Head Neck Advanced Case #1

FIELD#	FIELD NAME	CODE AND RATIONALE/DOCUMENTATION	
PATIENT IDENTIFICATION			
1	Medical Record #	999905	From record
2	Accession #	2007xxxxx	
3	Sequence #	00	No history other malignancies
4	Patient Name	Doe, Othmar	From record
5	Race 1	01	White per 3/18 PE
6	Spanish Origin	0	No mention of Hispanic origin
7	Sex	1	Male
CANCER IDENTIFICATION			
8	Class of Case	1	Dx and Tx at this facility
9	DATE 1st Contact	02/13/2007	Date of FNA lymph node
10	DATE Initial Dx	02/13/2007	First date MD stated cancer
11	Primary Site	C099	Tonsil documented by several doctors
12	Laterality	1	Right tonsil noted by several doctors
13	Histology	8070	Squamous cell cancer on LN path report
14	Behavior	3	Malignant, primary site
15	Grade	9	Bx non-primary (LN) so grade not possible
16	Diagnostic Confirmation	2	Cytopathology report (smears = cytology)
17	Ambiguous Terminology Dx	0	Definitive statement malignancy (cytology report)
18	Date of Conclusive Dx	88/88/8888	Dx made with definitive statement
19	Date of Multiple Tumors	00/00/0000	Single tumor
20	Mult Tumors Reported as 1 Prim	00	Single tumor
21	Multiplicity Counter	01	1 tumor only
STAGE OF DISEASE AT DIAGNOSIS			
22	DATE Surg Dx/Stage Procedure	02/13/2007	Bx LN (tonsil bx not diagnostic)
23	Surg Dx/Stage Procedure Code	01	Bx LN
24	Clinical T	2	2.4 cm on 3/07 H&P
25	Clinical N	1	3.2 cm LN on 3/07 H&P
26	Clinical M	0	No distant mets documented
27	Clinical Stage Group	3	T2 N1 M0
28	Clinical Stage Descriptor	0	None
29	Clinical Staged By	5	Registrar (no doctor staging found)
30	Pathologic T	0	No evidence tumor on tonsillectomy path
31	Pathologic N	1	2.4 cm necrotic tumor LN on tonsillectomy path
32	Pathologic M	0	No distant mets documented
33	Pathologic Stage Group	99	No stage group when T0
34	Pathologic Stage Descriptor	4	“y” staging (surgery after neoadjuvant therapy)
35	Pathologic Staged By	5	Registrar (no doctor staging found)
36	SEER Summary Stage 2000	3	Regional to lymph nodes
COLLABORATIVE STAGING			
37	CS Tumor Size	024	Original size 2.4 cm per H&P
38	CS Extension	30	Localized NOS
39	CS Tumor Size/Ext Eval	5	Surgery done but info from clinical info pre-op
40	CS Lymph Nodes	10	Level II per path report
41	CS Reg Nodes Eval	6	LN excised w/PRE-surgical treatment (by using “6”, we get “y” code so we can remove case from analysis studies) Arguably, the Eval code could be 5 and the lymph node would map to cN1
42	Regional Nodes Positive	01	1 positive on path report-2/13/07
43	Regional Nodes Examined	27	1 + 21 + 5 LNs on path report
44	CS Mets at Dx	00	No mets documented

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45	CS Mets Eval	0	No path exam of mets disease; Clinical
46	CS Site-Specific Factor 1	032	Original size 3.2 cm LN per H&P 3/18/07
47	CS Site-Specific Factor 2	000	Mass described as mobile on PE note 2/13/07
48	CS Site-Specific Factor 3	010	Level II per path report
49	CS Site-Specific Factor 4	000	No IV, V, retropharyngeal positive on PE or CT
50	CS Site-Specific Factor 5	000	No VI, VII, or facial nodes positive on PE or CT
51	CS Site-Specific Factor 6	000	No LNs this category posotive on PE or CT
FIRST COURSE OF TREATMENT (FCOT)			
52	DATE of FCOT	02/12/2007	Chemo/RT started
53	DATE 1st Surgical Procedure	06/03/2007	Tonsillectomy and selective LN dissection
54	DATE Most Definitive Surg Primary	06/03/2007	Tonsillectomy and selective LN dissection
55	Surg Procedure Primary Site	31	Tonsillectomy
56	Surg Margins Primary Site	0	No residual disease
57	Scope Regional LN Surgery	5	> 4 LNs removed
58	Surg Procedure Other Site	0	No other surgery
59	DATE Surg Discharge	06/16/2007	Date per discharge summary
60	Readmit Same Hosp w/in 30 Days	0	No readmission documented
61	Reason No Surg Primary Site	0	Surgery was done
62	DATE Radiation Started	02/12/2007	RT started per H&P 3/18/07
63	DATE Radiation Ended	03/15/2007	RT ended per H&P 3/18/07 due to mucositis
64	Location of Radiation Treatment	1	Given at this facility
65	Radiation Treatment Volume	05	Head & neck NOS
66	Regional Treatment Modality	20	External beam NOS (no details found)
67	Regional Dose: cGy	99999	Dose is unknown
68	Boost Treatment Modality	00	No boost (patient did not finish regional RT)
69	Boost Dose: cGy	00000	No boost dose
70	Number Treatments per Volume	99	Exact number treatments unknown
71	Radiation/Surgery Sequence	2	RT before surgery
72	Reason No Radiation	0	RT done
73	DATE Systemic Therapy Started	02/12/2007	Chemo started per H&P 3/18/07
74	Chemotherapy Code	02	Taxotere only drug documented
75	Hormone Code	00	Not done
76	Immunotherapy Code	00	Not done
77	Hematologic Trsplt & Endo Code	00	Not done
78	Systemic/Surgery Sequence	2	Chemo before surgery
79	DATE Other Treatment Started	00/00/0000	Not done
80	Other Treatment Code	00	Not done
81	Palliative Treatment Code	00	Not done
RECURRENCE			
82	DATE 1st Recurrence	00/00/0000	No recurrence documented
83	Type 1st Recurrence	0	No recurrence documented
84	DATE Last Contact/Death	02/01/2008	Radiology Report: CT Scan of Neck
85	Vital Status	1	Alive
86	Cancer Status	1	Status post right-sided neck dissection. No recurrent or residual neoplasm on examination.
CASE ADMINISTRATION			
87	Is Case Complete?	Maybe	RT details are minimal. Registrar should call for End-of-Treatment note to improve documentation.