Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

TRANSVAGINAL ULTRASOUND SCREENING EXAMINATION (TVU2)

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

1. Date of Examination: ___________________________________________
   Month   Day   Year

2. Satellite Center: ___ ___

3. Study Year:
   ○ T₀
   ○ T₁
   ○ T₂
   ○ T₃

4. Visit Number:
   ○ One
   ○ Two
   ○ Three

5. Reason for Repeat Visit:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
### PART A: TRANSVAGINAL ULTRASOUND EXAMINATION FINDINGS

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RIGHT</th>
<th>LEFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sonographically Detectable Ovary</td>
<td>○ No (GO TO 3)  ○ Yes</td>
<td>○ No (GO TO 3)  ○ Yes</td>
</tr>
<tr>
<td>2. Ovary Size</td>
<td>Longitudinal diameter (cm): ___ . ___</td>
<td>Longitudinal diameter (cm): ___ . ___</td>
</tr>
<tr>
<td>(CALCULATE VOLUME: WIDTH X HEIGHT X THICKNESS X 0.523)</td>
<td>Transverse diameter (cm): ___ . ___</td>
<td>Transverse diameter (cm): ___ . ___</td>
</tr>
<tr>
<td></td>
<td>Anteroposterior diameter (cm): ___ . ___</td>
<td>Anteroposterior diameter (cm): ___ . ___</td>
</tr>
<tr>
<td></td>
<td>Volume (cc): ___ ___ ___ . ___</td>
<td>Volume (cc): ___ ___ ___ . ___</td>
</tr>
<tr>
<td>3. Number of Morphologic Abnormalities in Adnexal Area</td>
<td>○ None (GO TO LEFT)</td>
<td>○ None (GO TO 5)</td>
</tr>
<tr>
<td></td>
<td>○ One</td>
<td>○ One</td>
</tr>
<tr>
<td></td>
<td>○ Two</td>
<td>○ Two</td>
</tr>
<tr>
<td></td>
<td>○ Three or more</td>
<td>○ Three or more</td>
</tr>
<tr>
<td>4. Complete for Three Largest Discrete Cysts or Abnormalities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Maximum Diameter of Cyst or Abnormality (in cm.)</td>
<td>#1: ___ . ___</td>
<td>#1: ___ . ___</td>
</tr>
<tr>
<td></td>
<td>#2: ___ . ___</td>
<td>#2: ___ . ___</td>
</tr>
<tr>
<td></td>
<td>#3: ___ . ___</td>
<td>#3: ___ . ___</td>
</tr>
<tr>
<td>B. Volume of Cyst or Abnormality (in cc.)</td>
<td>#1: ___ ___ ___ . ___</td>
<td>#1: ___ ___ ___ . ___</td>
</tr>
<tr>
<td></td>
<td>#2: ___ ___ ___ . ___</td>
<td>#2: ___ ___ ___ . ___</td>
</tr>
<tr>
<td></td>
<td>#3: ___ ___ ___ . ___</td>
<td>#3: ___ ___ ___ . ___</td>
</tr>
<tr>
<td>C. Solid Area</td>
<td>0 = None</td>
<td>0 = None</td>
</tr>
<tr>
<td></td>
<td>1 = Mixed</td>
<td>1 = Mixed</td>
</tr>
<tr>
<td></td>
<td>2 = All Solid (GO TO 4G)</td>
<td>2 = All Solid (GO TO 4G)</td>
</tr>
<tr>
<td>D. Septal Structure</td>
<td>0 = No septae</td>
<td>0 = No septae</td>
</tr>
<tr>
<td></td>
<td>1 = Yes, thin (≤3mm)</td>
<td>1 = Yes, thin (≤3mm)</td>
</tr>
<tr>
<td></td>
<td>2 = Yes, thick (&gt;3mm)</td>
<td>2 = Yes, thick (&gt;3mm)</td>
</tr>
<tr>
<td>E. Cyst Outline</td>
<td>1 = Smooth</td>
<td>1 = Smooth</td>
</tr>
<tr>
<td></td>
<td>2 = Irregularities</td>
<td>2 = Irregularities</td>
</tr>
<tr>
<td></td>
<td>3 = Papillarities</td>
<td>3 = Papillarities</td>
</tr>
<tr>
<td>F. Cyst Wall Thickness</td>
<td>1 = Thin (≤3mm)</td>
<td>1 = Thin (≤3mm)</td>
</tr>
<tr>
<td></td>
<td>2 = Thick (&gt;3mm)</td>
<td>2 = Thick (&gt;3mm)</td>
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<tr>
<td>G. Echogenicity</td>
<td>1 = Sonolucent</td>
<td>1 = Sonolucent</td>
</tr>
<tr>
<td></td>
<td>2 = Low</td>
<td>2 = Low</td>
</tr>
<tr>
<td></td>
<td>3 = Low with echogenic core</td>
<td>3 = Low with echogenic core</td>
</tr>
<tr>
<td></td>
<td>4 = Mixed</td>
<td>4 = Mixed</td>
</tr>
<tr>
<td></td>
<td>5 = High</td>
<td>5 = High</td>
</tr>
<tr>
<td>5. Other Abnormalities Noted:</td>
<td>○ No</td>
<td>○ No</td>
</tr>
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<td></td>
<td>○ Yes (SPECIFY)</td>
<td>○ Yes (SPECIFY)</td>
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</table>
1. **Examination Result:**
   - Positive Screen – Referral Required (GO TO 3)
   - Negative Screen – No Abnormalities (GO TO 3)
   - Negative Screen – Other Abnormalities (GO TO 3)
   - Inadequate

2. **Reason for Inadequate Exam: (MARK ALL THAT APPLY)**
   - Participant Discomfort
   - Participant Refusal
   - Equipment Malfunction
   - Inability to Insert Probe
   - Bowel Interference
   - Other (SPECIFY)

3. **Level of Referral:**
   - 1 – Significant Abnormality, Referral
   - 2 – Moderate Abnormality, Referral
   - 3 – Slight Variation from Normal, No Referral
   - 4 – Normal/Result Not Available, No Referral

4. **Photo Documentation:**
   - No
   - Yes

5. **Medical Complications of Examination**
   - No
   - Yes (SPECIFY)

_______________________________
_______________________________
_______________________________
_______________________________
6. **COMMENTS:**
   - ☐ No
   - ☐ Yes (SPECIFY)

<table>
<thead>
<tr>
<th>Item #</th>
<th>Comments</th>
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<tbody>
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☐ (CONTINUED)

7. **Examiner ID:** __ __ __ __

8. **Consultant ID:**
   - ☐ No
   - ☐ Yes (SPECIFY) __ __ __ __

**FOR OFFICE USE ONLY**

*Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)*
   - ☐ Form Receipted into SMS
   - ☐ Manual Review Completed

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

*Data Retrieval:*
   - ☐ Attempted OR
   - ☐ None Required

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