

Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

Version No.: 07/01

MEDICAL RECORD ABSTRACT FORM DIAGNOSTIC EVALUATION - COLORECTUM (DEC3/DCQ3)

1.	Date Abstracted:			2.	Abstractor ID #:	3.	Nosologist ID #:	4.	CTR ID#:	5.	Study Year T0-T13:	6.	Purpose of Abstract:	
	MO.	DAY	YEAR											
			20								T		☐ Initial abstract ☐ Re-abstract for QA	
	9	9	9	9		0	0	0	0		0	0		☐ Multiple Primary Cancer #: 2 3 4 5 6 7 8 9 (GO TO A.7)
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FOR OFFICE USE ONLY

8.

Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)

Data Entry of Non-Scannable Items:

Data Retrieval:

Form Received into SMS ☐
Manual Review Completed ☐

Completed ☐ None Required ☐

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
☐ No, Participant self-report

(GO TO A.7)

2.

Reason for Initial Visit for Clinical Assessment:

(MARK ALL THAT APPLY)

- ☐ Symptomatic
☐ Follow-up of positive PLCO screen
☐ Other (SPECIFY) _____



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PLEASE DO NOT WRITE IN THIS AREA



054417

PART A CONTINUED . . .

3. Sigmoidoscopy or Colonoscopy: (DO NOT RECORD RESULTS OF PLCO SCREENING EXAMINATIONS)

☐ No

☐ Yes (COMPLETE TABLE BELOW)

☐ Unknown

PROCEDURE #	1	2	3																																																																																																			
PROCEDURE TYPE 1 = Sigmoidoscopy 3 = Colonoscopy 4 = Endoscopy (NOS)	1 3 4	1 3 4	1 3 4																																																																																																			
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BOWEL PREPARATION 0 = Inadequate 1 = Adequate 9 = Not available	0 1 9	0 1 9	0 1 9																																																																																																			
HYPERPLASTIC POLYPS 0 = None 1 = One 2 = Multiple	0 1 2	0 1 2	0 1 2																																																																																																			

PART A CONTINUED . . .

4. Adenomas on Sigmoidoscopy or Colonoscopy: (DO NOT RECORD RESULTS OF PLCO SCREENING EXAMINATIONS)

☐ No ☐ Yes (COMPLETE TABLE BELOW) ☐ Unknown

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4a. NUMBER OF NON-ADVANCED AND/OR ADVANCED ADENOMAS ADVANCED ADENOMA CRITERIA: (must fulfill at least one to be classified as advanced) - greater than or equal to 1 cm - villous elements in histology - severe or high-grade dysplasia	Total # of confirmed non-advanced adenomas <table border="1"><tr><td>0</td><td>0</td></tr><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr><tr><td>3</td><td>3</td></tr><tr><td>4</td><td>4</td></tr><tr><td>5</td><td>5</td></tr><tr><td>6</td><td>6</td></tr><tr><td>7</td><td>7</td></tr><tr><td>8</td><td>8</td></tr><tr><td>9</td><td>9</td></tr></table>	0	0	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	Total # of confirmed advanced adenomas <table border="1"><tr><td>0</td><td>0</td></tr><tr><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td></tr><tr><td>3</td><td>3</td></tr><tr><td>4</td><td>4</td></tr><tr><td>5</td><td>5</td></tr><tr><td>6</td><td>6</td></tr><tr><td>7</td><td>7</td></tr><tr><td>8</td><td>8</td></tr><tr><td>9</td><td>9</td></tr></table>	0	0	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	4b. CAN EXACT # OF ADENOMAS BE DETERMINED? 0 = No 1 = Yes	0 1																																																																																
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PART A CONTINUED . . .

5. Other Diagnostic/Staging Procedures: (DO NOT RECORD RESULTS OF PLCO SCREENING EXAMINATIONS)

☐ No

☐ Yes (COMPLETE TABLE BELOW)

☐ Unknown

PROCEDURE #	1	2	3
TYPE OF PROCEDURE (SEE PROCEDURE CODES BELOW. IF CEA, RECORD VALUE; IF OTHER, SPECIFY)	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88
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DATE OF PROCEDURE (MO. - DAY - YEAR)	MO. DAY YEAR 0 0 0 0 0 0 1 1 1 1 1 1 2 2 2 2 2 2 3 3 3 3 3 3 4 4 4 4 4 4 5 5 5 5 5 5 6 6 6 6 6 6 7 7 7 7 7 7 8 8 8 8 8 8 9 9 9 9 9 9	MO. DAY YEAR 0 0 0 0 0 0 1 1 1 1 1 1 2 2 2 2 2 2 3 3 3 3 3 3 4 4 4 4 4 4 5 5 5 5 5 5 6 6 6 6 6 6 7 7 7 7 7 7 8 8 8 8 8 8 9 9 9 9 9 9	MO. DAY YEAR 0 0 0 0 0 0 1 1 1 1 1 1 2 2 2 2 2 2 3 3 3 3 3 3 4 4 4 4 4 4 5 5 5 5 5 5 6 6 6 6 6 6 7 7 7 7 7 7 8 8 8 8 8 8 9 9 9 9 9 9

PROCEDURE #	4	5	6
TYPE OF PROCEDURE (SEE PROCEDURE CODES BELOW. IF CEA, RECORD VALUE; IF OTHER, SPECIFY)	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 88
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PROCEDURE CODES

01 = Abdominal flat plate (plain film)
 02 = Barium enema radiograph
 03 = Biopsy (SPECIFY)
 04 = Chest radiograph
 05 = Clinical evaluation
 06 = CT scan - abdominal
 07 = CT scan - other (SPECIFY)
 08 = CT scan - pelvic
 09 = Cystoscopy
 10 = DRE

11 = Intravenous pyelography (IVP)/excretory urography
 12 = MRI scan - abdominal
 13 = MRI scan - other (SPECIFY)
 14 = MRI scan - pelvic
 15 = Preoperative carcinoembryonic antigen (CEA) (RECORD VALUE)
 16 = Stool occult blood
 17 = Record review
 18 = Resection (SPECIFY)

19 = Abdominal ultrasound
 20 = CT scan - abdomen and pelvis combined
 21 = Hemicolectomy
 22 = Laparoscopy
 23 = Laparotomy
 24 = Lymphadenectomy/Lymph node sampling
 25 = Other radiograph (SPECIFY)
 26 = Ultrasound (SPECIFY)
 27 = Upper GI evaluation - endoscopic/radiographic
 88 = Other (SPECIFY)

PLEASE DO NOT WRITE IN THIS AREA



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PART A CONTINUED . . .

PROCEDURE #	7	8	9																																																																																																																																																																																																						
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5b. DIAGNOSTIC/STAGING PROCEDURES SUPPLEMENTED FORM COMPLETED ☐

PROCEDURE CODES

- | | | |
|--|--|--|
| 01 = Abdominal flat plate (plain film)
02 = Barium enema radiograph
03 = Biopsy (SPECIFY)
04 = Chest radiograph
05 = Clinical evaluation
06 = CT scan - abdominal
07 = CT scan - other (SPECIFY)
08 = CT scan - pelvic
09 = Cystoscopy
10 = DRE | 11 = Intravenous pyelography (IVP)/excretory urography
12 = MRI scan - abdominal
13 = MRI scan - other (SPECIFY)
14 = MRI scan - pelvic
15 = Preoperative carcinoembryonic antigen (CEA) (RECORD VALUE)
16 = Stool occult blood
17 = Record review
18 = Resection (SPECIFY) | 19 = Abdominal ultrasound
20 = CT scan - abdomen and pelvis combined
21 = Hemicolectomy
22 = Laparoscopy
23 = Laparotomy
24 = Lymphadenectomy/Lymph node sampling
25 = Other radiograph (SPECIFY)
26 = Ultrasound (SPECIFY)
27 = Upper GI evaluation - endoscopic/radiographic
88 = Other (SPECIFY) |
|--|--|--|

PLEASE DO NOT WRITE IN THIS AREA



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PART A CONTINUED . . .

6. Medical Complications of Diagnostic Evaluation and Staging:

☐ No

☐ Yes (COMPLETE TABLE BELOW)

☐ Unknown

COMPLICATION #	1	2	3
TYPE OF COMPLICATION (SEE COMPLICATION CODES BELOW)	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY
DATE OF COMPLICATION (MO. - DAY - YEAR)	MO. DAY YEAR 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	MO. DAY YEAR 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	MO. DAY YEAR 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
COMPLICATION #	4	5	6
TYPE OF COMPLICATION (SEE COMPLICATION CODES BELOW)	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY	1 2 3 4 6 20 22 23 24 25 26 27 28 29 30 31 32 33 300 301 302 304 307 SPECIFY
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MEDICAL COMPLICATION CODES

1 = Infection (SPECIFY)
2 = Fever requiring antibiotics
3 = Perforation
4 = Hemorrhage
6 = Respiratory arrest
20 = Cardiac 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

300 = Diarrhea
301 = Small bowel obstruction/partial or complete
302 = Ileus
306 = Rectal damage
307 = Blood in stool

PART A CONTINUED . . .

7. Result of Diagnostic Evaluation for Colorectal Cancer:

- ☐ No malignancy (GO TO PART D)
☐ No malignancy and no diagnostic/staging procedures performed (GO TO PART D)
☐ Colorectal malignancy confirmed histologically (exclude carcinoma in situ) (GO TO PART C)
☐ Colorectal malignancy confirmed cytologically (GO TO PART C)
☐ Colorectal 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 COLORECTAL CANCER

8. Other Cancer Diagnosis:

- ☐ No ☐ Yes (COMPLETE TABLE BELOW)

OTHER CANCER DIAGNOSIS 1

OTHER CANCER DIAGNOSIS 2

ICD-9-CM CLASSIFICATION			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
X	X		

DATE OF OTHER CANCER DIAGNOSIS					
MO.		DAY		YEAR	
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

ICD-9-CM CLASSIFICATION			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9
X	X		

DATE OF OTHER CANCER DIAGNOSIS					
MO.		DAY		YEAR	
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

GO TO PART D

PART C: PRIMARY COLORECTAL CANCER DIAGNOSIS INFORMATION

9. Description of Colorectal Carcinoma:

- ☐ No ☐ Yes (COMPLETE TABLE BELOW) ☐ Unknown

PROCEDURE (MARK ALL THAT APPLY)

- 1 = Sigmoidoscopy
2 = Colonoscopy
3 = Polypectomy
4 = Surgical resection
5 = Local transanal or other resection
8 = Endoscopy (NOS)

1 2 3 4 5 8

1 2 3 4 5 8

1 2 3 4 5 8

LOCATION

a. Anatomic (MARK ALL THAT APPLY)

- 01 = Cecum
02 = Ascending colon
03 = Hepatic flexure
04 = Transverse colon
05 = Splenic flexure
06 = Descending colon
07 = Sigmoid colon
08 = Rectum
09 = Appendix
99 = Not available

a.

01 02
03 04
05 06
07 08
09 99

b.

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

a.

01 02
03 04
05 06
07 08
09 99

b.

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

a.

01 02
03 04
05 06
07 08
09 99

b.

0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

GROSS MORPHOLOGY

- 1 = Exophytic
2 = Endophytic
3 = Annular
4 = Diffusely infiltrative
9 = Not available

1 2 3 4 9

1 2 3 4 9

1 2 3 4 9

PART C CONTINUED . . .

10. Date of Primary Colorectal Cancer Diagnosis:

MO.		DAY		YEAR	
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

11. Verbatim Description of Primary Colorectal Cancer Diagnosis:

12. ICD-O-2 Cancer Classification:

Topography				Morphology				Behavior		Grade	
C	0	0	0	0	0	0	0				
1	1	1	1	1	1	1	1	1		1	1
2	2	2	2	2	2	2	2			2	2
3	3	3	3	3	3	3	3	3		3	3
4	4	4	4	4	4	4	4			4	4
5	5	5	5	5	5	5	5			5	5
6	6	6	6	6	6	6	6			6	6
7	7	7	7	7	7	7	7			7	7
8	8	8	8	8	8	8	8				
9	9	9	9	9	9	9	9	9		9	9

13. Photocopy of Report Confirming Primary Colorectal Cancer: (MARK ONE)

- ☐ Pathology/Histopathology (ATTACH COPY)
☐ Cytology/Cytopathology (ATTACH COPY)
☐ Not available

14. Histopathologic Type for Primary Colorectal Cancer:

- | | |
|--|--|
| ☐ Adenocarcinoma | ☐ Undifferentiated carcinoma |
| ☐ Mucinous (colloid) adenocarcinoma | ☐ Carcinoma |
| ☐ Signet ring cell carcinoma | ☐ Other (SPECIFY) _____ |
| ☐ Squamous cell (epidermoid) carcinoma | ☐ Unknown |
| ☐ Adenosquamous carcinoma | |

15. Histopathologic Grade for Primary Colorectal Cancer:

- | | |
|--|--|
| ☐ Grade cannot be assessed (GX) | ☐ Poorly differentiated (G3) |
| ☐ Well differentiated (G1) | ☐ Undifferentiated (G4) |
| ☐ Moderately differentiated (G2) | ☐ Unknown |

16. TNM Staging for Primary Colorectal Cancer:

If TNM Staging performed, what AJCC Cancer Staging Manual did you use? ☐ 4th Edition ☐ 5th Edition

a. TNM Clinical Staging: ☐ Yes (COMPLETE 16.a.1, 16.a.2, 16.a.3) ☐ No (GO TO C.16.b)

1. PRIMARY TUMOR (T)	2. NODAL INVOLVEMENT (N)	3. DISTANT METASTASES (M)
(T) Codes	(N) Codes	(M) Codes
☐ Tx ☐ T2 ☐ T0 ☐ T3 ☐ T1 ☐ T4 ☐ Not available	☐ Nx ☐ N2 ☐ N0 ☐ N3 ☐ N1 ☐ Not available	☐ Mx ☐ M0 ☐ M1 ☐ Not available

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PART C CONTINUED . .

b. TNM Pathologic Staging:

☐ Yes (COMPLETE 16.b.1, 16.b.2, 16.b.3)
 ☐ No (GO TO C.17)

1. PRIMARY TUMOR (T)	2. NODAL INVOLVEMENT (N)	3. DISTANT METASTASES (M)
(T) Codes ☐ Tx ☐ T2 ☐ T0 ☐ T3 ☐ T1 ☐ T4 ☐ Not available	(N) Codes ☐ Nx ☐ N2 ☐ N0 ☐ N3 ☐ N1 ☐ Not available	(M) Codes ☐ Mx ☐ M0 ☐ M1 ☐ Not available

17. Record Stage: (COMPLETE IF 16.b.1, 16.b.2, OR 16.b.3 IS NOT AVAILABLE, OTHERWISE SKIP)
☐ Yes (COMPLETE 17.1, 17.2, 17.3, 17.4)
 ☐ No (GO TO PART E)

1. STAGE ONLY	2. DUKES	3. MODIFIED DUKES (ASTLER-COLLER)	4. SUMMARY STAGING
☐ I ☐ II ☐ III ☐ IV ☐ Not available	☐ A ☐ B ☐ C ☐ Not available	☐ A ☐ C1 ☐ B1 ☐ C2 ☐ B2 ☐ D ☐ Not available	☐ Localized ☐ Regional ☐ Distant ☐ Not available

GO TO PART E

PART D: DATE OF DIAGNOSTIC EVALUATION DETERMINATION

18. Complete this item if:
 Item A.7 = No malignancy **OR**
 Item A.7 = No malignancy and no diagnostic procedures performed **OR**
 Item A.7 = No information available

MO.	DAY	YEAR
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3	3	3
4	4	4
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6	6	6
7	7	7
8	8	8
9	9	9

PART E: PHYSICIAN/HOSPITAL LOCATION INFORMATION

19. Physician for Diagnostic Evaluation:

a. Name: _____
 Address: _____
 Telephone: (____) _____ City _____ State _____ ZIP Code _____
 Medical Record/Chart # _____

b. Name: _____
 Address: _____
 Telephone: (____) _____ City _____ State _____ ZIP Code _____
 Medical Record/Chart # _____

20. Hospital or Clinic for Diagnostic Evaluation:

a. Name: _____
 Address: _____
 Telephone: (____) _____ City _____ State _____ ZIP Code _____
 Medical Record/Chart # _____

b. Name: _____
 Address: _____
 Telephone: (____) _____ City _____ State _____ ZIP Code _____
 Medical Record/Chart # _____

21.

Comments:

☐ No ☐ Yes (SPECIFY)

Item #

Comments

(☐ CONTINUED)

PLEASE DO NOT WRITE IN THIS AREA



21. Comments: (Continued)

☐ No ☐ Yes (SPECIFY)

(☐ CONTINUED)

Comments: (Continued)

Item #	Comments
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