

**ACRIN 4703
Detection of Early Lung Cancer
Among Military Personnel (DECAMP)**

Place Label Here

Institution _____ Institution No. _____
Case No. _____

Study Evaluation and Diagnosis Worksheet

Instructions: The Study Evaluation and Diagnosis Worksheet should be completed by the Treating Physician at each SOC follow up visit for the patient. Any malignancy identified during the two-year follow-up time period will need to be reported on the Study Evaluation and Diagnosis Form.

1. Was the Study Evaluation and Diagnosis Form completed by the treating physician?

- No, complete Q1a and sign off worksheet
- Yes, continue to Q2

- 1a. If no, provide primary reason:**
- Patient refused follow up
 - Patient lost to follow up
 - Treating physician did not complete form
 - Other, specify _____

2. Date study evaluation and diagnosis completed: _____ - _____ - _____ *MMM-dd-yyyy*

3. Is there malignancy in the lung? No, further follow up is required *Q4 and Part IV are required*

- No, this is a benign case, follow up will cease **Q4, Part III, and Part IV are required*
- Yes*, *Q3a, Q3b, Q4, and Part IV are required. Part II is also required for primary lung malignancies*
- Uncertain, but presumed malignant **Q3a, Q3b, Q4, and Part IV are required.*
- Uncertain, *Q4 and Part IV are required*

**These cases will be sent to the Adjudication Committee and should not be taken off trial until the outcome is determined*

3a. If yes, provide date established: _____ - _____ - _____ *MMM-dd-yyyy*

- 3b. If yes, the malignancy is:**
- Primary Lung, *complete Q4, then continue to Part II*
 - Metastatic to the Lung, *complete Q3b1, then continue to Part IV*
 - Presumed Cancer- primary lung- *continue to Part IV*
 - Presumed Cancer- metastatic to the lung *complete Q3b1, then continue to Part IV*
 - Uncertain, *continue to Part IV*

3b1. If metastatic, provide the primary site of origin: _____

4. Did the case have any other cancer diagnosis? No

- Yes, *Q4a is required*

4a. If yes, provide the primary site: _____

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Part II. Lung Malignancy *complete this section only if Q3b=primary lung*

- 5. Has the lung malignancy been reported on a previous Study Evaluation and Diagnosis form?** No, skip to Q6
 Yes, continue to Q5a
 Unknown, skip to Q6
 Not applicable, skip to Q6

- 5a. Has the patient developed progressive disease (e.g., progression at primary site, metastases, other recurrence) following treatment for lung cancer?** No, skip to Part IV
 Yes, complete Q5a1 and 5a2, then skip to Part IV
 Unknown, skip to Part IV

5a1. If yes, date of first documentation of progressive lung cancer: _____ - _____ - _____ *MMM-dd-yyyy*

5a2. List the site(s) of progression of lung cancer: _____

- 6. Lung Cancer Type** Small Cell Lung Cancer
 Non-Small Cell Lung Cancer
 Carcinoid
 Unknown
 Other, specify _____

- 7. Histologic Class** Adenocarcinoma Large Cell Carcinoma
 Adenosquamous Carcinoma Small Cell Carcinoma
 Epidermoid Carcinoma Squamous Cell Carcinoma
 Bronchioloalveolar Carcinoma Unknown
 Carcinoid Other, specify _____

- 8. Histologic Subtype** Acinar Pure small cell carcinoma
 Bronchioalveola Combined small cell carcinoma
 Papillary Large cell neuroendocrine
 Solid carcinoma with mucus formation Basaloid
 Mixed Lymphoepithelial-like
 Large cell with rhabdoid phenotype Unknown
 Other, specify _____

- 9. Cancer Stage** Occult IIIA
 0 IIIB
 IA IV
 IB
 IIA
 IIB

After completion of Part II, skip to Part IV of this form

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Part III. No Malignancy *complete this section only if Q3= No, this is a benign case, follow up will cease*

- 10. Provide the reasoning for the no malignancy diagnosis:**
- No Definitive Diagnosis During Two-Year Follow Up
 - Alternate Diagnosis, *continue to Q11*
 - Resolution of Abnormality, *skip to Part IV*
 - Stable mass, no additional FU, *skip to Part IV*
 - Stable mass, additional FU required, *skip to Part IV*
 - Other, specify _____

- 11. If alternative diagnosis, what is the alternate diagnosis?**
- Sarcoid
 - Alveolactasis
 - Carcinoid
 - Infection
 - Other, specify _____

- 11a. If the alternative diagnosis is infection, provide the type:**
- TB
 - Bacterial Pneumonia
 - Fungus
 - Viral Pneumonia
 - Other, specify _____

After completion of Part III, continue to Part IV of this form

Part IV. Diagnostic tests performed since the last Study Evaluation and Diagnosis Form was completed *required if Q1=yes*

Note: For all diagnostic tests, sites will need to upload a de-identified copy of the report into Rave

Diagnostic Test Type	Was test performed since last Study Evaluation and Diagnosis form was completed?	If performed, date of test MMM-dd-yyyy	Was test used to establish diagnosis described above?
Bone Scan	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Bronchoscopy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Chest X Ray	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
CT Scan	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Lobectomy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Mediastinoscopy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
MRI	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
PET	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Sputum	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
TBNA	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Surgical Lung Biopsy	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
TTNA	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Other, specify	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Other, specify	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Other, specify	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes
Other, specify	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown		<input type="radio"/> No <input type="radio"/> Yes

Signature of Treating Physician

_____ *MMM-dd-yyyy*
Date Form Completed