

Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

TRANSVAGINAL ULTRASOUND SCREENING EXAMINATION (TVU2)

1. Date of Examination: MO. DAY YR. 0 0 0 0 0 0 0 1 1 1 1 1 1 1 2 2 2 2 2 2 2 3 3 3 3 3 3 3 4 4 4 4 4 4 4 5 5 5 5 5 5 5 6 6 6 6 6 6 6 7 7 7 7 7 7 7 8 8 8 8 8 8 8 9 9 9 9 9 9 9			2. Satellite Center: 0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9		3. Study Year: <input type="radio"/> T ₀ <input type="radio"/> T ₁ <input type="radio"/> T ₂ <input type="radio"/> T ₃		4. Visit Number: <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three		5. Reason for Repeat Visit: _____ _____ _____ _____ _____	
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DO NOT FOLD, STAPLE, OR TEAR THIS FORM. USE A NO. 2 PENCIL TO COMPLETE THIS FORM.

PART A: TRANSVAGINAL ULTRASOUND EXAMINATION FINDINGS

QUESTION	RIGHT	LEFT																
1. Sonographically Detectable Ovary	<input type="radio"/> No (GO TO 3) <input type="radio"/> Yes	<input type="radio"/> No (GO TO 3) <input type="radio"/> Yes																
2. Ovary Size (CALCULATE VOLUME: WIDTH X HEIGHT X THICKNESS X 0.523)	<table border="1"> <tr> <th>Longitudinal diameter (cm)</th> <th>Transverse diameter (cm)</th> <th>Antero-posterior diameter (cm)</th> <th>Volume (cc)</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 0 0 1 1 1 1 1 2 2 2 2 2 3 3 3 3 3 4 4 4 4 4 5 5 5 5 5 6 6 6 6 6 7 7 7 7 7 8 8 8 8 8 9 9 9 9 9</td> </tr> </table>	Longitudinal diameter (cm)	Transverse diameter (cm)	Antero-posterior diameter (cm)	Volume (cc)	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 0 0 1 1 1 1 1 2 2 2 2 2 3 3 3 3 3 4 4 4 4 4 5 5 5 5 5 6 6 6 6 6 7 7 7 7 7 8 8 8 8 8 9 9 9 9 9	<table border="1"> <tr> <th>Longitudinal diameter (cm)</th> <th>Transverse diameter (cm)</th> <th>Antero-posterior diameter (cm)</th> <th>Volume (cc)</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 0 0 1 1 1 1 1 2 2 2 2 2 3 3 3 3 3 4 4 4 4 4 5 5 5 5 5 6 6 6 6 6 7 7 7 7 7 8 8 8 8 8 9 9 9 9 9</td> </tr> </table>	Longitudinal diameter (cm)	Transverse diameter (cm)	Antero-posterior diameter (cm)	Volume (cc)	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 0 0 1 1 1 1 1 2 2 2 2 2 3 3 3 3 3 4 4 4 4 4 5 5 5 5 5 6 6 6 6 6 7 7 7 7 7 8 8 8 8 8 9 9 9 9 9
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3. Number of Morphologic Abnormalities in Adnexal Area	<input type="radio"/> None (GO TO LEFT) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three or more	<input type="radio"/> None (GO TO 5) <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three or more																
4. Complete for Three Largest Discrete Cysts or Abnormalities :	<table border="1"> <tr> <th>#1</th> <th>#2</th> <th>#3</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> </tr> </table>	#1	#2	#3	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	<table border="1"> <tr> <th>#1</th> <th>#2</th> <th>#3</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> </tr> </table>	#1	#2	#3	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9				
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A. Maximum Diameter of Cyst or Abnormality (in cm.)	<table border="1"> <tr> <th>#1</th> <th>#2</th> <th>#3</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> </tr> </table>	#1	#2	#3	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	<table border="1"> <tr> <th>#1</th> <th>#2</th> <th>#3</th> </tr> <tr> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> <td>0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9</td> </tr> </table>	#1	#2	#3	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 0 1 1 1 2 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9				
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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0407). Do not return the completed form to this address.

PLEASE DO NOT WRITE IN THIS AREA

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QUESTION	RIGHT									LEFT																	
	#1			#2			#3			#1			#2			#3											
B. Volume of Cyst or Abnormality (in cc.) CALCULATE VOLUME: [MAXIMUM DIAMETER] ³ x 0.523	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
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	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
C. Solid Area 0 = None 2 = All solid (GO TO 4G) 1 = Mixed	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2
D. Septal Structure 0 = No septae 2 = Yes, thick (>3 mm) 1 = Yes, thin (≤3mm)	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2
E. Cyst Outline 1 = Smooth 2 = Irregularities 3 = Papillarities	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
F. Cyst Wall Thickness 1 = Thin (≤3mm) 2 = Thick (>3mm)	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	
G. Echogenicity 1 = Sonolucent 4 = Mixed 2 = Low 5 = High 3 = Low with echogenic core	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
5. Other Abnormalities Noted: <input type="radio"/> No <input type="radio"/> Yes (SPECIFY) _____																											

PART B: EXAMINATION RESULTS

1. Examination Result: <input type="radio"/> Positive Screen - Re-referral Required (GO TO 3) <input type="radio"/> Negative Screen - No Abnormalities (GO TO 3) <input type="radio"/> Negative Screen - Other Abnormalities (GO TO 3) <input type="radio"/> Inadequate	2. Reason for Inadequate Exam: (MARK ALL THAT APPLY) <input type="radio"/> Participant Discomfort <input type="radio"/> Participant Refusal <input type="radio"/> Equipment Malfunction <input type="radio"/> Inability to Insert Probe <input type="radio"/> Bowel Interference <input type="radio"/> Other (SPECIFY) _____	3. Level of Referral: <input type="radio"/> 1 - Significant Abnormality, Referral <input type="radio"/> 2 - Moderate Abnormality, Referral <input type="radio"/> 3 - Slight Variation from Normal, No Referral <input type="radio"/> 4 - Normal/Result Not Available, No Referral	4. Photo Documentation: <input type="radio"/> No <input type="radio"/> Yes
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5. Medical Complications of Examination: <input type="radio"/> No <input type="radio"/> Yes (SPECIFY)	6. Comments: <input type="radio"/> No <input type="radio"/> Yes (SPECIFY) <table border="1"> <thead> <tr> <th>Item #</th> <th>Comments</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> </tbody> </table> <input type="radio"/> Continued	Item #	Comments																					7. Examiner ID: _____ Signature	8. Consultant ID: <input type="radio"/> No <input type="radio"/> Yes (SPECIFY) _____ Signature
Item #	Comments																								

For Office Use Only

Forms Processing (DARKEN CIRCLES AS STEPS ARE COMPLETED)

Form Received into SMS <input type="radio"/> Manual Review Completed <input type="radio"/>	Data Retrieval: Attempted <input type="radio"/> OR None Required <input type="radio"/>	Data Entry of Non-Scannable Items: Completed <input type="radio"/> OR None Required <input type="radio"/>	Final Disposition: Final Complete (FCM) <input type="radio"/> OR Final Incomplete (FIC) <input type="radio"/>
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