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Section 1:

Core Instructions for Reporting Facilities
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</table>
## Oklahoma Central Cancer Registry (OCCR) Staff

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Title</th>
<th>Email Address</th>
<th>(405) 271-9444 Extension</th>
</tr>
</thead>
<tbody>
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<td>Facility Consultant</td>
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<td>57108</td>
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<td>Data Manager</td>
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<td>57121</td>
</tr>
</tbody>
</table>
Electronic Coding Manuals/Databases

Facility Oncology Registry Data Standards (FORDS) Manual (Instructions for coding OCCR required fields)
https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual

Multiple Primary/Histology Coding Manual

Hematopoietic Database (Use for coding leukemia and lymphoma)
http://seer.cancer.gov/seertools/hemelymph/

SEER Rx-Interactive Antineoplastic Drugs Database
http://seer.cancer.gov/seertools/seerrx/

Other Resources

Registry Plus Online Help (Centers for Disease Control) Download
http://www.cdc.gov/cancer/npcr/tools/registryplus/rpoh_tech_info.htm

Scroll down to “Installation” and click on the link “RP_Help_NAACCR_140.exe”. Download the software to your PC. (You may need to work with your local IT department to help with the download.) Registry Plus contains some of the manuals listed above: Collaborative Stage, FORDS Manual, Multiple Primary/Histology Manual, ICD-O-3 Numerical Histology Listing, as well as NAACCR Data Standards and Dictionary, SEER Program Staging Manual, and NAACCR Edit Online Help.

SEER Training Modules

NAACCR Data Dictionary

Oklahoma Cancer Registrars Association (OCRA) Helpful Links
http://ocra-ok.org/links.asp
## Submission Schedule, Diagnosis Year 2017

<table>
<thead>
<tr>
<th>Patients Diagnosed or First Seen at Your Facility in:</th>
<th>Should be Reported to OCCR in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017</td>
<td>July 2017</td>
</tr>
<tr>
<td>February 2017</td>
<td>August 2017</td>
</tr>
<tr>
<td>March 2017</td>
<td>September 2017</td>
</tr>
<tr>
<td>April 2017</td>
<td>October 2017</td>
</tr>
<tr>
<td>May 2017</td>
<td>November 2017</td>
</tr>
<tr>
<td>June 2017</td>
<td>December 2017</td>
</tr>
<tr>
<td>July 2017</td>
<td>January 2018</td>
</tr>
<tr>
<td>August 2017</td>
<td>February 2018</td>
</tr>
<tr>
<td>September 2017</td>
<td>March 2018</td>
</tr>
<tr>
<td>October 2017</td>
<td>April 2018</td>
</tr>
<tr>
<td>November 2017</td>
<td>May 2018</td>
</tr>
<tr>
<td>December 2017</td>
<td>June 2018</td>
</tr>
</tbody>
</table>
## Reportable Conditions List

### REPORTABLE CONDITIONS as of 1/1/2017

**Malignancies** with an ICD-O-3 behavior code of 2 (in-situ) or 3 (malignant) are reportable for all sites with the following **exceptions**:

- Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, **is reportable**. (Assign code 9421/3).
- Code 8240/1 for carcinoid tumor, NOS of appendix is obsolete. Carcinoid tumors of the appendix (C18.1) **must be coded** to 8240/3 effective with cases diagnosed 1/1/2015 and after.
- Malignant primary skin cancers (C44._) with histology codes 8000-8110 **are not reportable**. (Examples: squamous cell carcinoma (8070) and basal cell carcinoma (8090) of skin are not reportable).
- Carcinoma in situ of the cervix (CIS), cervical intraepithelial neoplasia grade III (CIN III), and prostatic intraepithelial neoplasia (PIN III) **are not reportable**.
- Vulvar intraepithelial neoplasia (VIN III), vaginal intraepithelial neoplasia (VAIN III), and anal intraepithelial neoplasia (AIN III), **are reportable**.
- Non-invasive mucinous cystic neoplasm of the pancreas with high grade dysplasia (8470/2) (Replaces the terminology mucinous cystadenocarcinoma, non-invasive).
- Solid pseudopapillary neoplasm of pancreas (8452/3) (Synonymous with solid pseudopapillary carcinoma)
- Cystic pancreatic endocrine neoplasm (CPEN), use code 8150/3 unless specified as a neuroendocrine tumor Grade 1 (8240/3) or neuroendocrine tumor Grade 2 (8249/3).
- Mature teratoma of the testis in adults is malignant (assign 9080/3), but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. **Do not report if there is no mention of pubescence in the medical record.**

**Non-malignant primary intracranial and central nervous system tumors**, diagnosed on or after 1/1/04 with an ICD-O-3 behavior code of 0 or 1 are reportable for the following sites: Meninges (C70._), Brain (C71._), Spinal cord, cranial nerves, and other parts of the central nervous system (C72._). Pituitary gland (C75.1), Cranioopharyngeal duct (C75.2), Pineal gland (C75.3)

**Gastrointestinal stromal tumors** (GIST) and **thymomas are reportable** if they are noted to have multiple foci, metastasis, and positive lymph nodes.
Casefinding

Casefinding is the means by which a facility identifies patients with a reportable tumor. The following casefinding list should be used by your facility to identify these patients. It is suggested that you use the reportable list as a filter and generate a report listing all discharged patients with a diagnosis of a reportable tumor. The report should be sorted alphabetically to group patients with multiple encounters. All patients on the report will be reviewed to determine their eligibility for reporting. Patients admitted to your facility for an eligible tumor diagnosis, or for tumor-directed treatment must be reported and a tumor abstract completed. No tumor abstract is necessary if it is determined that a patient was admitted with only a history of a malignancy or with a history of benign intracranial/central nervous system tumor (i.e., no procedure done, no treatment tumor-directed).

The report should include the following: Patient last name, patient first name, patient middle name, medical record number, date of birth, social security number, date of service, ICD-10-CM code(s) and type of encounter.
## Comprehensive ICD-10-CM Casefinding Code List for Reportable Tumors

**Effective October 1, 2016 – September 30, 2017**

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Explanation of code</th>
</tr>
</thead>
<tbody>
<tr>
<td>C00._ - C43.<em>, C4A.</em>, C45._ - C96._</td>
<td>Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified sites), and certain specified histologies. New for FY2017; C49.A._, Gastrointestinal stromal tumors, effective 10/1/16.</td>
</tr>
<tr>
<td>C44.00_, C44.09_</td>
<td>Unspecified/other malignant neoplasm of skin of lip</td>
</tr>
<tr>
<td>C44.10_ , C44.19_</td>
<td>Unspecified/other malignant neoplasm of skin of eyelid</td>
</tr>
<tr>
<td>C44.20_, C44.29_</td>
<td>Unspecified/other malignant neoplasm of skin of ear and external auricular canal</td>
</tr>
<tr>
<td>C44.30_, C44.39_</td>
<td>Unspecified/other malignant neoplasm of skin of other/unspecified parts of face</td>
</tr>
<tr>
<td>C44.40, C44.49</td>
<td>Unspecified/other malignant neoplasm of skin of scalp and neck</td>
</tr>
<tr>
<td>C44.50_, C44.59_</td>
<td>Unspecified/other malignant neoplasm of skin of trunk</td>
</tr>
<tr>
<td>C44.60_, C44.69_</td>
<td>Unspecified/other malignant neoplasm of skin of upper limb, including shoulder</td>
</tr>
<tr>
<td>C44.70_, C44.79_</td>
<td>Unspecified/other malignant neoplasm of skin of lower limb, including hip</td>
</tr>
<tr>
<td>C44.80, C44.89</td>
<td>Unspecified/other malignant neoplasm of skin of overlapping sites of skin</td>
</tr>
<tr>
<td>C44.90, C44.99</td>
<td>Unspecified/other malignant neoplasm of skin of unspecified sites of skin</td>
</tr>
<tr>
<td>D00._ - D09._</td>
<td>In-situ neoplasms [Note: Carcinoma in situ of the cervix (CIN III – 8077/2) and prostatic intraepithelial carcinoma (PIN III – 8148/2) are not reportable]</td>
</tr>
<tr>
<td>D18.02</td>
<td>Hemangioma of intracranial structures and any site</td>
</tr>
<tr>
<td>D18.1</td>
<td>Lymphangioma, any site [Note: includes lymphangiomas of brain, other parts of nervous system and endocrine glands, which are reportable]</td>
</tr>
<tr>
<td>D32._</td>
<td>Benign neoplasm of meninges (cerebral, spinal and unspecified)</td>
</tr>
<tr>
<td>D33._</td>
<td>Benign neoplasm of brain and other parts of central nervous system</td>
</tr>
<tr>
<td>D35.2 – D35.4</td>
<td>Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland</td>
</tr>
<tr>
<td>D42._ , D43._</td>
<td>Neoplasm of uncertain or unknown behavior of meninges, brain, CNS</td>
</tr>
<tr>
<td>D44.3 – D44.5</td>
<td>Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland</td>
</tr>
<tr>
<td>D45</td>
<td>Polycythemia vera (9950/3) [ICD-10-CM Coding instruction: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)]</td>
</tr>
<tr>
<td>D46._</td>
<td>Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)</td>
</tr>
<tr>
<td>D47.1</td>
<td>Chronic myeloproliferative disease (9963/3, 9975/3) [ICD-10-CM Coding instruction note: Excludes the following: Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_), Chronic myeloid leukemia BCR/ABL-positive (C92.1_), Myelofibrosis &amp; Secondary myelofibrosis (D75.81) and Myelophthisic anemia &amp; Myelophthisis]</td>
</tr>
<tr>
<td>D47.3</td>
<td>Essential (hemorrhagic) thrombocytopenia (9962/3) [Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocytosis]</td>
</tr>
<tr>
<td>D47.4</td>
<td>Osteomyelofibrosis (9961/3) [Includes: Chronic idiopathic myelofibrosis, Myelofibrosis (idiopathic) (with myeloid metaplasia), Myelosclerosis (megakaryocytic) with myeloid metaplasia, and Secondary myelofibrosis in myeloproliferative disease.</td>
</tr>
<tr>
<td>D47.Z_</td>
<td>Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)</td>
</tr>
<tr>
<td>D47.9</td>
<td>Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)</td>
</tr>
<tr>
<td>D49.6, D49.7</td>
<td>Neoplasm of unspecified behavior of brain, endocrine glands and other CNS</td>
</tr>
<tr>
<td>R85.614</td>
<td>Cytologic evidence of malignancy of smear of anus</td>
</tr>
<tr>
<td>R87.614</td>
<td>Cytologic evidence of malignancy of smear of cervix</td>
</tr>
<tr>
<td>R87.624</td>
<td>Cytologic evidence of malignancy of smear of vagina</td>
</tr>
</tbody>
</table>
Ambiguous Diagnostic Terms

As part of the casefinding activities, all diagnostic reports (radiology, pathology, autopsy, history and physical, discharge summary) should be reviewed to confirm whether a case is required to be reported. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be reported.

List of Ambiguous Diagnostic Terms

<table>
<thead>
<tr>
<th>Terms That Constitute a Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apparent (ly)</td>
</tr>
<tr>
<td>Neoplasm * (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)</td>
</tr>
<tr>
<td>Appears</td>
</tr>
<tr>
<td>Presumed</td>
</tr>
<tr>
<td>Comparable with</td>
</tr>
<tr>
<td>Probable</td>
</tr>
<tr>
<td>Consistent with</td>
</tr>
<tr>
<td>Suspect(ed)</td>
</tr>
<tr>
<td>Favors</td>
</tr>
<tr>
<td>Suspicious (for)</td>
</tr>
<tr>
<td>Malignant appearing</td>
</tr>
<tr>
<td>Typical of</td>
</tr>
<tr>
<td>Most likely</td>
</tr>
<tr>
<td>Tumor* (beginning with 2004 diagnoses and only for C70.0-C72.9, C75.1-C75.3)</td>
</tr>
</tbody>
</table>

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

**NOTE**: Do not substitute synonym such as “supposed” for “presumed” or “equal” for “comparable”. Do not substitute “likely” for “most likely”. Use only the exact words on the list.

<table>
<thead>
<tr>
<th>Terms That DO NOT Constitute a Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot be ruled out</td>
</tr>
<tr>
<td>Questionable</td>
</tr>
<tr>
<td>Equivocal</td>
</tr>
<tr>
<td>Rule out</td>
</tr>
<tr>
<td>Possible</td>
</tr>
<tr>
<td>Suggests</td>
</tr>
<tr>
<td>Potentially malignant</td>
</tr>
<tr>
<td>Worrisome</td>
</tr>
</tbody>
</table>

Examples of Ambiguous Diagnostic Terms:

- The inpatient discharge summary documents a chest x-ray consistent with carcinoma of the right upper lobe. The patient refused work-up and treatment. *Consistent with carcinoma* is reportable terminology and this case will be abstracted.

- The mammogram report states suspicious for malignancy. Suspicious for malignancy is reportable terminology and this case will be abstracted.

- An outpatient CT scan of the chest documents a right lower lobe nodule, possibly malignant. The patient has no other admissions to your facility. *Possible* is not a reportable term and this case would not be abstracted.
Class of Case

Class of case reflects your facility’s role in the management of the cancer. Code the Class of Case that most precisely describes the patient’s relationship to your facility. Classes of Case 00 - 13 indicate that the patient was diagnosed at your facility or in the office of a physician with admitting privileges at your facility. Classes of Case 20 - 22 indicate that the patient was diagnosed somewhere else (not at your facility and not in the office of a physician with admitting privileges at your facility).

**Class of Case Table**

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Reportable</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Initial diagnosis at the reporting facility AND all treatment or a decision not to treat done elsewhere</td>
<td>R</td>
</tr>
<tr>
<td>10</td>
<td>Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at reporting facility, NOS</td>
<td>R</td>
</tr>
<tr>
<td>11</td>
<td>Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility</td>
<td>R</td>
</tr>
<tr>
<td>13</td>
<td>Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere</td>
<td>R</td>
</tr>
<tr>
<td>14</td>
<td>Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility</td>
<td>R</td>
</tr>
<tr>
<td>20</td>
<td>Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS</td>
<td>R</td>
</tr>
<tr>
<td>21</td>
<td>Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere</td>
<td>R</td>
</tr>
<tr>
<td>22</td>
<td>Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility</td>
<td>R</td>
</tr>
<tr>
<td>30</td>
<td>Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging work, after initial diagnosis elsewhere)</td>
<td>N</td>
</tr>
<tr>
<td>31</td>
<td>Initial diagnosis and all first course treatment provided elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement, port placement for chemotherapy)</td>
<td>N</td>
</tr>
<tr>
<td>32</td>
<td>Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)</td>
<td>R</td>
</tr>
<tr>
<td>33</td>
<td>Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)</td>
<td>N</td>
</tr>
</tbody>
</table>

**R** = reportable to OCCR  **N** = not reportable to OCCR

Continued on next page
**Class of Case**

**ADDITIONAL EXPLANATION:**

*Class of Case* 00 can be used only if the patient was diagnosed at your facility and you know that the patient received treatment elsewhere. If, after diagnosis at your facility, it is unknown if patient received any treatment, you must code *Class of Case* as 10.

“No therapy” is considered a treatment (i.e., patient refuses treatment, patient expires before treatment is given, or physician recommends no treatment). If a decision of no treatment is made at your facility, *class of case* should reflect “treatment was done at your facility”.

**EXAMPLES OF CLASS OF CASE:**

1. Patient admitted to your facility with rectal bleeding. Colonoscopy performed after admission shows the patient has colon cancer. Two days later, the patient has a hemicolecetomy to remove the cancer. The surgeon states the cancer is Stage I and no further treatment is necessary. ANSWER: This would be a *class of case* 14 – initial diagnosis at reporting (your) facility and all first course of treatment was done at your facility.

2. 90-year old patient with multiple comorbidities admitted to reporting facility with shortness of breath. Lung biopsy is positive for small cell carcinoma. Patient opts to receive no treatment. ANSWER: This would be a *class of case* 14 – initial diagnosis and all first course treatment done at your facility. (“No treatment” is treatment).

3. Patient presents to ER having a cardiovascular event and a history of colon cancer. During the hospitalization it is determined that patient has a newly diagnosed liver lesion confirmed to be metastasis on pathology examination. You do not treat this metastasis at your facility. ANSWER: This case is reportable since progression of disease was diagnosed at your facility. This would be *class of case* 32 – diagnosis and all first course treatment elsewhere AND patient presents to your facility with disease recurrence or persistence (active disease).
# List of Paired Sites

<table>
<thead>
<tr>
<th>ICD-O-3 Code</th>
<th>Paired Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>C07.9</td>
<td>Parotid gland</td>
</tr>
<tr>
<td>C08.0</td>
<td>Submandibular gland</td>
</tr>
<tr>
<td>C08.1</td>
<td>Sublingual gland</td>
</tr>
<tr>
<td>C09.0</td>
<td>Tonsillar fossa</td>
</tr>
<tr>
<td>C09.1</td>
<td>Tonsillar pillar</td>
</tr>
<tr>
<td>C09.8</td>
<td>Overlapping lesion of tonsil</td>
</tr>
<tr>
<td>C09.9</td>
<td>Tonsil, NOS</td>
</tr>
<tr>
<td>C30.0</td>
<td>Nasal cavity (excluding nasal cartilage and nasal septum)</td>
</tr>
<tr>
<td>C30.1</td>
<td>Middle ear</td>
</tr>
<tr>
<td>C31.0</td>
<td>Maxillary sinus</td>
</tr>
<tr>
<td>C31.2</td>
<td>Frontal sinus</td>
</tr>
<tr>
<td>C34.0</td>
<td>Main bronchus (excluding carina)</td>
</tr>
<tr>
<td>C34.1-C34.9</td>
<td>Lung</td>
</tr>
<tr>
<td>C38.4</td>
<td>Pleura</td>
</tr>
<tr>
<td>C40.0</td>
<td>Long bones of upper limb and scapula</td>
</tr>
<tr>
<td>C40.1</td>
<td>Short bone of upper limb</td>
</tr>
<tr>
<td>C40.2</td>
<td>Long bones of lower limb</td>
</tr>
<tr>
<td>C40.3</td>
<td>Short bones of lower limb</td>
</tr>
<tr>
<td>C41.3</td>
<td>Rib and clavicle (excluding sternum)</td>
</tr>
<tr>
<td>C41.4</td>
<td>Pelvic bones (excluding sacrum, coccyx and symphysis pubis)</td>
</tr>
<tr>
<td>C44.1</td>
<td>Skin of eyelid</td>
</tr>
<tr>
<td>C44.2</td>
<td>Skin of external ear</td>
</tr>
<tr>
<td>C44.3</td>
<td>Skin of other and unspecified parts of face</td>
</tr>
<tr>
<td>C44.5</td>
<td>Skin of trunk</td>
</tr>
<tr>
<td>C44.6</td>
<td>Skin of upper limb and shoulder</td>
</tr>
<tr>
<td>C44.7</td>
<td>Skin of lower limb and hip</td>
</tr>
<tr>
<td>C47.1</td>
<td>Peripheral nerves and autonomic nervous system of upper limb and shoulder</td>
</tr>
<tr>
<td>C47.2</td>
<td>Peripheral nerves and autonomic nervous system of lower limb and hip</td>
</tr>
<tr>
<td>C49.1</td>
<td>Connective, subcutaneous and other soft tissues of upper limb and shoulder</td>
</tr>
<tr>
<td>C49.2</td>
<td>Connective, subcutaneous and other soft tissues of lower limb and hip</td>
</tr>
<tr>
<td>C50.0-C50.9</td>
<td>Breast</td>
</tr>
<tr>
<td>C56.9</td>
<td>Ovary</td>
</tr>
<tr>
<td>C57.0</td>
<td>Fallopian tube</td>
</tr>
<tr>
<td>C62.0-62.9</td>
<td>Testis</td>
</tr>
<tr>
<td>C63.0</td>
<td>Epididymis</td>
</tr>
<tr>
<td>C63.1</td>
<td>Spermatic cord</td>
</tr>
<tr>
<td>C64.9</td>
<td>Kidney</td>
</tr>
<tr>
<td>C65.9</td>
<td>Renal pelvis</td>
</tr>
<tr>
<td>C66.9</td>
<td>Ureter</td>
</tr>
<tr>
<td>C69.0-C69.9</td>
<td>Eye and lacrimal gland</td>
</tr>
<tr>
<td>C70.0</td>
<td>Cerebral meninges, NOS</td>
</tr>
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<tr>
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<th>Paired Site</th>
</tr>
</thead>
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<td>Cerebrum</td>
</tr>
<tr>
<td>C71.1</td>
<td>Frontal lobe</td>
</tr>
<tr>
<td>C71.2</td>
<td>Temporal lobe</td>
</tr>
<tr>
<td>C71.3</td>
<td>Parietal lobe</td>
</tr>
<tr>
<td>C71.4</td>
<td>Occipital lobe</td>
</tr>
<tr>
<td>C72.2</td>
<td>Olfactory nerve</td>
</tr>
<tr>
<td>C72.3</td>
<td>Optic nerve</td>
</tr>
<tr>
<td>C72.4</td>
<td>Acoustic nerve</td>
</tr>
<tr>
<td>C72.5</td>
<td>Cranial nerve, NOS</td>
</tr>
<tr>
<td>C74.0-74.9</td>
<td>Adrenal gland</td>
</tr>
<tr>
<td>C75.4</td>
<td>Carotid body</td>
</tr>
</tbody>
</table>
Diagnostic Confirmation

Diagnostic confirmation is an indicator of the precision of diagnosis. The codes for diagnostic confirmation are in priority order; code 1 has the highest priority.

Codes 1, 2, and 4 indicate that the diagnosis of cancer was microscopically confirmed. The cancer diagnosis will be confirmed in a pathology report.

Codes 5, 6, 7 and 8 indicate that the diagnosis was clinically confirmed. There will be no pathology report associated with this diagnosis of cancer. The confirmation will be a physician statement using either definitive terminology or ambiguous terminology. The physician statement may be in a discharge summary, progress note, radiology report, history and physical examination, or other physician note. Code 5 will rarely be used as a means of diagnostic confirmation since laboratory tests/tumor markers are not usually diagnostic of cancer.

Codes for Solid Tumors:

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<thead>
<tr>
<th>Code</th>
<th>Label</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Positive histology</td>
<td>Histologic confirmation (tissue microscopically examined).</td>
</tr>
<tr>
<td>2</td>
<td>Positive cytology</td>
<td>Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).</td>
</tr>
<tr>
<td>4</td>
<td>Positive microscopic confirmation, method not specified</td>
<td>Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.</td>
</tr>
<tr>
<td>5</td>
<td>Positive laboratory test/marker study</td>
<td>A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5.</td>
</tr>
<tr>
<td>6</td>
<td>Direct visualization without microscopic confirmation</td>
<td>The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.</td>
</tr>
<tr>
<td>7</td>
<td>Radiography and other imaging techniques without microscopic confirmation</td>
<td>The malignancy was reported by the physician from an imaging technique report only.</td>
</tr>
<tr>
<td>8</td>
<td>Clinical diagnosis only, other than 5, 6 or 7</td>
<td>The malignancy was reported by the physician in the medical record.</td>
</tr>
<tr>
<td>9</td>
<td>Unknown whether or not microscopically confirmed</td>
<td>A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).</td>
</tr>
</tbody>
</table>

Continued on next page
Examples of diagnostic confirmation:

1. Patient admitted to your facility with shortness of breath and productive cough. CT scan of the chest demonstrates a right upper lobe lung mass with enlarged mediastinal lymph nodes. The patient refuses any additional work-up. On the discharge summary, the attending physician states the final diagnosis is lung cancer.

   ANSWER: The diagnostic confirmation code assigned is 8 – clinical diagnosis only. The physician gave a definitive diagnosis in the discharge summary.

2. Patient referred to your facility for a breast biopsy. The biopsy is performed and the pathologic diagnosis is infiltrating duct carcinoma of the right breast.

   ANSWER: The diagnostic confirmation code assigned is 1 – positive histology. There is a pathology report with a histologic diagnosis of cancer.
Section 2:

Web Plus Training Narrative
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<td>Date of Birth</td>
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Enter New Abstract

**Note 1:** All dates are entered using the following format: YYYYMMDD. If the day is unknown, leave blank (YYYYMM_ _). If the month and day are both unknown, leave both blank (YYYY_ _ _ _). If the entire date is unknown, leave field blank.

**Note 2:** Some fields have a drop down arrow 🔄. Use this arrow to display a list of available choices to use for coding.

**Note 3:** Some fields have a search icon 🔍. Click the search icon to display a search bar/list of available choices for coding.

**Note 4:** All fields with an asterisk (*) are required fields and must be completed by the reporter, unless otherwise specified.

**Note 5:** To navigate within the abstract, use the “Enter” key or the “Tab” key.

**Hospital Specific**

**Reporting Facility:**
Unique number assigned by OCCR. Data item is auto-coded.

**Abstracted By:**
Initials of person logged into Web Plus. Data item is auto-coded.

**Date of 1st Contact:**
Date of first patient contact, inpatient or outpatient, for the diagnosis and/or treatment of the tumor. The date may represent an outpatient visit for biopsy, x-ray, scan or laboratory test. If the patient is diagnosed at the reporting facility, the date of diagnosis and the date of first contact will be the same. If the patient is diagnosed at an outside facility, the date of first contact is the date the treatment starts at reporting facility. (Treatment is surgery or palliative therapy). (Refer to Note 1 for date format).

**Date 1st Contact Flag:**
Flag explains why no appropriate value is in the field Date of 1st Contact. Data item will be left blank if the Date of 1st Contact is known. Use drop down and select “12” if Date of 1st Contact is not known.

**Type of Rep Source:**
Codes the source used to abstract the majority of information on the tumor being reported. Data item is auto-coded.
**Accession No:**
Provides a unique identifier (9-digit number) for the patient and consists of the year in which the patient was first seen at the reporting facility, as well as the consecutive order in which the patient was abstracted. A patient will have only one accession number in their lifetime. A log of accession numbers must be maintained to avoid duplication. (An example of an accession log will be provided by the OCCR consultant.)

_Example:_ First patient abstracted for year 2015 will have accession number 201500001. Second patient abstracted for year 2015 will have accession number 201500002. If first patient returns to facility in year 2017, their accession number will remain 201500001.

**Sequence No:**
Indicates the sequence of all malignant and non-malignant neoplasms over the lifetime of the patient. Sequence number 00 indicates that a patient has only one malignant neoplasm in a lifetime. If this same patient is diagnosed with a second malignant neoplasm, the sequence number for the first neoplasm is changed to 01, while the sequence number for the second neoplasm is coded 02.

Sequence number 60 indicates that a patient has only one non-malignant reportable neoplasm in a lifetime. If this same patient is diagnosed with a second non-malignant reportable neoplasm, the sequence number for the first neoplasm is changed to 61, while the sequence number for the second neoplasm is coded 62. Do not mix malignant and non-malignant sequence numbers.

**Class of Case:**
Use the drop down and select the class of case that reflects the facility’s role in the management of the cancer. A decision to not treat is still considered _treatment_. (See Section 1, pages 10-11 for additional coding instructions).

**Patient Information**

**Name - Last:**
Record the last name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. Do not leave blank. If the last name is unknown, record as UNKNOWN.

_Examples:_ Record with space “Mc Donald”; record with a hyphen “Smith-Jones”

**Name - First:**
Record the first name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If the first name is unknown, leave blank.

**Name - Middle:**
Record the middle name of the patient. Blanks, spaces, hyphens and apostrophes ARE allowed. Do not use other punctuation. If only a middle initial is known, record the letter only. If the middle name is unknown, leave blank.
**Name - Alias:**
Record here if the patient is called by a name other than their first name. If alias is unknown or not applicable, leave blank.

*Example: Patient name is Robert, but goes by Bob. Record Bob in this field.

**Name - Maiden:**
Record patient’s surname if female patient has ever been married. If maiden name is unknown or not applicable, leave blank.

**Name - Suffix:**
Record the title that follows a patient’s last name, such as generation order or credential status. (e.g., “Jr” or “MD”). If name suffix is unknown or not applicable, leave blank.

**Social Security No:**
Record the patient’s social security number without dashes. If social security number is unknown or the patient does not have one, code as 999999999. If a partial social security only is known (i.e., last 4 digits), code as 999999999. Record the partial social security in the text field *Physician/Facility Referral*.

**Medical Rec No:**
Record the medical record number, usually assigned by the reporting facility’s health information management (HIM) department. If medical record is unknown, leave blank.

**Date of Birth:**
Record the patient’s date of birth. Leave the year, month and/or day blank when they cannot be estimated or are unknown. If the date of birth is unknown, but the age at diagnosis and date of diagnosis are known, calculate the year of birth by subtracting the patient’s age at diagnosis from the year of diagnosis. Leave the month and day blank. (Refer to Note 1).

**Date Birth Flag:**
Flag explains why no appropriate value is in the field *Date of Birth*. Data item will be left blank if the *Date of Birth* is known. Use the drop down and select “12” if the date is not known.

**Birthplace State:**
Use the drop down and select the state in which the patient was born. If unknown, select “ZZ” for unknown.

**Birthplace Country:**
Use the search icon and select or search for the country in which the patient was born. If unknown, select “ZZU” for unknown.

**Sex:**
Use the drop down and choose the appropriate code to record the sex of the patient.
*Race 1-5: Use the drop down and choose the appropriate code to record the patient’s race. Race codes 1-5 must ALL be completed, even if race is unknown. If the patient is multiracial, record the minority race in Race 1 and other race in Race 2. (code 88 = no additional races; code 99 = unknown).

Examples:

<table>
<thead>
<tr>
<th>Patient is Caucasian only:</th>
<th>Patient is Black and Caucasian:</th>
<th>Patient race is Unknown:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race 1: 01</td>
<td>Race 1: 02</td>
<td>Race 1: 99</td>
</tr>
<tr>
<td>Race 2: 88</td>
<td>Race 2: 01</td>
<td>Race 2: 99</td>
</tr>
<tr>
<td>Race 5: 88</td>
<td>Race 5: 88</td>
<td>Race 5: 99</td>
</tr>
</tbody>
</table>

*Hispanic Ethnicity:*
Use the drop down and record the patient’s Hispanic ethnicity. If ethnicity is unknown, select “9” for unknown. Do not leave blank.

*Primary Payer at DX:*
Use the drop down and select the code that describes the primary payer or insurance carrier at the time of the initial diagnosis and/or treatment. If primary payer is unknown, select “99” for unknown. Do not leave blank.

**Patient Address Information**

*Addr at Dx – No & St:*
Record the physical address of the patient at the time of diagnosis.

Addr DX Supplemental:
Record additional information listed for the patient’s address at diagnosis, including nursing home, post office box, etc. If supplemental address is unknown or not applicable, leave blank.

*Addr at Dx - City:*
Record the city of patient’s physical address at the time of diagnosis.

*Addr at Dx - State:*
Use the drop down and select the patient’s state of residence at the time of diagnosis.

*Zip Code at Dx:*
Record the extended 9-digit code or the short 5-digit code for the patient’s address at the time of diagnosis.

*County at Dx:*
Use the search icon and select or search for the county of the patient’s residence at the time of diagnosis. The website at Zip Express (http://www.getzips.com/zip.htm) may be used to determine county.
*Current No & St:*
Record the patient’s current physical address. This address may be the same or different from the patient’s address at diagnosis.

**Addr Current Supplemental:**
Record additional information listed for patient’s current address, including nursing home, post office box, etc. If current supplemental address is unknown or not applicable, leave blank.

*Current City:*
Record the city of the patient’s current residence.

*Current State:*
Use the drop down and record the state of the patient’s current residence.

*Current Zip Code:*
Record the extended 9-digit zip code or the short 5-digit zip code of the patient’s current residence.

**Cancer Information**

*Date of Diagnosis:*
Record the date the cancer was first diagnosed, whether clinically (physician’s documentation, x-ray, CT scan) or pathologically (biopsy, surgery). Refer to the list of “ambiguous terms” in Section 1, page 9 for language that represents a diagnosis of cancer. (Refer to Note 1 for date format).

**Date Diagnosis Flag:**
Flag explains why no appropriate value is in the field Date of Diagnosis. Data item will be left blank if Date of Diagnosis is known. Use the drop down and select “12” if the date is not known.

**Age at Diagnosis:**
Click the calculate button to compute/derive the age of the patient at diagnosis. Data items Date of Diagnosis and Date of Birth must be completed to derive the age at diagnosis.

*Primary Site - Text:*
Document the primary tumor site, including sub-site and laterality. Do not leave blank.

*Example: right lower lobe of lung.*
**Primary Site:**
For solid tumors, use the search icon or use the ICD-O book (purple book) to search for the primary site code. Code the site in which the primary tumor originated, even if it extends into an adjacent “sub-site”. Code the primary site, not the site of metastasis. If primary site is not stated, code to unknown primary site (C809).

For hematopoietic and lymphoid neoplasms, use the following guide:
- Leukemia – Use primary site code C421 (bone marrow)
- Multiple myeloma – Use primary site code C421
- Lymphoma/Hodgkin’s – Use primary site code C779 (lymph nodes, NOS)

**Laterality:**
Use the drop down and select the laterality of the primary tumor. Review the list of paired sites in Section 1, pages 12-13 to determine which primary sites require tumor laterality coded. For tumors which are not listed as a paired organ, select “0” (organ is not a paired site).

**Histology - Text:**
Document the histology (morphology) of the primary tumor site, including grade and behavior. Do not leave blank.

**Histologic Type:**
For solid tumors, use the search icon or use the ICD-O book (purple book) to search for the histology code. If a report has a diagnosis of “cancer”, code to carcinoma, NOS (8010).

For hematopoietic and lymphoid neoplasms, use the following guide for histology coding:
- Acute myeloid leukemia (AML) – 9861
- Chronic myeloid leukemia (CML) – 9863
- Acute lymphoblastic leukemia (ALL) – 9811
- Chronic lymphocytic leukemia (CLL) – 9823
- Non Hodgkin Lymphoma – 9591
- Hodgkin’s Disease (lymphoma) – 9650
- Multiple myeloma – 9732
- Myelodysplastic syndrome – 9939

**Behavior Code:**
Use the drop down and select the behavior of the primary tumor. Tumor behavior is used by pathologists to describe whether the tumor is benign (0), borderline (1), in situ (2) or malignant (3). Benign and borderline behavior codes are used for intracranial and central nervous system primary sites only. In the absence of pathologic examination, code behavior as invasive (3). In situ behavior (2) can only be identified by pathologic examination.

**Grade/Differentiation:**
Use the drop down and select the histologic grade of the primary tumor. Code grade as unknown (9) if no grade is mentioned in the pathology report or if there is no pathology report.
*Diagnostic Confirmation:
Use the drop down and select the appropriate method of diagnostic confirmation. (See Section 1, pages 14-15 for instructions for coding diagnostic confirmation).

Text – Diagnosis

*Physical Exam - Text:
Document the patient’s risk factors and the clinical description from their history and physical. Include gender, age, race and ethnicity. Do not leave blank. If Physical Exam text is unknown or not applicable, record “N/A”.

Example: 54 year old, white, male with right lung mass, shortness of breath and blood in sputum. History of smoking, 2 packs a day for 20 years.

*X-ray/Scan - Text:
Document all imaging examinations which provide information on tumor characteristics. Include the date tests were done, along with a brief description of the findings. Do not leave blank. If X-ray/Scan text is unknown or not applicable, record “N/A”.

Example: 11/21/12 CT chest: 2.5 cm lesion within the RML of lung, with hilar and mediastinal adenopathy.

*Dx Procedures - Text:
Document all diagnostic procedures which provided information for diagnosis. Include the date of procedures and name of procedures. Do not leave blank. If Dx Procedures text is unknown or not applicable, record “N/A”.

Example: 8/6/12 Biopsy of primary site.

*Pathology - Text:
Document information from pathology reports. Include date of procedure, site of biopsy, tumor type, grade, involvement of resected margins, number of nodes removed and any additional comments. Do not leave blank. If Pathology text is unknown or not applicable, record “N/A”.

Example: 9/5/12 RML lung: 2.5 cm lesion showing adenocarcinoma, grade 2, 00/03 LN. Margins clear.

Stage of Disease

*Tumor Size Summary:
Record the largest dimension or diameter of the primary tumor in millimeters in a 3-digit field. 1 centimeter (cm) is equal to 10 millimeters (mm). To convert centimeters to millimeters, multiply by 10. Use the search icon and select an appropriate tumor size if no exact measurement is stated.

Example: Tumor is described as 3.5 cm. 3.5 cm x 10 = 35 mm. Record Tumor Size as 035.
*Regional LN Positive:
Record the exact number of regional nodes examined by the pathologist and found to contain metastasis. If biopsy or aspiration of regional node is positive, code “95”. If no regional lymph nodes were examined by pathologist, code “98”. Use the search icon and select appropriate positive regional nodes value if no exact number is stated.

Example: Two regional nodes are positive as reported by the pathologist. Record Regional LN Positive as 02.

*Regional LN Examined:
Record the total number of regional lymph nodes that were removed and examined by the pathologist. If only biopsy or aspiration of regional node is performed, code “95”. If no regional lymph nodes were examined by pathologist, code “00”. Use the search icon and select appropriate examined regional nodes if no exact number is stated.

Example: Pathologists states that 15 regional lymph nodes were removed during resection of a colon cancer. Record Regional LN Examined as 15.

First Course of Treatment

*Diagnostic Procedure:
Use the drop down and select the appropriate diagnostic procedure, usually biopsy of primary site or biopsy of other site. If no diagnostic procedure was performed, leave blank.

Date Diagnostic Procedure:
Record the date of the biopsy of primary site or the biopsy of other site. If no diagnostic procedure was performed, leave blank. (Refer to Note 1 for date format).

Date DX Procedure Flag:
Flag explains why no appropriate value is in the field Date Diagnostic Procedure. Data item will be left blank if the Date Diagnostic Procedure is known. Use the drop down and select the appropriate value if date is not known.

*Surgery - Text:
Document information from operative report. Include date of surgery, name of procedure performed and any surgical findings noted. Do not leave blank. If Surgery text is unknown or not applicable, record “N/A”.

Example: 2/12/12 Right hemicolecctiony: 7 cm mass in right colon. No liver metastasis. No enlarged lymph nodes.

*Surgery Primary Site:
Use the search icon and select the surgical procedure performed to the primary site. If no surgery to primary site was performed, leave blank.
Date – Surgery:
Record the date of the surgical procedure to the primary site. If no surgery to primary site was performed, leave blank. (Refer to Note 1 for date format).

Date – Surgery Flag:
Flag explains why no appropriate value is in the field Date - Surgery. Data item will be left blank if the date is known. Use the drop down and select the appropriate value if the date is not known.

Scope Regional LN:
Use the drop down and select the surgery performed to regional lymph nodes.

Surgery Other Reg/Distant:
Use the drop down and select the surgery performed to other regional sites or other metastatic sites.

Patient Outcomes

DateLastContact/Death:
Record the date of last contact with the patient or record the date of death. (Refer to Note 1 for date format).

DateLastContact/DeathFlag:
Code explains why no appropriate value is in the field DateLastContact/Death. Data item will be left blank if the date is known. Use the drop down and select “12” if the date is not known.

*Vital Status:
Use the drop down and select the vital status of the patient. If the patient has multiple tumors, vital status should be the same for all tumors.

Treatment Referral Information

PhysicianPrimarySurg:
Use the search icon and select or search for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Files from the Oklahoma State Medical Board are used to populate this field. If a physician is not listed in the look-up table, leave this field blank.

Physician/Facility Referral:
If a physician is not listed in the look-up table in the PhysicianPrimarySurg field, document the name of the physician in this text field. If applicable, record the name of the facility the patient was referred to.
Save Abstract and Run Data Edits

Click the “Save” button in the lower left corner of the screen. The abstract will be saved and data edits will run. Edit errors will be displayed on the right side of the screen. All edit errors must be resolved before the abstract can be considered complete and ready to be released.
Section 3:
Web Plus Training Manual for Facility Abstractors
Web Plus
Training Manual for
Facility Abstractors

Version 3.0
(Based on Web Plus Version 3.1, NAACCR v12.1)

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
National Program of Cancer Registries
Registry Plus™ Software for Cancer Registries
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Chapter 1: Introduction

Overall Learning Objectives

These are the overall learning objectives for the Web Plus Facility Abstractor training manual:

- Learn the major functions of Web Plus
- Create abstracts in compliance with cancer registry standards
- Correct errors so that the abstract is error-free and complete
- Release abstracts
- Complete and release abstracts

Overview of the Web Plus Training Manual

The Web Plus Facility Abstractor Training Manual provides you with the information to understand and use this web application. In this manual you not only learn about the tools in Web Plus, you also create an abstract and follow the process of updating and correcting the abstract until it is complete and released to the central registry.

Web Plus Features

Web Plus is a web-based application that collects cancer data securely over the public Internet. It is ideal for use by central cancer registries for all electronic reporting needs. Web Plus supports three main functions; online abstracting (which is addressed in this training manual), file upload/download, and follow-back efforts. The online abstracting capability of Web Plus is ideal for reporting from physicians’ offices and other low-volume reporting sources, while the file upload feature can be used for electronic submission of data from all other reporting sources to the central cancer registry.

All records are saved in a database at the hosting central cancer registry and cases entered by one facility or office are not visible to other facilities. Data entered are validated by the CDC EDITS Engine running on a web server. Users, display types, and edit configurations are managed at the hosting central registry. Web Plus is hosted on a secure web server that has a digital certificate installed; the communication between the client and the server is encrypted with Secure Socket Layer (SSL) technology.

Web Plus Users

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

<table>
<thead>
<tr>
<th>Users</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Users</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Facility Abstractor</td>
<td>Works in a facility or doctor’s office and handles patients’ medical records and paperwork. When a patient is diagnosed with cancer, the Facility Abstractor reports the case to the state’s central cancer registry. The Facility Abstractor also completes and submits any follow-back abstracts that the central registry has posted for their facility.</td>
</tr>
<tr>
<td>File Uploader</td>
<td>Uploads either files of abstracts in the appropriate NAACCR format that were not abstracted using Web Plus or non-NAACCR files in any format, views EDITS error report and cleans, or works with abstractors to clean, errors on rejected abstracts prior to resubmitting, downloads files posted by the central registry, and views reports.</td>
</tr>
<tr>
<td>Local Administrator</td>
<td>Manages local users of a facility.</td>
</tr>
<tr>
<td>Central Registry Administrator</td>
<td>Sets up facilities with access to the Web Plus software to report their data, manages facility accounts and users at both the central registry and facilities, configures display types, edit sets and system preferences, manages assignment of abstracts to central registry staff, exports data, and views reports.</td>
</tr>
<tr>
<td>Follow-back Supervisor</td>
<td>Uploads files of partially-filled follow-back abstracts, manually adds follow-back abstracts online, tracks follow-back abstracts by uploaded file or by facility, and generates and views Web Plus follow-back reports.</td>
</tr>
<tr>
<td>Follow-back Monitor</td>
<td>Tracks follow-back abstracts by assigned facility, generates and views Web Plus follow-back reports.</td>
</tr>
<tr>
<td>File Upload Supervisor</td>
<td>Monitors upload of files to the central registry; tracks file uploads and rejected abstracts by facility, communicates with facility to ensure resubmission of rejected abstracts, and views reports.</td>
</tr>
<tr>
<td>Central Registry Abstractor/Reviewer</td>
<td>Reviews abstracts submitted to the central registry for completeness and accuracy and may abstract additional data items from submitted text; also abstracts new cases.</td>
</tr>
</tbody>
</table>

**Requirements for Web Access**

Web Plus requires Microsoft Internet Explorer version 5.0 or later or a Mozilla browser to operate the system fully. Although Web Plus may work at 800 X 600 resolution, you may have trouble with some features; it can be best viewed at 1024 X 768 or higher resolution. It is highly recommended that you change your resolution to 1024 X 768 or higher when using the Web Plus application.
Chapter 2: The Basics

Learning Objectives
In this chapter, you will learn to:

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

Overview
This lesson covers the basics of Web Plus. You’ll learn about logging in and out of Web Plus and the key elements of Web Plus.

Log In
To log in, complete these steps:
1. Open your Internet browser and type the following link in the address field:
   https://occrweb.health.ok.gov/
2. Press Enter.
3. Type in the User ID and password provided to you by your central registry into the User ID and Password fields, or type **johndoe** in the User ID field and **abstract1** in the Password field.

4. Click **Log in**.

**Result:** Your Web Plus homepage opens, with a list of links to the facilities and roles that have been assigned to you.

![Web Plus Home Page for John Doe](image)

<table>
<thead>
<tr>
<th>Web Plus Home Page for John Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please select a cancer reporting activity from those listed below the facility for which you would like to report.</td>
</tr>
</tbody>
</table>

**Test Facility 1**
- Facility Abstractor Training
- File Upload
- Death Certificate Follow-back Requests (Outstanding 2, Released 1)
- Pathlab Follow-back Requests (Outstanding 4, Released 0)

**Test Facility 2**
- Cancer Reporting Help
- File Upload
- Death Certificate Follow-back Requests (Outstanding 2, Released 1)
- Pathlab Follow-back Requests (Outstanding 3, Released 0)

5. Click the **Facility Abstractor Training** link.

---

**Important**

The **link** that you click on your homepage is associated with a specific abstract **“Source”**, indicated by the name of the link. You can only abstract information for abstracts of the Source (or link) that you select. For example, if you select Facility Abstractor Training, you cannot open and work on follow-back abstracts. To work on abstracts of a different Source, click **Home** on the Web Plus menu, and click the link for the type of abstract you would like to work with.

**Result:** The Facility Abstractor menu items are displayed.

![Web Plus](image)

<table>
<thead>
<tr>
<th>Web Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
</tr>
</tbody>
</table>

Choose one of the above options to proceed.

From this page you can access the main parts of Web Plus. Click on an option to open the page for the option.

This table describes the menu options on the home page:
## Abstracting Process

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

1. **Create abstract**
2. **Update data**
3. **Correct errors**
4. **Complete abstract**
5. **Release abstract**

The process of generating an abstract includes the following steps:

1. Create the abstract with the patient’s name and social security number and save. You can add more information to the abstract and complete it whenever you want.

2. Enter codes using the codes supplied by the Web Plus application and text in the in the data entry fields. Save the abstract to retain the information you have entered.

3. Correct errors. Each time you open or save the abstract, Web Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Web Plus Administrator.

4. After you have entered all your data and corrected all errors, save the abstract and the system will designate your new abstract as complete.

5. Release the completed abstract to the central registry. You can release abstracts individually or several at a time.
Data Entry Page

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

1. Log in to Web Plus.

Result: The Data Entry page opens.

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

3. In the entry box on the left, scroll down the list to view all of the fields in the data entry grid, including the text fields.

The fields you see depend on your facility or center and the set up chosen by your Web Plus Administrator. The headings, such as Hospital Specific and Demographic, can vary. These are only headings; they do not signify a group of required fields. Your Web Plus Administrator uses them to organize the fields for clearer viewing and to help with data entry.
Refer to “Creating an Abstract,” page 33, to learn how to enter data in these fields.

In the right box, click each of the tabs to see the content. These are the Web Plus tabs:

<table>
<thead>
<tr>
<th>Tab</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help</td>
<td>This area describes the saving and editing of an abstract and provides a description of the data entry help icons available to the abstractor.</td>
</tr>
<tr>
<td>Edit Errors</td>
<td>This area lists any errors that may exist in an abstract after you have opened or saved the abstract. This editing feature helps you complete the abstract until it meets the standards acceptable to the central registry. You will learn more about the edit errors tab on page 45.</td>
</tr>
</tbody>
</table>

4. Click the Help tab, if the section is not already open. This area provides a legend describing the data entry help icons available to the abstractor and briefly describes the process of saving your abstract.

**Result:** The Help box opens.

These are the Web Plus icons:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
<th>Click the icon to . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Icon]</td>
<td>Special Lookups</td>
<td>open a listing of codes and terms to choose from. Find the term that best applies, and click on the code to the left of the term. When a specific code is clicked, it is automatically filled into the abstract for the data item.</td>
</tr>
<tr>
<td>Icon</td>
<td>Description</td>
<td>Click the icon to . . .</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td>Calculate Field Value</td>
<td>calculate a value for a field from values in other fields.</td>
</tr>
<tr>
<td><img src="image2.png" alt="Image" /></td>
<td>Context-sensitive Help</td>
<td>open Help page with the NAACCR Standards for Cancer Registries Volume II: Data Standards and Data Dictionary for information about the data item.</td>
</tr>
<tr>
<td><img src="image3.png" alt="Image" /></td>
<td>Print Preview</td>
<td>open page that shows all of the fields and the content you have entered in your abstract; this page allows you to print a copy of your abstract.</td>
</tr>
</tbody>
</table>

**Changing Your Password**

To change your password, complete these steps:

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

   **Result:** The Change Password page opens.

   ![Change Password](image4.png)

   2. Type your **current** password in the **Old Password** field.

   3. Type your **new** password in both of the **New Password** fields.

   4. Click **Change**.

      **Result:** Your password is successfully changed.

**Web Plus Version Information**

To view Web Plus, NAACCR, and Collaborative Staging Algorithm Version information, complete these steps:

1. On the Web Plus menu, point to **Help**.
2. Click on **About**.

**Result:** A page opens with information about the version of the Web Plus application, and the NAACCR and Collaborative Staging Algorithm versions included in the Web Plus application.

![About Web Plus](image)

---

**Logging Out**

To log out of the Web Plus application, click **Log out** on the Home page menu.

**Result:** The Web Plus Log In page opens.

![Web Plus Log In](image)
Chapter 3: Creating an Abstract

Learning Objectives

In this chapter, you will learn to:

- Enter information into the data entry fields
- Understand the process for completing an abstract
- Use these data entry tools: drop-down lists, Help, and Special Lookups

Overview

In this chapter you create an abstract that you continue to work with throughout this manual. In succeeding chapters you will complete and release this abstract. This chapter also introduces you to some basic entry tools to help you enter information in Web Plus.

Entering Information into Fields

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

To create an abstract, complete these steps:

1. Log in, as described in “Log In,” page 26.
   
   **Result:** The Data Entry page opens. Notice that the Abstractor field is pre-filled with your Abstractor ID.

3. Type JOHNSON in the **Last Name** field, and press Enter. Notice that the next field is now highlighted.
When you enter name and address information into Web Plus, the application automatically capitalizes the entered text.

4. Click the Help icon beside the Last Name field.
   **Result:** A separate window opens giving you information about the field.

   ![Help Window](image)

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

5. Close the Help window.

6. Enter the following information in the following fields:

<table>
<thead>
<tr>
<th>Field</th>
<th>Value to be Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>JOHN</td>
</tr>
<tr>
<td>Middle Name</td>
<td>M</td>
</tr>
<tr>
<td>Maiden Name</td>
<td>Leave blank (press enter to move to next field)</td>
</tr>
<tr>
<td>Alias</td>
<td>Leave blank (press enter to move to next field)</td>
</tr>
<tr>
<td>Social Security No.</td>
<td>9999999999</td>
</tr>
<tr>
<td>Number and Street</td>
<td>123 EAST MAIN ST</td>
</tr>
<tr>
<td>Supp Address</td>
<td>Leave blank (press enter to move to next field)</td>
</tr>
<tr>
<td>City</td>
<td>ATLANTA</td>
</tr>
</tbody>
</table>

7. Click **Save** to save your work.
   **Result:** The Web Plus system saves your new abstract.

   ![Note Icon](image)

   When you save the abstract the system displays edit errors. Notice that the Edit Errors tab is automatically opened on the right and displays the total number of and details of the edit errors contained in the abstract. The procedures for resolving edit errors are described in a later chapter in this manual.
8. Press **enter** or tab into the **State** field, and click the arrow $\downarrow$ to display the drop-down list.

**Result:** A list of states appears in the pull-down menu.

9. Scroll down and **select** the value of **Georgia** by **clicking** on it.
Result: GA is filled into the State field in the data entry grid.

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

10. Type **999999999** in the Zip Code field, and press Enter.

11. Click on the magnifying glass icon to the left of the County field.

Result: The Select county code window opens, which provides a list of county codes.

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

You can also find the code by scrolling down the page or by clicking a page number at the top of the page to see other codes in the list.
Result: The system finds DeKalb county and its code.

![Select county code]

13. Click the **089** code number for **DeKalb County**.

**Result:** The value of **089** is automatically entered into the data entry grid for the County field, and the Select county code window automatically closes.

14. **Enter** the following information in the following fields, either by typing the value, using the drop-down list feature, or using the advanced search feature by clicking on the magnifying glass icon where available.

As of the NAACCR version 12 record layout, all dates are in the YYYYMMDD format. Because the NAACCR standards are so tightly integrated with Web Plus, dates are entered in the YYYYMMDD format.

The Abstractor will enter dates in the new YYYYMMDD format as follows:

- YYYYMMDD – when complete date is known and valid
- YYYYMM – when year and month are known and valid, and day is unknown
- YYYY – when year is known and valid, and month and day are unknown
- Blank – when no known date applies

A **date flag field** is filled out for each date field which is “unknown” or “not applicable” explaining why the corresponding date field is blank. The date field flag is **left blank if a valid date** is transmitted in its associated date item.

<table>
<thead>
<tr>
<th>Field</th>
<th>Value to be Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race 1</td>
<td>01 – White</td>
</tr>
<tr>
<td>Race 2</td>
<td>88 – No further race documented</td>
</tr>
<tr>
<td>Race 3</td>
<td>88 – No further race documented</td>
</tr>
<tr>
<td>Race 4</td>
<td>88 – No further race documented</td>
</tr>
<tr>
<td>Race 5</td>
<td>88 – No further race documented</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>0 – Non-Spanish; non-Hispanic</td>
</tr>
<tr>
<td>Birth Date</td>
<td>19610316</td>
</tr>
<tr>
<td>Birth Date Flag</td>
<td>Leave blank (press enter to move to next field)</td>
</tr>
<tr>
<td>Place of Birth</td>
<td>000 – United States, NOS</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Sex</td>
<td>1 – Male</td>
</tr>
<tr>
<td>Usual Occupation</td>
<td>FARMER</td>
</tr>
<tr>
<td>Occup Census Code</td>
<td>605-- Farmworkers, Farm and Ranch Animals</td>
</tr>
<tr>
<td>Occupation Source</td>
<td>1-Reporting facility records</td>
</tr>
<tr>
<td>Usual Industry</td>
<td>FARMER/RANCHER</td>
</tr>
<tr>
<td>Indus Census Code</td>
<td>018</td>
</tr>
<tr>
<td>Industry Source</td>
<td>1-Reporting facility records</td>
</tr>
</tbody>
</table>

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

**Result:** The Web Plus system saves your new abstract. If you so choose, you can close the abstract and open it later and continue to work on it until completion.

In the next chapter, “Chapter 4: Adding Data to an Abstract, page 39” you continue to add data to this abstract.
Chapter 4: Adding Data to an Abstract

Learning Objectives
In this chapter, you will learn to:

- Find a specific abstract
- Enter information into text fields
- Identify and use tools necessary for entering information into an abstract
- Add comments to an abstract
- Preview an abstract for printing
- Delete an unreleased abstract

Overview
In this chapter you continue to enter data in the abstract you have already started. This chapter does not address correcting edits; this will be done in the next chapter, “Correcting Errors,” page 45.

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

Opening and Updating an Abstract
In this section, you learn to find an existing abstract and open it, use a calculator field, and use pop-up window information.

To update an abstract, follow these steps:

1. Log in, if you are not already, as described in “Log In,” page 26.
2. On the Web Plus menu, click Find/Open Abstract.

Result: The Find Abstract page opens.

The Find Abstract page is searchable by patient name, social security number, abstract status, and/or abstract source.
The link that you click on your homepage is associated with a specific abstract Source, indicated by the name of the link. You can only open abstracts of the Source (or link) that you select from your homepage. For example, if you select Facility Abstractor Training, you cannot open and work on follow-back abstracts. To open abstracts of a different Source, click Home on the Web Plus menu, and click the link for the type of abstract you would like to open.

3. Select **Facility Abstractor Training** from the Source pull-down menu, and click **Find**.

You can search on partial name or social security number.

**Result:** A list of all abstracts that were abstracted under the Facility Abstractor Training link opens.

The list of abstracts has these following twelve columns:
### Column Head | Description
--- | ---
Actions | You have the option to open or delete an abstract
AbsRefID | A system-generated number identifying the abstract
Last Name | Last name of patient
First Name | First name of patient
DxDate | Diagnosis date
Social Security | Patient’s social security number
Birth Date | Patient’s date of birth
Primary Site | The location of the major tumor
Laterality | Code for the side of a paired organ, or the side of the body on which the reportable tumor originated
Abstractor | Code for the person who created the abstract
Edit Errors | The number of errors found in the edit process after an abstract has been saved
Status | Web Plus has three types of statuses:
| - Incomplete (not all data have been entered)
| - Complete (all errors have been addressed)
| - Released (sent to the central registry)
Source | The type of Web Plus abstract; this is the name of the link that you clicked on your home page

4. Click **Open** in the **Action** column of the incomplete abstract you started for **JOHN JOHNSON**.

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

5. Type **20110223** in the **Date of Diagnosis** field, and press **Enter**.

6. Press **Enter** again to leave the **Diagnosis Date Flag** field blank.

7. At the **Age at Diagnosis** field, click the **calculator** icon.

**Result:** The Age at Diagnosis (049) is automatically calculated and entered into the Age at Diagnosis field.

### Text Fields

Text Fields are another type of data entry field. This is an area where you enter text to describe diagnostic information, such as information from a pathology report, and
treatment information, such as X-rays or surgery. The text fields displayed depend on those collected by your central registry.

You can use text fields to document supplemental information not contained within the coded values. You can also provide information that you are uncertain how to code so that a central abstractor/reviewer may code it properly in the data fields when the abstract is released to the central registry. The text is limited only by the maximum number of characters indicated for each field (for the majority of text fields, 1,000 characters are allowed).

Note: Critical (required) fields are labeled with an asterisk (*).

## Adding Comments to an Abstract

It may be helpful to save notes about an abstract while you are in the process of abstracting it, or to relate supplemental information about the abstract to the central registry. Comments may be added to the abstract while abstracting it so that you can reference the information at a later time.

To add a comment to an abstract, complete these steps:

1. Click on **Add/View Comments** in the upper right-hand corner of the page.

Result: The abstract comments window opens.
2. Enter your comments and click **Save**.

![Note](image.png)

The abstract comments are available for viewing until you complete and release the abstract. After the abstract is released, the comments are then available for viewing by central registry staff.

**Print Preview**

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

1. Open an abstract.

2. Click **Print Preview** 📃.
   
   **Result:** A separate window opens that displays all of your abstract entry fields and content.

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

**Deleting an Abstract**

To delete an existing abstract, use the Find Abstract page. In this section, you create a new abstract, save it, find it, and then delete it.

To create and then delete an abstract, follow these steps:

1. Log in, if you are not already, as described in “Log In,” page 26.

2. On the Web Plus menu, click **New Abstract**.
   
   **Result:** The Data Entry page opens.

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

4. Click **Save**.
   
   **Result:** The system saves the abstract to the database.

5. On the Web Plus menu, click **Find/Open Abstract**.
   
   **Result:** The Find Abstract page opens.

6. Type **891234567** in the Social Security number field.
   
   **Result:** The results display the Chung abstract entry.

7. Click **Delete** in the **Action** column. Be sure to note the Abstract Reference ID (AbsRefID) number.
   
   **Result:** The Confirm Delete window opens. It displays the Abstract Reference ID number of the abstract you want to delete (ID number 205 is an example; your Abstract Reference ID number will be different).
8. Click **Delete**.

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

8. Click **Delete**.

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

9. Click **Close**.

10. On the Find Abstract window, click **Find** and confirm in the results window that the system has deleted the abstract.
Chapter 5: Correcting Errors

Learning Objectives
In this chapter, you will learn to:

- Correct edit errors
- Understand how edit sets affect the completion of an abstract
- Understand the edit error messages

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

Understanding Edit Sets
Each abstract is edited for data quality and completeness whenever you save or open it. The edits applied to the information depend on the edit set selected for your facility by your Web Plus Administrator at your central registry.

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

Edit Errors Tab
The edit errors pane lists edits in the abstract. The edit set runs each time the abstract is saved or re-opened. To correct abstract edit errors, complete these steps:

1. Find and open the JOHN JOHNSON abstract. For more information on finding and opening abstracts click here.
2. On the Data Entry page, view the Edit Errors tab in the information pane on the right.
3. In the Edit Errors list, click on the **Class of Case = <BLANK>** link.

   **Result:** The application directs you to the **Class of Case** field in the data entry grid, so that you can correct the error.

4. Enter **14** to indicate that the patient was diagnosed at and all treatment given at the reporting facility to resolve the edit error.

5. **Save** the abstract to re-run the edits.

   **Result:** The application re-runs the edits. The Class of Case edit error is **removed** from the Edit Set Results window, and the **Total Edit Errors for Abstract count goes down by 1**. In the example shown, the edit error count goes down from 46 to 45.

To resolve all edit errors, you would continue to click on links to fields containing edit errors and enter correct values for the fields.
Chapter 6: Completing and Releasing Abstracts

Learning Objectives
In this chapter, you will learn to:

- Complete an abstract
- Understand the two different ways to release a completed abstract to your central registry

Overview
In this chapter, you complete working on your abstract, and will about the two different ways to release the completed abstract to your central registry. You can only release completed abstracts which have no edit errors.

Completing the Abstract
As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, Web Plus informs you that the abstract is complete and ready for release to the central registry.

1. As you abstract the below fields, remember to save your work often. It is good practice to click the Save button each time after you enter a few fields. If you do not click Save often enough, you will lose the work you have done as Web Plus will log you out of the system due to inactivity.

2. Click Save to save the last entries that you made.

Result: Edits are run; the Edit Result shows no errors, and the application informs you that the abstract is complete and ready for release to the central registry.
3. **Do not** release the abstract now. Click **No** and go to the next section of this training manual, “Releasing the Abstract”.

**Result:** The abstract is saved and completed, but not released.

You could release your abstract at this point by clicking **Yes**, but you can also release one or more abstracts on the Release Abstracts page. For further details, see the next section, “Releasing the Abstract.”

**Releasing the Abstract**

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

Follow these steps to release an abstract:

1. On the Web Plus menu, click **Release Abstracts**.

**Result:** The system displays a list of completed abstracts.
2. Click the box in the Release column for the JOHN JOHNSON abstract.

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

3. Click Release Selected Abstracts.

   **Result:** The system releases the selected abstracts to your designated central registry and changes the status of the abstracts to Released. Use the Find/Open page to view the released abstracts. Note that you can view an abstract that has been released but cannot revise it.