

# Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

## FLEXIBLE SIGMOIDOSCOPY SCREENING EXAMINATION (FSG2)

1. Date of Examination: MO. DAY YEAR	2. Screening Center:	3. Satellite Center:	4. Study Year:	5. Visit Number:
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> One
<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> T <sub>0</sub>	<input type="radio"/> Two
<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> T <sub>5</sub>	<input type="radio"/> Three
<input type="radio"/> 3	<input type="radio"/> 3	<input type="radio"/> 3		
<input type="radio"/> 4	<input type="radio"/> 4	<input type="radio"/> 4		
<input type="radio"/> 5	<input type="radio"/> 5	<input type="radio"/> 5		
<input type="radio"/> 6	<input type="radio"/> 6	<input type="radio"/> 6		
<input type="radio"/> 7	<input type="radio"/> 7	<input type="radio"/> 7		
<input type="radio"/> 8	<input type="radio"/> 8	<input type="radio"/> 8		
<input type="radio"/> 9	<input type="radio"/> 9	<input type="radio"/> 9		

• DO NOT FOLD, STAPLE OR TEAR THIS FORM.  
• USE A NO. 2 PENCIL TO COMPLETE THIS FORM.

6. Reason for Repeat Visit:

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**For Office Use Only**

7. Form Processing (DARKEN CIRCLES AS STEPS ARE COMPLETED)

Form Receipted into SMS

Manual Review Completed

**Data Retrieval:**  
Attempted  OR None Required

**Data Entry of Non-Scannable Items:**  
Completed  OR None Required

**Final Disposition:**  
Final Complete (FCM)  OR Final Incomplete (FIC)

**PART A: RECTAL EXAMINATION FINDINGS**

1. Rectal Examination Findings: (MARK ALL THAT APPLY)

None (GO TO PART B)

External hemorrhoids

Tenderness

Masses, Polyps, or Nodules

Blood

Stricture

Fistula or Fissures

Other (SPECIFY) \_\_\_\_\_

**PART B: FLEXIBLE SIGMOIDOSCOPY FINDINGS**

1. Number of Attempts:	2. Reason for Repeat Exam: (MARK ALL THAT APPLY)	3. Depth of Sigmoidoscope Insertion: cm	4. Number of Lesions Seen: (INCLUDES POLYPS AND MASSES)	
				MO.
<input type="radio"/> One (GO TO 3)	<input type="radio"/> Participant Discomfort	<input type="radio"/> 0	<input type="radio"/> None (GO TO 6)	
<input type="radio"/> Two	<input type="radio"/> Participant Refusal	<input type="radio"/> 1	<input type="radio"/> One	
	<input type="radio"/> Equipment Malfunction	<input type="radio"/> 2	<input type="radio"/> Two	
	<input type="radio"/> Inadequate Preparation	<input type="radio"/> 3	<input type="radio"/> Three	
	<input type="radio"/> Vasovagal Response	<input type="radio"/> 4	<input type="radio"/> Four or More	
	<input type="radio"/> Other (SPECIFY) _____	<input type="radio"/> 5		
		<input type="radio"/> 6		
		<input type="radio"/> 7		
		<input type="radio"/> 8		
		<input type="radio"/> 9		

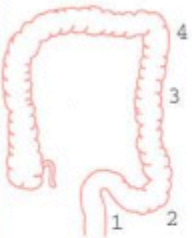
Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency 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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**PART B CONTINUED...**

DIAGRAM	5. RECORD INFORMATION FOR LARGEST FOUR LESIONS:				
	LESION 1	LESION 2	LESION 3	LESION 4	
 <p>1 = Rectum 2 = Sigmoid colon 3 = Descending colon 4 = Splenic flexure</p>	<b>TYPE</b> 1 = Polyp 2 = Mass (1) (2)	(1) (2)	(1) (2)	(1) (2)	
	<b>LOCATION</b> (RECORD A NUMBER, 1-4, FROM THE DIAGRAM) (1) (2) (3) (4)	(1) (2) (3) (4)	(1) (2) (3) (4)	(1) (2) (3) (4)	
	<b>SIZE</b> (LARGEST DIMENSION IN CM)	(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)	(0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
	<b>SHAPE</b> 1 = Sessile 2 = Pedunculated 8 = Other (SPECIFY)	(1) (2) (8)	(1) (2) (8)	(1) (2) (8)	(1) (2) (8)
	<b>BIOPSY PERFORMED</b>	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES
	<b>VIDEO/PHOTO DOCUMENTATION</b>	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NO <input type="radio"/> YES

**6. Other Irregular Findings: (MARK ALL THAT APPLY)**

<input type="radio"/> None (GO TO PART C)	<input type="radio"/> Vascular Lesions	<input type="radio"/> Stricture	<input type="radio"/> Anal Warts
<input type="radio"/> Diverticulosis	<input type="radio"/> Ulcers	<input type="radio"/> Fissures	<input type="radio"/> Other (SPECIFY) _____
<input type="radio"/> Diverticulitis	<input type="radio"/> Melanosis Coli	<input type="radio"/> Internal Hemorrhoids	
<input type="radio"/> Colitis	<input type="radio"/> Blood		

**PART C: EXAMINATION RESULTS**

<b>1. Examination Results:</b> <input type="radio"/> Positive Screen - 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 (Less than 90% mucosa is visible, or insertion of flexible sigmoidoscope to less than 50 cm, with no obstructing lesions and no abnormalities suspicious for cancer in the region visualized.)	<b>2. Reason for Inadequate Exam: (MARK ALL THAT APPLY)</b> <input type="radio"/> Participant Discomfort <input type="radio"/> Participant Refusal <input type="radio"/> Equipment Malfunction <input type="radio"/> Inadequate Preparation with Unclear Lumen <input type="radio"/> Vasovagal Response <input type="radio"/> Palpitations With Tachycardia <input type="radio"/> Severe Diverticulosis With Unclear Lumen <input type="radio"/> Severe Ulcerative Colitis <input type="radio"/> Other (SPECIFY) _____	<b>3. Level of Referral:</b> <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	<b>4. Medical Complications of Procedure: (MARK ALL THAT APPLY)</b> <input type="radio"/> None (GO TO 5) <input type="radio"/> Fainting <input type="radio"/> Perforation <input type="radio"/> Bleeding <input type="radio"/> Other (SPECIFY) _____
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<b>5. Comments:</b> <input type="radio"/> No <input type="radio"/> Yes (SPECIFY)	<b>6. Examiner ID:</b>	<b>7. Consultant ID:</b>																						
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Item #	Comments																							