**MARYLAND CANCER REGISRY**

**INSTRUCTIONS FOR**

**MEDICAL RECORD ABSTRACT**

**Hardcopy Submissions of Information on Reportable Tumors**

**BLADDER CANCER**

**February 2019**

**PLEASE DO NOT EMAIL ANY CONFIDENTIAL PATIENT INFORMATION**

**MARYLAND CANCER REGISTRY**

**Instructions for Hard Copy Medical Record Abstracts February 2019**

The Maryland Cancer Registry (MCR) of the Maryland Department of Health contracts with Myriddian, LLC. to collect Medical Record Abstracts on tumors reportable by Maryland law (Health-General, Article §18-203, and 18-204) and Code of Maryland Regulations 10.14.01. For more information on reporting and reportable invasive, in situ tumors, and benign tumors, see

http://phpa.dhmh.maryland.gov/cancer/SitePages/mcr\_reporter.aspx.

The hardcopy abstract format allows a reporter to record the required information directly onto the Medical Record Abstract form. Please **attach a copy of the pathology or laboratory report** corresponding to the tumor being reported to the Medical Record Abstract and submit each Abstract to Myriddian, LLC. by fax or by mail:

**Mail or Fax report to:**

**Myriddian, LLC., Maryland Cancer Registry**

**6711 Columbia Gateway Drive, Suite 475**

**Columbia, MD 21046**

**Fax: 240-833-4111**

**Questions? Call 1-866-986-6575 or 410-344-2851**

**DO NOT REPORT THESE TUMORS TO THE MCR:**

If cytology is reported as *suspicious*, **do not** interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician’s clinical impression of cancer supports the cytology findings.

If a final diagnosis is reported as *possible* carcinoma of the bladder, *possible* **is not** a diagnostic term for cancer.

**INSTRUCTIONS FOR EACH FIELD**

**REPORTER IDENTIFICATION**

**FACILITY NAME**: Enter the full name of your facility

**ABSTRACTOR INITIALS:** Enter the initials of the person reporting the case.

**FACILITY ID #:** Enter your 10 digit facility identification number as assigned by the Maryland Cancer Registry. If unknown or your facility does not have one, leave blank.

**PHYSICIANS NPI #:** Enter your physician’s NPI number. If unknown, leave blank.

**MEDICAL RECORD #:** Enter the medical record number assigned by your facility, if applicable. Leave blank if this does not apply.

**PATIENT DEMOGRAPHICS**

**PATIENT NAME:** Enter patient name, Last Name, First Name, MI

**SOCIAL SECURITY #:** XXX-XX-XXXX

**DATE OF BIRTH**: YYYY/MM/DD

**PATIENT RESIDENTIAL ADDRESS:** Enter the patient address ## and Street Name only.

**PATIENT RESIDENTIAL ADDRESS:** Include identifiers such as Apt #, RR # or PO Box #.

**CITY/STATE/ZIP:** Enter City/State (2 digit format)/Zip Code (5-digit format)

**COUNTY OF RESIDENCE:** Please indicate county of residence if known, otherwise, leave blank.

**GENDER (check one):** Male  Female  Other

**PLACE OF BIRTH** (if known): Enter the patient’s Country or U.S. State of birth if known. If not known, record as Unknown.

**RACE:** Check the appropriate code or codes to describe race, such as: White, Black, Native American, Asian (give country of origin, if known, for example, China, Japan, Asian Indian, Pakistani), Pacific Islander (give country of origin, if known, e.g., Tahiti, Samoa, Fiji), Other, or Unknown. If Multi-racial, please check/list as many boxes that may apply.

**SPANISH/HISPANIC ORIGIN:** If this information is available, please document as Hispanic, Latino, Non-Hispanic or Unknown, etc. If this is not documented, record as Unknown. Please specify country of origin if known; otherwise, leave country of origin blank.

**OCCUPATION:** Please enter the information about the patient's usual occupation, also known as usual type of job or work. Do not record "Retired". If the information is not available or is unknown, check the box marked” Unknown”.

**DIAGNOSIS/TUMOR INFORMATION**

**DATE OF INITIAL DIAGNOSIS:** YYYY/MM/DD Date of initial diagnosis by a recognized medical practitioner for the tumor being reported.

**SITE OF TUMOR:** This refers to the anatomic site (on the body) where the tumor being reported was found. Bladder tumors are delineated as follows:

Anterior Wall Dome Internal Urethral Orifice Base

Lateral Wall Trigone Urachus Floor

Posterior Wall Neck Urinary, NOS Roof

Sidewall Wall, NOS Bladder, NOS Overlapping

If you cannot tell the area of the bladder in which the biopsy was taken, please use Bladder, NOS (Not Otherwise Specified) as your choice.

**SIZE OF TUMOR:** Record in Centimeters in the following format XX.X. If a tumor is recorded in terms of millimeters, you may convert by moving the decimal for the number, for example: if a tumor is reported as 8mm, it would be recorded as 00.8cm. Conversly, 10mm would equal 01.0cm.

If tumor size is not stated, please leave blank.

**TYPE OF TUMOR:** Record the histology that best describes the type of tumor found. If unknown, please indicate as Unknown. For example:

Transitional Cell Carcinoma is the most common type of bladder cancer.

Other histology's include:

Transitional Cell Carcinoma, In-Situ

Papillary

Flat

With squamous differentiation

With glandular differentiation

With squamous and glandular differentiation

Squamous Cell Carcinoma

Adenocarcinoma

Undifferentiated Carcinoma

**BEHAVIOR**: Pathologists use these terms to describe the type of tumor.

|  |  |
| --- | --- |
| **Label** | **Definition** |
| Benign | Benign. |
| Borderline | Uncertain whether benign or malignant. |
| Borderline malignancy. |
| Low malignant potential. |
| Uncertain malignant potential |
| Clark level 1 for melanoma (limited to epithelium). |
| Synonymous with  in situ (non-invasive) | Confined to epithelium. |
| Hutchinson melanotic freckle, NOS (C44.-). |
| Intracystic, noninfiltrating. |
| Intraepidermal, NOS. |
| Intraepithelial, NOS. |
| Involvement up to, but not including the basement membrane. |
| Lentigo maligna (C44.-). |
| Noninfiltrating. |
| Noninvasive. |
| No stromal involvement. |
| Precancerous melanosis (C44.-). |
| Malignant (Invasive) | Invasive or microinvasive. |

**GRADE:** Review the pathology report for reference to ‘Grade’. Record either the terms or the number if available from the pathology report. If not documented, record as Unknown.

|  |  |
| --- | --- |
| **Description** | **Grade** |
| Differentiated, NOS | I |
| Well differentiated | I |
|  |  |
| Fairly well differentiated | II |
| Intermediate differentiation | II |
| Low grade | I-II |
| Mod differentiated | II |
| Moderately differentiated | II |
| Moderately well differentiated | II |
| Partially differentiated | II |
| Partially well differentiated | I-II |
| Relatively or generally well differentiated | II |
|  |  |
| Medium grade, intermediate grade | II-III |
| Moderately poorly differentiated | III |
| Moderately undifferentiated | III |
| Pleomorphic | III |
| Poorly differentiated | III |
| Relatively poorly differentiated | III |
| Relatively undifferentiated | III |
| Slightly differentiated | III |
| Dedifferentiated | III |
|  |  |
| High grade | III-IV |
| Undifferentiated, anaplastic, not differentiated | IV |
| Unknown | Not stated |
|  |  |

**METASTATIC DISEASE:** Check ‘Yes’ box if distant site metastasis was identfied at diagnosis. If yes, please indicate the site of the distant metastasis such as Lung, Bone, or Liver. Check ‘No’ box if metastasis was not identified or not stated. Check ‘Unknown’ box if metastasis at diagnosis is unknown.

**Tumor Characteristics** (for Staging): Check ‘Yes’ box if condition if present and/or described in the pathology report. If Unknown, skip to the next selection and leave blank. Also indicate the extension of the disease within the organ and to neighboring organs with the appropriate checkbox.

Non-Invasive Papillary Tumor  Yes  No

Solid/nodule  Yes  No

Carcinoma “*in-situ*”: Flat  Yes  No

Lymphovascular Invasion  Yes  No

Other Specify:

WHO/ISUP Grade (***transitional/urothelial cell only***):

Low Grade High Grade Not applicable, tumor type is not transitional

No tumor type known Unknown

**TREATMENT INFORMATION – First Course of Therapy**

**SURGERY:** Check the appropriate box that best describes the surgery performed. Check as many as apply. If the response is ‘Yes’, provide a date the procedure was performed.

If no surgery was performed, please check the appropriate box, state a brief reason why no surgery was performed and the Date that decision was made.

If Lymph Nodes were involved, please describe name of lymph nodes or area, total number examined, and total number positive.

Lymph node region: Describe the region of the body where the lymph nodes were examined.

Total Number Nodes Examined: ### (up to 3 numbers) Total Number Nodes Positive:### (up to 3 numbers)

Size of Metastasis in lymph nodes: If available, indicate of size pf metastasis in lymph nodes.

Extranodal Extension: If available, indicate whether there is extranodal extension by checking the “Yes” or the “\No” box.

**OTHER TREATMENT:** This category includes chemotherapy, radiation therapy, hormonal, immunotherapy (vaccine), or any other treatment the patient may have received for their diagnosis. Choose the response that best describes the treatment and date, if known.

Otherwise, mark as ‘unknown’ and disregard the date field. Choose as many as may apply.

Please provide any additional information which may be important regarding the patient’s treatment/care. If no additional information is available, leave blank.

**Additional Information (if available)**

Referring or Managing Physician:

Medical Oncologist:

Radiation Oncologist:

**PLEASE ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS ABSTRACT FORM.**

Mail or Fax [DO NOT email] report to:

**Mail or Fax (Do not email) report to:**

**Myriddian, LLC., Maryland Cancer Registry**

**6711 Columbia Gateway Drive, Suite 475**

**Columbia, MD 21046**

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