OF BOWEL OBSTRUCTION
718 DURATION OF BOWEL HABIT CHANGE
719 DURATION OF EMERGENCY PRES-OBS
720 DURATION OF JAUNDICE
721 DURATION OF MALAISE
722 DURATION OF BLOOD IN STOOL
723 DURATION OF PAIN (ABDOMINAL)
724 DURATION OF PAIN (PELVIC)
725 DURATION OF RECTAL BLEEDING
726 DURATION OF OTHER
727 ENDOSCOPIC METHOD
728 RADIOGRAPHIC METHOD
729 SCREENING DIGITAL RECTAL EXAM
730 SCREENING PHYSICAL EXAM METHOD
731 OTHER INITIAL METHOD
732 REASON LEADING TO EVENTUAL DX
733 BARIUM ENEMA, DOUBLE CONTRAST
734 BARIUM ENEMA, SINGLE CONTRAST
735 BARIUM ENEMA, NOS
736 BIOPSY OF PRIMARY SITE
737 BIOPSY OF METASTATIC SITE
738 CT SCAN OF LIVER
739 CT SCAN OF PRIMARY SITE (COL)
740 CARCINOEMBRYONIC ANTIGEN (CEA)
741 CHEST ROENTGENOGRAM
742 COLONOSCOPY
743 DIGITAL RECTAL EXAM
744 FLEXIBLE SIGMOIDOSCOPY
745 INTRAVENOUS PYELOGRAM (COL)

746 SERUM-LIVER FUNCTION TEST
747 MRI (COL)
748 PROCTOSCOPY (RIGID)
749 STOOL GUAIAC (OCCULT BLOOD)
750 ULTRASOUND, LIVER, ABDOMEN
751 ULTRASOUND, ENDORECTAL
752 TUMOR LEVEL-ENDOSCOPIC EXAM
753 LEVEL OF RECTAL TUMOR
754 PROXIMAL MARGIN OF RESECTION
755 DISTAL MARGIN OF RESECTION
756 RADIAL MARGIN OF RESECTION
757 DIST TO CLOSEST MUCOSAL MARGIN
758 DIST TO CLOSEST RADIAL MARGIN
759 BLOOD VESSEL OR LYMPHATIC INV
760 EXTRAMURAL VENOUS INVASION
761 PROMINENT LYMPHOID INFILTRATE
762 PHYS PROVIDING DEF TREATMENT
763 ADDITIONAL SURGICAL PROCEDURES
764 LAPAROSCOPY USED DURING CDS
765 METHOD OF ANASTOMOSIS
766 CM FROM ANASTOMOSIS TO DENTATE
767 COLOSTOMY
768 OOPHORECTOMY
769 PATHOLOGICAL STATUS
770 ABDOMINAL INFECTION
771 ABSCESS
772 ADMISSION FOR NEUTROPENIA
773 ANASTOMOTIC DEHISCENCE
774 DEHYDRATION
775 DIARRHEA
776 EARLY BOWEL OBSTRUCTION
777 PERINEAL INFECTION
778 PNEUMONIA (COL)
779 PROCTITIS
780 PULMONARY EMBOLISM (COL)
781 RADIATION ENTERITIS
782 STOMA COMPLICATION
783 URINARY TRACT INFECTION
784 ENDOCAVITARY RADIATION (ECRT)
785 INTRA-OPERATIVE RAD THERAPY
786 PRIMARY TUMOR RAD DOSE (cGy)
787 NUMBER OF RADIATION TREATMENTS
788 ADJUVANT CHEMOTHERAPY (COL)
789 5 FU (FLUOROURACIL)
790 LEUCOVORIN
791 LEVAMISOLE
792 CPT 11
793 OTHER ADJUVANT THERAPY
794 DURATION OF ADJUVANT THERAPY
795 COMPLETED DURATION OF THERAPY
796 NUTRITIONAL CONSULTATION
797 OCCUPATIONAL THERAPY
798 OSTOMY CONSULTATION
799 PSYCHOSOCIAL
800 HISTORY OF LEUKEMIA (FAM)
801 HISTORY OF NON-HODGKIN'S LYMPH
802 HISTORY OF HODGKIN'S LYMPHOMA
803 1ST PRIMARY SITE
804 1ST PRIMARY HISTOLOGY
805 2ND PRIMARY SITE
806 2ND PRIMARY HISTOLOGY
807 ORGAN TRANSPLANT
808 HIV POSITIVE
809 CROHN'S DISEASE
810 HASHIMOTO'S THYROIDITIS
811 SYSTEMIC LUPUS ERYTHEMATOSUS

812 RHEUMATOID ARTHRITIS
813 PNEUMOCYSTIS CARINII
814 CMV INFECTION
815 TUBERCULOSIS
816 MYCOBACTERIUM AVIUM
817 OTHER PARASITIC INFECTIONS
818 OTHER CONGENITAL DISEASES
819 OPPORTUNISTIC DISEASE
820 PREVIOUS CHEMOTHERAPY
821 PREVIOUS RADIATION THERAPY
822 AIDS RISK CATEGORY
823 CT SCAN OF BRAIN
824 CT SCAN OF ABDOMEN/PELVIS
825 MRI OF BRAIN
826 MRI OF CHEST
827 MRI OF ABDOMEN/PELVIS
828 GALLIUM SCAN
829 PET SCAN
830 LUMBAR PUNCTURE
831 HEMOGLOBIN/HEMATOCRIT
832 WHITE COUNT
833 PLATELET COUNT
834 LACTIC DEHYDROGENASE (LDH)
835 LIVER FUNCTION STUDIES (NHL)
836 TOTAL PROTEIN/ALBUMIN
837 GENE REARRANGEMENTS
838 REVIEW OF PATHOLOGY/OTHER INST
839 LYMPH NODE BIOPSY
840 BONE MARROW BIOPSY
841 CSF CYTOLOGY
842 OTHER SITE BIOPSY
843 SYSTEMIC SYMPTOMS
844 CD4 COUNT
845 HIV VIRAL LOADS
846 SPECIFIC HISTOLOGIC INFO
847 CELL TYPE OF LYMPHOMA
848 PATIENT STATUS AT DIAGNOSIS
849 TYPE OF STAGING SYSTEM (PED)
850 PEDIATRIC STAGE
851 STAGED BY (PEDIATRIC STAGE)
852 EXTRANODAL SITE 1
853 EXTRANODAL SITE 2
854 EXTRANODAL SITE 3
855 EXTRANODAL SITE W/C-D SURGERY
856 EXTRANODAL SITE SURGICAL PROC
857 LYMPH NODES ABOVE DIAPHRAGM
858 LYMPH NODES BELOW DIAPHRAGM
859 BRAIN
860 OTHER EXTRANODAL SITE(S)
861 TOTAL BODY
862 RADIATION/CHEMO SEQUENCE
863 PROTOCOL
864 SYSTEMIC CHEMOTHERAPY
865 SYSTEMIC CHEMOTHERAPY DATE
866 SYSTEMIC CHEMOTHERAPY CYCLES
867 CHLORAMBUCIL
868 CYCLOPHOSPHAMIDE (NHL)
869 DOXORUBICIN (NHL)
870 FLUDARABINE
871 CHOP
872 CVP
873 COMLA
874 MACOP-B
875 M-BACOD
876 PRO-MACE-Cyta BOM
877 OTHER SYSTEMIC CHEMO AGENTS

878 HIGH DOSE SYSTEMIC CHEMO
 879 INTRATHECAL CHEMOTHERAPY
 880 PURPOSE OF INTRATHECAL CHEMO
 881 INTERFERON (NHL)
 882 INTERLEUKIN-2 (IL-2) (NHL)
 883 MONOCLONAL ANTIBODIES
 884 VACCINE THERAPY
 900 DAUGHTER (BR98)
 901 MATERNAL AUNT (BR98)
 902 MATERNAL GRANDMOTHER (BR98)
 903 MOTHER (BR98)
 904 ONE SISTER (BR98)
 905 MORE THAN ONE SISTER (BR98)
 906 FATHER (BR98)
 907 BROTHER (BR98)
 908 FAM HISTORY BREAST CA (BR98)
 909 HISTORY OF BREAST CA (BR98)
 910 SYNCHRONOUS BREAST CA (BR98)
 911 COLON (BR98)
 912 OVARY (BR98)
 913 UTERUS (BR98)
 914 PROSTATE (BR98)
 915 OTHER (BR98)
 916 HORMONE REPLACEMENT TPY (BR98)
 917 HORMONE REPLACEMENT YRS (BR98)
 918 UNKNOWN MAMMOGRAM (BR98)
 919 UNKNOWN MAMMOGRAM DT (BR98)
 920 SCREENING MAMMOGRAM (BR98)
 921 SCREENING MAMMOGRAM DT (BR98)
 922 DIAGNOSTIC MAMMOGRAM (BR98)
 923 DIAGNOSTIC MAMMOGRAM DT (BR98)
 924 MAGNIFICATION MAMMOGRAM (BR98)
 925 MAGNIFICATION MAMM DT (BR98)
 926 MAMMOGRAM (BR98)
 927 ULTRASOUND (BR98)
 928 MOST DEFINITIVE MAMM (BR98)
 929 DATE OF PATHOLOGIC DX (BR98)
 930 DCSI ALSO PRESENT (BR98)
 931 ARCHITECTURE PATTERN (BR98)
 932 NUCLEAR GRADE (BR98)
 933 SKIN INVOLVEMENT (BR98)
 934 CHEST WALL INVOLVEMENT (BR98)
 935 PECTORAL INVOLVEMENT (BR98)
 936 DERMAL/LYMPHATIC INV (BR98)
 937 DNA INDEX/PLOIDY (BR98)
 940 ANDROGEN RECEPTOR (BR98)
 941 TYPE OF TEST (BR98)
 942 SIZE OF DCIS TUMOR (MM) (BR98)
 943 SENTINEL NODE BIOPSY
 944 SENTINEL NODES EXAMINED (BR98)
 945 SENTINEL NODES POSITIVE (BR98)
 946 SENTINEL NODES DETECTED (BR98)
 947 SPECIMEN RADIOGRAPH (BR98)
 948 SUBMITTED TO PATHOLOGY (BR98)
 949 MARGIN DISTANCE (BR98)
 950 RE-EXCISION (BR98)
 951 MICROSCOPIC STATUS (BR98)
 952 PRE-RADIATION MAMMOGRAM (BR98)
 953 SITES IRRADIATED (BR98)
 954 cGy DOSE TO BREAST (BR98)
 955 SPECIFIC HORMONE THPY (BR98)
 956 CHEMOTHERAPY REGIME (BR98)
 997 STAGE FLAG
 998 *POSTAL CODE AT DIAGNOSIS FLAG
 999 *STATE AT DIAGNOSIS FLAG
 1000 *OLD TNM STAGE

1001 T-ICDOSITE
1100 HISTORY OF MELANOMA (PT)
1101 HISTORY OF OTHER CANCER (PT)
1102 FIRST SITE CODE
1103 FIRST SITE DIAGNOSIS DATE
1104 SECOND SITE CODE
1105 SECOND SITE DIAGNOSIS DATE
1106 PREGNANCY AT INITIAL DIAGNOSIS
1107 EXOGENOUS HORMONES
1108 DISEASE PRESENTATION LOCATION
1109 TYPE OF BIOPSY
1110 EXTRANODAL EXTENSION
1111 MICROSATELLITOSIS
1112 NUMBER OF SATELLITE NODULES
1113 LOCATION OF IN-TRANSIT NODULES
1114 BRESLOW'S THICKNESS
1115 CLARK'S LEVEL OF INVASION
1116 ANGIOLYMPHATIC INVASION
1117 PERINEURAL INVASION
1118 ULCERATION
1119 CLINICALLY AMELANOTIC
1120 MARGIN DISTANCE (MEL)
1121 SURGICAL CLOSURE
1122 PRE-OP LYMPHOSCINTIGRAPHY
1123 SENTINEL NODES DETECTED BY
1124 SENTINEL NODES EXAMINED (MEL)
1125 SENTINEL NODES POSITIVE (MEL)
1126 METHOD OF PATHOLOGIC EXAM
1127 LYMPH NODE DISSECTION
1128 NUMBER OF BASINS DISSECTED
1129 NUMBER OF BASINS POSITIVE
1130 INTRAVENOUS THERAPY
1131 GENE THERAPY
1132 SIZE OF TUMOR (MELANOMA)

XVII. Appendix IV: VA FileMan Sorts and Searches to Go!

The sorts and searches created in the following pages use either the option Print Custom Reports under the Annual Reports menu or the Define Search Criteria under the Statistical Reports menu.

Modified Suspense List

This sort will give you more information regarding patients in suspense than the canned suspense list. It gives the PID#, patient name, date of suspense, and for patients already abstracted, the topography of the site for which they have an abstract and the status of that abstract.

Note: *Italics* is used below to show when you are in the Oncology Primary file.
+ is used on sort fields and ! on print fields to provide counts for those fields.

Annual Reports ... Print Custom Reports

```
Select one of the following:
  1      PRIMARY
  2      PATIENT
  3      CONTACT
Select File to Search: 2  PATIENT
CREATE CUSTOM REPORT for PATIENT file
SORT BY: NUMBER// +SUSPENSE MONTH
START WITH SUSPENSE MONTH: FIRST// <ret>
```

```
WITHIN SUSPENSE MONTH, SORT BY: NAME
START WITH NAME: FIRST// <ret>
WITHIN NAME, SORT BY: <ret>
FIRST PRINT FIELD: !PID#
THEN PRINT FIELD: NAME;L8
```

```
THEN PRINT FIELD: SUSPENSE DATE
THEN PRINT FIELD: ONC:
```

```
By 'ONC', do you mean the ONCOLOGY PRIMARY File,
pointing via its 'PATIENT NAME' Field? Yes// <ret>
THEN PRINT ONCOLOGY PRIMARY FIELD: ICDO-TOPOGRAPHY;L6
THEN PRINT ONCOLOGY PRIMARY FIELD: ABSTRACT STATUS;L1
THEN PRINT ONCOLOGY PRIMARY FIELD: <ret>
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PATIENT STATISTICS  Replace ... With SUSPENSE LIST
Replace
SUSPENSE LIST
STORE PRINT LOGIC IN TEMPLATE:
DEVICE: (Enter a printer name)
```

If you want to start with a specific month, you may do so by typing it here. E.g., 5-99.

This will give you an alphabetical list for each month.

;L limits the field to the number of characters requested. In this case, the name will be limited to 8 characters.

This will allow you to jump from the Oncology Patient file to the Oncology Primary file.

Example Report:

SUSPENSE LIST			DATE	PAGE #
PID#	NAME	SUSPENSE DATE	ICDO-TOPOGRAPHY	ABSTRACT STATUS

SUSPENSE MONTH: JAN 1999				
B9999	BBBBBB,B	01/10/1999	PROSTA	I
C9999	CCCCC,MO	01/30/1999	SOFT T	C

SUBCOUNT	2			
SUSPENSE MONTH: FEB 1999				
B0000	BRZZZ,DO	FEB 11 1999	BLADDE	C
D9999	ZZZZZ,ZZ	FEB 5 1999		
D8947	ZZZZZZZZ	FEB 21 1999	LUNG,	C

SUBCOUNT	3			
SUSPENSE MONTH: MAR 1999				
B0000	BRZZZ,DO	03/21/1999	BLADDE	C
D9999	ZZZZZ,ZZ	03/05/1999	PROSTA	I
D8947	ZZZZZZZZ	03/01/1999	LUNG,	C

SUBCOUNT	3			

COUNT	8			

Note: The second patient in February does not have an abstract in this registry, therefore the TOPOGRAPHY and ABSTRACT STATUS are blank.

Number of Cases Staged by Physicians

The AJCC Staging by physicians became a requirement in 1999 for all Approved Cancer Programs. Near the end of the VISTA abstract, there is a field to record the Physician's Stage and the name of the Physician. This sort will compile that information.

Note: + is used on sort fields and ! on print fields to provide counts for those fields.

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file
SORT BY: NUMBER// +ACCESSION YEAR

START WITH ACCESSION YEAR: FIRST//1999
GO TO ACCESSION YEAR: LAST//1999

WITHIN ACCESSION YEAR, SORT BY: +PHYSICIAN
STAGING;" "

START WITH PHYSICIAN STAGING: FIRST// <ret>

WITHIN PHYSICIAN STAGING, SORT BY: <ret>

FIRST PRINT FIELD: !PHYSICIAN STAGING

THEN PRINT FIELD: <ret>

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **Number of cases staged by physicians in 1999 (breakdown by physician)**

;" " suppresses the sub-header caption.

Number of cases staged by physicians in 1999 (breakdown by physician)		DATE	PAGE #
PHYSICIAN STAGING			

ACCESSION YEAR: 1999			
BBBBB,BART			
SUBCOUNT	15		
CCCCC,JOHN J			
SUBCOUNT	10		
KKKKKK,MARK			
SUBCOUNT	1		
SSSSSS,HANK			
SUBCOUNT	26		
COUNT	52		

Tobacco, Alcohol, Family History

This format may be used to find the tobacco, alcohol or family history. This sort will jump from the Oncology Primary file to a field in the Oncology Patient file.

Note: *Italics* is used below to show when you have left the Oncology Primary file and are in the Oncology Patient file.

+ is used on sort fields and ! on print fields to provide counts for those fields.

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: **1 PRIMARY**

CREATE CUSTOM REPORT for PRIMARY file
SORT BY: NUMBER// **+ACCESSION YEAR**
START WITH ACCESSION YEAR: FIRST// **1999**
GO TO ACCESSION YEAR: LAST// **1999**
WITHIN ACCESSION YEAR, SORT BY: **PATIENT:**

ONCOLOGY PATIENT FIELD: +TOBACCO HISTORY
START WITH TOBACCO HISTORY: FIRST// <ret>
WITHIN TOBACCO HISTORY, SORT BY: <ret>

FIRST PRINT FIELD: **PATIENT:**

THEN PRINT ONCOLOGY PATIENT FIELD: !TOBACCO HISTORY
THEN PRINT ONCOLOGY PATIENT FIELD: <ret>

THEN PRINT FIELD: **<ret>**

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **TOBACCO HISTORY FOR 1999**
Replace

TOBACCO HISTORY FOR 1999

STORE PRINT LOGIC IN TEMPLATE: (Enter a print template name if you want to use this)

DEVICE: (Enter a device name)

"PATIENT<colon>" to jump to the Patient field in the Oncology Patient file.

If you want Alcohol or Family History of Cancer, enter either of them instead of Tobacco History. To return to the Oncology Patient file, enter "PATIENT<colon>" again.

If you want Alcohol or Family History of Cancer, enter either of them instead of Tobacco History.

TOBACCO HISTORY FOR 1999

ACCESSION YEAR: 1999
TOBACCO HISTORY: Never used
SUBCOUNT 78
TOBACCO HISTORY: Unknown
SUBCOUNT 226
TOBACCO HISTORY: Cigarette smoker, current
SUBCOUNT 394
SUBCOUNT 698
COUNT 698

With 226 cases with an Unknown tobacco history, it looks like tobacco history needs to be recorded better by the registrar or documented better by the physician.

Breakdown of Skin Cancer by Histology

This report may be helpful for those registries that collect all skin cancers and want to see a breakdown by histology.

Note: + is used on sort fields and ! on print fields to provide counts for those fields.

You can use field numbers instead of names as shown in the First Print Field below.

Annual Reports ...

Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

```
CREATE CUSTOM REPORT for PRIMARY file
Select File to Search: 1 PRIMARY
SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1999
GO TO ACCESSION YEAR: LAST// 1999
  WITHIN ACCESSION YEAR, SORT BY: SITE/GP
START WITH SITE/GP: FIRST// SKIN
GO TO SITE/GP: LAST// SKIN
  WITHIN SITE/GP, SORT BY: +HISTOLOGY
START WITH HISTOLOGY: FIRST// <ret>
  WITHIN HISTOLOGY, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !22 HISTOLOGY
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With
1999 SKIN CANCER BROKEN DOWN BY HISTOLOGY
DEVICE: <ret>
```

```
1999 SKIN CANCER BROKEN DOWN BY HISTOLOGY
```

```
-----
      ACCESSION YEAR: 1999
        SITE/GP: SKIN
          HISTOLOGY: BASAL CELL CA NOS
SUBCOUNT 147
          HISTOLOGY: MELANOMA IN GIANT NEVUS
SUBCOUNT  1
          HISTOLOGY: MELANOMA NOS
SUBCOUNT  4
          HISTOLOGY: MELANOMA NOS IN SITU
SUBCOUNT  3
          HISTOLOGY: MYCOSIS FUNGOIDES
SUBCOUNT  1
          HISTOLOGY: SQUAMOUS CELL CA IN SITU NOS
SUBCOUNT  8
          HISTOLOGY: SQUAMOUS CELL CARCINOMA NOS
SUBCOUNT 32
SUBCOUNT 196
```

Cancer Status of Living Patients

This report can be used as a QA monitor for recording the status of the patient's cancer when follow-up is done.

Note: + is used on sort fields and ! on print fields to provide counts for those fields.
You can use field numbers instead of names as shown in the "WITHIN STATUS, SORT BY" prompt below.
For the Status, type Alive as shown or the program won't recognize what you want. To get both Alive and Dead, hit <ret> at the "START WITH STATUS" PROMPT.

Annual Reports ... Print Custom Reports

```
Select one of the following:
    1      PRIMARY
    2      PATIENT
    3      CONTACT
Select File to Search: 1 PRIMARY
CREATE CUSTOM REPORT for PRIMARY file
```

```
SORT BY: NUMBER// +STATUS
START WITH STATUS: FIRST// Alive
GO TO STATUS: LAST// Alive
WITHIN STATUS, SORT BY: +95.1 V.STATUS/TUMOR STATUS
START WITH V.STATUS/TUMOR STATUS: FIRST// <ret>
WITHIN V.STATUS/TUMOR STATUS, SORT BY: <ret>
FIRST PRINT FIELD: !95.1 V.STATUS/TUMOR STATUS
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With FOLLOW-UP STATUS
Replace <ret>
FOLLOW-UP STATUS
START AT PAGE: 1// <ret>
DEVICE: (Enter a printer name)
```

FOLLOW-UP STATUS	APR 2,1999 13:44	PAGE 1
V.STATUS/TUMOR STATUS		

STATUS: Alive		
V.STATUS/TUMOR STATUS: Alive/CA-Evidence		
SUBCOUNT 682		
V.STATUS/TUMOR STATUS: Alive/NO-Evidence		
SUBCOUNT 2147		
V.STATUS/TUMOR STATUS: Alive/Unknown		
SUBCOUNT 152		
SUBCOUNT 2981		
COUNT 2981		

The fewer patients with Unknown tumor status the better.

Surgery of Primary Site

Use this report to get a list of all surgeries of a primary site.

Note: The example below is for Lung but you may select any Site/Gp for this sort.
+ is used on sort fields and ! on print fields to provide counts for those fields.
@ is used to suppress the sub-header caption and value since it will always be INTERNAL (SURGERY OF PRIMARY SITE).

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

```
SORT BY: NUMBER// ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1999
GO TO ACCESSION YEAR: LAST// 1999
WITHIN ACCESSION YEAR, SORT BY: +SITE/GP
START WITH SITE/GP: FIRST// LUNG
GO TO SITE/GP: LAST// LUNG
WITHIN SITE/GP, SORT BY: @+INTERNAL(SURGERY OF PRIMARY SITE)
START WITH INTERNAL(SURGERY OF PRIMARY SITE): FIRST// 10
GO TO INTERNAL(SURGERY OF PRIMARY SITE): LAST// 40
WITHIN INTERNAL(SURGERY OF PRIMARY SITE), SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: SURGERY OF PRIMARY SITE
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With SURGERY FOR LUNG
Replace <ret>
SURGERY FOR LUNG
START AT PAGE: 1// <ret>
DEVICE: (Enter a printer name)
```

ACC/SEQ NO.	SURGERY OF PRIMARY SITE

ACCESSION YEAR: 1999	
SITE/GP: LUNG	
1998-00038/00	30 Res of at least 1 lobe, < whole lung;part pneumonectomy, NOS
1998-00218/00	30 Res of at least 1 lobe, < whole lung;part pneumonectomy, NOS

SUBCOUNT 2	
1997-00046/02	31 Res at least 1 lobe, < whole lung; lobectomy
1998-00207/00	31 Res at least 1 lobe, < whole lung; lobectomy

SUBCOUNT 2	
1998-00344/02	32 Res at least 1 lobe, < whole lung; bilobectomy

SUBCOUNT 1	
1998-00432/00	40 Resection of whole lung

SUBCOUNT 1	
...	

All Head and Neck Including Larynx

This report gives you the stages of all head and neck cases including larynx.

Note: + is used on sort fields and ! on print fields to provide counts for those fields.

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// +ACCESSION YEAR

START WITH ACCESSION YEAR: FIRST// 1999

GO TO ACCESSION YEAR: LAST// 1999

WITHIN ACCESSION YEAR, **SORT BY: +SITE/GP**

START WITH SITE/GP: FIRST// (ICDO TOPOGRAPHY-CODE["C0"]!(ICDO TOPOGRAPHY-CODE[10]!(ICDO TOPOGRAPHY-CODE[11]!(ICDO TOPOGRAPHY-CODE[12]!(ICDO TOPOGRAPHY-CODE[13]!(ICDO TOPOGRAPHY-CODE[14]!(ICDO TOPOGRAPHY-CODE[32]);L1

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

By 'ICDO TOPOGRAPHY', do you mean ONCOLOGY PRIMARY 'ICDO TOPOGRAPHY-CODE'? Yes//
<ret> (Yes)

WITHIN (ICDO TOPOGRAPHY-CODE["C0"]!(ICDO TOPOGRAPHY-CODE[10]!(ICDO TOPOGRAPHY-CODE[11]!(ICDO TOPOGRAPHY-CODE[12]!(ICDO TOPOGRAPHY-CODE[13]!(ICDO TOPOGRAPHY-CODE[14]!(ICDO TOPOGRAPHY-CODE[32]), **SORT BY: AJCC STAGE**

START WITH AJCC STAGE: FIRST// <ret>

WITHIN AJCC STAGE, **SORT BY: <ret>**

STORE IN 'SORT' TEMPLATE: <ret>

FIRST PRINT FIELD: **!ACC/SEQ NO.**

THEN PRINT FIELD: **20;L20 ICDO-TOPOGRAPHY**

THEN PRINT FIELD: **AJCC STAGE**

THEN PRINT FIELD: <ret>

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **ALL HEAD AND NECK CASES FOR 1999 INCLUDING LARYNX WITH STAGE**

Replace <ret>

ALL HEAD AND NECK CASES FOR 1999 INCLUDING LARYNX WITH STAGE

STORE PRINT LOGIC IN TEMPLATE: <ret>

START AT PAGE: 1// <ret>

DEVICE: (Enter a printer name)

ALL HEAD AND NECK CASES FOR 1999 INCLUDING LARYNX WITH STAGE

MAY 19,1999 14:29 PAGE 1

ACC/SEQ NO.	ICDO-TOPOGRAPHY	AJCC STAGE

ACCESSION YEAR: 1998		
SITE/GP: LARYNX		
1998-00437/00	LARYNX, SUPRAGLOTTIS	IVC
1998-00370/00	LARYNX, GLOTTIS	I
1998-00439/00	LARYNX, GLOTTIS	I
1998-00146/00	LARYNX, SUPRAGLOTTIS	IE (A)
1998-00011/00	LARYNX, SUPRAGLOTTIS	I
1998-00417/00	LARYNX NOS	II

SUBCOUNT	6	
SITE/GP: LIP		
1998-00258/00	LIP, EXTERNAL LOWER	I

SUBCOUNT	1	
SITE/GP: ORAL CAVITY		
1994-00305/02	MOUTH FLOOR NOS	0
1998-00338/00	MOUTH, CHEEK MUCOSA	II

SUBCOUNT	2	
SITE/GP: OTHER/MISCELLANEOUS		
1998-00122/01	PAROTID GLAND	II

SUBCOUNT	1	
SITE/GP: PHARYNX		
1998-00131/00	NASOPHARYNX NOS	III
1998-00142/00	NASOPHARYNX NOS	III
1998-00192/00	TONSIL NOS	IVA
1998-00195/00	OROPHARYNX, POSTERIO	IVA
1998-00209/01	TONSIL OVERLAP	IVA
1998-00414/02	OROPHARYNX OVERLAP	IVA

SUBCOUNT	6	

COUNT	16	

Number of Cases Abstracted by Registry Staff

For registries with more than one person abstracting, this report may be useful to review workloads

Note: + is used on sort fields and ! on print fields to provide counts for those fields.

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

```
SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1999
GO TO ACCESSION YEAR: LAST// <ret>
  WITHIN ACCESSION YEAR, SORT BY: +ABSTRACTER
  START WITH ABSTRACTER: FIRST// <ret>
  WITHIN ABSTRACTER, SORT BY: <ret>
FIRST PRINT FIELD: !ABSTRACTER
THEN PRINT FIELD: <ret>
```

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **BREAKDOWN OF NUMBER OF CASES ABSTRACTED BY EACH PERSON IN THE REGISTRY IN 1999**

Replace

BREAKDOWN OF NUMBER OF CASES ABSTRACTED BY EACH PERSON IN THE REGISTRY IN 1999
DEVICE: <ret>

BREAKDOWN OF NUMBER OF CASES ABSTRACTED BY EACH PERSON IN THE REGISTRY IN 1999

MAY 20,1999 08:00 PAGE 1

ABSTRACTER

```
-----
  ACCESSION YEAR: 1999
    ABSTRACTER: SMITH,JOHN
SUBCOUNT 157
    ABSTRACTER: DOE,JANE
SUBCOUNT 55
COUNT    212
```



```

and ICDO HISTOLOGY-CODE NOT CONTAINS "8042/3"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8043/3"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8044/3"
and SURGERY OF PRIMARY SITE GREATER THAN 0
and CLASS NO. CONTAINS 1
OR: A&B&C&D&E&F&H Or SITE/GP CONTAINS "LUNG"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8041/3"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8042/3"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8043/3"
and ICDO HISTOLOGY-CODE NOT CONTAINS "8044/3"
and SURGERY OF PRIMARY SITE GREATER THAN 0
and CLASS NO. CONTAINS 2

OR: <ret>

STORE RESULTS OF SEARCH IN TEMPLATE: <ret>

SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1992
GO TO ACCESSION YEAR: LAST// 1994
  WITHIN ACCESSION YEAR, SORT BY: +AJCC STAGE
  START WITH AJCC STAGE: FIRST// <ret>
  WITHIN AJCC STAGE, SORT BY: HISTOLOGY
  START WITH HISTOLOGY: FIRST// <ret>
  WITHIN HISTOLOGY, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !PID##
THEN PRINT FIELD: ICDO-TOPOGRAPHY;"ICDO-TOP";L10
THEN PRINT FIELD: HISTOLOGY;"HIST";L10
THEN PRINT FIELD: TNM;L9
THEN PRINT FIELD: AJCC STAGE;L4;"AJCC"
THEN PRINT FIELD: SURGERY OF PRIMARY SITE;L2;"SURG"
  1 SURGERY OF PRIMARY SITE
  2 SURGERY OF PRIMARY SITE DATE
CHOOSE 1-2: 1 SURGERY OF PRIMARY SITE
THEN PRINT FIELD: <ret>

*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With NONSMALL LUNG OF CLASS OF
CASE 1 & 2 WITH SURGERY
  Replace <ret>
  NONSMALL LUNG OF CLASS OF CASE 1 & 2 WITH SURGERY
STORE PRINT LOGIC IN TEMPLATE: <ret>
DEVICE: (Enter printer name)

```

NONSMALL LUNG OF CLASS OF CASE 1 & 2 WITH SURGERY

MAY 20,1999 14:03 PAGE 1

PID#	ICDO-TOP	HIST	TNM	AJCC	SURG

ACCESSION YEAR:	1992				
M7666	LUNG, UP	ADENOCAR	T1 N0 M0	I	40
M3915	LUNG, UP	BRONCHIO	T2 N0 M0	I	30
R0195	LUNG, UP	SIGNET R	T2 N0 M0	I	40
C9552	LUNG, LO	SQUAMOUS	T2 N0 M0	I	40
S9121	LUNG, UP	SQUAMOUS	T2 N0 M0	I	30

SUBCOUNT	5				
W4347	LUNG, UP	ADENOCAR	T1 N1 M0	II	40
B8318	LUNG, UP	SQUAMOUS	T1 N1 M0	II	3

SUBCOUNT	2				
C4491	LUNG, UP	ADENOCAR	T3 N0 M0	IIIA	20
H0902	LUNG, UP	ADENOSQU	T3 N1 M0	IIIA	40

SUBCOUNT	2				
H6651	LUNG, MA	SQUAMOUS	T4 N1 M0	IIIB	50

SUBCOUNT	1				

SUBCOUNT	10				
ACCESSION YEAR:	1993				
K5246	LUNG, UP	ADENOCAR	T2 N0 M0	I	50
O6034	LUNG, LO	BRONCHIO	T1 N0 M0	I	20
P4988	LUNG, LO	CARCINOM	T2 N0 M0	I	30
M3430	LUNG, UP	CLEAR CE	T1 N0 M0	I	20
S9345	LUNG, LO	MUCIN-PR	T1 N0 M0	I	40
J7897	LUNG, LO	NEUROEND	T2 N0 M0	I	30
W7014	LUNG, OV	SQUAMOUS	T2 N0 M0	I	40

SUBCOUNT	7				
P6465	LUNG, UP	ADENOCAR	T2 N1 M0	II	40
A7100	LUNG, UP	ADENOCAR	T2 N1 M0	II	40
W9867	LUNG, UP	SQUAMOUS	T2 N1 M0	II	50

SUBCOUNT	3				
L1552	LUNG, MA	SQUAMOUS	T3 N0 M0	IIIA	20

SUBCOUNT	1				
S3646	LUNG, UP	LARGE CE	T4 N0 M0	IIIB	40

SUBCOUNT	1				
Y0245	LUNG, UP	ADENOSQU	TX NX M1	IV	80

SUBCOUNT	1				

SUBCOUNT	14				
ACCESSION YEAR:	1994				
W2708	LUNG, UP	ADENOCAR	T1 N0 M0	I	20
M8964	LUNG, UP	NEUROEND	T2 N0 M0	I	40
K3369	LUNG, LO	PAPILLAR	T2 N0 M0	I	40
C7205	LUNG, UP	SQUAMOUS	T2 N0 M0	I	40

SUBCOUNT	4				
W2613	LUNG, UP	ADENOCAR	T2 N1 M0	II	40
R6997	LUNG, UP	SQUAMOUS	T2 N1 M0	II	40

SUBCOUNT	2				
C9452	LUNG, UP	LARGE CE		III	30

SUBCOUNT	1				
T9817	LUNG, UP	ADENOCAR	T3 N0 M0	IIIA	20
D7780	LUNG, UP	SQUAMOUS	T3 N0 M0	IIIA	40

SUBCOUNT	2				

SUBCOUNT	9				

COUNT	33				

Specific Site and Specific AJCC Stage

This report is helpful when a physician wants to know how many Stage II Lung Cancers were seen in 1994.

Note: You can substitute any site or any stage.

+ is used on sort fields and ! on print fields to provide counts for those fields.

Use Roman Numerals for the stage and be sure to use the B or C if the stage for the site is divided.

Use of the ;L limits the length of the data to save space.

Annual Reports ...

Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// +SITE/GP

START WITH SITE/GP: FIRST// LUNG

GO TO SITE/GP: LAST// LUNG

WITHIN SITE/GP, SORT BY: ACCESSION YEAR

START WITH ACCESSION YEAR: FIRST// 1994

GO TO ACCESSION YEAR: LAST// 1994

WITHIN ACCESSION YEAR, SORT BY: AJCC STAGE

START WITH AJCC STAGE: FIRST// II

GO TO AJCC STAGE: LAST// IIB

WITHIN AJCC STAGE, SORT BY:

STORE IN 'SORT' TEMPLATE: <ret>

FIRST PRINT FIELD: !ACC/SEQ NO.

THEN PRINT FIELD: TNM;L10

THEN PRINT FIELD: ICDO-TOPOGRAPHY;L10

THEN PRINT FIELD: HISTOLOGY;L10

THEN PRINT FIELD: TREATMENT;L10

THEN PRINT FIELD: <ret>

**Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With 1994 STAGE II LUNG
CANCER**

Replace <ret>

1994 STAGE II LUNG CANCER

STORE PRINT LOGIC IN TEMPLATE: <ret>

START AT PAGE: 1// <ret>

DEVICE: (Enter a printer name)

...EXCUSE ME, HOLD ON...

ACC/SEQ NO.	TNM	ICDO-TOPOGRAPHY	HISTOLOGY	TREATMENT

SITE/GP: LUNG				
ACCESSION YEAR: 1994				
AJCC STAGE: IIB				
1994-00093/00	T2 N1 M0	LUNG, LOWE	BRONCHIOL	SUR
1994-00145/01	T2 N1 M0	LUNG, UPPE	ADENOCARCI	SUR
1994-00284/00	T2 N1 M0	LUNG, UPPE	SQUAMOUS C	SUR

SUBCOUNT	3			

COUNT	3			

Specific T-Code

Use this report to show the number of cases that were T4, their histologies, and the treatment they received.

Note: You may use any site or you can also choose to search for a specific N-Code or M-Code.
+ is used on sort fields and ! on print fields to provide counts for those fields.
Class Category is case sensitive so be sure to type Analytic as you see it.

Statistical Reports ... Define Search Criteria

```
Select one of the following:
  1      PRIMARY
  2      PATIENT
  3      CONTACT
Select File to Search: 1 PRIMARY
We will search entries in PRIMARY file...

-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: SITE/GP
-A- CONDITION: CONTAINS
-A- CONTAINS: LUNG

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: T-CODE
-B- CONDITION: CONTAINS
-B- CONTAINS: 4

-C- SEARCH FOR ONCOLOGY PRIMARY FIELD: CLASS CATEGORY
-C- CONDITION: EQUALS
-C- EQUALS: Analytic

-D- SEARCH FOR ONCOLOGY PRIMARY FIELD: <ret>

IF: A&B&C    SITE/GP CONTAINS "LUNG"    and T-CODE CONTAINS 4
           and CLASS CATEGORY EQUALS 1 (Analytic)
OR: <ret>
STORE RESULTS OF SEARCH IN TEMPLATE: <ret>

SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST//1994
GO TO ACCESSION YEAR: LAST// 1994
  WITHIN ACCESSION YEAR, SORT BY: +HISTOLOGY
    START WITH HISTOLOGY: FIRST// <ret>
      WITHIN HISTOLOGY, SORT BY: TREATMENT
        START WITH TREATMENT: FIRST// <ret>
          WITHIN TREATMENT, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: TNM
THEN PRINT FIELD: AJCC STAGE
THEN PRINT FIELD: TREATMENT
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS  Replace ... With 1994 ANALYTIC T4 LUNG
CASES BY HISTOLOGY SHOWING TREATMENT.
  Replace <ret>
1994 ANALYTIC T4 LUNG CASES BY HISTOLOGY SHOWING TREATMENT.
STORE PRINT LOGIC IN TEMPLATE: <ret>
DEVICE: (Enter printer name)
```

1994 ANALYTIC T4 LUNG CASES BY HISTOLOGY SHOWING TREATMENT.

ACC/SEQ NO.	TNM	AJCC STAGE	TREATMENT

ACCESSION YEAR: 1994			
HISTOLOGY: ADENOCARCINOMA NOS			
1994-00397/00	T4 N2 M1	IV	CMX
1994-00176/00	T4 NX M1	IV	NONE
1986-00663/03	T4 NX M1	IV	NONE
1994-00004/00	T4 N0 M0	IIIB	XRT
1994-00117/00	T4 N0 M0	IIIB	XRT
1994-00200/00	T4 N0 M0	IIIB	XRT
1994-00393/00	T4 N2 M1	IV	XRT

SUBCOUNT	7		
HISTOLOGY: SMALL CELL CARCINOMA NOS			
1994-00058/00	T4 N2 M1	IV	CMX
1994-00223/00	T4 N3 M1	IV	CMX
1994-00485/00	T4 N2 M1	IV	CMX
1994-00026/00	T4 N1 M0	IIIB	CMX/XRT
1994-00277/00	T4 N1 M0	IIIB	CMX/XRT
1994-00417/00	T4 N3 M0	IIIB	CMX/XRT

SUBCOUNT	6		
HISTOLOGY: SQUAMOUS CA, KERATINIZING NOS			
1994-00123/00	T4 N2 M1	IV	CMX

SUBCOUNT	1		
HISTOLOGY: SQUAMOUS CELL CARCINOMA NOS			
1994-00161/00	T4 N2 M1	IV	CMX/XRT
1994-00539/00	T4 N3 M1	IV	CNS/XRT
1994-00144/00	T4 N2 M0	IIIB	NONE
1994-00027/02	T4 N1 M0	IIIB	SUR
1994-00440/00	T4 NX M1	IV	XRT
SUBCOUNT	5		

SUBCOUNT	19		

COUNT	19		

Head and Neck Cases with Lymph Node Involvement

This sort will cover a range of head and neck sites which have regional nodes involved.

Note: Class Category is case sensitive so be sure to type Analytic as you see it.
+ is used on sort fields and ! on print fields to provide counts for those fields.
Use of the @ sign suppresses the sub-header.
Be sure to type the C with the topography code.

Annual Reports ... Print Custom Reports

```
Select one of the following:
  1      PRIMARY
  2      PATIENT
  3      CONTACT
Select File to Search: 1 PRIMARY
```

```
SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1999
GO TO ACCESSION YEAR: LAST// 1999
  WITHIN ACCESSION YEAR, SORT BY: CLASS CATEGORY
  START WITH CLASS CATEGORY: FIRST// Analytic    USES INTERNAL CODE: 1
  GO TO CLASS CATEGORY: LAST// Analytic    USES INTERNAL CODE: 1
  WITHIN CLASS CATEGORY, SORT BY: @ICDO TOPOGRAPHY-CODE
  START WITH ICDO TOPOGRAPHY-CODE: FIRST// C00.0
  GO TO ICDO TOPOGRAPHY-CODE: LAST// C14.9
  WITHIN ICDO TOPOGRAPHY-CODE, SORT BY: @37.2 CLINICAL N
  START WITH CLINICAL N: FIRST// N1
  GO TO CLINICAL N: LAST// <ret>
  WITHIN CLINICAL N, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: ICDO-TOPOGRAPHY
THEN PRINT FIELD: TNM
THEN PRINT FIELD: <ret>
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With 1999 ANALYTIC HEAD
AND NECK CASES (EXCLUDING LARYNX) WITH LYMPH NODE INVOLVEMENT
  Replace <ret>
  1999 ANALYTIC HEAD AND NECK CASES (EXCLUDING LARYNX) WITH LYMPH NODE INVOLVEMENT
START AT PAGE: 1// <ret>
DEVICE: (Enter printer name)
```

1999 ANALYTIC HEAD AND NECK CASES (EXCLUDING LARYNX) WITH LYMPH NODE INVOLVEMENT

ACC/SEQ NO.	ICDO-TOPOGRAPHY	TNM

ACCESSION YEAR: 95		
CLASS CATEGORY: Analytic		
1995-00207/00	TONGUE BASE	T1 N2C M0
1995-00158/00	TONGUE, ANTERIOR 2/3 NOS	T2 N1 M0
1995-00099/00	TONSILLAR PILLAR	T4 N3 M0
1995-00027/00	OROPHARYNX NOS	T2 N2B M0
1995-00098/00	NASOPHARYNX NOS	T4 N1 M0
1995-00047/00	NASOPHARYNX NOS	T4 N3 M1
1995-00033/00	PYRIFORM SINUS	T4 N3 M0

COUNT	7	

QA of In-Situ Cases

This report may be used to QA the T-code, Summary stage and Extension of cases where the 5th digit in the 6 character code (e.g., 8010/2) is 2 (In-Situ) .

Note: + is used on sort fields and ! on print fields to provide counts for those fields.

Dollar Extract (\$E) is used in the sort to find all those ICDO Histology codes with a 2 as the 6th character. If you type =6 instead of =2, you could check for any metastatic behavior codes which registries **DO NOT USE**.

To keep the length of the printed data short, the ;L qualifier is used.

To shorten the column header names, the "xxx" qualifier is used.

Annual Reports ...

Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

```
SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1994
GO TO ACCESSION YEAR: LAST// 1994
  WITHIN ACCESSION YEAR, SORT BY: +$E(#22.1,6)=2
    WITHIN $E(#22.1,6)=2, SORT BY: +SITE/GP
      START WITH SITE/GP: FIRST// <ret>
        WITHIN SITE/GP, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: ICDO HISTOLOGY-CODE;"ICDO HIST-CODE";L10
THEN PRINT FIELD: HISTOLOGY;L20
THEN PRINT FIELD: EXTENSION;"EXT";L2
  1 EXTENSION
  2 EXTENSION LIST USED
CHOOSE 1-2: 1 EXTENSION
THEN PRINT FIELD: SUMMARY STAGE;"SUM";L3
THEN PRINT FIELD: T-CODE
THEN PRINT FIELD: <ret>
```

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With IN-SITU CASES IN 1994

Replace <ret>

IN-SITU CASES IN 1994

STORE PRINT LOGIC IN TEMPLATE: <ret>

START AT PAGE: 1// <ret>

DEVICE: (Enter a printer name)

IN-SITU CASES IN 1994		MAY 20,1999 10:26		PAGE 1		
ACC/SEQ NO.	ICDO HIST-CODE	HISTOLOGY	EXT	SUM	T-CODE	

ACCESSION YEAR: 1994						
SITE/GP: BLADDER						
1994-00102/02	8010/2	CARCINOMA-IN-SITU, N	0	In	Tis	
1994-00187/02	8120/2	TRANSITIONAL CELL CA	0	In	Tis	
1994-00253/01	8130/2	TRANSITIONAL CELL CA	5	In	Ta	

SUBCOUNT	3					
SITE/GP: CERVIX						
1994-00167/00	8010/2	CARCINOMA-IN-SITU, N	0	In	Tis	

SUBCOUNT	1					
SITE/GP: ORAL CAVITY						
1994-00203/00	8070/2	SQUAMOUS CELL CA IN	10	In	T1	

SUBCOUNT	1					

COUNT	5					

Notice anything wrong with the last case?

5th Digit Behavior Codes of 0 or 1

This report may be used for QA of properly coded sequence numbers for cases with a 5th digit (6th character) morphology code of 0 or 1. Cases entered into the registry that have a 5th digit morphology code (behavior code) may be collected by some registries, however these cases should have a sequence letter rather than a sequence number.

Note: + is used on sort fields and ! on print fields to provide counts for those fields.
Dollar Extract (\$E) is used in the sort to find all those ICDO Histology codes with a 2 as the 6th character. If you type =6 instead of =2, you could check for any metastatic behavior codes which registries **DO NOT USE**.
The ! used between the two \$E statements is an OR relationship.
To obtain a separate page for codes 0 and 1, the # sort qualifier is used (e.g., # $\$E(\#22.1,6)$)
To keep the length of the printed data short, the ;L qualifier is used.
To shorten a column header name, the "xxx" qualifier is used.

Annual Reports ... Print Custom Reports

```
Select one of the following:
  1      PRIMARY
  2      PATIENT
  3      CONTACT
Select File to Search: 1 PRIMARY
CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// + $\$E(\#22.1,6)=1!(\$E(\#22.1,6)=0)$ 
  WITHIN  $\$E(\#22.1,6)=1!(\$E(\#22.1,6)=0)$ , SORT BY: # $\$E(\#22.1,6)$ 
  START WITH  $\$E(\#22.1,6)$ : FIRST// <ret>
  WITHIN  $\$E(\#22.1,6)$ , SORT BY: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: PID#
THEN PRINT FIELD: ICDO HISTOLOGY-CODE;"ICDO HIST-CODE";L10
THEN PRINT FIELD: HISTOLOGY;L20
THEN PRINT FIELD: <ret>

*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS  Replace ... With QA OF 5TH DIGIT HISTOLOGY
CODE
  Replace <ret>
  QA OF 5TH DIGIT HISTOLOGY CODE
STORE PRINT LOGIC IN TEMPLATE: <ret>
START AT PAGE: 1// <ret>
DEVICE: (Enter printer name)
```

QA OF 5TH DIGIT HISTOLOGY CODE		MAY 20,1999 10:49		PAGE 1
ACC/SEQ NO.	PID#	ICDO HIST-CODE	HISTOLOGY	

\$(#22.1,6): 0				
1988-00236/XX	M3915	8053/0	INVERTED PAPILLOMA	
1982-00117/02	M6178	8700/0	PHEOCHROMOCYTOMA NOS	
1984-00305/XX	C0088	9530/0	MENINGIOMA NOS	
1988-00083/XX	W0925	8140/0	ADENOMA NOS	

QA OF 5TH DIGIT HISTOLOGY CODE		MAY 20,1999 10:49		PAGE 2
ACC/SEQ NO.	PID#	ICDO HIST-CODE	HISTOLOGY	

\$(#22.1,6): 1				
1986-00186/XX	D7639	8120/1	POLYCYTHEMIA VERA	
1989-00492/AA	C8827	9960/1	CHRONIC MYELOPROLIF DISEASE	
1989-00492/BB	R8337	9980/1	REFRACTORY ANEMIA, NOS	
1995-00236/XX	P5224	9989/1	MYELOYDYSPLASTIC SYNDROME,	

SUBCOUNT	8			

COUNT	8			

82-0117/02 needs to be changed from sequence 02 to LETTER sequence.

Living Patients Who Have Mets (Search)

This is a search that will find all living patients with metastasis.

Statistical Reports ... Define Search Criteria

```
Select one of the following:
  1          PRIMARY
  2          PATIENT
  3          CONTACT
Select File to Search: 1  PRIMARY
```

We will search entries in PRIMARY file...

```
-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: METASTASIS 1
-A- CONDITION: GREATER THAN
-A- GREATER THAN: 0
  [ WILL APPLY TO: '0' (None), '1' (Peritoneum), '2' (Lung),
  '3' (Pleura), '4' (Liver), '5' (Bone),
  '6' (Central nervous system), '7' (Skin),
  '8' (Lymph nodes (distant)), AND '9' (Other/Gen/Carcinomatosis/Unkn) ]

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: METASTASIS 1
-B- CONDITION: -NULL

-C- SEARCH FOR ONCOLOGY PRIMARY FIELD: DISTANT SITE 1
-C- CONDITION: -CONTAINS
-C- NOT CONTAINS: None
  [ WILL APPLY TO: '0' (None), '1' (Peritoneum), '2' (Lung),
  '3' (Pleura), '4' (Liver), '5' (Bone),
  '6' (Central Nervous System), '7' (Skin),
  '8' (Lymph Nodes (Distant)), AND '9' (Other/Generalized/NOS) ]

-D- SEARCH FOR ONCOLOGY PRIMARY FIELD: DISTANT SITE 1
-D- CONDITION: -NULL

-E- SEARCH FOR ONCOLOGY PRIMARY FIELD: <ret>
```

```
IF: A&B    METASTASIS 1 GREATER THAN 0    and METASTASIS 1 NOT NULL
OR: C&D    Or DISTANT SITE 1 NOT CONTAINS "None"
           and DISTANT SITE 1 NOT NULL
OR: <ret>
```

STORE RESULTS OF SEARCH IN TEMPLATE: <ret>

```
SORT BY: NUMBER// +STATUS
START WITH STATUS: FIRST// Alive
GO TO STATUS: LAST// Alive
  WITHIN STATUS, SORT BY: <ret>
FIRST PRINT FIELD: !ACC/SEQ NO.
THEN PRINT FIELD: 34 METASTASIS 1
THEN PRINT FIELD: 71.1 DISTANT SITE 1
THEN PRINT FIELD: <ret>
```

```
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS  Replace ... With LIVING PATIENTS WITH METS
  Replace <ret>
  LIVING PATIENTS WITH METS
START AT PAGE: 1// <ret>
DEVICE: (Enter printer name)
```

LIVING PATIENTS WITH METS.

ACC/SEQ NO.	METASTASIS 1	DISTANT SITE 1

STATUS: Alive		
1991-00241/02	OTHER/Gen/Carcinamatosi/Unkn	
1992-00045/00	NONE	Lung
1992-00026/00	LYMPH NODES (Distant)	
1992-00048/01	NONE	Bone
1992-00049/02	OTHER/Gen/Carcinamatosi/Unkn	
1992-00058/01	NONE	Lymph Nodes (Distant)
1991-00361/01	OTHER/Gen/Carcinamatosi/Unkn	
1988-00127/02	NONE	Lung
1992-00069/01	BONE	Bone
1992-00072/03	OTHER/Gen/Carcinamatosi/Unkn	
1992-00074/00	OTHER/Gen/Carcinamatosi/Unkn	None
1992-00083/01	BONE	
1991-00393/00	OTHER/Gen/Carcinamatosi/Unkn	
1992-00121/00	NONE	Other/Generalized/NOS
1967-00353/02	NONE	Bone
1972-00203/00	NONE	Lung
1974-00285/02	LIVER	

Count	19	

Living Patients Who Have Mets (Sort)

This sort finds the same data as the search in the previous chapter.

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// **+STATUS**

START WITH STATUS: FIRST// **Alive**

GO TO STATUS: LAST// **Alive**

WITHIN STATUS, SORT BY: **INTERNAL(METASTASIS 1)>0!(INTERNAL(DISTANT SITE 1)>0)**

WITHIN INTERNAL(METASTASIS 1)>0!(INTERNAL(DISTANT SITE 1)>0), SORT BY: **<ret>**

STORE IN 'SORT' TEMPLATE: **<ret>**

FIRST PRINT FIELD: **!ACC/SEQ NO.**

THEN PRINT FIELD: **METASTASIS 1**

THEN PRINT FIELD: **DISTANT SITE 1**

THEN PRINT FIELD: **<ret>**

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **LIVING PATIENTS WITH METS**

Replace **<ret>**

LIVING PATIENTS WITH METS

START AT PAGE: 1// **<ret>**

DEVICE: (Enter printer name)

ACC/SEQ NO.	METASTASIS 1	DISTANT SITE 1

STATUS: Alive		
1991-00241/02	OTHER/Gen/Carcinamatosi/Unkn	
1992-00045/00	NONE	Lung
1992-00026/00	LYMPH NODES (Distant)	
1992-00048/01	NONE	Bone
1992-00049/02	OTHER/Gen/Carcinamatosi/Unkn	
1992-00058/01	NONE	Lymph Nodes (Distant)
1991-00361/01	OTHER/Gen/Carcinamatosi/Unkn	
1988-00127/02	NONE	Lung
1992-00069/01	BONE	Bone
1992-00072/03	OTHER/Gen/Carcinamatosi/Unkn	
1992-00074/00	OTHER/Gen/Carcinamatosi/Unkn	None
1992-00083/01	BONE	
1991-00393/00	OTHER/Gen/Carcinamatosi/Unkn	
1992-00121/00	NONE	Other/Generalized/NOS
1967-00353/02	NONE	Bone
1972-00203/00	NONE	Lung
1974-00285/02	LIVER	

SUBCOUNT	19	

COUNT	19	

Cases that Did Not Get TNM Staging

Use this report to do a QA check that all TNM fields have been filled in for sites which require them.

Statistical Reports ... Define Search Criteria

```
      Select one of the following:
          1      PRIMARY
          2      PATIENT
          3      CONTACT
      Select File to Search: 1 PRIMARY
We will search entries in PRIMARY file...

-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: TNM
-A- CONDITION: NULL

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: <ret>

IF: A// <ret>      TNM NULL

STORE RESULTS OF SEARCH IN TEMPLATE: <ret>

SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// <ret>
  WITHIN ACCESSION YEAR, SORT BY: +SITE/GP
    START WITH SITE/GP: FIRST// <ret>
      WITHIN SITE/GP, SORT BY: <ret>
FIRST PRINT FIELD: !PID##
THEN PRINT FIELD: PATIENT NAME;L15
THEN PRINT FIELD: 20;L12;"TOPOGRAPHY"  ICDO-TOPOGRAPHY
THEN PRINT FIELD: 22;L15  HISTOLOGY
THEN PRINT FIELD: ABSTRACT STATUS;L1;"STATUS"
THEN PRINT FIELD: <ret>

*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS  Replace ... With 1994 CASES WITH NULL TNM
FIELDS
  Replace <ret>
    1994 CASES WITH NULL TNM FIELDS
STORE PRINT LOGIC IN TEMPLATE: <ret>
DEVICE: <ret>
```

1994 CASES WITH NULL TNM FIELDS			MAY 21, 1999 10:58		PAGE 1
PID#	PATIENT NAME	TOPOGRAPHY	HISTOLOGY	STATUS	

ACCESSION YEAR: 1994					
SITE/GP: BONE					
E6662	EEEEEEE, ERIC	BONES NOS	CHORDOMA	I	

SUBCOUNT	1				
SITE/GP: BREAST					
G9201	GGGGG, ZSA	SKIN, TRUNK	BOWEN'S DISEASE	C	

SUBCOUNT	1				
SITE/GP: CERVIX					
E5915	EEEE, BARBARA	CERVIX, ENDO		I	

SUBCOUNT	1				
SITE/GP: COLON					
S0415	SCCCCCCCCCCCC,	COLON, TRANS	ADENOCARCINOMA	I	
J9513	JAAAAAA, MICHEAL	COLON, CECUM	ADENOCARCINOMA	C	
D2389	DEEEEEEE, ELWOOD			I	
E6662	EEEEEEE, ERIC	PENIS, PREPU	CARCINOMA, UNDI	I	

SUBCOUNT	4				

Remember that leukemia and lymphoma do not have TNM.

Female Patients (Search)

Use this search to find the number of female patients by site in your registry.

Statistical Reports ... Define Search Criteria

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: **1** PRIMARY
We will search entries in PRIMARY file...

-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: **SEX**
-A- CONDITION: **CONTAINS**
-A- CONTAINS: **F**

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD:

IF: A// SEX CONTAINS "F"

STORE RESULTS OF SEARCH IN TEMPLATE:

SORT BY: NUMBER// **+SITE/GP**
START WITH SITE/GP: FIRST//
WITHIN SITE/GP, SORT BY:
FIRST PRINT FIELD: **!SITE/GP**
THEN PRINT FIELD:

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... WITH **NUMBER OF FEMALES IN THE REGISTRY, BROKEN DOWN BY SITE**

Replace **<ret>**

NUMBER OF FEMALES IN THE REGISTRY, BROKEN DOWN BY SITE
DEVICE: (Enter a printer name)

NUMBER OF FEMALES IN THE REGISTRY, BROKEN DOWN BY SITE		MAY 21,1999	11:16	PAGE 1
SITE/GP				

SEX: FEMALE				
SITE/GP: BLADDER				
SUBCOUNT	1			
SITE/GP: BONE				
SUBCOUNT	1			
SITE/GP: BRAIN				
SUBCOUNT	1			
SITE/GP: BREAST				
SUBCOUNT	29			
SITE/GP: CERVIX				
SUBCOUNT	10			
SITE/GP: COLON				
SUBCOUNT	11			

COUNT	53			

Female Patients (Sort)

Instead of using the search functionality, you can use this sort to find the number of female patients by site in your registry.

Annual Reports ... Print Custom Reports

```
Select one of the following:
  1      PRIMARY
  2      PATIENT
  3      CONTACT
Select File to Search: 1  PRIMARY
```

```
SORT BY: NUMBER// SEX
START WITH SEX: FIRST// FEMALE
GO TO SEX: LAST// FEMALE
  WITHIN SEX, SORT BY: +SITE/GP
  START WITH SITE/GP: FIRST// <ret>
  WITHIN SITE/GP, SORT BY: <ret>
FIRST PRINT FIELD: !SITE/GP
THEN PRINT FIELD: <ret>
```

```
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS  Replace ... With NUMBER OF FEMALES IN THE
REGISTRY, BROKEN DOWN BY SITE
Replace <ret>
  NUMBER OF FEMALES IN THE REGISTRY, BROKEN DOWN BY SITE
DEVICE: (Enter a printer name)
```

NUMBER OF FEMALES IN THE REGISTRY, BROKEN DOWN BY SITE		MAY 21,1999	11:16	PAGE 1
SITE/GP		-----		
SEX: FEMALE				
SITE/GP: BLADDER				
SUBCOUNT	1			
SITE/GP: BONE				
SUBCOUNT	1			
SITE/GP: BRAIN				
SUBCOUNT	1			
SITE/GP: BREAST				
SUBCOUNT	29			
SITE/GP: CERVIX				
SUBCOUNT	10			
SITE/GP: COLON				
SUBCOUNT	11			

COUNT	53			

Age Sort (10 Year Increments)

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// +ACCESSION YEAR

START WITH ACCESSION YEAR: FIRST// 1999

GO TO ACCESSION YEAR: LAST// 1999

WITHIN ACCESSION YEAR, SORT BY: +AGE\10+1*10;"AGE UP TO:"

By 'AGE', do you mean ONCOLOGY PRIMARY 'AGE AT DX'? Yes// <ret>

START WITH AGE UP TO: FIRST// <ret>

WITHIN AGE UP TO, SORT BY: <ret>

FIRST PRINT FIELD: !AGE AT DX

THEN PRINT FIELD: <ret>

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With 1999 CASES AGE AT
DIAGNOSIS

Replace <ret>

1999 CASES AGE AT DIAGNOSIS

START AT PAGE: 1// <ret>

DEVICE: (Enter printer name)

1999 CASES AGE AT DIAGNOSIS

AGE

AT

DX

ACCESSION YEAR: 1999

AGE UP TO:30

SUBCOUNT 2

AGE UP TO:40

SUBCOUNT 4

AGE UP TO:50

SUBCOUNT 33

AGE UP TO:60

SUBCOUNT 58

AGE UP TO:70

SUBCOUNT 227

AGE UP TO:80

SUBCOUNT 334

AGE UP TO:90

SUBCOUNT 50

AGE UP TO:100

SUBCOUNT 1

SUBCOUNT 709

COUNT 709

Age Sort (5 Year Increments)

Annual Reports ... Print Custom Reports

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

CREATE CUSTOM REPORT for PRIMARY file

SORT BY: NUMBER// +ACCESSION YEAR

START WITH ACCESSION YEAR: FIRST// 1997

GO TO ACCESSION YEAR: LAST// 1997

WITHIN ACCESSION YEAR, SORT BY +AGE\5+1*5;"AGE UP TO:"

By 'AGE', do you mean ONCOLOGY PRIMARY 'AGE AT DX'? Yes// <ret> (Yes)

START WITH AGE UP TO: FIRST// <ret>

WITHIN AGE UP TO, SORT BY: <ret>

FIRST PRINT FIELD: !AGE AT DX

THEN PRINT FIELD: <ret>

Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With **5 YEAR BREAKDOWN**

Replace <ret>

5 YEAR BREAKDOWN

DEVICE: (Enter printer name)

5 YEAR BREAKDOWN

AGE

AT

DX

ACCESSION YEAR: 1997

AGE UP TO:35

SUBCOUNT 4

AGE UP TO:45

SUBCOUNT 5

AGE UP TO:50

SUBCOUNT 10

AGE UP TO:55

SUBCOUNT 6

AGE UP TO:60

SUBCOUNT 11

AGE UP TO:65

SUBCOUNT 34

AGE UP TO:70

SUBCOUNT 47

AGE UP TO:75

SUBCOUNT 91

AGE UP TO:80

SUBCOUNT 46

AGE UP TO:85

SUBCOUNT 11

AGE UP TO:90

SUBCOUNT 9

COUNT 274

QA - Lung (Left) Middle Lobe

Statistical Reports ... Define Search Criteria

Select one of the following:

- 1 PRIMARY
- 2 PATIENT
- 3 CONTACT

Select File to Search: 1 PRIMARY

We will search entries in PRIMARY file...

-A- SEARCH FOR ONCOLOGY PRIMARY FIELD: **ICDO-TOPOGRAPHY**
-A- CONDITION: **CONTAINS**
-A- CONTAINS: **MIDDLE**

-B- SEARCH FOR ONCOLOGY PRIMARY FIELD: <ret>

IF: A// ICDO-TOPOGRAPHY CONTAINS "MIDDLE"

STORE RESULTS OF SEARCH IN TEMPLATE: <ret>

SORT BY: NUMBER// **SITE/GP**
START WITH SITE/GP: FIRST// **LUNG**
GO TO SITE/GP: LAST// **LUNG**
WITHIN SITE/GP, SORT BY: **LATERALITY**
START WITH LATERALITY: FIRST// 2 Left (origin of primary)
GO TO LATERALITY: LAST// 2 Left (origin of primary)
WITHIN LATERALITY, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: **PID#**
THEN PRINT FIELD: <ret>

Heading (S/C): ONCOLOGY PRIMARY SEARCH Replace ... With **QA LUNG-LEFT MIDDLE LOBE**
Replace <ret>
QA LUNG-LEFT MIDDLE LOBE
START AT PAGE: 1// <ret>
DEVICE: (Enter printer name)

QA LUNG-LEFT MIDDLE LOBE	MAY 21,1999	13:41	PAGE 1
PID#			

SITE/GP: LUNG			
LATERALITY: Left (origin of primary)			
H9999			

One patient to review - left lung does not have a middle lobe.

Histology Sort

A physician wants to find out how many patients who were diagnosed in 1998 with lymphoma are alive. You need a range of histology codes to do so.

Note: When sorting by a specific Class Category, use the numeric value or upper and lower case (e.g., either 1 or Analytic)
The @ sign is used to suppress printing of the sub-header for the field (see @ICDO Histology-Code below)
When typing in Histology codes, be sure to use the / as part of the code.

Annual Reports ... Print Custom Reports

Select one of the following:

1	PRIMARY
2	PATIENT
3	CONTACT

Select File to Search: 1 PRIMARY
CREATE CUSTOM REPORT for PRIMARY file

```
SORT BY: NUMBER// +ACCESSION YEAR
START WITH ACCESSION YEAR: FIRST// 1998
GO TO ACCESSION YEAR: LAST// 1998
WITHIN ACCESSION YEAR, SORT BY: CLASS CATEGORY
START WITH CLASS CATEGORY: FIRST// 1
GO TO CLASS CATEGORY: LAST// 1 Analytic
WITHIN CLASS CATEGORY, SORT BY: STATUS
START WITH STATUS: FIRST// Alive
GO TO STATUS: LAST// Alive
WITHIN STATUS, SORT BY: @ICDO HISTOLOGY-CODE
START WITH ICDO HISTOLOGY-CODE: FIRST// 9590/3
GO TO ICDO HISTOLOGY-CODE: LAST// 9723/3
WITHIN ICDO HISTOLOGY-CODE, SORT BY: <ret>
STORE IN 'SORT' TEMPLATE: <ret>
FIRST PRINT FIELD: !ACC//SEQ NO.
THEN PRINT FIELD: HISTOLOGY
THEN PRINT FIELD: <ret>
```

```
*****
Heading (S/C): ONCOLOGY PRIMARY STATISTICS Replace ... With 1998 LYMPHOMA
1998 LYMPHOMA
START AT PAGE: 1// <ret>
DEVICE: (Enter printer name)
```

1998 LYMPHOMA

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ACC/SEQ
NO. HISTOLOGY

ACCESSION YEAR: 1998
CLASS CATEGORY: Analytic
STATUS: Alive
1994-00377/00 HODGKIN'S MIXED CELL.
1994-00538/00 LYMPHOMA, SM LYMPHOCYTIC NOS
1994-00549/00 LYMPHOMA, SM LYMPHOCYTIC NOS

(if you had not used the @ your results would look like this)

ICDO HISTOLOGY-CODE: 9685/3
1994-00540/00 MALIG LYMPHOMA LYMPHOBLASTIC
ICDO HISTOLOGY-CODE: 9714/3
1994-00041/00 LARGE CELL LYMPHOMA

SUBCOUNT 5

COUNT 5

