**INDIANA STATE CANCER REGISTRY 2 North Meridian Street, Floor 6
Indianapolis, IN 46204-3010**

POLICIES AND PROCEDURES

FOR NON-HOSPITAL CANCER REPORTING

(applicable to physician offices, outpatient facilities, laboratories, and other providers that are not hospitals)

Effective 01/01/2025

Note: transition from scanned/ faxed/ mailed case submission to electronic submission as described here is expected in 2025, electronic submission by reporters is expected from 01/01/2026

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Indiana State Central Cancer Registry

NON-HOSPITAL CANCER REPORTING POLICIES AND PROCEDURES

II. INTRODUCTION

a) State legislation (IC 16-38-2, 410 IAC 21-1) makes cancer a reportable disease in Indiana, effective January 1, 1987. The law requires all health care providers, as described in section II. A. below, to report confirmed cases of cancer and other specified tumors and precancerous diseases so that the Indiana State Department of Health can conduct epidemiologic surveys of cancer and apply appropriate preventive and control measures. In addition, federal legislation (PL102-515) established the National Program of Cancer Registries, whose goal is to develop a national comprehensive cancer prevention and control strategy. Because the State receives funds through this national program, the federal law also requires reporting by all Indiana health care providers who diagnose or treat cancer patients. Compliance with reporting requirements by all providers will ensure complete and accurate surveillance data and enable the registry to produce meaningful cancer statistics for public use.

b) Note: The term “cancer” is used throughout this document to describe all reportable tumors defined in section III of these policies and procedures.

III. WHO MUST REPORT

A. Health Care Providers Who Must Report

a) All health care providers who diagnose or treat cancer patients must report confirmed cases of cancer to the State Cancer Registry. The types of providers listed below are included in this requirement.
   (1) Hospitals
   (2) Physicians
   (3) Dentists
   (4) Medical laboratories
   (5) Freestanding radiation or medical oncology clinics
   (6) Ambulatory outpatient surgical centers
   (7) Nursing homes
   (8) Other health facilities, such as freestanding radiation or medical oncology clinics, mammography or other radiology facilities, or nursing homes

B. Determining Responsibility for Reporting

- Physicians must report all required cancer cases that are not referred to a hospital for further diagnosis or treatment. This includes:
  - Patients who are clinically diagnosed and receive no further work-up or treatment;
  - Patients who are newly diagnosed in the physician's own laboratory facility or by sending a specimen from the office to an outside laboratory, whether hospital based or independent;
  - Patients whose first course treatment is initiated in the physician's office or clinic. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.

    - **Exception: If a hospital reports cases diagnosed and treated in a staff physician's office, the physician need not duplicate reporting this case to the State.**

- Dentists must report all required cancer cases that are not referred to a hospital for further diagnosis or treatment. This includes:
    - Patients who are diagnosed or treated by a dentist who performs a biopsy and/or receives a pathology report of a malignant diagnosis
    - Cases also reported by either hospital based or private/independent medical laboratories.
- Medical Laboratories: Hospital based laboratories and private or independent laboratories licensed in Indiana must report all required cancer cases diagnosed in the lab for patients that are not referred to a hospital for further diagnosis and treatment. This includes cases also reported by physician or dentist offices as described in paragraph 1.b. above and paragraph 6 below. For hospital based laboratories these are "path only" cases that are reported by the hospital registry staff, but not necessarily included in the hospital registry.
- Freestanding Radiation or Medical Oncology Clinics: Must report any patient initially diagnosed with reportable cancer or when first course treatment is initiated at the nonhospital based facility. This includes cancer treatment by surgery, radiation, chemotherapy, immunotherapy, or hormones.
- Surgery Centers:
    - Freestanding surgery centers (independent centers not affiliated with any hospital) must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer. This includes cases also reported by either a hospital based or a private/independent medical laboratory as described in paragraph 3 above.
    - Surgery centers affiliated with a hospital must report any patient undergoing a biopsy or other surgical procedure at the facility for a newly diagnosed reportable cancer if the patient was not referred to the hospital for further diagnosis or treatment. This includes cases also reported by either hospital based or private/independent medical laboratories as described in paragraph 3 above.

- Nursing Homes:
    - Nursing homes must report the following types of newly diagnosed required cancer cases:
        - Cases clinically diagnosed but not confirmed through biopsy, cytology, or other microscopic methods.
        - Cases for whom the first course of cancer treatment is initiated at the facility. Treatment may include chemotherapy, immunotherapy, or hormone therapy.
        - Nursing homes should identify all patients with a cancer diagnosis at the time of admission, even if diagnosed and treated prior to the admission.

- Mammography or Other Radiology Facilities: Facilities that provide screening, diagnostic, or therapeutic cancer services must report confirmed cases of reportable cancer.

IV. REQUIRED CASES

A. General

i) All confirmed cases of cancer that have been diagnosed or treated in Indiana January 1, 1987 or later must be reported to the State Cancer Registry. This includes solid and hematopoietic malignancies. A clinical diagnosis or any case that is stated to be cancer by a recognized medical practitioner is reportable, even if there is no histologic or cytological confirmation. Any cancer or malignancy listed on the death certificate is reportable. In addition:

(a) Juvenile astrocytoma is reportable.
(b) Basal or squamous cell carcinoma of the skin of genitalia is reportable.

(c) All benign and borderline neoplasms of the brain and central nervous system diagnosed January 1, 2004 or later are reportable.

(d) All neoplasms with behavior code two (in situ) or three (malignant) in the most current edition of the *International Classification of Diseases for Oncology* (*ICD-O*) are reportable. Exceptions are described in section below:

B. **Exceptions:** Cases That Are Not Required or Reportable

- **Basal or squamous cell carcinoma of non-genital skin**
- **Pre-invasive cervical neoplasia, including carcinoma in situ of the cervix or cervical intraepithelial neoplasia, grade III (CIN III)**
- **Prostatic intraepithelial neoplasia, grade III (PIN III)**
- **A patient whose primary malignancy has previously been reported and who is receiving subsequent or second line/salvage treatment for recurrence or progression of disease**
- **A patient who was diagnosed or treated at a hospital and is receiving additional or follow-up treatment at the physician's office or clinic. The hospital should report this information on the first course of treatment, so it is important to get the information to the hospital for reporting**

C. Terminology

Diagnoses that include the following terms are malignant neoplasms and are reportable:

2) Cancer	3) Lymphoma
4) Carcinoma	5) Melanoma
6) Malignant	7) Sarcoma
8) Leukemia	

Malignant diagnoses that are not histologically confirmed, but are described by one of the following ambiguous terms, are considered confirmed cases and are reportable:

9) Apparent(ly)	10) Presumed
11) Compatible With	12) Probable(ly)
13) Consistent With	14) Suspect(ed)
15) Suspicious	16) Most Likely

(1) Diagnoses described as "possible," questionable," "suggests," "rule out," "worrisome," "potentially malignant," etc., are not to be reported.

(2) The most common types of cancer diagnosed or treated outside a hospital setting include: melanoma, prostate, leukemia, lymphoma, multiple myeloma, other bone marrow primaries, some breast tumors, noninvasive bladder tumors, tumors in colorectal polyps, oral or genital tumors, and small eye tumors.

V. WHEN TO REPORT

Cases must be reported to the State Registry no later than six (6) months after the date of diagnosis or the date you first saw the patient for this tumor, whichever is earlier.

VI. WHERE TO REPORT

Electronic submissions using Web Plus platform are encouraged. Non-Hospital reporters are expected to upload a Standard NAACCR XML file to Web Plus or directly submit abstracts (short form) through Web Plus 1/1/2026 and forward. For instructions on requesting and utilizing a Web Plus account, contact ISCR (CancerRegistry@health.IN.gov). For electronic reporting assistance

please review the "IDOH Web Plus Instructions" in section X of this document and ISCR webpage at: https://www.in.gov/health/cdpc/cancer/cancer-registry/policy-and-procedure-manuals/.

VII. CONFIDENTIALITY ISSUES

A. Reporting

a. State law requires the reporting of cancer cases. The law does not require patient consent to report a case.

b. In addition, federal law includes provisions for state registry access to patient records of all health care providers whose services involve identifying, establishing the characteristics of, treating, or assessing the medical status of cancer cases.

c. State Registry Disclosure

i. State Cancer Registry disclosure of confidential information that could lead to the identification of an individual cancer patient, except to other state cancer registries and local and State health officers, is strictly prohibited by state and federal regulations. Those regulations are reflected in the Indiana State Cancer Registry policies and procedures and in their operating practices.

B. HIPAA

(3) The State Cancer Registry is considered an exempt entity according to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at 45 CFR 164.512(a) because state law mandates cancer reporting. Therefore, HIPAA covered entities, such as the health care providers described in Section II.A, are permitted to disclose protected health information (PHI) to the State Registry without patient (or their personal representative's) consent.

VIII. DATA QUALITY

State Registry staff perform extensive visual and computerized edits of reports for the completeness and accuracy of the data submitted. State Registry staff may contact reporting entities when the edits identify incomplete or unclear information or discrepancies in data reported by multiple providers for one patient. Contact will be made in writing or by telephone.

IX. INSTRUCTIONS FOR REPORTING CANCER DATA

A. General

- Electronic Submissions: Cases may be reported by:
  - Submitting an "IN Non-Hospital Abstract" through Web Plus
  - Uploading a standard NAACCR XML file to Web Plus (must be in current version accepted, e.g., v25 as of 06/01/2025)

B. Patient Identification Data

- Patient Last Name: Record the patient's full last name (surname). If the name is hyphenated, include both names with the hyphen (Johnson-Brown).

- Patient First and Middle Names: Record the patient's first (given) name and middle name or initial, if known.

- Other Last Names, Maiden Names, or Aliases: Record, as known, any other *last* names the patient has had, including maiden name, aliases, and names from previous marriage(s).

- Other First Names or Nicknames: Record, as known, any other first names or nicknames the patient has used.

- Street Address at Diagnosis: Record the patient's usual home address at the time of diagnosis. Report the street address of residence instead of post office box number or mailing address, if different.

- City at Diagnosis: Record the city of the patient's usual home address at the time of diagnosis.

- State and ZIP Code at Diagnosis: Record the state and ZIP Code of the patient's usual home address at the time of diagnosis.

- County at Diagnosis: Record the county name of the patient's usual home address at the time of diagnosis.

- Medical Record Number: Record the patient's medical record number, if available.

- Social Security Number: Record the patient's Social Security Number. Do not record the spouse's number.

- Date of Birth: Record the patient's birth date (month-day-year). If you do not know the patient's date of birth, record an estimated age in years, if known.

- Race: Enter race as provided by the patient. If the race is neither white nor black, record the race after "Other, specify." If mixed, specify the race of each parent, if known.

- Hispanic Origin (Ethnicity): Enter Hispanic or Spanish Origin provided by patient. If patient is not Hispanic enter 0. If ethnicity is unknown enter 9-unknown. If the patient is of Hispanic origin, record the type after "Hispanic, specify" (e.g., Mexican, Puerto Rican, Cuban, etc.).

- Sex: Record the sex of the patient. If sex is neither male nor female, record the type as codes allow.

- Occupation: Record the kind of work the patient performed during most of his/her working life. This may be different from the occupation at the time of diagnosis. Do not record "retired."

- Industry: Record the primary type of activity carried on by the business/industry of the patient's usual occupation. This may be different from the company or industry at the time of diagnosis. Record the type of industry and not the name of the industry.

- Do not record metastatic sites (e.g., for a lung cancer that has metastasized/spread to the brain, record "lung," with the diagnosis date).

C. Tumor Data

- Date of First Contact (For This Cancer at Your Location): Record the date the patient was first seen at your location or facility for this malignancy. If the contact involved a specimen, rather than the patient, record the date the specimen was obtained. If the exact month, day, and year are unavailable, approximate the date.

- Date of Initial Diagnosis: Record the date the patient was first diagnosed for this malignancy by any recognized medical practitioner. If you did not physically see this patient, record the date the specimen was obtained. If the exact month, day, and year are unavailable, approximate the date.

- Laterality (Side of Origin): Report (1) for right or (2) for left.

    - Report (0) if the organ is a non-paired site or if the primary site is unknown.
    - Report (3) if the only one side is involved, but right or left is not specified.
    - Report (4) if there is bilateral involvement, but side of origin is unknown.
    - Report (4) if there is bilateral involvement but stated to be a single primary.
    - (e.g., bilateral retinoblastomas, bilateral Wilms' tumors, and simultaneous bilateral ovary tumors with the same histology)
    - Report (9) if the organ is a paired site, but there is no information on laterality.
    - Report (9) if the organ is a paired site, but the tumor is on the midline.
- Diagnosis Confirmed By: Indicate the method(s) used to confirm this diagnosis of cancer.

    - Histology-(1) includes peripheral blood smears for leukemia and tissue from autopsies. Box (6) includes diagnosis from gross autopsy report only.

- Primary Site (Where cancer started): Record the specific site of origin of the tumor (e.g., upper-outer quadrant of right breast, skin of left forearm). Identify the primary site and not a metastatic site. The primary site for leukemia is always bone marrow.
- Histologic Cell Type: Record the cell morphology type (e.g., papillary transitional cell carcinoma, superficial spreading melanoma, chronic lymphocytic leukemia).

- Behavior of Neoplasm: Indicate the cell behavior type according to the definitions provided below.

    - *Benign (0).* Use only for benign brain or CNS tumors
    - *In situ (2).* The behavior of a neoplasm that has all the characteristics of malignancy except invasion through the basement membrane of the organ. Some synonyms are intraepithelial, noninvasive, and non-infiltrating. For breast cancer, intraductal is in situ behavior.
    - *Malignant (3)*. The behavior of a neoplasm that has the properties of anaplasia, invasion, and metastasis; invasive.

- Tumor Grade/Differentiation: Indicate the grade or differentiation of the malignancy. If the diagnosis includes more than one grade of tumor, record the highest grade (e.g., for moderately well differentiated, record moderately differentiated, code 2).

- Stage at Diagnosis: Indicate how far the disease has spread from the site of origin at the time of diagnosis according to the definitions provided below. Consider only information available within 2 months of diagnosis (or within 4 months of diagnosis for prostate primaries only). Do not change stage as the disease progresses. If AJCC Staging (TNM Elements and/or Stage group) is available, record it in item TNM Staging.

- *In situ* (0). The tumor has not invaded through the basement membrane of the organ involved; noninvasive, non-infiltrating, or intraepithelial. Intraductal breast cancer and Clark's Level 1 melanoma are in situ.

- *Local* (1). The tumor is limited to the primary site of origin. It has progressed through the basement membrane but not beyond the walls of the organ involved. Clark's Level 2-5 melanomas and stage I lymphoma are local.

- *Regional*. The tumor has spread beyond the original primary site. There are four types of regional spread. Record the specific type of regional spread, if known, according to the definitions provided below.

- *Regional by direct* extension (2). Tumor has extended or spread directly into adjacent organs or tissues only.

- *Regional to nodes* (3). Tumor involves regional lymph nodes only.

- *Regional both to adjacent organs and lymph nodes* (4). Tumor involves both adjacent organs or tissues and regional lymph nodes.

- *Regional*, *Not Otherwise Specified* (5). Tumor has spread beyond original primary site to regional areas, but is not distant. Stage II lymphomas are stage 5.

- *Distant* (7). The tumor extends beyond adjacent organs or tissues, or has metastasized (spread) to distant sites or distant lymph nodes through blood or the lymphatic system. Leukemia and Stage III and IV lymphoma are distant.

- *Unknown* (9). No information is available to determine stage or extent of disease.

- Largest Tumor Size: Record the largest dimension of the largest tumor. Specify whether the measurement is in centimeters or millimeters (e.g., 4.2 cm or 6 mm). Record only the largest measurement reported and do not add together measurements recorded in biopsy and resection reports.
    - For melanomas, record both the depth of invasion and the diameter of the lesion.

    - Size is not applicable for lymphoma, leukemia, Kaposi's sarcoma, multiple myeloma, unknown primary site, etc. Leave the item blank for these diagnoses.

- Number of Regional Lymph Nodes Positive: Record the number of regional lymph nodes surgically removed, examined by a pathologist, and reported as containing tumor.

- Number of Regional Lymph Nodes Examined: Record the total number of regional lymph nodes surgically removed and pathologically examined.

- Sites of Distant Metastasis: Record the distant sites to which this cancer has spread. Distant sites are those organs or tissues that are not adjacent to the original primary site (Bone, Brain, Distant Lymph Nodes, Liver, Lung, Other).

    - Report None (0) if the cancer is local or regional and has not metastasized (spread) to distant sites.

- Report Yes (1) in the specified Met at Diagnosis field if distant mets to that site, leave all others as (0) None

- If distant mets to a site other than Bone, Brain, Distant Lymph Nodes, Liver, or Lung, code to "Other"
  - If Generalized metastasis such as carcinomatosis code to (2) in "Mets at Diagnosis-Other"
  - Malignant pleural effusion for a lung primary is coded to Mets at Dx-Other
- Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant
  - Use code 8 when primary site is C420, C421, C423, C424 or histology is 9671, 9734, 9731 or 9761 for any primary site.

D. First Course of Treatment and Follow-Up Data

Definitions:

- Cancer-directed treatment. Treatment that is tumor directed. Its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Cancer-directed treatment is given to minimize the size of tumor or to delay the spread of disease. Report all first course cancer directed treatment.

- Non cancer-directed treatment. Treatment that prolongs the patient's life, alleviates pain, makes the patient comfortable, or prepares the patient for cancer-directed therapy. It is not meant to reduce the size of the tumor or delay the spread of disease. Procedures include diagnostic procedures and supportive care. Diagnostic procedures are the only non-cancer-directed treatment that should be reported.

- First course treatment. Cancer-directed treatment that is planned by the physician(s) during or after the first diagnosis of cancer. Administration of the treatment may span a year or more. If the plan or protocol is not available, consider treatment that begins within four months after the initial diagnosis date as the first course of treatment. Treatment that is part of the first course plan, but is initiated more than four months after diagnosis, is still considered first course treatment. Report all first course cancer-directed treatment.

- Subsequent treatment. Treatment for recurrence or progression of disease. Treatment that is administered after the first course is stopped is subsequent treatment. **Do not record subsequent treatment.**

Treatment:

- Diagnostic or Surgical Procedure(s) Performed: Record cancer-directed surgical procedures or diagnostic procedures. Examples: Incisional biopsy of (site), lumpectomy, polypectomy, wide resection or excision.

- Date(s) Performed: Record the date each procedure was performed.

- Cancer Therapy Drugs: List any drug given to the patient for the purpose of modifying, controlling, removing, or destroying cancer tissue. Do not list drugs given for palliation (relief of pain or symptoms) only.

- Examples of chemotherapy: 5-FU, Cytoxan, Platinum.
- Examples of hormone therapy: Tamoxifen, Nolvadex, Lupron. Prednisone is hormone therapy only when administered in combination with chemotherapy, such as R-CHOP.
- Examples of immunotherapy drugs: Interferon, Levamisole, monoclonal antibodies.

- Date(s) Started: Record only the first date the drug therapy was started. If reporting more than one drug, record each date.

- Other Cancer Treatment: Record other types of treatment given for the purpose of modifying, controlling, removing, or destroying cancer tissue. Examples: Radiation therapy (RT), immunotherapy procedures (e.g., bone marrow transplant), experimental drugs. For RT, describe whether beam, radioactive implants, radioisotopes, or a combination was administered.

- Date(s) Started: Record the date the other treatment recorded in item 35 was started. If reporting more than one other treatment, record each date.

- Date of Last Patient Contact: Record the last date that you had any contact with the patient. If the patient has expired, record the date of death. If the exact month, day, and year are unavailable, approximate the date.

- Patient Status at Last Contact: Indicate whether the patient was alive (1) or dead (0) at the time of your last contact with him/her. If the patient has expired after the last contact, report dead.

- Cancer Status at Last Contact: Indicate whether the patient was without (1) or with (2) this cancer at the time of your last contact with him/her.

- Source of Information: Record the source used to obtain the information on this report. (E.g., if a hospital were collecting information from a physician's office, the source would be Physician (4) since the information came from physician records.) If the reporting source used is not listed, record the source after "Other, specify." Enter the physician's 8-digit medical license number if a physician is the source of information.

- Was the patient seen or referred elsewhere for further diagnosis or treatment? If "Yes" is reported, record the name of the health care provider and city to which the patient was referred.

- Person Completing Form: Record the Abstractor Initials of the individual who completed the Web Plus short form.

- Date Report Completed: Record the date (month-day-year) the form was completed.

- Remarks: Record any additional information available that may help in the coding and staging of this cancer case. (e.g., Record the sites or types of primary malignant tumors the patient has had over the course of his/her lifetime (e.g., breast, melanoma, lymphoma, etc.) and the dates of diagnosis, if known (month/year). SEE TEXT EXAMPLES

E. Text fields-examples

Text is needed to justify the codes selected for the data items and to record information that is not coded at all. The text is used for quality control and special studies. Please include as much text as

possible. Use these text examples as guidance for entering text into the short form within Web Plus. If you do not have information to enter in each text field please add “NO INFORMATION”.

- **TxDxPE (Physical Exam Text):** Patient’s age, sex and race. Positive and negative clinical findings. History that relates to cancer diagnoses (including treatments delivered). Smoking history and history of previous cancers must be included. *(e.g., 78 YEAR OLD WHITE MALE WITH 2.2CM LESION ON LT POSTERIOR SCALP, PURPLE IN COLOR, IRREGULAR BORDERS. FORMER SMOKER, CIGARS, QUIT >30YRS AGO (1996). SHAVE BIOPSY ON 03/07/2023 AT REPORTING FACILITY CONFIRMED MALIGNANT MELANOMA. PATIENT REFERRED TO OUTSIDE SURGICAL ONCOLOGY FOR FURTHER TREATMENT.)*

- **TxDxPlace (Place of Diagnosis):** Name of facility where patient was diagnosed with cancer that is being reported. Spell out complete facility name, city, state *(e.g., UNIVERSITY OF INDIANA MEDICAL CENTER, INDIANAPOLIS, INDIANA)*

- **TxDxXray (X-ray/Scan):** Date(s)/Performing Location of x-ray/scan(s); tumor location, size and lymph nodes, distant disease or metastasis (if appropriate). *(e.g., 02/01/2023 CT CAP @ UNIVERSITY OF INDIANA MEDICAL CENTER (UIMC), LIVER LESIONS CONSISTENT WITH METASTASIS)*

- **Text-Primary Site Title (Primary Site Text):** Location of primary tumor including laterality if appropriate. *(e.g., SKIN OF LT SCALP)*

- **Text-Histology Title (Histology Text):** Type of tissue specimen cancer identified, grade clinical, grade pathological, grade post therapy (if no grade or unknown enter "Grade Unk" *(e.g., MELANOMA, SUPERFICIAL SPREADING TYPE, GRADE UNK)*

- **Text-DX Proc Path (Pathology Text):** Date(s) of procedure(s), Path Accession #, Tumor type and grade (include all modifying adjectives, i.e. predominately, with features of, with foci of, etc), tumor size, extent of tumor spread, involvement of resection margins, number of lymph nodes examined and involved. Record any differential diagnoses considered and ruled out, if appropriate. If synoptic report provides more specific information include those findings. *(e.g., 02/15/2023 (S23-012354) SHAVE BX, SKIN OF LEFT POST SCALP, MELANOMA, SUPERFICIAL SPREADING TYPE, BRESLOW 0.5MM, CLARK II, ULCERATION PRESENT, MITOSIS 2 PER MM2, NO LVI, NO PNI, NO REGRESSION, MARGINS POSITIVE AT DEEP AND PERIPHERAL, STAGE PT1B.)*

- **Text-Staging:** SEER Summary Stage Assignment required (*e.g.,SEER SUMMARY STAGE 1-LOCALIZED)*. **Optional if available: AJCC TNM Staging (clinical, pathological, post-therapy) *(e.g.,CLINICAL AJCC 8TH: CT1 CN0 CM0 STAGE 1, PATHOLOGICAL AJCC 8TH: PT2 PN1 CM0 STAGE 2)*

- **TxDxLab (Lab Results Text):** Date(s) of lab tests, type of lab test/tissue specimen, record positive and negative findings. Information can include tumor markers such as ERA, PRA, Her2/NEU, PSA, hCG, AFP and LDH. *(e.g., 02/01/2023 LDH=550 Elevated (10-220 NORMAL))*

- **TxDxScope (Scopes Text):** Date(s)/Performing Location of scope(s); tumor location, size and lymph nodes, distant disease or metastasis (if appropriate). *(e.g., 02/01/2023 COLONOSCOPY@ UNIVERSITY OF INDIANA MEDICAL CENTER (UIMC), SIGMOID COLON, SINGLE SESSILE POLYP/LESION, COMPLETELY REMOVED)*

- **TxDxOp (Operative Report Text):** Dates/Performing Location and descriptions of biopsies and all other surgical procedures from which staging information was derived. Record FIRST COURSE only. *(e.g., 02/15/2023 UIMC, DR JOHN SMITH, SHAVE BX, SKIN OF LEFT POSTERIOR SCALP, FINDINGS: 1.2CM LESION ENCROACHING ON MIDLINE, NO RESIDUAL LESION AT END OF PROCEDURE. 03/10/2023 UNIVERSITY SURGICAL ASSOC, WLE SKIN OF POST LT SCALP, HEALING BIOPSY SCAR, NO VISIBLE LESION, 1CM CLINICAL MARGINS)*

- **RX Text-Surgery (Surgery Text):** Dates of surgery, performing location and descriptions of surgical procedures from which staging information was derived. If the diagnostic procedure is used to stage clinically/pathologically, record type of procedure. Record FIRST COURSE only. *(e.g., 02/15/2023 DR JOHN SMITH, OPT DERMATOLOGY, SHAVE BX.. 03/10/2023 DR JOHN SMITH, OPT DERMATOLOGY, WIDE LOCAL EXCISION)*

- **RX Text-Radiation (Beam):** **External beam radiation treatment ONLY in this field (IMRT, 3DCT, SBRT, Gammaknife, etc.). Dates radiation started and ended, dose (cGy), modality, boost location and amount, number of treatments. If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. Record FIRST COURSE only. *(e.g., 01/01/2023-04/01/2023 UIMC, DR JOSEPH FIRST, IMRT TO PROSTATE & SEMINAL VESICLES, 6X PHOTONS, 4800CGY IN 20 FXS, 240CGY DOSE PER FX)*

- **RX Text-Radiation Other:** **Non-external beam radiation ONLY in this field (Radioisotopes, Brachytherapy, etc). Dates radiation started and ended, dose (cGy), modality, boost location and amount, number of treatments. If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. Record FIRST COURSE only. *(e.g., 01/01/2023-04/01/2023 UIMC, DR JOSEPH FIRST, INTERSTITIAL HDR BRACHYTHERAPY TO PROSTATE, 5 TX, 1000CGY PER TX)*

- **RX Text-Chemotherapy:** Facility/Physician Administering, Dates chemotherapy started and ended. Type of chemotherapy administered (include drug name).If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. *Record first course treatment only *(e.g., 01/01/2023-04/01/2023 UIMC, DR MARY JONES, PACLITAXEL AND CARBOPLATIN)*

- **Rx Text-Hormone:** Facility/Physician Administering, Type of hormone and dates hormone administered (include drug name). If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. Record FIRST COURSE only. *(e.g., 06/01/2023-CURRENTLY TAKING, UIMC, DR MARY JONES, LETROZOLE)*

- **Rx Text-BRM (Immunotherapy):** Facility/Physician Administering, Dates and type of immunotherapy administered, biological or chemical agents (include drug name). If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. Record FIRST COURSE only. *(e.g., 01/01/2023-04/01/2023 UIMC, DR MARY JONES, PERJETA)*

- **Rx Text-Other (Other Treatment):** Facility/Physician Administering, Dates and type of other treatment at any facility related to this cancer (not classifiable to Chemo, Hormone, or

Immunotherapy). If none, include "NONE" or "NONE RECOMMENDED". If patient declined, add "PATIENT DECLINED MM/DD/YYYY @ FACILITY/PHYSICIAN. Record FIRST COURSE only. *(e.g., 01/01/2023 UIMC, DR MARY JONES, OTHER THERAPY-EMBOLIZATION-NO REFERENCE TO AGENT)*

- **TxRemarks (Remarks):** Any other dates, treatment, information, not already recorded, that helps justify codes that were used in the abstract.

X. WEB PLUS INSTRUCTIONS

A. Introduction

- Web Plus is a web-based application that collects cancer data securely over the Internet. Records are saved in a secure database at the Indiana State Central Registry, and cases entered by one facility or office are not visible to other facilities. Data entered is validated by the NAACCR EDITS engine. Users, display types, and edit configurations are managed by ISCR. 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 does not have a derive/default feature for fields such as Registry Number.

B. Logging in to Web Plus

- Open the Web Plus in your browser: https://Web Plus.isdh.in.gov/logonen.aspx?logoff=11
- Log in using your user ID and password

Note: ISCR sends new users their user IDs and passwords via email. Please contact ISCR (CancerRegistry@health.IN.gov) for Web Plus user account access.

C. Creating a New Abstract

- On your Web Plus homepage, click on “Facility Abstractor- 22” or “Indiana Non-Hospital Abstract” depending on your reporting requirements and set up in Web Plus (Hospital vs Non-Hospital)
- Click on New Abstract

Note:** Web Plus times out after approximately 30 minutes of inactivity**. Save your work as you abstract as unsaved information will be deleted if Web Plus times out.

D. Abstracting Submission Format

Non-Hospital Reporters will complete an “Indiana Non-Hospital Abstract”: Utilize the “Web Plus Field Guide for Non-Hospitals” excel spreadsheet for field-by-field guidance and view the helpful webinars (available through IN education & training platform **FLccSC**) under the Web Plus Training category.

E. Entering an Abstract

- Enter an abstract and click on **Save** at the bottom of the page to save the abstract to the data base. The abstract is not edited each time you save (see Figure 3).
  - *The blue box with a triangle at the end of each field indicates a drop-down menu containing data choices for the field.*
  - *The question mark icon shows additional data entry help is available in the message area to the right of your abstract.*
  - *The magnify glass allows a “lookup” of a code*

Note: *All edit errors must be resolved to complete and release the abstract to ISCR. Although edit warnings are for your information and are not required to be corrected prior to completion of the abstract, all edits must be resolved prior to releasing the abstract to ISCR. Once an abstract is released the abstractor cannot make additional changes to the abstract. If additional updates need to be made after an abstract is released, contact your ISCR Representative.*

- To correct errors in your abstract, click on an error message to move to that field in the data entry area and make corrections. Click **Save** to save your corrections and select **Run Edits**.

Note: *If your abstract has passed all edits but you have not entered all information needed to complete your abstract,* ***do not*** *release your abstract to ISCR. Click on "No" to save and return later. If you release your abstract, you will no longer be able to edit it.*

F. Finding and Opening a Saved Abstracts

- From the facility abstractor page, click on Find/Open Abstract.
- To view a listing of all abstracts, click "Find" without entering any patient info in the search fields
- To search for a saved abstract for a specific patient, enter the patient's first or last name in the "Name" box or social security number in the Social Security box. Click on "Open"
- Once the information has been entered and the abstract is fully complete, click on "Yes" to release the abstract to ISCR. A message will appear indicating that the abstract has been released to the central cancer registry.

G. Releasing Abstracts

- For abstracts that are fully completed and ready for release, select the Release Abstract tab in the menu bar.
- Select the abstracts that you want to release to ISCR by checking the box in the release column.
- Click the "Release Selected Abstracts" button.

H. Web Plus Reports:

- Multiple reports are available to Web Plus abstractors. This table describes the information available in each report.
- To view a report, select **Reports** from the menu bar. Then click the name of the report you want to view. It will open in a separate window.

Local Reports	
Abstracts Submitted Sorted by Abstractor	All abstracts that a facility has released within a given timeframe. The abstracts are sorted first by the name of the abstractor and then by patient name.
Abstracts Accessed Sorted by Patient Name	All abstracts that a facility has released within a given timeframe sorted by patient name.
Descriptive Statistics on Released Abstracts	Descriptive statistics on released abstracts such as demographics and site group.

Activity Report	The number of released and unreleased abstracts for each month of the selected date range.
Audit Reports	
System Logins	The users from your facility and their times for logging in and out of Web Plus within a selected date range.
Abstract Updates	The dates and times that abstracts from your facility have been updated.
Abstract Searches	The abstractor, the date, and time for all searches for abstracts at your facility.
Abstract Deletions	The dates and times that abstracts have been deleted at your facility.
Abstract Releases	Information about abstracts released from your facility including release time, date, and abstractor.

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