Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

MEDICAL RECORD ABSTRACT FORM
DIAGNOSTIC EVALUATION – OVARY (DEO3/DOQ3)

1. Date Abstracted: ___________________________________________  
   Month   Day   Year

2. Abstractor ID#: ___ ___ ___ ___

3. Nosologist ID: ___ ___ ___ ___

4. CTR ID: ___ ___ ___ ___

5. Study Year T0-T13: ___ ___

6. Purpose of Abstract:
   ○ Initial abstract
   ○ Re-abstract for QA

7. Multiple Primary Cancer #: (Select 2 through 9)  
   (GO TO A.6)

FOR OFFICE USE ONLY

8. Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)
   ○ Form Receipted into SMS
   ○ Manual Review Completed

   Data Entry of Non-Scannable Items:
   ○ Completed
   ○ None Required

   Data Retrieval:
   ○ Attempted
   ○ None Required

   Disposition:
   ○ Interim Complete (ICM)
   ○ Final Complete (FCM)
   ○ Final Incomplete (FIC)
PART A: DIAGNOSTIC EVALUATION AND STAGING

1. Diagnostic Procedures Performed:
   - Yes
   - No, Physician report (GO TO A.6)
   - No, Participant self-report (GO TO A.6)

2. Reason for Initial Visit for Clinical Assessment: (MARK ALL THAT APPLY)
   - Symptomatic
   - Follow-up of positive PLCO screen
   - Other (SPECIFY) ___________________________

3. CA-125 Blood Test: (DO NOT RECORD RESULTS OF PLCO SCREENING EXAMINATIONS)
   - No
   - Yes (COMPLETE TABLE BELOW)
   - Unknown

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4. Other Diagnostic/Staging Procedures: (DO NOT RECORD RESULTS OF PLCO SCREENING EXAMINATIONS)
○ No
○ Yes (COMPLETE TABLE BELOW)
○ Unknown

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**PROCEDURE CODES**

01 = Barium enema  
02 = Biopsy (SPECIFY)  
03 = Chest radiograph  
04 = Color doppler  
05 = CT scan – abdominal  
06 = CT scan – other (SPECIFY)  
07 = CT scan – pelvic  
08 = Culdocentesis  
09 = Intra-abdominal washings (peritoneal or pelvic)  
10 = Intravenous pyelography (IVP)/excretory urography  
11 = Laparotomy  
12 = Lymphangiogram  
13 = MRI scan – abdominal  
14 = MRI scan – other (SPECIFY)  
15 = MRI scan – pelvic  
16 = Needle aspiration  
17 = Paracentesis  
21 = Transabdominal/pelvic ultrasound or sonogram  
22 = Transvaginal ultrasound  
23 = Oophorectomy/Salpingooophorectomy  
24 = Abdominal/vaginal hysterectomy  
25 = Clinical evaluation  
26 = CT scan – abdomen and pelvis combined  
27 = CT scan – chest  
28 = Hysteroscopy  
29 = Laparoscopy  
30 = Lymphadenectomy/Lymph node sampling  
31 = Omentectomy, complete/NOS  
32 = Omentectomy, partial  
33 = Radiograph, other (SPECIFY)  
34 = Record review  
35 = Resection (SPECIFY)  
36 = Sigmoidoscopy/Colonoscopy  
37 = Thoracentesis  
38 = Transabdominal/pelvic and transvaginal ultrasounds combined  
88 = Other (SPECIFY)

**4b. DIAGNOSTIC/STAGING PROCEDURES SUPPLEMENT FORM COMPLETED**

- [ ]

**5. Medical Complications of Diagnostic Evaluation and Staging:**

- [ ] No
- [ ] Yes (COMPLETE TABLE BELOW)
- [ ] Unknown

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<th>COMPLICATION #</th>
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MEDICAL COMPLICATION CODES
1 = Infection (SPECIFY)
2 = Fever requiring antibiotics
20 = Cardiac arrest
21 = Respiratory arrest
22 = Hospitalization
23 = Pulmonary embolus/emboli
24 = Myocardial infarction
25 = Cardiac arrhythmia
26 = Cerebral vascular accident (CVA)/Stroke
27 = Blood loss requiring transfusion
28 = Deep venous thrombosis (DVT)
29 = Acute/chronic respiratory failure
30 = Hypotension
31 = Congestive heart failure (CHF)
32 = Wound dehiscence
33 = Hypokalemia
400 = Diarrhea
401 = Small bowel obstruction/partial or complete
402 = Ileus
407 = Blood in stool
408 = Bowel injury
409 = Adhesions
412 = Peritonitis
413 = Pneumonia
414 = Urinary tract infection (UTI)
415 = Wound infection

6. **Result of Diagnostic Evaluation for Ovarian Cancer:**
   - ○ No malignancy (GO TO PART B)
   - ○ No malignancy and no diagnostic/staging procedures performed (GO TO PART D)
   - ○ Ovarian malignancy confirmed histologically (exclude carcinoma in situ) (GO TO PART C)
   - ○ Ovarian malignancy confirmed cytologically (GO TO PART C)
   - ○ Ovarian malignancy diagnosed by clinical examination only (GO TO PART C)
   - ○ Other malignancy confirmed histologically or cytologically (GO TO PART B)
   - ○ No information available (GO TO PART D)
PART B: DIAGNOSIS INFORMATION FOR CANCERS OTHER THAN OVARIAN CANCER

7. Specific Ovarian Diagnosis:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)

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<tr>
<th>DIAGNOSIS #</th>
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<tr>
<td>DIAGNOSIS</td>
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<tr>
<td>1 = Cyst</td>
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<td>2 = Polycystic ovary</td>
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<td>3 = Teratoma</td>
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<tr>
<td>4 = Benign neoplasm</td>
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8. Other Cancer Diagnosis:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)

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<th>OTHER CANCER DIAGNOSIS 1</th>
<th>OTHER CANCER DIAGNOSIS 2</th>
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<tr>
<td>ICD-9-CM CLASSIFICATION</td>
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GO TO PART D

PART C: PRIMARY OVARIAN CANCER DIAGNOSIS INFORMATION

9. Date of Primary Ovarian Cancer Diagnosis:
   (MO.-DAY-YEAR)

10. Verbatim Description of Primary Ovarian Cancer Diagnosis:
    ________________________________
    ________________________________
    ________________________________
    ________________________________
    ________________________________
    ________________________________
    ________________________________

11. ICD-O-2 Cancer Classification:
    ________________________________
    (Topography) ____________________
    ________________________________
    (Morphology) ____________________
    ________________________________
    (Behavior) _____________________
    ________________________________
    (Grade) _______________________
12. Photocopy of Report Confirming Primary Ovarian Cancer: (MARK ONE)
   ○ Pathology/Histopathology (ATTACH COPY)
   ○ Cytology/Cytopathology (ATTACH COPY)
   ○ Not available

13. Histopathologic Type for Primary Ovarian Cancer:
   ○ Serous cystadenoma (low potential/borderline malignancy)
   ○ Serous cystadenocarcinoma
   ○ Mucinous cystadenoma (low potential/borderline malignancy)
   ○ Mucinous cystadenocarcinoma
   ○ Endometrioid tumor (low potential/borderline malignancy)
   ○ Endometrioid adenocarcinoma
   ○ Clear cell tumor (low potential/borderline malignancy)
   ○ Undifferentiated carcinoma
   ○ Other (SPECIFY) ______________________________
   ○ Unknown

14. Histopathologic Grade for Primary Ovarian Cancer:
   ○ Grade cannot be assessed (GX)
   ○ Borderline malignancy (GB)
   ○ Well differentiated (G1)
   ○ Moderately differentiated (G2)
   ○ Poorly differentiated or undifferentiated (G3-4)
   ○ Unknown
15. TNM Staging for Primary Ovarian Cancer:

a. TNM Clinical Staging:
   ○ Yes (COMPLETE 15.a.1, 15.a.2, 15.a.3)
   ○ No (GO TO C.15.b)

   1. PRIMARY TUMOR (T)
      ○ Tx  ○ T2a
      ○ T0  ○ T2b
      ○ T1  ○ T2c
      ○ T1a  ○ T3
      ○ T1b  ○ T3a
      ○ T1c  ○ T3b
      ○ T2  ○ T3c
      ○ Not available

   2. NODAL INVOLVEMENT (N)
      ○ Nx  ○ N1
      ○ N0  ○ Not available

   3. DISTANT METASTASES (M)
      ○ Mx  ○ M1
      ○ M0  ○ Not available

b. TNM Pathologic Staging:
   ○ Yes (COMPLETE 15.b.1, 15.b.2, 15.b.3)
   ○ No (GO TO C.16)

   1. PRIMARY TUMOR (T)
      ○ Tx  ○ T2a
      ○ T0  ○ T2b
      ○ T1  ○ T2c
      ○ T1a  ○ T3
      ○ T1b  ○ T3a
      ○ T1c  ○ T3b
      ○ T2  ○ T3c
      ○ Not available

   2. NODAL INVOLVEMENT (N)
      ○ Nx  ○ N1
      ○ N0  ○ Not available

   3. DISTANT METASTASES (M)
      ○ Mx  ○ M1
      ○ M0  ○ Not available
16. Record Stage: (COMPLETE IF 15.b.1, 15.b.2, OR 15.b.3 IS NOT AVAILABLE, OTHERWISE SKIP)
   ○ Yes (RECORD STAGING BELOW)
   ○ No (GO TO PART E)

   FIGO
   ○ I   ○ II   ○ III   ○ IV
   ○ IA  ○ IIA  ○ IIIA
   ○ IB  ○ IIB  ○ IIIB
   ○ IC  ○ IIC  ○ IIIC

   GO TO PART E

PART D: DATE OF DIAGNOSTIC EVALUATION DETERMINATION

17. Complete this item if:
   Item A.6 = No malignancy and Item B.7 and Item B.8 = No OR
   Item A.6 = No malignancy and no diagnostic procedures performed OR
   Item A.6 = No information available

   (MO.-DAY-YEAR)

PART E: PHYSICIAN/HOSPITAL LOCATION INFORMATION

18. PHYSICIAN FOR DIAGNOSTIC EVALUATION:
   a. Name: _______________________________________________________________________________

      Address: ___________________________________________ City ____________________________
               ___________________________ State ___________________________ ZIP Code
      Telephone: (___) ___________________________ Medical Record/Chart # ______________________

   b. Name: _______________________________________________________________________________

      Address: ___________________________________________ City ____________________________
               ___________________________ State ___________________________ ZIP Code
      Telephone: (___) ___________________________ Medical Record/Chart # ______________________

19. HOSPITAL OR CLINIC FOR DIAGNOSTIC EVALUATION:
   a. Name: _______________________________________________________________________________

      Address: ___________________________________________ City ____________________________
               ___________________________ State ___________________________ ZIP Code
      Telephone: (___) ___________________________ Medical Record/Chart # ______________________

   b. Name: _______________________________________________________________________________
20. COMMENTS:

- ☐ No
- ☐ Yes (SPECIFY)

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