Updated February 2025

Wisconsin-specific Web Plus™ Quick Reference Guide

Dermatology Reporting

Wisconsin Cancer Reporting System
Office of Health Informatics
Division of Public Health
Wisconsin Department of Health Services

WISCONSIN DEPARTMENT of HEALTH SERVICES

P-02908 (02/2025)

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This Dermatology Quick Guide was created to reported in-situ and/or localized dermatology melanoma cases. Per requirement standards, dermatology cases with histology other than melanoma or a melanoma case with more advanced disease/treatment will require additional data fields completed.

To ensure treatment information is not inadvertently lost, please use the “Abstract 2018-2025 Diagnoses” form to abstract cases if you have information regarding a patient’s chemotherapy, hormone therapy, radiation therapy, or other type of treatment that is not listed in the “Dermatology Abstracts” form.

Please contact WCRS if you encounter a case required to be reported with additional data fields.

Summary of Changes

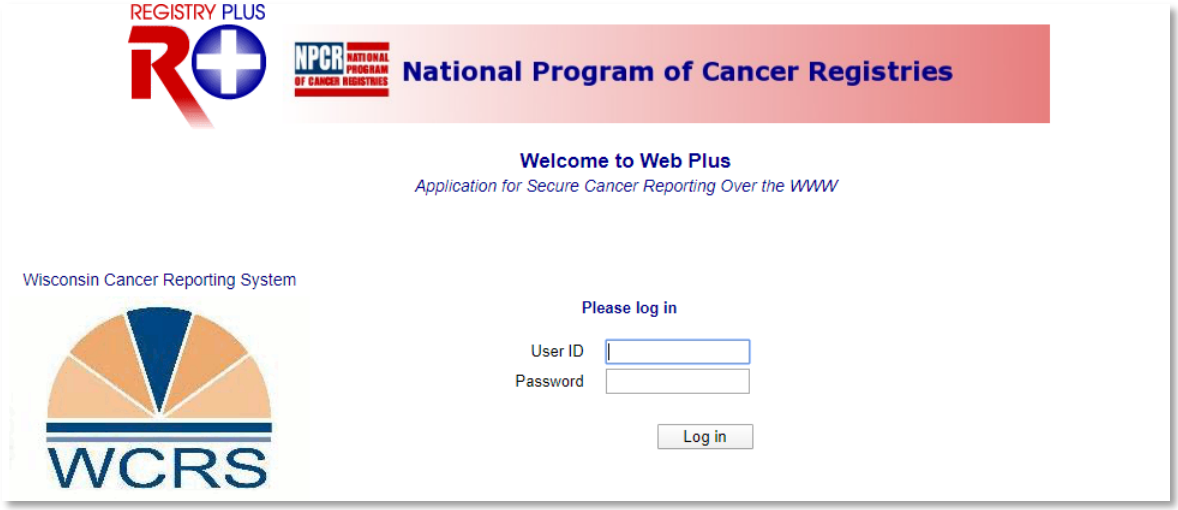
The following changes have been made to the Abstracting Display or data items.

- Removed Site Codes – please utilize the lookup tool in the Abstracting Display to find appropriate codes
- Removed Surgery codes – please utilize the lookup tool in the Abstracting Display to find appropriate codes
- Removed “Usual Occupation” and “Usual Industry” fields
- Added Text Field Requirements and Examples

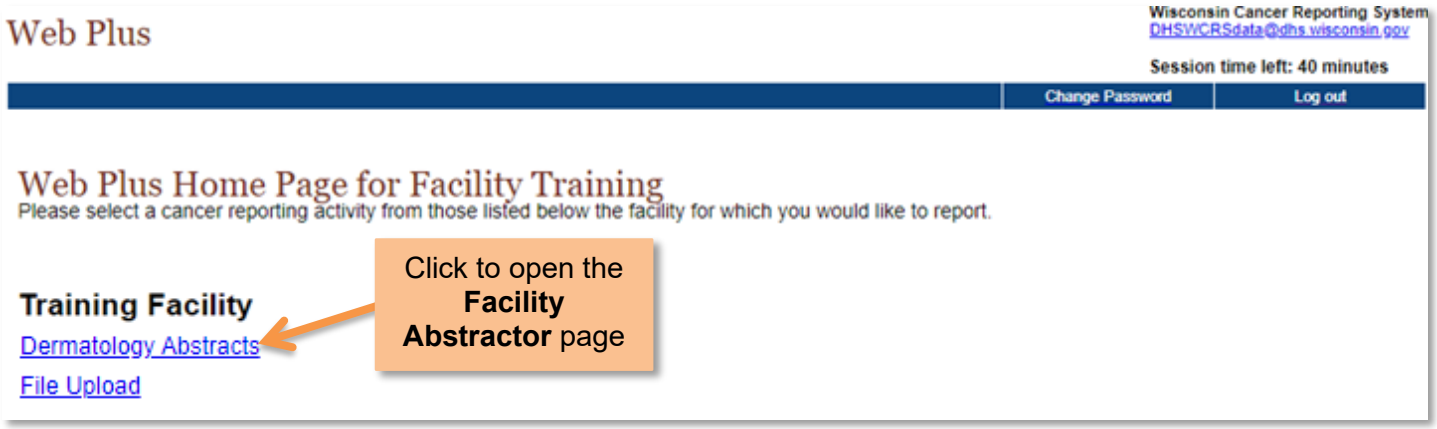
Create an Abstract

1. Go to https://webplus.wisconsin.gov/ and type in your User ID and password. Click **Log in.**

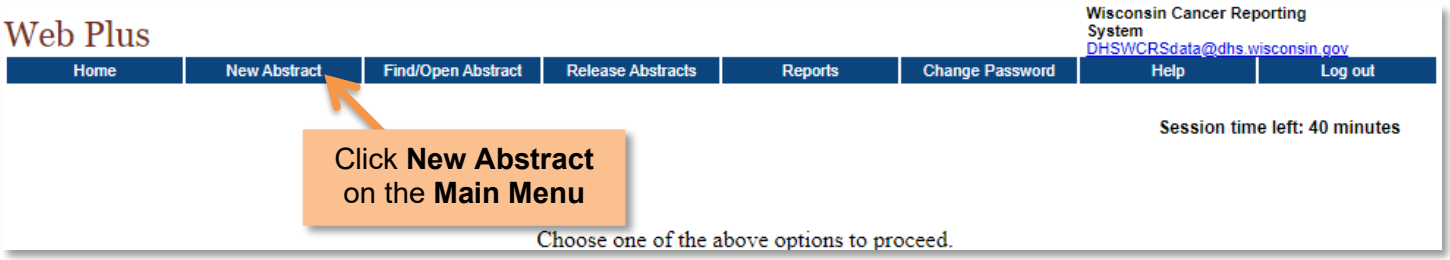
   Note: *Contact dhswcrsdata@dhs.wisconsin.gov for assistance with locked accounts, password resets, and username reminders.*



2. **Result:** The Home Page opens. Click the applicable **Dermatology** link.

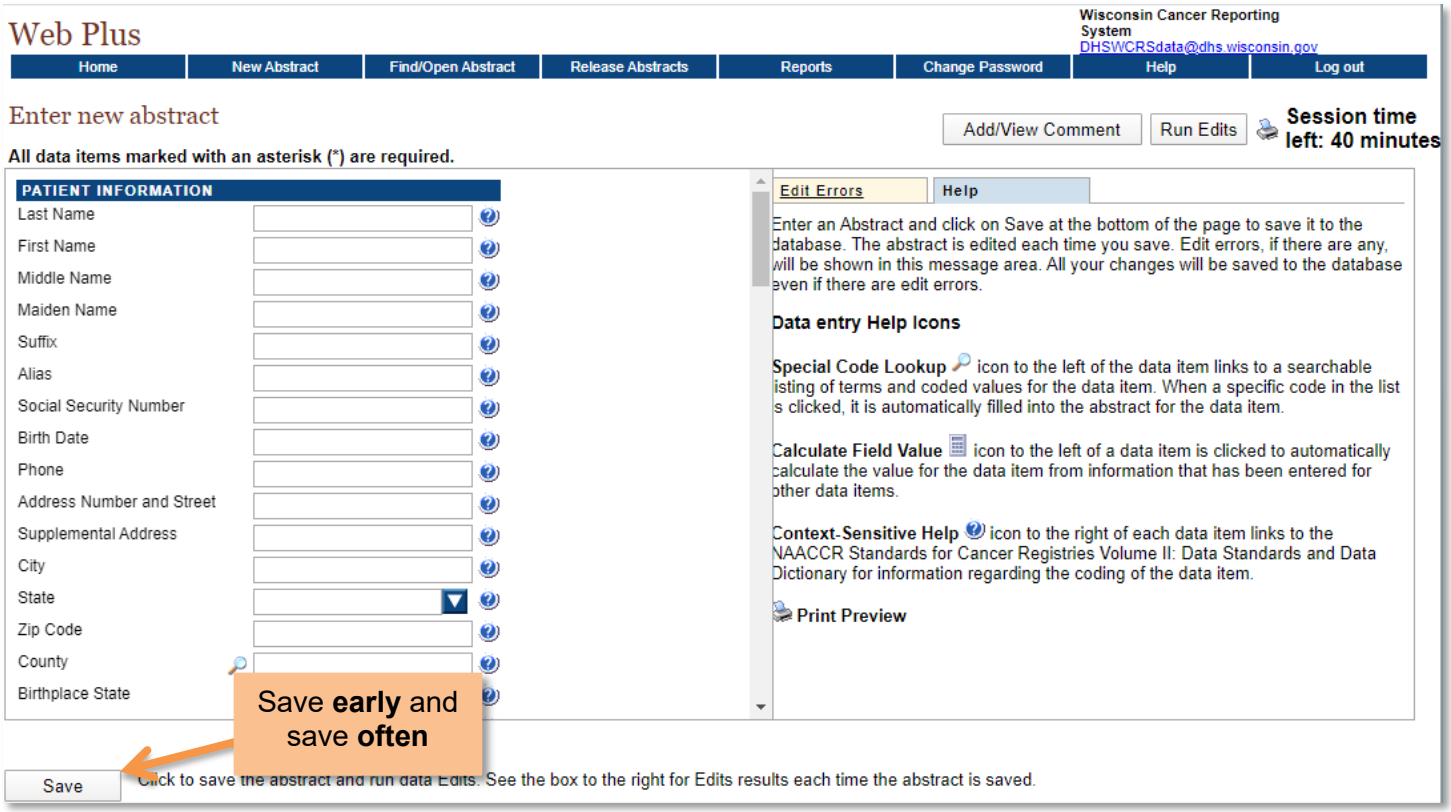


3. **Result:** The **Facility Abstractor** page and **Main Menu** appear. Select **New Abstract** on the **Main Menu**.



4. **Result**: An empty **abstract** appears. Fill out the abstract, working your way from top to bottom, in general. **Save early** and **save often.** Refer to Appendix: Data Items for field definitions and instructions.

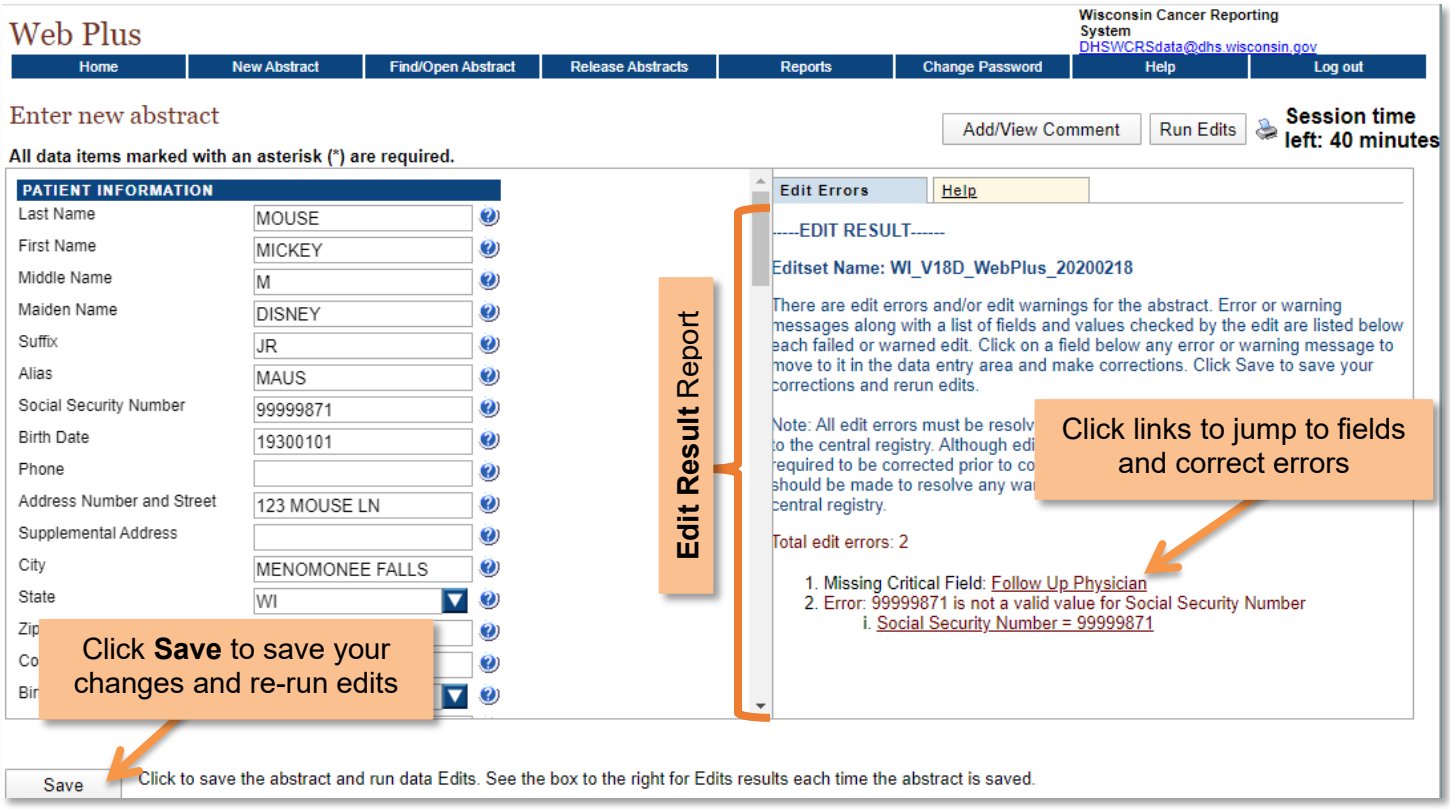
***Note:** You can save and come back to your abstracts at any time. See: [Find/Open Abstracts] for more information.*



!	**Your session time is limited to 90 minutes.** Session time refreshes whenever you save your abstract. Make sure you save often! Any unsaved work will be lost if your session expires.

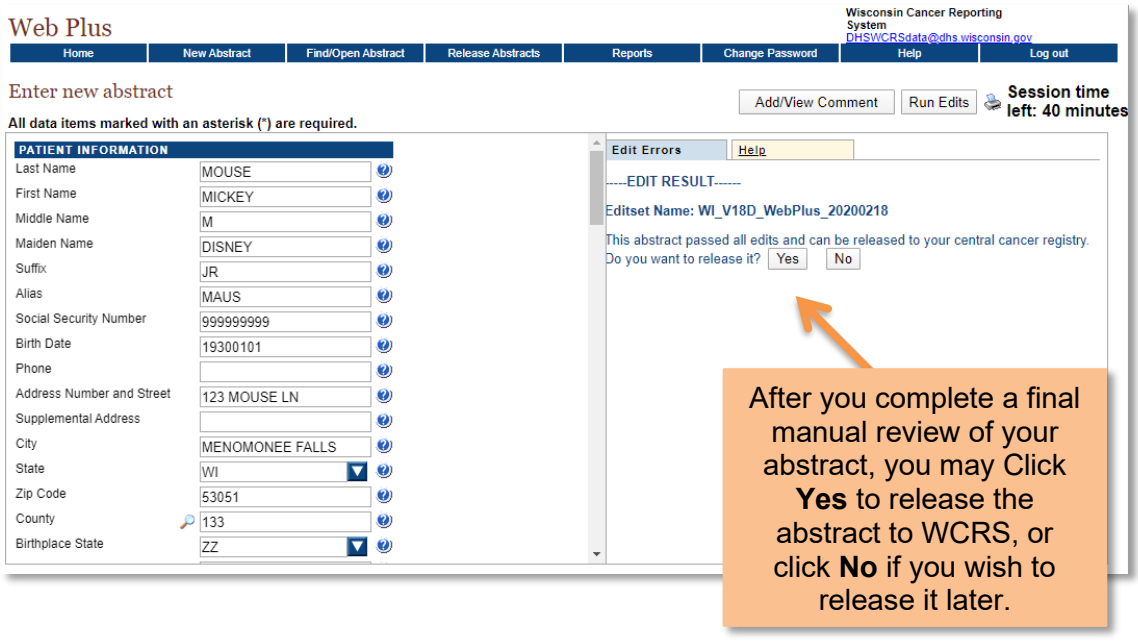
Data Entry Help Icons
Calculate Field Value Located to the left of some fields, such as *Age at Diagnosis* and *Schema ID*. Click to populate the derived value. Will only work if all items required for calculation have been entered (e.g. *Date of Birth* and *Diagnosis Date* to calculate *Age at Diagnosis*)
Special Code Lookup Located to the left of the some fields. Click to open a searchable listing of terms and coded values for the data item. Click a value from the list to add it to the abstract. Always use this option to enter data if it is available.
Context-Sensitive Help Located to the right of each data item. Opens a window with information from the *NAACCR Data Dictionary* regarding the coding of the data item.

5. When you save your abstract edits will run, and you will receive an **Edit Result** report.
6. Correct any **edit errors** as displayed in the **Edit Result Report** and continue to re-run edits and save your abstract until it is error-free.



7. **Result:** When the abstract is error-free, you will receive a prompt to release the abstract. **Before releasing, review the entire abstract for a final time**. After checking the abstract for the final time, you can click **Yes** to release, or click **No** if you wish to **Release Abstract** at a later time.

   ***Note**: **Once an abstract is released you will be unable to make changes to it.** If you accidentally released an abstract with mistakes, or need to make corrections to a released abstract, follow instructions for Reporting Errors and Requesting Abstracts be Sent Back for Correction*

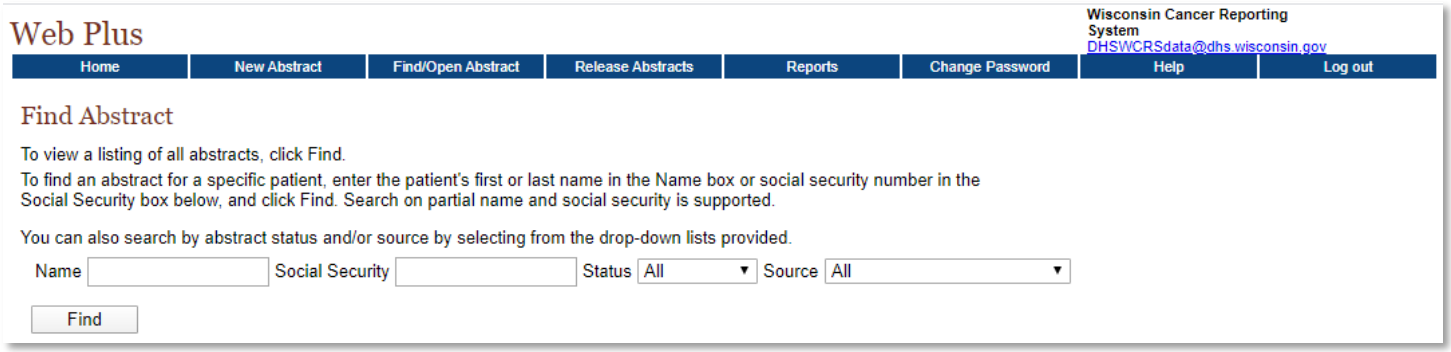


Find/Open Abstracts

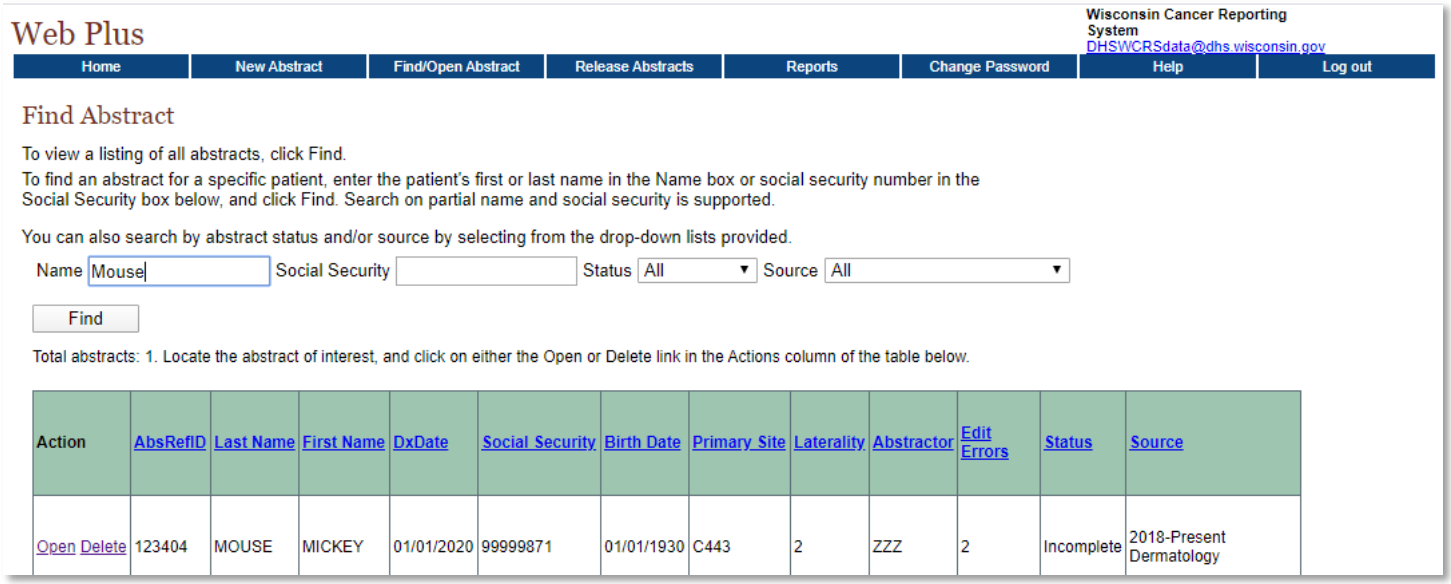
You can view and make changes to unreleased abstracts at any time. In addition, you can view, but cannot make changes, to all released abstracts. To find and open abstracts, follow these instructions.

1. Select **Find/Open Abstract** from the **Main Menu** on the **Facility Abstractor** screen.

2. **Result:** The **Find /Open Abstract** screen appears. Enter search criteria to narrow results, or just click **Find** to list all abstracts.



3. **Result:** Search results appear in a table format. Take note of the **Status** column.



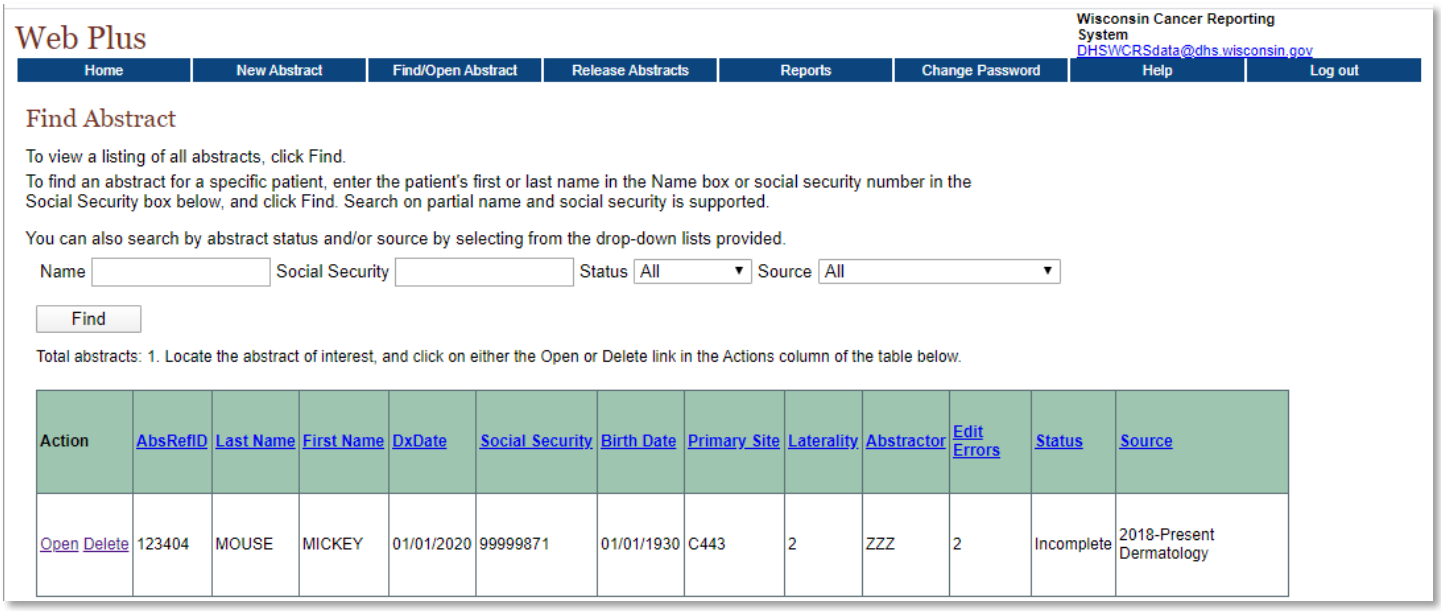
Abstract Statuses
Incomplete Abstract contains errors. All errors must be resolved before it is released to WCRS.
Complete Abstract is error-free and ready for release. **Open** the abstract to release it or go to the **Release Abstracts** page.

Released
Abstract has been released to WCRS and can be viewed. No further changes or edits can be made.

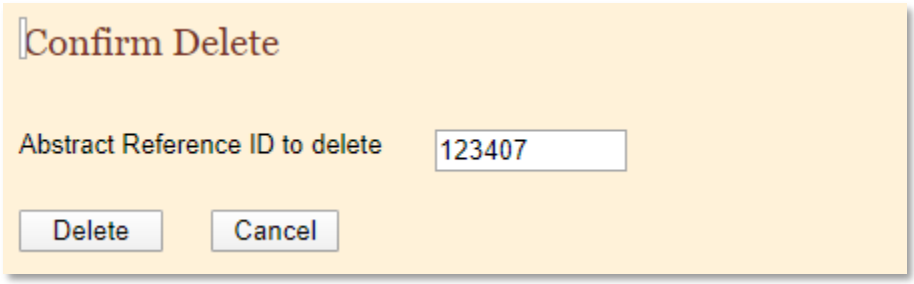
Delete Abstracts

You can delete abstracts from the **Find/Open Abstract** page. **Use this wisely.** In general, this should only be done if an abstract was created in error.

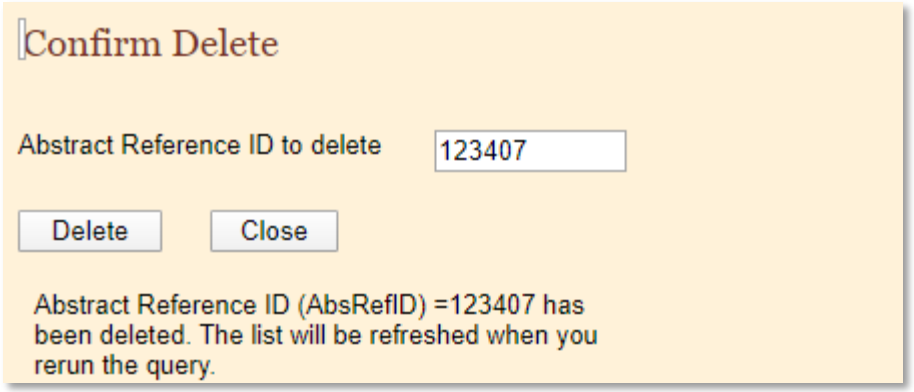
1. Find the abstract you wish to delete and click **Delete** in the **Action** column.



2. **Result:** The **Confirm Delete** window opens. Click **Delete.**



3. **Result:** The abstract is deleted from the database. You can close the **Confirm Delete** window.

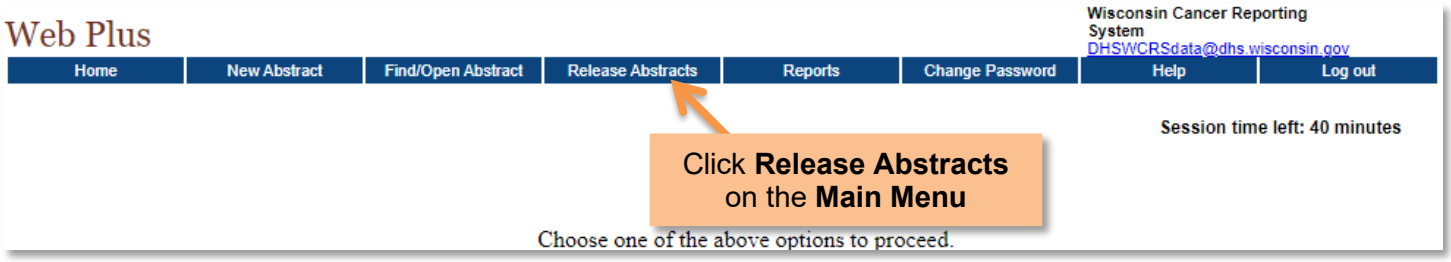


4. **Refresh** your page for changes to take effect. Your abstract will no longer appear in search results.

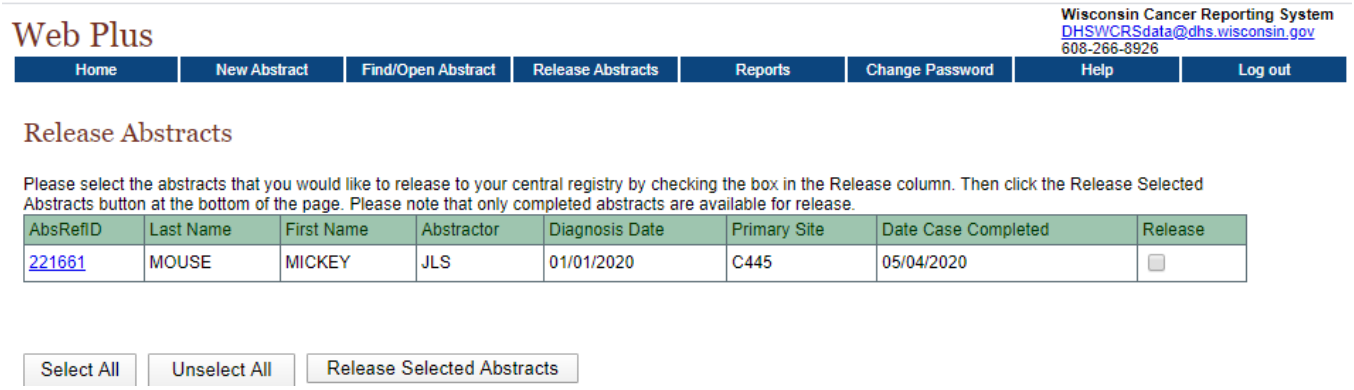
Release Abstracts

You can release completed abstracts from within the abstract, or from the **Release Abstracts** page. To release it from the **Release Abstracts** page, follow these steps.

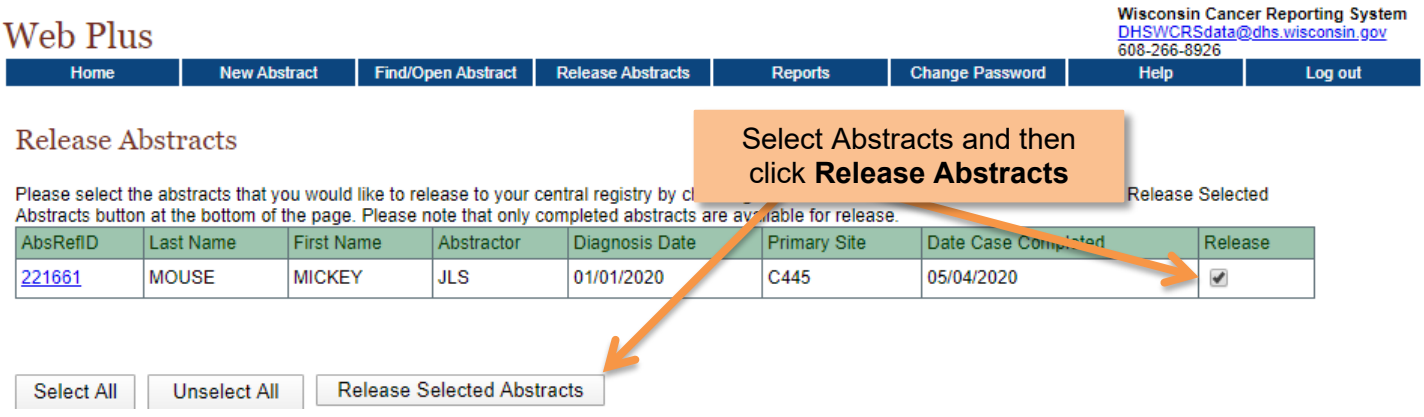
1. Select **Release Abstracts** from the **Main Menu**



2. **Result:** The **Release Abstracts** page appears, with a list of completed abstracts.



3. Select the **Release** checkbox for those you wish to release.



4. Click **Release Selected Abstracts. Result:** Abstract(s) are released to WCRS.

Reporting Errors and Requesting Abstracts be Sent Back for Correction

Once an abstract is released you will be unable to make changes to it. If you accidentally released an abstract with an error, or need to make corrections to a released abstract, follow these steps to report the error and initiate the correction process.

1. Upon discovery of an error, immediately email dhswcrsdata@dhs.wisconsin.gov with the following information:
    - The **Abstract Reference ID (AbsRefId)** of the abstract (can be found in the Find/Open Abstracts page)
    - Your **Facility Name** or Facility ID
    - A phone number to contact you, and your available hours

    Do NOT include any PII or PHI in your email.

!	**The sooner you notify WCRS of the incident, the more likely it is that we will be able to send the abstract back to you for correction.**

2. **If WCRS is able to send the abstract back,** we will do so and notify you of such. Once an abstract has been sent back, you can find it on the Find/Open Abstracts page, and it will be marked as **incomplete**. You can then open it, make any necessary changes, and release it once corrections have been made.
3. **If WCRS is unable to send the abstract back,** we will notify you of such and plan a phone call or meeting to gather additional information, as abstracts that cannot be sent back must be manually corrected by WCRS staff.

Appendix A: Data Items and Coding Instructions

Fields present in the current Abstracting Display are represented below. Tips or general instructions are also provided. Questions about coding instructions and value selection should be sent to dhswcrsdata@dhs.wisconsin.gov.

Patient Information	
Last Name	Enter the last name.
First Name	Enter the first name.
Middle Name	Enter middle name or middle initial. If there is no middle name or initial, leave this field blank.
Birth Surname	Last name (surname) of patient at birth, regardless of gender or marital status. Other alternate names should be recorded in the data item, Name--Alias. Last name (surname) of patient at birth, regardless of gender or marital status. *The field should be left blank if the birth surname is not known or not applicable.*
Suffix	Enter the name suffix (Sr., Jr., Esq., MD., etc.) if available. If there is no suffix, leave this field blank.
Alias	Enter alias name if available. If there is no alias, the field will remain blank. **Note**: The alias is not the same as birth surname.
Social Security Number	Enter social security number, no dashes. Enter 999999999 if unknown.
Birth Date	Enter birth date. Follow *Instructions for Dates*.
Phone	Enter area code and phone number, no dashes or parentheses. Enter 0000000000 if patient does not have a phone number. Enter 9999999999 if phone number unknown.
Address Number and Street	Enter street address of the patient's residence **at diagnosis**. Use standardized abbreviations, per USPS addressing standards. Avoid Punctuation if possible. Apartment or unit numbers should be included here. Enter UNKNOWN when patient address is not known. Punctuation limited to: . / - #
Supplemental Address	Enter additional address information such as the name of a place or facility e.g., Sunny Side Nursing Home, Waupun State Prison, etc.) at diagnosis. If there is no supplemental address, leave blank. **Note:** Do *not* enter apartment or unit number here.
City	Enter city **at the time of diagnosis**. No abbreviations are allowed in this field. Enter UNKNOWN if city is unknown.
State	Select state of residence **at the time of diagnosis** from the dropdown choices. Unknown code is ZZ.
Zip Code	Enter five or nine-digit zip code. Do not use spaces or dashes for nine-digit zip codes. Click on the blue question mark for unknown codes.
County	Enter county code of residence at diagnosis. Click on magnifying glass for a listing of codes. Click on the blue question mark for unknown codes.
Birthplace State	Select state of birth from dropdown choices. Scroll to the bottom of the dropdown list for unknown codes.

Birthplace Country	Enter country of birth. Click on magnifying glass for a listing of codes. If patient born in United States, code USA. If unknown, code ZZU.
Medical Record Number	Enter the medical record number used by the facility to identify the patient. If none used or unknown, leave blank.
Demographic	
Sex	Select the correct sex code from dropdown choices. Do not infer sex using names or other information. If unknown, code 9. Justify your code in the *Physical Exam text field*.
Race	Select the correct race code from dropdown choices. If unknown, code 99. Justify your code in the *Physical Exam text field*.
Race 2-5	Defaulted to 88. Change these values only if the patient is multiracial or race is unknown. If race is unknown, change all of these to 99.
Hispanic Ethnicity	Select the correct Spanish/Hispanic origin code from the dropdown choices. If unknown, code 9. Justify your code in *Physical Exam text field.*
Marital Status	Select the correct marital status code from the dropdown choices. If unknown, code 9. Justify your code in the *Physical Exam text field*.
Primary Payer at Dx	Select the appropriate code from the dropdown choices for the primary payer/insurance carrier **at the time of initial diagnosis or treatment** as listed in the patient's records. If unknown, code 99.
Medicare Beneficiary Identifier	Congress passed the Medicare Access and CHIP Reauthorization ACT to remove Social Security Number (SSN) from Medicare ID card and replace the existing Medicare Health Insurance Claim Numbers with a Medicare Beneficiary Identifier (MBI). The MBI will be a randomly generated identifier that will not include a SSN or any personal identifiable information. *Leave Blank if Not Available, Non-Medicare Patient, Not Applicable, or Unknown.*
Tobacco Use Smoking Status	Record the patient's past or current use of tobacco (cigarette, cigar and/or pipe). For cases diagnosed 2022 and later, code 9 if unknown. Leave blank for cases diagnosed 2021 and prior. Justify your code in the *Physical Exam text field*.
Diagnosis and Staging	
Date of 1st Contact	Enter date of 1st contact at your facility for this cancer. Follow *Instructions for Dates*.
Date of Diagnosis	Enter date of diagnosis. Follow *Instructions for Dates*.
Age at Diagnosis	Click on the calculator icon to the left to calculate and enter age at diagnosis. Include age at diagnosis in the *Physical Exam text field*.
Primary Site Code	Click the magnifying glass to the left, enter a search term for the primary site of the tumor being reported, locate the correct term, and click on the code to the left of the term to fill the value into the field. **Note:** For dermatology abstracting, use "skin" in your search terms.
Primary Site Text	Enter the primary site and laterality of the tumor being reported. **Example**: Skin, lower left back.
Diagnostic Confirmation	Select the best code for the method of diagnostic confirmation of the tumor from the dropdown choices. **Note:** This field is defaulted to 1 since all melanoma cases should be histologically confirmed.

Tumor Laterality	Select the code from the dropdown choices for laterality (the side of a paired organ or side of the body on which the reportable tumor originated).
Histology Code	Click the magnifying glass to the left, enter a search term for the histology of the tumor being reported, locate the correct term, and click on the code to the left of the term to fill the value into the field. **Examples**: 8720 Melanoma NOS; 8743 Melanoma superficial spreading.
Histology Text	Enter information regarding the histologic type, behavior and grade (differentiation) of the tumor being reported. **Example**: Melanoma, superficial spreading type.
Behavior Code	Select the tumor behavior code from the dropdown choices. **Examples:** Code 2 In Situ. Code 3 Invasive/Malignant You either have in situ (contained) or malignant (invasive). Synonyms for In Situ Behavior Behavior code '2' Bowen disease (not reportable for C440-C449) Clark level I for melanoma (limited to epithelium) Confined to epithelium Hutchinson melanotic freckle, NOS (C44_) Intracystic, noninfiltrating (carcinoma) Intraductal (carcinoma) Intraepidermal, NOS (carcinoma) Intraepithelial neoplasia, Grade III (e.g., AIN III, LIN III, SIN III, VAIN III, VIN III) Intraepithelial, NOS (carcinoma) Involvement up to, but not including the basement membrane Lentigo maligna (C44_) Lobular, noninfiltrating (C50_) (carcinoma) Noninfiltrating (carcinoma) Non-invasive (carcinoma) No stromal invasion/involvement Papillary, noninfiltrating or intraductal (carcinoma) Precancerous melanosis (C44_) Queyrat erythroplasia (C60_) Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
Physical Exam Text	Record text information from the history and physical exam about the history of the current tumor, patient race, patient age, history of other cancers. **Example**: White Hispanic female age 52 presented for biopsy after noticing abnormal mole on left cheek on 2/01/20. No Hx of cancer.
Sequence Number	Select the sequence code from the dropdown choices. This is the order of this tumor in the sequence of cancers over the lifetime of the patient (/00 if patient's only malignant cancer, /01 if patient's first of more than one malignant cancer, etc.). In Situ behavior is considered malignant for purposes of the sequence number data field.
Lab Tests/LDH Level Text	Record text information from laboratory examinations. Record pretreatment Lactate Dehydrogenase (LDH) level if given, specify if normal/elevated.
LDH Lab Value	Record Lactate Dehydrogenase (LDH) value in 0.0 U/L format. Click the magnifying glass to the left for a list of other applicable codes or unknown codes.

Pathology Text	Enter information from cytology and histopathology reports. Include date, procedure (example: Shave biopsy, Wide excision), size, depth of invasion, margin status, etc.
Lymphovascular Invasion	Select the LV invasion code from the dropdown choices. **Note**: Melanoma in situ is coded 0, no LV invasion. Records must explicitly state whether LV invasion is present or not. Otherwise, code 9 for unknown.
Breslow Thickness	Record measurement specifically labeled as “thickness” or “depth” or “Breslow depth of invasion” from the pathology report in actual measurement in tenths of millimeters. **Example**: A punch biopsy with a thickness of 0.5 mm is followed by a re-excision with a thickness of residual tumor of 0.2 mm. Code 0.5.
Grade Clinical	This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant). Click on the "?” for further help. **Note**: Melanoma is normally not given a grade, code 9 for unknown.
Grade Pathological	This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. Click on the "?" for further help. **Note**: Melanoma is normally not given a grade, code 9 for unknown.
Grade Post Therapy Clin	This data item records the grade of a solid primary tumor that has been microscopically sampled following neoadjuvant therapy or primary systemic/radiation therapy. **Note**: *This field should typically be left blank* as melanoma is not typically treated with neoadjuvant therapy and thus a post therapy grade is not applicable.
Grade Post Therapy Path	This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. **Note**: *This field should typically be left blank* as melanoma is not typically treated with neoadjuvant therapy and thus a post therapy grade is not applicable.
Summary Stage 2018	Click the magnifying glass to the left for help determining correct summary stage code. **Common codes for melanoma**: Code 0 In Situ. Code 1 Localized.
Staging Text	Please include description needed to justify coded values and supplemental information not transmitted within coded values. **Include:** Tumor size and extension, lymph node involvement, assessment for metastasis, any other information pertaining to staging.
Schema ID	Click on calculator to apply Schema ID.
AJCC ID	Click on calculator to apply AJCC ID.
Treatment	
Treatment Status	Select the treatment status code from the dropdown choices. **Note**: if only a biopsy is performed, that is considered a treatment.
Date Initial Rx	Enter date of initial treatment. Leave blank if unknown or no treatment administered. Follow *Instructions for Dates*. **Example:** Surgery (as defined under Surgery Primary Site data field), Immunotherapy

Surgery Date	Enter date of the first/earliest surgery. Leave blank if unknown or not performed. Follow *Instructions for Dates*. **Example**: Date of excisional biopsy.
Most Defn Surg Date	Enter date of the most definitive surgical resection of the primary site. **Note:** If only one surgical procedure is done, date of Most Defn Surg should be the same as Surgery Date**.** Leave blank if unknown or not performed. Follow *Instructions for Dates*. **Example**: Date of wide excision/re-excision, Mohs procedure.
Surgery Primary Site 2003-2022	**Use for cases diagnosed 2003-2022.** Leave blank for diagnoses 2023 forward. Enter the code for the surgical procedure that removes and/or destroys tissue of the primary site as the first course of treatment. **Note:** If only one surgical procedure is done, date of Most Defn Surg should be the same as Surgery Date. **Common codes for melanoma**: 02 Biopsy only. 27 Excisional biopsy. 45 Wide excision or re-excision of lesion with margins more than 1 cm, NOS.
Surgery Primary Site 2023	**Use for cases diagnosed 2023 forward.** Leave blank for diagnoses 2022 and prior. Enter the code for the surgical procedure that removes and/or destroys tissue of the primary site as the first course of treatment. **Note:** Punch biopsies and shave biopsies are coded as surgeries.
Surgery Text	Record type and date of all surgical procedures performed as part of first course treatment.
Reason No Surgery	Select the reason for no surgery code from the dropdown choices. **Note**: if surgery done, Code 0.
BRM Therapy Date	Enter the date that immunotherapeutic (biologic response modifiers) agents were administered site. Follow *Instructions for Dates*. Leave blank if unknown or not administered.
BRM Therapy Summary	Enter the code for whether immunotherapeutic (biologic response modifiers) agents were administered as first course of treatment. If no immunotheraphy was done, code 00.
BRM Therapy Text	Record type and date of immunotherapeutic (biologic response modifiers) agents were administered as first course of treatment. **Example**: topical agent, Imiquimod Cream (Aldara).
Reporting Source Information	
Reporting Facility	Defaulted to WCRS-assigned facility ID.
NPI Reporting Facility	Enter facility NPI number for the facility that is reporting the submitted case. Leave blank if unknown or no NPI number assigned. **Note**: This is not the same as the physician NPI.
Place of Diagnosis Text	Enter the name of the facility and/or physician office where the diagnosis was made.
Class of Case	Select the class of case from the dropdown choices. **Common codes**: 00 Dx at reporting facility AND all RX or decision not to treat ELSEWHERE. 14 DX and ALL 1st course treatment at reporting facility.
Facility Referred From	Select the code from the dropdown choices for the facility that referred the patient to the reporting facility.
Facility Referred To	Select the code from the dropdown choices for the facility that the patient was referred to for further care.

Follow Up Physician	Enter the correct code or use the magnifying glass to look up and select the physician responsible for patient follow up. Leave blank if unknown or no number assigned.
NPI Follow Up Physician	Enter the NPI number for the physician currently responsible for the patient's medical care. Leave blank if unknown or no NPI number assigned. **Note**: This is not the same as the facility NPI.
Date of Last Contact	Enter date of last contact at your facility for this cancer, date of last follow-up, or date of death. Follow *Instructions for Dates*.
Abstractor	Defaulted to abstractor initials.
Patient Death Information	
Vital Status	Vital status of the patient as of the date entered in Date of Last Contact. 1 is Alive, 0 is Dead.
DthCause	Underlying cause of death as coded from the death certificate in ICD format. Code 0000 if patient alive or 7777 if death certificate not available.
ICDRevNum	Indicator for the coding scheme used to code the cause of death. Code 0 if patient alive.
DthPlaceState	Place of Death – State. Use dropdown menu to select the appropriate state code or unknown value.
DthPlaceCounty	Place of Death – Country. Use dropdown menu to select the appropriate country code or unknown value.
SYSTEM GENERATED CODES	
This section may be visible at times, while other times it will not be visible. The fields contained in this section are used by software and for troubleshooting purposes by WCRS following major software upgrades. They are protected fields, meaning Abstractors cannot edit them. Some fields may be blank while others may be populated. These fields and the codes contained in them can generally be disregarded by abstractors.	

Notes on Dates

Dates must be transmitted in the year, month, day format (YYYYMMDD). If the date is fully unknown, then the date field should not be filled with anything – this includes the space character (i.e., any whitespace such as the space bar entry). Below are transmission examples for dates when only certain components are known:

- YYYYMMDD – when a date is complete, known, and valid, then all eight (8) digits are transmitted from left-to-right as a 4-digit year, then 2-digit month, then 2-digit day
- YYYYMM – when the year and month are known and valid, but the day is unknown, then the first 6 digits are transmitted
- YYYY – when the year is known and valid, but the month and day are unknown, then the first 4 digits are transmitted

Recording Treatment

Since treatment is typically completed within 6-months of diagnosis, WCRS recommends waiting for treatment to be completed prior to completing the case and releasing it to WCRS.

The dermatology form is developed as a faster, streamlined way to report melanoma of the skin which is treated in dermatology outpatient clinics. If treatment other than Surgery and Biologic Response Modifiers (BRM) is given – which is atypical of dermatology outpatient clinics – a separate, more comprehensive reporting form must be used. Reach out to WCRS should this situation arise.

Surgery Coding Examples

1. Patient presents for excision of a suspicious mole on her left arm.

   The Operative Report says Shave biopsy.

   Pathology Report: Malignant melanoma, with extension to a single peripheral margin.

   Breslow's depth 2.1mm.

   - If this is a 2023 case the Rx Summ-Surg 2023 would be B220.
   - For older case, we would had to make a decision, is it a diagnostic procedure or surgery of the primary site. For a 2022 case this would not have been recorded as a surgery due to the positive margin status.

2. Patient comes back and they do get a wide excision.

   The surgeon says: Wide excision, margins 2 cm. Pathology report: Results from wide excision: Microscopic residual melanoma present at site of previous surgery. All other margins negative.

   - 2023: Rx Summ Surg is a B520, which is a shave biopsy followed by a wide excision.
   - 2022 case, this would be coded as a 31, Shave biopsy followed by a gross excision (no margin info).

   Pre 2023 cases, we either had to show what the initial biopsy was and then they do some wider excision, we lose the margin information. If the margin would have been stated on the pathology report, we would have coded in in the 40's, we would have got the margin info but lost the initial biopsy info.

Appendix B: Text Field Recommendations and Requirements

There are various text fields that need to be filled out in abstracts. The following text is provided to help you understand the information needed in the text fields. When in doubt, provide more information than you think necessary – it's okay to repeat information in several fields if you are unsure where it belongs.

Primary Site Text

Example: Skin, left anterior shoulder

- Location of the primary site of the tumor (including subsite)
- Tumor laterality

Histology Text

Example: Superficial spreading melanoma, Clark's level II, Breslow depth 0.3 mm

- Histologic type (adenocarcinoma, sarcoma, CLL, squamous cell, etc.)
- Behavior (benign, in situ, malignant)
- Grade Clinical, differentiation from scoring systems such as Gleason's Score, Bloom-Richardson Grade, etc.

Physical Exam Text

Example: *83 year-old Black Hispanic married female. Prior Melanoma of Skin (right palmar hand) diagnosed 3/5/2022 and treated at this facility. No smoking, tobacco, or alcohol use. No family history of cancer. Pt presents 5/3/2024 with complaints of nevus on left shoulder which has recently changed shape and size.*

- Age, sex, marital status, **race** and **ethnicity**
- Prior cancer history (previous cancers diagnosed and when)
- Date of physical exam
- Impression (when stated and pertains to cancer diagnosis)
- Smoking history
- Family history of cancer

Lab Tests/ Lactate Dehydrogenase (LDH) Level Text

Example:

- Type of lab test/tissue specimen(s)
- Record both positive and negative findings. Record positive test results first.
- Date(s) of lab test(s)

Pathology Text

Example:

- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Tumor markers include, but are not limited to:
- Date(s) of procedure(s) and type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, such as predominantly, with features of, with foci of)
- Tumor **size** and **extent** of tumor **spread**
- Involvement of resection margins
- Number of lymph nodes involved and examined
- Positive and negative findings. Record positive test results first.
- Note if pathology report is a slide review or a second opinion from an outside source (AFIP, Mayo, etc.).
- Record any additional comments from the pathologist, including differential diagnoses considered, ruled out or favored.

Staging Text

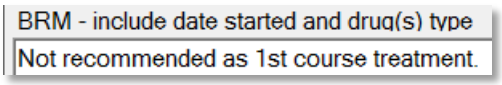
Example:

- Size of tumor.
- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived.
- Documentation of residual tumor.
- Evidence of invasion of surrounding areas.
- Date(s) of biopsy and/or other procedure(s) (including clinical) that provided information for assigning stage.
- Extent of tumor: the depth of spread in primary and other organs involved by direct extension.
- Status of margins.
- Site(s) of distant metastasis.
- Notation of and summary stage schema specifics, if known.

Surgery Text

- Size of tumor removed.
- Date and type of each surgical procedure, including excisional biopsies and surgery to other distant sites.
- Removal of lymph nodes, regional tissues, or metastatic sites, including number removed and anatomic location.
- Facility where each procedure was performed.
- Positive and negative findings. Record positive findings first.
- If surgery planned but not performed, reason primary site surgery could not be completed.
- Other treatment information, like planned procedure aborted; unknown if surgery performed.

Biological Response Modifier (BRM) Therapy Text



- What BRM Therapy Agent was provided, for example, Aldara (Imiquimod)
- Where BRM Therapy was performed (at this facility or another facility)
- When BRM Therapy was performed, including dates and whether the treatment cycle was completed
- If no BRM therapy provided, or unknown if provided, state as such.