SPIRAL CT SCREENING EXAMINATION FORM (SCT)

Administrative Section

Screening Center ID: |___|___|

Date of Examination: |___|___| / |___|___| / |__|__|___|___|
Month Day Year

Study Year (T_0 - T_2): T |___|

Visit Number: ☐ One ☐ Two

Reason for repeat visit _____

Interval Follow Up Information:

Has the participant had any imaging studies since the previous screening exam that may be useful for the radiologist to review if needed? ☐ Yes ☐ No ☐ N/A

If YES, dates obtained (Month /Year): |___|___| / |__|__|___|___|

Initials Complete: _____

Initials QC: _____

Participant ID Label

PART A. SPIRAL CT EXAMINATION FINDINGS (COMPLETED BY TECHNOLOGIST)

1. Number of Attempts:

☐ None (GO TO A.3)
☐ One
☐ Two
☐ Three

2. Adequate Scan Obtained:

☐ No
☐ Yes (GO TO A.4)

3. Reason for Inadequate or No Scan: (MARK ALL THAT APPLY)

☐ Participant refusal
☐ Equipment malfunction
☐ Poor image quality
☐ Other (SPECIFY)
_____

4. Technical Parameters:

A. |___|___|___| kVp
B. |___|___|___| mAs
C. |___|___|___| mA
D. |___|___| Display FOV
E. |___|___| Effective mAs
F. |___|.|___|___| Pitch

5. Indicate CT reconstruction algorithm/filter:

☐ GE Bone
☐ GE Standard
☐ GE, other: _____
☐ Philips D
☐ Philips C
☐ Philips, other: _____
☐ Siemens B50F
☐ Siemens B30
☐ Siemens, other: _____
☐ Toshiba FC10
☐ Toshiba FC51
☐ Toshiba, other: _____

6. Comments: ☐ No ☐ Yes

_____

☐ Continued

7. Tech ID:

|___|___|___|___| **Signature:** _____

PARTS B, C, D AND E COMPLETED BY RADIOLOGIST

PART B. SPIRAL CT OVERALL DIAGNOSTIC QUALITY (COMPLETED BY RADIOLOGIST)

1. Indicate the overall diagnostic quality of the CT image acquisition sequence:

- ☐ A. Diagnostic CT (GO TO C.1)
- ☐ B. Limited CT, but interpretable (COMPLETE B.2 AND GO TO C.1)
- ☐ C. Non-diagnostic CT exam, reschedule CT (COMPLETE B.2 AND GO TO D.1)
- ☐ D. No image available (GO TO D.3, COMMENTS)

2. Which of the following affected the quality of the limited or non-diagnostic CT? (MARK ALL THAT APPLY)

- ☐ Submaximal inspiratory breath-hold
- ☐ Motion artifact
- ☐ Respiratory misregistration
- ☐ Incorrect technical parameter(s)
- ☐ Lungs not completely imaged
- ☐ Severe beam hardening artifact
- ☐ Excessive quantum mottle or graininess
- ☐ Other (SPECIFY)_____

PART C. SPIRAL CT EXAMINATION FINDINGS (COMPLETED BY RADIOLOGIST)

1. Radiologic Abnormality Noted:

- ☐ No (GO TO D.1 AND MARK RESULT "E")
- ☐ Yes (COMPLETE C.2. RECORD INFORMATION FOR EACH ABNORMALITY)

2. Record Information for Each Abnormality:

Abn #	Description of Abnormality		Complete for Code 51 Only: CT Slice	Location of Epicenter	Longest Diameter (mm)	Longest Perpendicular Diameter (mm)	Margins	Predominant Attenuation
	51 = Non-calcified nodule/mass ≥ 4 mm (MUST MARK "A" IN D.1) 52 = Non-calcified nodule < 4 mm 53 = Benign lung nodule(s) (benign calcification) 54 = Atelectasis, segmental or greater 55 = Pleural thickening or effusion 56 = Non-calcified hilar/mediastinal adenopathy/mass ≥ 10 mm short axis 57 = Chest wall abnormality (e.g. bone destruction, metastasis) 58 = Consolidation 59 = Reticular/reticulonodular opacities, honeycombing, fibrosis, scar 62 = 6 or more nodules, not suspicious for cancer (opacities ≥ 4mm) (ANY SUSPICIOUS NODULES MUST BE CODED AS 51) 63 = Emphysema 64 = Significant cardiovascular abnormality (SPECIFY) 70 = Other significant abnormality above the diaphragm (SPECIFY) 71 = Other significant abnormality at/below the diaphragm (SPECIFY) 72 = Other minor abnormality noted (SPECIFY IF DESIRED)	CHECK BOX IF IDENTIFIED AFTER COMPARISON WITH HISTORICAL IMAGES:	Record slice number containing abnormality's greatest diameter	1 = RUL 2 = RML 3 = RLL 4 = LUL 5 = Lingula 6 = LLL 8 = Other, SPECIFY (in Comments section)	(same CT slice) 999 = Unable to determine	(same CT slice) 999 = Unable to determine	1 = Spiculated (Stellate) 3 = Smooth 4 = Poorly defined 9 = Unable to determine	1 = Soft tissue 2 = Ground glass 3 = Mixed 4 = Fluid/ water 6 = Fat 7 = Other 9 = Unable to determine
1	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|
2	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|
3	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|
4	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|
5	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|
6	|___|___|	☐	|___|___|___|	|___|	|___|___|___|	|___|___|___|	|___|	|___|

PART D. SPIRAL CT INTERPRETATION RESULTS (COMPLETED BY RADIOLOGIST)

1. Lung Screening Result:

- ☐ A. **Positive Screen – Abnormalities suspicious for lung cancer**
- ☐ C. **Negative Screen** – Clinically significant abnormalities not suspicious for lung cancer (GO TO D.3)
- ☐ D. **Negative Screen** – Minor abnormalities not suspicious for lung cancer (GO TO D.3)
- ☐ E. **Negative Screen** – No significant abnormalities (GO TO D.3)
- ☐ F. **Inadequate** (COMPLETE PART D.3 AND GO TO E.6)

2. Other Significant Abnormalities (in addition to lung screening results) that need to be reported:

☐ No ☐ Yes (SPECIFY IN D.3)

3. Comments: ☐ No ☐ Yes

____

____ ☐ Continued

PART E. SPIRAL CT COMPARISON RESULTS – COMPLETE FOR ALL LUNG SCREENING RESULTS (COMPLETED BY RADIOLOGIST)

1. Comparison Image: (MARK ALL THAT APPLY)

- ☐ No image available (GO TO E.4)
- ☐ T_0
- ☐ T_1
- ☐ T_2 Inadequate scan
- ☐ Previous scan not completed as part of NLST (RECORD SCAN TYPE AND DATES FOR UP TO 3 PREVIOUS SCANS)

Scan Types
1 = CT
2 = CXR
3 = MRI

Previous Scan Type(s):	Date(s) of Previous Scan(s) (MONTH/DAY/YEAR)
|___|	|___|___| / |___|___| / |___|___|___|___|
|___|	|___|___| / |___|___| / |___|___|___|___|
|___|	|___|___| / |___|___| / |___|___|___|___|

2. Enter abnormality number and code for <u>all</u> Code 51 abnormalities AND other significant abnormalities seen on this screening exam. (IF NONE, GO TO E.3)

Abn. # (FROM ITEM C.2.)	Abn.Code (FROM ITEM C.2)	Was Abnormality Pre-existing? 1 = No 2 = Yes 9 = Unable to determine	Earliest Date Visible (COMPLETE ONLY FOR PRE-EXISTING ABNORMALITIES) (Month/Day/Year) 99/99/9999 = Unable to determine	COMPLETE FOR CODE 51 ABNORMALITIES ONLY: Interval Growth of Abnormality? 1 = No 2 = Yes 9 = Unable to determine	COMPLETE FOR CODE 51 ABNORMALITIES ONLY: Interval suspicious change in attenuation? 1 = No 2 = Yes 9 = Unable to determine	COMPLETE FOR OTHER SIGNIFICANT ABNORMALITIES ONLY: Interval change warrants further investigation? 1 = No 2 = Yes 9 = Unable to determine
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|
|___|	|___|___|	|___|	|___|___| / |___|___| / |___|___|___|___|	|___|	|___|	|___|

3a. Lung Screening Comparison Result:

- ☐ A. **Positive Screen –** Abnormalities suspicious for lung cancer
- ☐ B. **Positive Screen –** Abnormalities suspicious for lung cancer, no significant change
- ☐ C. **Negative Screen** – Clinically significant abnormalities not suspicious for lung cancer (GO TO E.4)
- ☐ D. **Negative Screen** – Minor abnormalities not suspicious for lung cancer (GO TO E.4)
- ☐ E. **Negative Screen** – No significant abnormalities (GO TO E.4)

3b. Other Significant Abnormalities (in addition to lung screening results) that need to be reported:

☐ No ☐ Yes (SPECIFY IN E.5)

4. Which of the following diagnostic procedures for screening examination results should the screening result letter include?

(MARK ALL THAT APPLY)

- ☐ No diagnostic intervention necessary
- ☐ Continue NLST screening CT
- ☐ Comparison with historical images (NOTE: CHECK OTHER PROCEDURES IN CASE HISTORICAL IMAGES UNAVAILABLE)
- ☐ Low dose CT with NLST parameters at:

  (MARK ALL THAT APPLY)
  - ☐ 3 months
  - ☐ 6 months
  - ☐ 3-6 months
  - ☐ 12 months
  - ☐ 24 months

  (MARK AN AREA OF FOCUS)
  - ☐ Limited
  - ☐ Entire chest
- ☐ Diagnostic chest CT
- ☐ Contrast-enhanced CT nodule densitometry
- ☐ FDG-PET
- ☐ Tech 99m depreotide scintigraphy
- ☐ Biopsy (percutaneous, thoracoscopic, open, etc.)
- ☐ Other (SPECIFY)_____

5. Comments: ☐ No ☐ Yes

_____

_____

☐ Continued

6. Radiologist ID: |___|___|___|___| **Date:** |___|___| / |___|___| / |__|__|___|___|
MO DAY YEAR

_____
Signature