MOP for follow-up MRA

Notes:

- About the MRA database
  - To close an ID's abstraction (the record), click the small "X" icon (close window) near the top right corner of the screen.
    - This will take you back to the initial entry screen; from there you can open an abstraction (record) for another ID.
  - Entering text
    - When entering text in fields such as "other," use either all lowercase or mixed (e.g., "enlarged" or "Enlarged").
    - Do not use all capital letters
      - Exception "NS" ("ns" is also acceptable)
  - Multiple entries within a record
    - Multiple entries within a record are allowed for all fields.
    - When multiple entries are needed for a field (e.g., DRE), click the icon for a new entry (→*) on that specific sub-form window.
    - When you have multiple entries (e.g., DRE), for the first DRE, select "Yes" to indicate that information is available, and then for all subsequent DRE entries the "info available" question can be skipped.
    - If you close and then re-open an entire record, most fields will sort by date (e.g., PSAs will be sorted chronologically).
  - Correcting mistakes / deleting
    - To correct a mistake in the most recent field in which you typed, hit "escape" on your keyboard **once**.
    - To delete an entry within a record (e.g., a single DRE), click the "trashcan" icon within the entry's window.
    - To delete a whole record (i.e., the entire abstraction for a subject) click the "trashcan" icon at the top of the screen. This should only be done rarely, in extreme circumstances.
  - Back-ups
    - MRA database does not have an audit trail.
    - Manual back-ups (saving "snapshot" copies of database at different points in time) will serve as alternative for audit trail.
      - Andrew will manually copy the database: 1) once per week (if abstracting frequently), 2) just before and just after any data cleaning (will typically be done in batch, maybe 1/month).
      - To make those copies: right click on "PCaP Followup MRA Tables" (located at I:\Mohler-DoD\Follow-up\medical records\MRA\database), choose Add to zip, change filename to include date, and save to I:\Mohler-DoD\Follow-up\medical records\MRA\back-ups for audit trail, which has automatic daily back-up.
- Preparing records for abstraction
  - Sorting records
    - Option 1: Group by physician
      - If the same doctor sends records in both years 1 and 2, all records from that doctor can be combined and abstracted together. In that case, call that doctor whatever he's labeled as in year 2 on the physician-event category tab in ST.
        - For example, if Raj Pruthi is a subject's Y1 MD1 and Y2 MD2, those 2 sets of records can be abstracted together; call him Y2 MD2 when entering MD-specific fields (because we will file all Y1 and Y2 records together in the subject's Y2 chart after abstracting).

- For each physician, divide the record into the following sections:
    - pathology report and operative report
    - PSA and lab values (separate if possible, although sometimes lab reports showing Hemoglobin etc will also show PSA results on the same page)
    - imaging reports
    - clinic notes
- sort records chronologically within each section, from earliest to latest

OR

- Option 2: Everything chronological
    - Combine all records (regardless of year/MD) but make sure to write the year/MD and date if not explicit on each sheet (i.e., 5 pages within Y1 MD1's records are all from the same visit date, but it only lists the visit date & MD on the 1st page → write the date & MD on the other 4 pages)
    - sort records chronologically from earliest to latest, regardless of what type of record they are (PSA, imaging, etc.)

- MDs
    - Each individual MD should be treated separately. For example, even if two MDs are members of the same practice, they should be considered separately when abstracting records.
        - Exception: Records from a VA medical center (e.g., Durham or Fayetteville VAMC) are abstracted together as DVAMC or FVAMC, respectively; providers from a single VA are not separated.
    - If an MD's name/signature is illegible then MD=NS.
    - For efficiency, records from the same MD in years 1 and 2 can be combined.
        - Abstract that doctor as whatever his # is for year 2. (For example, if Dr. Jones is Y1 MD2 and Y2 MD1, abstract all info from him as Y2 MD1).
        - When re-filing, place all year 1 and 2 records in the subject's year 2 chart.
    - Outside MDs
        - An outside MD is a physician (1) not already listed on the Physician-Event Category tab for a subject for a particular year (i.e., outside physician whose records were contained in records sent by another MD), and (2) who did not / will not send his own set of records.
        - Abstractors will need to assign a letter to Outside MDs who provide information that requires an MD when it is entered (e.g., PSA, treatment, etc. – but not weight or comorbidity).
            - Read through all info from any outside MDs and determine whether any MD-specific info will be entered, as opposed to only items like comorbidity and weight that don't require doctor info.
            - If MD-specific info will be entered, assign them a letter and enter them in ST. (This will prevent entering info from Dr. B without a Dr. A.)
            - If an MD is not already listed in ST, add him to the drop-down menu under physician. Minimal information should include MD name and City in which he or she is practicing.
        - When assigning an MD letter to an Outside MD, ALWAYS start with Outside MD A, even if a subject has <3 physicians assigned.

        - If the subject signed a blank release form, and if we decide to request additional records from an outside physician, then that physician could be entered in ST as whichever number the blank release form was assigned. This would allow us to track the request for that physician.
    - An MD that is just reading results (e.g., a radiologist reading an x-ray) is not considered a reporting MD (i.e., he wouldn't be added as Outside MD A).
        - Those items should be classified under the MD who requested the procedure.
    - If an outside record includes a nurse practitioner or physician's assistant who is performing a task that requires a practitioner label (e.g., PSA, discussion of bowel/urinary/sexual problems), the NP/PA should be entered in ST as an outside MD and labeled accordingly in MRA.
        - Exception: if the NP/PA signs a record as "dictating for Dr. X," the information from that record should be abstracted under Dr. X.
    - If 2 physicians (e.g., a teaching physician and an intern/resident) are noted on the same visit date, it's likely that the resident will dictate the notes but both will sign (and both of them must have been present at the visit).
        - Therefore, use the name of the physician who has already been assigned a Y# MD# (instead of entering an additional outside MD).
        - If both of them are outside MDs, then use the name of the supervising physician (not necessarily the one who dictated the notes).
- Duplicate records
    - If duplicate copies of the same record/page are received, shred the copy that is more difficult to read.
    - On the copy you keep, make a note that a duplicate of that same page was also sent in the record sent by Dr. X. (This is done because sometimes a duplicate copy of a record is the only proof we have that 2 doctors were communicating.)
- Read and highlight
    - Read through and highlight each item that should be entered into the database, including dates.
    - Only information in records dating from approximately a year before diagnosis (use subject's diagnosis date in the top section of the MRA screen for reference) to present should be abstracted.
        - Exception: comorbidities from >1 year prior to diagnosis should be abstracted.
    - Make sure date for labs/procedures is date of collection (not date it was reported).
    - Be very careful with VA records – they are tricky!

- Entering information into the database
    - Gray questions must be answered once.
        - If multiple entries are warranted, the gray question can be left blank on subsequent entries.
            - *Exception: on the 3 treatment tabs, answer the gray question (Selected?) for every entry.
        - If gray question = No, then all subsequent questions in that set should be left blank.
    - Be conscious of the format for each field.
    - An entry should be considered Not Specified (X=NS) unless specifically stated in the record.
        - Drop-down menus use the term "X=NS" to avoid having multiple items that start with the letter N; this allows for easier tabbing.
        - However, abstractors can just type "X" or "x" or "ns" or "NS" (as opposed to "X=NS") in text fields.

- Be careful when selecting a physician from the drop-down menu; because the items look similar (e.g., Y1 MD1, Y1 MD2), it can be easy to accidentally select the wrong one.
- Dates
  - If part of a date is missing (i.e. only the month and year is available, or only the year is available), enter 01 for the missing day or month and check the "Estimate?" box.
  - If you find information that is important to abstract but does not have a date, bring this item for discussion at the next meeting so that a decision can be made and documented and all abstractors informed.
  - If there is no date given for a co-morbidity, and absolutely no way to estimate it, then leave the date field blank and check the "estimate?" box.
  - If both the numeric result and date are missing (i.e., last PSA was nearly 0), then check previous records for the exact number and date.
    - If they are not found in previous records, then don't abstract anything for that comment.
  - If one doctor writes a letter to another doctor and the letter is dated after a visit (not on the date of a visit with the patient), then use the date of the previous visit for dating any relevant notes from that letter (e.g., DRE performed on date of visit, not date of letter 2 days later).
- Numbers
  - If the record gives more than 2 decimal places, round to the nearest hundredth (2 decimal places).
- "Other" fields
  - If there are multiple items for entry in an "other" field, they can all be entered in a single "other-specify" text field.
  - All fields for "other" (e.g., other result, other type of exam) can be left blank if no information is available for those fields; an entry of "ns" is not required.
- Medicines
  - If a medicine list is provided and if a specific medicine is mentioned in the notes as well, search online to determine whether the medicine is related to treatment of prostate cancer; if so, record it on the appropriate tab (e.g., ADT, bisphosphonate, chemo).
  - Don't infer co-morbidities based on medicines.

- After abstracting:
  - Scroll through each tab to make sure you don't have any inappropriate blanks or duplicates.
  - Remember to update MRA events in ST.
    - E.g., if Y1 MD1, Y1 MD2, Y1 MD3, Y2 MD1 and Y2 MD2 were all abstracted and treatment information was complete, then update 128, 129, 130, 228 and 229 to status Completed.
    - See instructions in this MOP (under Tabs 4-6: Treatment) about subjects with incomplete treatment info.
  - Also update the file where IDs are randomly assigned to abstractors (see I:\Mohler-DoD\Follow-up\medical records\MRA\status of requests - who's ready for MRA). In the column "Completed by," add your name and the date the MRA was completed. *If the record was incomplete, also add a note in the "Notes" column; when additional info is also abstracted, add a 2nd note in the "Notes" column.
  - File all Y1 and Y2 records together in the subject's Y2 chart. Or file all Y3 records in the subject's Y3 chart.

Initial Entry Screen

PCaP ID	4 digits	
Re-enter PCaP ID	4 digits	Do NOT copy and paste from the first entry of the ID.
Subject's year of birth	4 digits	Find this in the medical record, or in ST.

- If a record for a specific PCaP ID and Date of Birth already exists, you will be asked if you would like to update this record.
    - Otherwise, you will be asked if you would like to create a new record.
- Once a record is open, the top section will show the PCaP ID, Year of Birth (YOB) and Diagnosis (Dx) Date for the record. These can NOT be edited.

Tab 1: General Information, Wt

Abstractor	Drop-down	0153 0155 0161 0162 0163 0164	Choose your 4-digit abstractor ID number.
Abstraction Date	Date	MM/DD/YY	Date when a record is entered into the database
Is this abstraction to update already abstracted information?	Check box	Blank	e.g., when you finish abstracting from a previous day
		Checkmark	e.g., when data cleaning or when adding new info received after requesting additional info from MD, create 2nd entry (→*) with abstractor ID, the current date, and the checkmark (next 3 questions can be left blank unless they require update)
Were multiple treatment modalities discussed/considered?	Drop-down	Yes	
		X=NS	
Did the patient consult with multiple doctors concerning their diagnosis or treatment?	Drop-down	Yes	e.g., if record states "patient will get a second opinion from Dr. Z" – even if records from Dr. Z are not available; patient visits "multidisciplinary clinic" …
		X=NS	
Is there evidence of communication between the CaP doctor and their general healthcare doctor?	Drop-down	Yes	e.g., letter between doctors; records with "Cc Dr. Z;" notes describing a discussion between doctors; a copy of one doctor's records in the set of records sent by another doctor (note this when sorting)
		X=NS	

Is **weight** available?	Drop-down	Yes	A weight was recorded within 1 year prior to CaP dx or later
		No	No weight information within the required time frame is available.
Weight	Text	Number	
		ns	
Unit	Drop-down	kg	
		lb	
Date	Date	MM/DD/YY	Date weight was measured
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of weight was estimated

Tab 2: DRE, Imaging Exams, Post-diagnostic Biopsy

Info on **Dx DRE** available?		Drop-down	Yes	A DRE was done within 1 year before dx, or soon after dx but before any tx. *If multiple Dx DREs are recorded, choose the one closest to dx date.
			No	
DRE Date		Date	MM/DD/YY	Date DRE was performed
Estimate?		Check box	Blank	Exact date is known
			Checkmark	Date of DRE was estimated
Doctor		Drop-down	Y1 MD1… A… X=NS	Doctor who performed the DRE
Size of prostate		Text	Number	If prostate size is given in units g (grams) or +, enter just the number here. If prostate size is given in other units, enter all size info here (value and units) – e.g., 5cm diameter – and leave the units field empty. *only enter prostate size from DRE here (e.g., NOT 37ml reported from ultrasound)
			ns	
Units		Drop-down	g	May be left empty if prostate size is given in other units (see note above) or if size of prostate is ns.
			+	
Specific descriptions: *Only answer Yes or No if specified as such. If the record doesn't specifically say Benign, Asymmetric (or symmetric), etc, then enter X=NS.	Asymmetric?	Drop-down	Yes	"asymmetric," "elevated on right side," "L>R"
			No	"symmetric"
			X=NS	"right side harder than left"
	Benign?	Drop-down	Yes	"benign," "normal," "no abnormalities," "benign-textured" (but do NOT extend your interpretation of this – do NOT also put boggy, enlarged, etc as No; they would be NS unless specified)
			No	"abnormal", stage indicated (ie. T1c, T2a, T2b, etc…)
			X=NS	"normal consistency"
	Boggy?	Drop-down	Yes	"boggy"
			No	"smooth"
			X=NS	"benign-textured"
	Enlarged?	Drop-down	Yes	"enlarged," "wide"
			No	"atrophied," "flat," "moderate sized," "small"
			X=NS	
	Firm?	Drop-down	Yes	"firm," "right side harder than left" (because of "hard")
			No	"soft"
			X=NS	
	Indurated?	Drop-down	Yes	
			No	
			X=NS	

	Nodule?	Drop-down	Confined to prostate	
			Extending beyond prostate	
			Yes – NOS	"nodule on left side," "nodular"
			No	
			X=NS	
	Mass?	Drop-down	Yes	Intrarectal mass
			No	No intrarectal mass
			X=NS	"rectal mass" or "no rectal masses"
	Tender?	Drop-down	Yes	
			No	
			X=NS	

Info on **post-dx DREs** available?	Drop-down	Yes	A DRE was performed after dx (and did not already count as the Dx DRE above).
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the DRE
Date	Date	MM/DD/YY	Date DRE was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of DRE was estimated
Mass/local recurrence?	Drop-down	Yes	Intrarectal mass or local recurrence
		No	"empty rectal vault," "DRE reveals no evidence of recurrent or residual disease," "no palpable intrarectal mass," "prostate surgically absent"
		X=NS	"no abnormalities," "no nodules", "rectal mass" or "no rectal masses"

- If multiple post-dx DREs are recorded, enter all of them.
- "No palpable intrarectal mass" on a post-Tx DRE = no local recurrence and is different from just a "rectal mass" otherwise noted on a DRE; we don't abstract rectal masses on DRE unless it's something like the "no palpable intrarectal mass" indicating no local recurrence after tx.

Info on **imaging exams** available?	Drop-down	Yes	A (relevant type of) imaging exam was done 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who ordered the imaging exam *not the radiologist who performed the exam or interpreted the image
Date	Date	MM/DD/YY	Date imaging exam was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of imaging exam was estimated
Type of exam	Drop-down	Bone scan	Sometimes called "whole body bone scan" *not DEXA scan or other tests of bone density
		CT-abdomen/ pelvis	
		MRI	
		ProstaScint	
		X=NS	
Prostate size	Text	Number	If prostate size is given in units cc or g, enter just the # here. If it's given in other units, enter all size info here (value and units)– e.g., 5cm diameter, 40x30x20mm– and leave the units field empty.
		ns	
Units		cc	1cc = 1ml
		g	
Bone Degeneration	Drop-down	Yes	"degenerative disc disease," "DJD"
		No	
		X=NS	
Enlarged Prostate	Drop-down	Yes	"prostate is generous" (also see examples at DRE enlarged)
		No	
		X=NS	
Metastases	Drop-down	Yes	*Seminal vesicle invasion or extracapsular extension = NS *Record must specify. Do NOT interpret presence/absence of adenopathy, nodules, or increased uptake; their presence should be recorded in Other. *Blastic and lytic lesions = bone (osseous) metastasis *If exam is reinterpreted by the patient's doctors, enter their original assessment in drop-down and their final decision in Other.
		Possible	
		No	
		X=NS	
Other Imaging result	Text	-Enter <u>significant</u> results (including "stable") not already captured in drop-downs and <u>related to CaP or its treatment</u> (e.g., bladder lesions – but not "no bladder lesions") -Any results that can be entered on another tab should NOT be recorded here (e.g., if MRI diagnoses another cancer, record the MRI here and then record the cancer in the "other cancers" tab but not in the "other imaging result" field) -Prostate calcification does NOT need to be abstracted. -ex: If CT shows "increased uptake of unknown significance," enter that here. If x-ray is later done for further evaluation of that, enter x-ray results in the same Other field. -Do NOT enter details already accounted for in Metastases field (e.g., "enlarged pelvic lymph nodes concerning for metastases" would be entered as Metastases = Possible, and note about enlarged nodes does NOT need to be entered in Other)	

- When entering results from imaging exams, focus on the results provided in the "assessment" or "impressions" section of the report; this typically follows a paragraph or two of more detailed findings. Then if those more detailed findings include something that is already specifically listed for abstraction (e.g., "enlarged prostate" is listed in detailed findings but not in assessment), make sure you abstract that info. Additional info from the detailed findings does not need to be abstracted. In other words, you don't have to fill up the "other results" field with everything they comment on.

- Use radiology reports as your primary source for imaging info. If those aren't available, use information in clinic notes, etc.

Info on **Repeat Biopsies** (after diagnosis) available?	Drop-down	Yes	A prostate biopsy was performed after the date of dx.
		No	
Date	Date	MM/DD/YY	Date repeat biopsy was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of repeat biopsy was estimated
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the repeat biopsy
Primary Gleason	Text	Number	*If multiple Gleason scores are assigned, use the 1 with highest sum. If multiple Gleasons have the same sum, use the one with the highest primary. (e.g., if 4+3=7 in 1 core and 3+4=7 in another, enter primary 4, secondary 3, sum 7).
		ns	
Secondary Gleason	Text	Number	
		ns	
Tertiary Gleason	Text	Number	
		ns	"ns" is common here; tertiary gleason scores are rarely given
Gleason Sum	Text	Number	Enter the sum only if it is given (regardless of whether 1º and 2º are given)
		ns	
Prostate size	Text	Number	Commonly reported as result of ultrasound done to guide the biopsy. If prostate size is given in units cc or g, enter just the number here. If prostate size is given in other units, enter all size info here (value and units) – e.g., 5cm diameter, 40x30x20mm – and leave the units field empty.
		ns	
Units	Drop-down	cc	1cc = 1ml May be left empty if prostate size is given in other units (see note above) or if size of prostate is ns.
		g	
		X=NS	
Indication	Drop-down	PSA	Rising or elevated PSA prompted the repeat biopsy
		DRE	Abnormal DRE prompted the repeat biopsy
		active surveillance	Repeat biopsy was done as part of active surveillance (watchful waiting) plan
		treatment eval	Repeat biopsy was done to evaluate treatment results/progress
		2nd opinion	Repeat biopsy was done by 2nd MD for additional opinion on dx or tx
		other-specify	Reason for repeat biopsy is given but doesn't fit one of the above reasons
		X=NS	
Other indication	Text		If "other-specify" was selected from the "Indication" drop-down, type in the other reason.
Total # cores	Text	Number	*Sometimes found in the operative report or clinic note, rather than on the pathology report.
		ns	

# positive cores	Text	Number	
		ns	
% cancer in cores	Text	Number(s)	-If multiple positive cores, provide each % (even if 2 are the same) separated by a comma. -Might need to calculate – for example, if path report shows 20mm core with 5mm involved by adenocarcinoma, then that core is 25% cancer.
		ns	
Hyperplasia	Drop-down	Yes	
		No	Path report or notes specifically state no hyperplasia
		X=NS	
Inflammation	Drop-down	Acute	
		Chronic	
		Both acute and chronic	
		Granulomatous	
		Inflammation/prostatitis NOS	Inflammation or prostatitis is specifically noted as a result of the biopsy but details about acute vs. chronic are not given. Prostatitis as a general condition, not a path result, would not be abstracted.
		No	Path report or notes specifically state no inflammation
		X=NS	
PIN (prostatic intraepithelial neoplasia)	Drop-down	High grade/grade 2 or 3	
		Low grade	
		PIN NOS	PIN is specifically noted but grade of PIN is not given
		No	Path report or notes specifically state no PIN
		X=NS	

- Use pathology reports as your primary source for info about repeat biopsies. If the path report is not available, use clinic notes, etc.
- If no cancer is found on repeat biopsy, enter zeros in Gleason score boxes.

Info on **PSAs** available?	Drop-down	Yes	A PSA was performed 1 year pre-dx or later.
		No	
Date	Date	MM/DD/YY	Date blood was collected for PSA
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of PSA was estimated
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who ordered the PSA test *must be indicated on the result page or in clinic notes, don't assume
PSA value or category	Text	Number	May also include symbol if reported as such (e.g., <0.1). *Labs occasionally show PSA value with > to the right of the # (e.g., 14>). This is most likely a flag indicating that PSA is high, not that the value was greater than 14. It should probably be entered as just 14, but double check with another abstractor.
		detectable	Type this if MD calls PSA "detectable" instead of giving a #
		undetectable	Type this if MD calls PSA "undetectable" instead of giving a #
		ns	Type this If both value and category (un/detectable) are unavailable but PSA was done.
PSA doubling time	Text	Number	e.g., "<6 months"
		ns	
% free PSA	Text	Number	percent free PSA = 100 x amount of free PSA / total PSA *not just the amount of free PSA
		ns	
Lab/Assay	Drop-down	UNC	*If both lab and assay are available, enter the assay. Enter Roche Elecsys2010 in "other" It is different from Roche ECLIA
		Abbot MEIA	
		Access Hyb.	
		Bayer Chemil.	
		Beckman	
		Carolinas MedCtr	
		DVAMC	
		Dianon	
		LabCorp	
		Maria Parham	
		New Bern Urol.	
		Pinehurst Surg. Clinic	
		Urology Spec. of Carolinas	
		FastPak	
		Roche ECLIA	
		Other-specify	
		X=NS	
Other lab/assay	Text		If "other-specify" was selected from the "Lab/Assay" drop-down, type in the name of the other assay or lab.

- If lab reports of PSA results are available, enter those first (because they usually contain more detail – e.g., exact dates – than clinic notes). Then edit those as needed using the information found when reviewing doctor's/clinic notes.

Tabs 4-6: Treatment

- DO NOT abstract planned dosages. Only abstract treatment dosages documented during or after treatment.
- Do Not enter chemo (or other tx) that is performed to address other cancers (not CaP), unless it is for CaP mets – this should be indicated by checking "supportive care"
- Supportive care = treatment for CaP mets; palliative care
- When the required information related to treatment (highlighted in blue below) is not available in follow-up records, refer to the baseline treatment excel spreadsheet . I:\Mohler-DoD\Follow-up\medical records\MRA\MOP\baselinetrt_formissingtrtinfo09-01-10.
- Search the excel file for the ID to see if this information is available from baseline MRA.
    - If it is, then the abstractor can update the record to "Completed" and does not have to request additional information. Indicate in the excel randomization file that treatment information was completed from baseline records.
    - If it is not available, update the MRA event in Subject Tracking to "partially completed" and specify what MD to get records from (could be MD who's already sent records or a new MD)
- Note: Bisphosphonate treatment and supportive care are secondary to CaP treatment (not for specifically for CaP, but for CaP side effects/mets), so they are not required
- Clinical trials and other treatments information was not abstracted at baseline, so the abstractor should refer to actual baseline records and request more information if they do not find it in baseline. If a treatment that we are currently abstracting is part of a clinical trial, that treatments required fields are required to describe the clinical trial
- MOP for requesting additional treatment information: I:\Mohler-DoD\Follow-up\medical records\MRA\MOP\MRA_MOP_RequiredTxInfo-MissingTxInfo-07-13-10

Tab 4: RT, Brachy, ADT, Chemo, Cryo

- **RT: type, dose, and start/end dates required**

RT	Drop-down	Planned	RT chosen but not yet initiated
		Cancelled	RT chosen but then did not happen (e.g., other health problems)
		Discontinued	RT was initiated but ended early (e.g., due to side effects)
		Ongoing	RT was initiated and the end date is unknown (treatment continues beyond what information you have in the medical records)
		Finished	RT was completed
		X=NS	
Reason, if discontinued/canceled	Text		e.g., severe bowel problems, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who administered/oversaw the RT
Clinical Trial?	Check box	Blank	RT is not specifically stated to be part of a clinical trial
		Checkmark	RT is part of a clinical trial
Supportive Care?	Check box	Blank	RT is not specifically stated to be part of supportive care
		Checkmark	RT is part of supportive care
Type	Drop-down	Conventional external beam	EBRT
		3-D conformal	
		Intensity-modulated	IMRT
		Conformal proton beam	
		X=NS	
Image-guided	Drop-down	Yes	e.g., regular/daily CT/ultrasound/MRI, BAT ultrasound localization, fiducial (gold) implants monitored by plain x-ray
		No	
		X=NS	
Region	Drop-down	Whole-pelvis	
		Prostate-specific	Prostate and seminal vesicles, RT to periprostatic bed
		Mets site	
		X=NS	
Lymph node irradiation	Drop-down	Yes	
		No	
		X=NS	
Dose	Text	Number	
		ns	

	(Unit)	Drop-down	mCi	*if both activity (in mCi) and dose (in cGy or Gy) are reported, create 2 entries to capture both
			cGy	
			Gy	
	(Category)	Drop-down	total	
			per fraction	
Number of fractions		Text	Number	
			ns	
Date started		Date	MM/DD/YY	-Should be provided in an RT treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another doctor, etc). - Example: MD notes "radiation given over 51 elapsed days through 01/18/2008;" therefore, abstractor is able to calculate that the start date must have been 11/29/07 and enter as such.
Estimate?		Check box	Blank	Exact date is known
			Checkmark	Date when RT started was estimated
Date ended		Date	MM/DD/YY	Should be provided in an RT treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last RT administration noted in the record is necessarily the last RT performed.
Estimate?		Check box	Blank	Exact date is known
			Checkmark	Date when RT ended was estimated
Date administered		Date	MM/DD/YY	*Only enter dates of RT administration if start and end dates are not provided (or cannot be estimated with reasonable certainty).
Estimate?		Check box	Blank	Exact date is known
			Checkmark	Date of RT administration was estimated

- Use radiation treatment summaries as your primary source for info about RT. If that's not available, use clinic notes, etc.
- If it is noted that the radiation was given to 2 separate regions (pelvic and prostate-specific), make 2 separate entries. For example, a subject received 1700cgy to the pelvis and 2300 cgy to the prostate, make two separate entries.

- **Brachytherapy: type, dose or activity, and start date required**

Brachyherapy: Selected?	Drop-down	Yes	Brachytherapy has begun (may be incomplete/ongoing but not discontinued)
		Planned	Brachytherapy chosen but not yet initiated
		Cancelled	Brachytherapy chosen but then did not happen (e.g., other health problems)
		Discontinued	Brachytherapy was initiated but ended early (e.g., due to side effects)
		X=NS	
Reason, if discontinued/canceled	Text		e.g., severe bowel problems, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the seed/rod placement
Clinical trial?	Check box	Blank	Brachytherapy is not specifically stated to be part of a clinical trial
		Checkmark	Brachytherapy is part of a clinical trial
HDR?	Drop-down	Yes	High dose rate (HDR), which involves temporary placement of rods (not seeds)
		No	
		X=NS	
Type of seeds/rods	Drop-down	Iodine125	^{125}I
		Iodine131	^{131}I
		Palladium103	^{103}Pd
		Iridium192	^{192}Ir
		Other – specify	
		X=NS	
Other	Text		Enter type of seeds/rods if specified but not available above in “type” drop-down
Dose	Text	Number	
		ns	
(Unit)	Drop-down	cGy	
		Gy	
Total activity	Text	Number	*units should be in mCi
		ns	
Post-implant dosimetry performed?	Drop-down	Yes	e.g., ultrasound done to confirm successful seed placement
		No	
		X=NS	
Date started	Date	MM/DD/YY	Date seeds/rods were implanted
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of implant was estimated

Date ended	Date	MM/DD/YY	Date seeds/rods were removed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of removal was estimated

- Use operative reports/ procedural notes as your primary source for info about brachytherapy. If that is not available, use clinic notes, etc.

- **ADT: start/end dates or admin dates required**

ADT	Drop-down	Planned	Hormone/ADT chosen but not yet initiated
		Cancelled	Hormone/ADT chosen but then did not happen (e.g., other health problems)
		Discontinued	Hormone/ADT was initiated but ended early (e.g., due to side effects)
		Ongoing	Hormone/ADT was initiated and the end date is unknown (treatment continues beyond what information you have in the medical records)
		Finished	Hormone/ADT completed
		X=NS	
Reason, if discontinued/canceled	Text		e.g., severe hot flashes, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who administered/oversaw the ADT
Clinical Trial?	Check box	Blank	ADT is not specifically stated to be part of a clinical trial
		Checkmark	ADT is part of a clinical trial
Supportive Care?	Check box	Blank	ADT is not specifically stated to be part of supportive care
		Checkmark	ADT is part of supportive care
Name	Drop-down	Lupron, Viadur, Eligard [leuprolide]	*Sometimes a record may include the type (category) of hormone used, instead of the specific name. In that case, enter Name as X=NS and enter the Type in its drop-down.
		Zoladex [goserelin]	
		Trelstar [triptorelin]	
		Plenaxis [Abarelix]	
		degarelix	
		Eulexin [flutamide]	
		Casodex [bicalutamide]	
		Nilandron, Anandron [nilutamide]	
		Nizoral [Ketoconazole]	
		DES [diethylstibesterol]	
		Megace [Megesterol acetate]	
		Cytadren [Aminoglutethimide]	
		Other – specify	
		X=NS	

Other name	Text		Enter medication name if specified but not available above in "name" drop-down
Dose	Text	Number	*include units (e.g., 22.5mg)
		ns	
Type	Drop-down	Orchiectomy	*If a record only provides the name of the hormone used but not the type, this field should be entered as X=NS. (i.e., The abstractor does not need to determine the type based on a search of the hormone name.)
		LHRH agonists/analogs	
		LHRH antagonists	
		Non-steroidal antiandrogens	
		Steroidal antiandrogens	
		5α-reductase Inhibitors	
		Adrenal Suppressants	
		Estrogens	
		Other – specify	
		X=NS	
Other	Text		Enter ADT category if specified but not available above in "type" drop-down
Date started	Date	MM/DD/YY	Date ADT was initiated (date of 1st ADT administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another MD, etc).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when ADT started was estimated
Date ended	Date	MM/DD/YY	Date when ADT ended (date of <u>last</u> ADT administration) May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last ADT administration noted in the record is necessarily the "date ended."
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when ADT ended was estimated
Date administered	Date	MM/DD/YY	*Date administered <u>and</u> date started/ended should be entered for ADT when available. (This differs from RT, where date administered is entered only if start/end dates are not available.)
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of ADT administration was estimated

1. If the start date is known to be within the 1 year prior to CaP dx, enter it as given (or best estimate).
   - Example: subject dx on 4/14/05, 10/31/04 record states "PSA is elevated; I'm giving him some Casodex samples to see if that lowers his PSA" → enter 10/31/04 as start date
   - Example: subject dx on 9/3/05, 7/16/05 record states "patient has been taking Casodex since last month due to previously elevated PSA" → enter start date as 6/1/06 and check the estimate box

2. If the start date appears to be prior to the 1 year before diagnosis and it is known or can be reasonably estimated based on records from 1 year before diagnosis or later, enter it as given (or best estimate).
   - Example: subject dx on 5/4/04, 3/10/04 record states "patient has been on Casodex since 2003" → enter start date as 1/1/03 and check the estimate box
   - Example: subject dx on 8/20/05, 6/15/05 record states "patient has been on Casodex for the last year" → enter start date as 6/1/04 and check the estimate box
3. If the start date appears to be prior to the 1 year before diagnosis and a start date cannot be found or reasonably estimated based on records from 1 year before diagnosis or later (again, you don't have to search through the records from >1 year pre-dx), enter the date of exactly 1 year prior to diagnosis as the start date, and check the estimate box.
   - Example: subject dx on 12/16/06, 1/29/06 record states "patient continues to take Casodex" → enter start date as 12/16/05 and check the estimate box

- **Chemotherapy: name, and start/end dates or admin dates required**

Chemotherapy	Drop-down	Planned	Chemotherapy chosen but not yet initiated	
		Cancelled	Chemotherapy chosen but then did not happen (e.g., other health problems)	
		Discontinued	Chemotherapy was initiated but ended early (e.g., due to side effects)	
		Ongoing	Chemotherapy was initiated and the end date is unknown (treatment continues beyond what information you have in the medical records)	
		Finished	Chemotherapy completed	
		X=NS		
Reason, if discontinued/canceled	Text		e.g., severe hot flashes, wife had heart attack	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who administered/oversaw the chemotherapy	
Clinical Trial?	Check box	Blank	Chemo is not specifically mentioned to be part of a clinical trial	
		Checkmark	Chemo is part of a clinical trial	
Supportive Care?	Check box	Blank	Chemo is not specifically mentioned to be part of supportive care	
		Checkmark	Chemo is part of supportive care	
Name	Drop-down	mitoxantrone		Novantrone
		doxorubicin		(also called hydroxydaunorubicin) Adriamycin, Rubex
		vinblastine		Velban, Velsar, Velbe
		paclitaxel		Taxol, Onxol
		estramustine phosphate		Emcyt
		docetaxel		Taxotere
		carboplatin		Paraplatin
		etoposide		Etopophos, Vepesid, VP-16, Eposin
		cisplatin		Platinol
		Other – specify		
		X=NS		

Other name	Text		Enter medication name if specified but not available above in "name" drop-down
Date administered	Date	MM/DD/YY	*Only enter dates of chemo administration if start and end dates are not provided (or cannot be estimated with reasonable certainty).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of chemo administration was estimated
Date started	Date	MM/DD/YY	Date chemo was initiated (date of 1st chemo administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another MD, etc).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when chemo started was estimated
Date ended	Date	MM/DD/YY	Date when chemo ended (date of last chemo administration) May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last chemo administration noted in the record is necessarily the "date ended."
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when chemo ended was estimated

- **Cryotherapy: start/end dates or admin dates required**

Cryotherapy: Selected?	Drop-down	Yes	Cryotherapy has begun (may be incomplete/ongoing but not discontinued)
		Planned	Cryotherapy chosen but not yet initiated
		Cancelled	Cryotherapy chosen but then did not happen (e.g., other health problems)
		Discontinued	Cryotherapy was initiated but ended early (e.g., due to side effects)
		X=NS	
Reason, if discontinued/canceled	Text		e.g., severe hot flashes, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the cryotherapy (also referred to as cryosurgery or cryoablation)
Clinical Trial?	Check box	Blank	Cryotherapy is not specifically stated to be part of a clinical trial
		Checkmark	Cryotherapy is part of a clinical trial
Date administered	Date	MM/DD/YY	Date cryotherapy was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of cryotherapy administration was estimated
Date started	Date	MM/DD/YY	Date cryotherapy was initiated (date of 1st cryotherapy administration) *Cryotherapy is typically a 1-time procedure; start/end dates will rarely be used here -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another MD, etc).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when cryotherapy started was estimated
Date ended	Date	MM/DD/YY	Date when cryotherapy ended (date of <u>last</u> cryotherapy administration) *Cryotherapy is typically a 1-time procedure; start/end dates will rarely be used here -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last cryotherapy administration noted in the record is necessarily the "date ended."
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when cryotherapy ended was estimated

Tab 5: RP, PLND

- **RP: date, type, stage (just T is okay), and Gleason sum or primary and secondary required**

Radical Prostatectomy: Selected?	Drop-down	Yes	RP was performed
		Planned	RP chosen but not yet initiated
		Cancelled	RP chosen but then did not happen (e.g., other health problems)
		Discontinued	RP was initiated but ended early (e.g., due to extreme drop in blood pressure)
		X=NS	
Reason, if discontinued/canceled	Text		e.g., other health problems, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the RP
Date	Date	MM/DD/YY	Date RP was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of RP was estimated
Clinical trial?	Check box	Blank	RP is not specifically stated to be part of a clinical trial
		Checkmark	RP is part of a clinical trial
Type	Drop-down	Radical retropubic	
		Radical perineal	
		Robotic	"da Vinci" *robotic RPs are done laparoscopically, but only enter as type robotic
		Laparoscopic	*if "robotic laparoscopic," enter as type = robotic
		X=NS	"radical prostatectomy"
Nerve Sparing	Drop-down	Left	
		Right	
		Both	
		Neither	
		X=NS	*Record should specify "nerve sparing;" do NOT interpret from operative note
Stage T:	Drop-down	X=NS	*This should be the pathological stage (according to RP sample, typically provided on RP path report but might also be referenced in the clinic notes), NOT the clinical stage (assigned during the time of diagnosis)
		T1 (NOS)	
		T1a	
		T1b	
		T1c	
		T1/T2 (NOS)	
		T2 (NOS)	
		T2a	
		T2b	

		T2c	
		T3 (NOS)	
		T3/4 (NOS)	
		T3a	
		T3b	
		T4	
Stage N:	Drop-down	X=NS	
		N0	
		N1	
		NX	*not to be confused with X=NS (not specified)
Stage M:	Drop-down	X=NS	
		M0	
		M1a	
		M1b	
		M1c	
		MX	*not to be confused with X=NS (not specified)
Gleason: Primary	Text	Number	1-5
		ns	
Gleason: Secondary	Text	Number	1-5
		Ns	
Gleason: Tertiary	Text	Number	1-5
		Ns	
Gleason Sum	Text	Number	2-10, *enter only if provided in record (regardless of whether 1^{o} & 2^{o} are given)
		Ns	
Tumor size	Text		*include # and units and which side of prostate (e.g., 1cm L, 2mm R); alternately, give % of prostate involved by tumor and which side of prostate (or bilateral)
Prostate size	Text		*If prostate size is given in units other than cc or g (in the next drop-down), include the units in this text field for size and leave the units drop-down blank.
(Units)	Drop-down	cc	
		g	
Surgical margin(s) involved?	Drop-down	Yes	"margins positive," "tumor extends to margin"
		No	"margins negative"
		Could not be determined	
		X=NS	
Seminal vesicle involvement?	Drop-down	Yes	
		No	

		Seminal vesicle not present in sample	
		X=NS	
Perineural invasion?	Drop-down	Yes	"Insignificant perineural invasion"
		No	
		X=NS	
Lymphatic invasion?	Drop-down	Yes	Lymphatic invasion will be specified on the path report as such; this is not the same as whether or not dissected lymph nodes were positive (which is entered below in the lymph node dissection (PLND) section).
		No	
		X=NS	
Venous invasion?	Drop-down	Yes	Venous or vascular invasion present or identified
		No	
		X=NS	
Organ confined?	Drop-down	Yes	"extracapsular extension (ECE) identified"
		No	"extracapsular extension (ECE) not present"
		X=NS	
Atypical adenomatous hyperplasia?	Drop-down	Yes	
		No	
		X=NS	
PIN?	Drop-down	Yes	Prostatic Intraepithelial Neoplasia
		No	
		X=NS	
Inflammation?	Drop-down	Yes	
		No	
		X=NS	
Intra-operative and immediate post-operative blood loss	Text	Number	*enter both the value and the units – e.g., 200cc or 250ml
		ns	

- Use pathology reports and operative notes as your primary source for info about RP. If those aren't available, use clinic notes, etc.
- If an RP is re-evaluated, go with which ever report indicates a more "severe" cancer diagnosis (for example higher grade)
- If no cancer is found on the path report (e.g., "vanishing carcinoma"), enter zeros for Gleason score and enter TNM stages as X=NS.

- **PLND: date required**

Lymph node dissection: Selected?	Drop-down	Yes	PLND was performed (most often during RP)
		Planned	PLND chosen but not yet initiated
		Cancelled	PLND chosen but then did not happen (e.g., other health problems)
		Discontinued	PLND was initiated but ended early (e.g., due to extreme drop in blood pressure)
		X=NS	
Reason, if discontinued/canceled	Text		e.g., other health problems, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the PLND (pelvic lymph node dissection, lymphadenectomy)
Date	Date	MM/DD/YY	Date PLND was performed
Estimate?	Check box	Blank	Exact date is known
		Estimate	Date of PLND was estimated
Clinical trial?	Check box	Blank	PLND was not specifically stated to be part of a clinical trial
		Checkmark	PLND was part of a clinical trial
Supportive care?	Check box	Blank	PLND was not specifically stated to be part of supportive care
		Checkmark	PLND was part of supportive care
Extent of lymph node dissection	Drop-down	Limited	*should be stated in the record; do NOT interpret from operative note
		Extended	
		X=NS	
Number of lymph nodes examined	Text	Number	
		ns	
Number of positive lymph nodes	Text	Number	
		ns	

- Use pathology reports and operative notes as your primary source for info about PLND. If those aren't available, use clinic notes, etc.

Tab 6: Watchful waiting, Bisphosphonate treatment, TURP, Clinical Trial, Supportive Care, Other

- **WW: start date required**

Watchful waiting/Active surveillance	Drop-down	Ongoing	WW was initiated and is ongoing
		Discontinued	WW was initiated but ended early (e.g., due to rising PSA)
		X=NS	
Reason, if discontinued	Text		e.g., rising PSA, abnormal DRE, high grade CaP on repeat biopsy
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who oversaw the WW
Date started	Date	MM/DD/YY	Date WW was initiated (chosen, confirmed – not just discussed as an option)
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when WW started was estimated
Date ended	Date	MM/DD/YY	Date when WW ended
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when WW ended was estimated

- WW can only be entered when it is the first line of treatment. It cannot be chosen as a treatment option if the patient already had some other form of prostate treatment. In other words, if a patient already had RP then WW cannot be a treatment option post-RP.

- **TURP: date, stage (just T is okay), and Gleason sum or primary and secondary required**
- **Abstract any TURP after diagnosis, NOT including a TURP that was used to diagnose the prostate cancer.**

TURP: Selected?	Drop-down	Yes	TURP was performed
		Planned	TURP chosen but not yet initiated
		Cancelled	TURP chosen but then did not happen (e.g., other health problems)
		Discontinued	TURP was initiated but ended early (e.g., due to extreme drop in blood pressure)
		X=NS	
Reason, if discontinued/canceled	Text		e.g., other health problems, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who performed the TURP (transurethral resection of the prostate)
Date performed	Date	MM/DD/YY	Date TURP was performed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of TURP was estimated
Clinical trial?	Check box	Blank	TURP is not specifically stated to be part of a clinical trial
		Checkmark	TURP is part of a clinical trial
Stage T:	Drop-down	X=NS	*This should be the pathological stage (according to TURP sample, typically provided on TURP path report but might also be referenced in the clinic notes), NOT the clinical stage (assigned during the time of diagnosis)
		T1 (NOS)	
		T1a	
		T1b	
		T1c	
		T1/T2 (NOS)	
		T2 (NOS)	
		T2a	
		T2b	
		T2c	
		T3 (NOS)	
		T3/4 (NOS)	
		T3a	
		T3b	
		T4	
Stage N:	Drop-down	X=NS	
		N0	
		N1	
		NX	*not to be confused with X=NS (not specified)
Stage M:	Drop-down	X=NS	

		M0	
		M1a	
		M1b	
		M1c	
		MX	*not to be confused with X=NS (not specified)
Gleason: Primary	Text	Number	1-5
		ns	
Gleason: Secondary	Text	Number	1-5
		Ns	
Gleason: Tertiary	Text	Number	1-5
		Ns	
Gleason Sum	Text	Number	2-10, *enter only if provided in record (regardless of whether 1º & 2º are given)
		Ns	
Atypical adenomatous hyperplasia?	Drop-down	Yes	
		No	
		X=NS	
PIN?	Drop-down	Yes	Prostatic Intraepithelial Neoplasia
		No	
		X=NS	
Perineural invasion?	Drop-down	Yes	
		No	
		X=NS	
Lymphatic invasion?	Drop-down	Yes	Lymphatic invasion will be specified on the path report as such; this is not the same as whether or not dissected lymph nodes were positive (which is entered on the bottom of Tab 5 in the Lymph node dissection (PLND) section)
		No	
		X=NS	
Inflammation?	Drop-down	Yes	
		No	
		X=NS	

- If no cancer is found on the path report, enter zeros for Gleason score and enter TNM stages as X=NS.

- **Bisphosphonate tx: NO specific info required**

Bisphosphonate treatment: Selected?	Drop-down	Yes	Bisphosphonate treatment has begun (may be incomplete/ongoing but not discontinued)
		Planned	Bisphosphonate treatment chosen but not yet initiated
		Cancelled	Bisphosphonate treatment chosen but then did not happen (e.g., other health problems)
		Discontinued	Bisphosphonate treatment was initiated but ended early (e.g., due to side effects)
		X=NS	
Reason, if discontinued/cancelled	Text		e.g., severe hot flashes, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who administered/oversaw the bisphosphonate treatment
Date administered	Date	MM/DD/YY	Date bisphosphonate treatment was administered
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of administration was estimated
Date started	Date	MM/DD/YY	Date bisphosphonate treatment was initiated (date of 1st administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another MD, etc).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when bisphosphonate treatment started was estimated
Date ended	Date	MM/DD/YY	Date when bisphosphonate treatment ended (date of <u>last</u> administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last administration noted in the record is necessarily the "date ended."
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when bisphosphonate treatment ended was estimated

- **Other tx: specify (description) and start/end or admin dates required**

Other treatment: Selected?	Drop-down	Yes	Other treatment has begun (may be incomplete/ongoing but not discontinued)
		Planned	Other treatment chosen but not yet initiated
		Cancelled	Other treatment chosen but then did not happen (e.g., other health problems)
		Discontinued	Other treatment was initiated but ended early (e.g., due to side effects)
		X=NS	
Specify	Text		Provide a brief description of the Other treatment
Reason, if discontinued/cancelled	Text		e.g., severe hot flashes, wife had heart attack
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who administered/oversaw the Other treatment
Date administered	Date	MM/DD/YY	Date Other treatment was administered
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of administration was estimated
Date started	Date	MM/DD/YY	Date Other treatment was initiated (date of 1st administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the 1st treatment mentioned in record is actually the "date started" (could have had a treatment not mentioned in record, by another MD, etc).
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when Other treatment started was estimated
Date ended	Date	MM/DD/YY	Date when Other treatment ended (date of last administration) -May be provided in a treatment summary, or can sometimes be estimated based on clinic notes. However, do NOT assume that the last administration noted in the record is necessarily the "date ended."
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date when Other treatment ended was estimated
Clinical Trial?	Check box	Blank	This treatment is not specifically stated to be part of a clinical trial
		Checkmark	This treatment is part of a clinical trial
Supportive Care?	Check box	Blank	This treatment is not specifically stated to be part of supportive care
		Checkmark	This treatment is part of supportive care

Tab 7: Bowel, Urinary, ED Symptoms

- Entries on this tab are for discussions at MD visits related to bowel, urinary or sexual function.
  - Do not create entries for symptoms/problems that were reportedly happening between visits but resolved by the time of the visit with the doctor. For example, if a record states that a patient was having "constipation last week but it's now resolved," enter Constipation = No for the date of that doctor visit; the constipation from the previous week would not be abstracted (unless the patient had also had a doctor visit during the time he was having that problem).
  - Likewise, do not create entries for records that are only providing a history of symptoms/problems. For example, if a record includes a treatment summary for radiation that says "patient tolerated RT without any problems; no constipation, diarrhea or urinary difficulties," that is a history, not current information/discussion; it does not warrant an entry.
- For each of the 3 symptom types, if something is indicated as happening "rarely," it is still a positive finding and should be entered as such. For example, "rare dysuria" should be entered as Dysuria = Yes.
  - Similarly, if a symptom has "decreased" or "begun to resolve," then it is still happening to some extent. For example, "urinary frequency has decreased" should be entered as Frequency = Yes; "constipation has begun to resolve" should be entered as Constipation = Yes.
- Record all discussions about problems that are on different dates, even if the information is repeated, if it is clear that this issue was discussed again (not if the record is just summarizing the patient's history)
- If a record for a single date includes conflicting information (e.g., impression/notes indicate a symptom (e.g., diarrhea or loose stools) but review of systems under GI says "denies diarrhea") enter the positive information (e.g., enter diarrhea = yes).
- Enter all symptoms within the appropriate date range, even if they appear to be unrelated to CaP (or doctor specifies that they are unrelated to CaP).
- Do NOT abstract abdominal, testicular, flank, or similar types of pain under "Other bowel/urinary/ED problems."

Info on **Bowel problems** available?	Drop-down	Yes	Info about bowels was discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed bowels with patient
Date	Date	MM/DD/YY	Date bowels were discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of bowel discussion was estimated
Are they having general (NOS) Bowel Problems?	Drop-down	Yes	"Bowel Incontinece"
		No	"no bowel problems," "bowels OK," "bm regular," "no GI symptoms" (even in review of systems, ROS), "no bowel incontinence"
		X=NS	
Info available on specific bowel problems?	Drop-down	Yes	*all specific bowel problems must be current symptoms, not a history
		No	If no specific bowel symptoms are noted, the next 6 fields may be left blank.
Constipation	Drop-down	Yes	
		No	"bowel movements twice a day" (or anything ≥3 times/week)
		X=NS	
Diarrhea	Drop-down	Yes	"loose stools," "loose bowel movements"
		No	"well-formed bowel movements"
		X=NS	
Hemorrhoids	Drop-down	Yes	
		No	
		X=NS	
Skin irritation	Drop-down	Yes	"rectal itching" = NS
		No	
		X=NS	
Bleeding	Drop-down	Yes	"bright red blood per rectum (BRBPR)"
		No	
		X=NS	*do NOT abstract "stool guiac positive" or "heme-negative" from a rectal exam (just as we don't abstract microscopic hematuria)
Other bowel problems	Text		-only include problems (i.e., significant findings) – e.g., do not enter "no pain" -include bowel problems found on rectal exam – e.g., "fissure present" -do not enter bowel symptoms found during a colonoscopy -"hematochezia" (maroon colored stool), "melena" (black/tarry stool), abnormal stool caliber, "pain w/ bm"

Bowel meds/trt info available?	Drop-down	Yes	Info about bowel medication and treatment discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed bowel meds/trt with patient
Date	Date	MM/DD/YY	Date bowel/trt info was discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date that bowel med/trt info was estimated
Name	Drop-down	Dietary changes	MD recommends dietary changes (e.g., high fiber diet, reduce fat, etc…). This does NOT include exercise.
		OTC meds	MD recommends a over-the-counter medication
		Rx meds	MD recommends a prescription medication
Status	Drop-down	Begin	MD gives a new prescription/sample medications starting today. This also includes one time treatments.
		On it before this visit	The patient was already on this medication/trt prior to this visit. This can also a continuation of treatment
		Stopped before this visit	The patient was on this medication/treatment at the last visit, but has since stopped. (e.g., The patient did not like the side effects, therefore stopped the medication)
		Never attempted	Subject was prescribed a medication or treatment but has not attempted since last visit
		Discontinue	As of today the medication/treatment was stopped.
		Med list only	Name of medication came from a medication list only

Info on **Urinary problems** available?	Drop-down	Yes	Info about urinary function was discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed urinary function with patient
Date	Date	MM/DD/YY	Date urinary function was discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of urinary discussion was estimated
Are they having general (NOS) Incontinence problems?	Drop-down	Incontinence	"stress incontinence", "wears diaper," "wears 3-4 pads/day," "2 stained pads per day," leakage, "urinary loss of control," "poor urinary control"
		LUTS	"lower urinary tract symptoms," "prostatism"
		Yes-NOS	"difficulty voiding"
		No	"no difficulty voiding," "no voiding problems," "voiding OK," "no genitourinary (GU) symptoms" (even in a review of systems, ROS), "no urological problems," "leaks only a few drops"
		X=NS	"improved continence"
Info available on specific urinary symptoms?	Drop-down	Yes	*all specific urinary symptoms must be current symptoms, not a history
		No	If no specific urinary symptoms are noted, the next 12 fields may be left blank.
Dysuria	Drop-down	Yes	"painful urination," "burning"
		No	
		X=NS	
Frequency	Drop-down	Yes	urinating more than 8 times a day or less than every 4 hours.
		No	
		X=NS	
Hematuria	Drop-down	Yes	Blood visible in urine with naked eye (i.e., gross hematuria); *do NOT abstract hematuria reported during a urinalysis (e.g., microscopic hematuria)
		No	
		X=NS	
Hesitancy	Drop-down	Yes	"straining to void," "waiting to void"
		No	
		X=NS	
Incomplete emptying	Drop-down	Yes	"retention," post-void residual (PVR) >100cc
		No	"minimal residual," PVR of ≤100cc
		X=NS	
Nocturia	Drop-down	Yes	waking up to urinate 2 or more times at night
		No	"nocturia x0-1" (this # should still be entered in the next field)

		X=NS	
Number of times per night	Text		Enter the # exactly as reported in the record – e.g., "usually 1-2 but sometimes 7-8 times a night" should be entered exactly that way –don't abbreviate to 1-8x
Post-void dribbling	Drop-down	Yes	
		No	
		X=NS	
Urgency	Drop-down	Yes	
		No	
		X=NS	
Weak stream	Drop-down	Yes	"fair stream"
		No	"fairly good flow," "moderate force of stream (FOS)"
		X=NS	
Other urinary problems	Text		-only include problems (i.e., significant findings) – e.g., do not enter "no pain" -example: Polyuria = urine output >3L/day, NOT the same as frequency -"bladder outlet obstruction (BOO)"

- Urinalysis results (e.g., microscopic hematuria, proteinuria) are NOT abstracted.

Urinary meds/trt info available?	Drop-down	Yes	Info about urinary medication and treatment discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed urinary meds/treatment with patient
Date	Date	MM/DD/YY	Date urinary meds/treatment info was discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date that urinary meds/treatment info was estimated
Name	Drop-down	Flomax [tamsulosin HCl]	
		Proscar/Propecia [finasteride]	
		Avodart [dutasteride]	
		Cardura [doxazosin]	
		Ditropan	
		Ditropan XL	
		Oxytrol [oxybutynin]	
		Detrol	
		Detrol LA [tolterodine]	

		Transderm scop [scopolamine]	
		Sanctura [hyoscyamine]	
		Vesicare [solifenacin]	
		Enablex [darifenacin]	
		Imipramine	
		Duloxetine	
		Kegels	
		Bulking agents like a collagen injection	
		Neuromuscular electrical stimulation	
		Artificial sphincter	
		Bulbourethral sling	
		Bladder entercystoplasty	
		Penile/Cunningham clamp	
		Condom catheter	
		InterStim therapy	
		Cysto hydrodistention	
		Other-specify	
Other	Text		Other medication/treatment pertaining to prostate cancer, ie. Stricture dilation surgery
Status	Drop-down	Begin	MD gives a new prescription/sample medications starting today. This can also include one time treatments.
		On it before this visit	The patient was already on this medication prior to this visit . This can also be a continuation on a treatment
		Stopped before this visit	The patient was on this medication at the last visit, but has since stopped. (ie. The patient did not like the side effects, therefore stopped the medication)
		Never attempted	Subject was prescribed a medication or treatment but has not attempted use since last visit
		Discontinue	As of today the medication was stopped
		Med list only	Name of medication came from a medication list only

Info on **ED/ sexual problems** available?	Drop-down	Yes	Info about ED/ sexual problems was discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed sexual function with patient
Date	Date	MM/DD/YY	Date sexual function was discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date of sexual function discussion was estimated
Are they having general (NOS) sexual dysfunction problems?	Drop-down	Yes	"ED," "erectile dysfunction," "impotence," "organic impotence (ICD-9 code 607.84)"
		No	
		X=NS	
Info available on specific sexual symptoms?	Drop-down	Yes	*all specific ED symptoms must be current symptoms, not a history
		No	If no specific ED symptoms are noted, the next 5 fields may be left blank.
Able to have an erection?	Drop-down	Full erection	
		Partial erection	
		Yes – NOS	
		No	
		X=NS	
Able to sustain an erection?	Drop-down	Yes	
		No	
		X=NS	
Firm enough for sex?	Drop-down	Yes	
		No	
		X=NS	
Firm enough for masturbation/foreplay?	Drop-down	Yes	
		No	
		X=NS	
Other sexual problems	Text		-only include problems (i.e., significant findings) – e.g., do not enter "no pain" -do not enter testicular info *enter "has not had erections" here; it does not = "has not been able to have erections" (which would be entered in "able to have an erection?" = No "decreased libido"

- Example: If MD only says that a patient is completely unable to get an erection, only enter “able to have an erection” = No, and enter all other symptoms = X=NS (don’t interpret).

ED med/trt info available?	Drop-down	Yes	Info about ED medication and treatment discussed at a visit 1 year pre-dx or later
		No	
Doctor	Drop-down	Y1 MD1… A… X=NS	Doctor who discussed ED meds/treatment with patient
Date	Date	MM/DD/YY	Date ED meds/treatment info was discussed
Estimate?	Check box	Blank	Exact date is known
		Checkmark	Date that ED meds/treatment info was estimated
Name	Drop-down	Cialis [Tadalafil]	
		Levitra [Vardenafil]	
		Viagra [Sildenafil]	
		Vacuum Erection Device	
		Urethral suppositories	
		Injection Therapy	
		Other-specify	
Other	Text		
Status	Drop-down	Begin	MD gives a new prescription/sample medications starting today. This can also be a one time treatment.
		On it before this visit	The patient was already on this medication prior to this visit . This can also be a continuation of treatment
		Stopped before this visit	The patient was on this medication at the last visit, but has since stopped. (e.g., The patient did not like the side effects, therefore stopped the medication)
		Never attempted	Subject was prescribed a medication or treatment but has not attempt use since last visit
		Discontinue	As of today the medication was stopped.
		Med list only	Name of medication came from a medication list only

Tab 8: General Comorbidities

- Dates refer to date of diagnosis for chronic diseases and date of occurrence for events, if specified in records; if these (or a solid estimate) are not available, use the earliest date when the disease was mentioned in the medical record.
- Make sure to highlight each mention of a comorbidity, then be careful about choosing the date of dx or earliest occurrence/mention.
    - This section does not need to be completed for every mention of a condition. For example, if diabetes is mentioned on 12 different dates throughout a record, choose diabetes = "yes." If the date of diabetes dx is available, enter it as such. If not, find the first date it is mentioned in the record and enter that, then choose date type = "earliest recorded." Also, if a record mentions 12 times that the subject does NOT have diabetes, it only needs to be entered once and a date is not required. However, in this situation, the abstractor should verify that the participant does not LATER develop diabetes and thus would need to document diabetes = "yes" and the date it was diagnosed.
- If a record states on 11/8/07 "the patient has had hypertension for 21 years," enter date as 11/8/1986, check the estimate box, and select date type = "occurrence/diagnosis". This also includes childhood/adolescent illnesses, like childhood asthma or polio (estimate date if possible).
- Keep in mind that an entry should be considered Not Specified (X=NS) unless otherwise indicated in the record.
    - Example: If a record states "the patient denies having any significant disorders of the skin, head, eyes, … respiratory system, cardiac system…, except high blood pressure," enter high blood pressure = "yes" and everything else = "no"
    - Only include comorbidity if specified in record; don't use medication names to deduce presence of a condition.
    - The comorbidity section in this MRA was built according to the Charlson Comorbidity Index (CCI), which only includes certain conditions. Not all possible comorbid conditions will be abstracted. Make sure any condition fits into CCI definitions (see "CharlsonCCI.doc" at I:\Mohler-DoD\Follow-up\medical records\MRA\MOP); note that they only include major events and chronic conditions.
- Comorbidities are often abbreviated – pay attention to this and if you aren't sure what it is, look it up.
- If it is stated that a patient has "never been exposed to" a communicable disease/condition (e.g., HIV/AIDS, hepatitis, etc.), then enter "no" for that condition.
- For "borderline" comorbidities, enter this information as if the subject does NOT have the condition. For example, if a record states that a subject has borderline hypertension, enter high blood pressure=no (unless he does develop hypertension later in the record).

Information on any **comorbidities** available?		Drop-down	Yes	
			No	
AIDS or HIV		Drop-down	Yes	
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	

			earliest recorded in MR	
Arthritis		Drop-down	Yes	Severe or chronic (*NOT immune-mediated arthritis which is classified under connective tissue disease below)
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Cerebrovascular Disease		Drop-down	Yes	Stroke, cerebrovascular accident (CVA), transient ischemic attack (TIA)
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Chronic Gastrointestinal Disease		Drop-down	Yes	Gastric/stomach ulcer/peptic ulcer in stomach, duodenal ulcer/peptic ulcer in duodenum, bleeding ulcers - NOS, esophageal ulcers or reflux ulcer (but not uncomplicated Barrett's esophagus), Crohn's disease, ulcerative colitis (but not inflammatory bowel disease or GERD), peptic ulcer disease (PUD)
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Chronic Liver Disease		Drop-down	Yes	Cirrhosis, hepatitis
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	

			earliest recorded in MR	
Chronic Pulmonary Disease		Drop-down	Yes	Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, severe asthma,, asbestosis, pulmonary fibrosis, sarcoidosis, tuberculosis, pulmonary hypertension *must be a diagnosed condition, NOT just “trouble breathing”
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Chronic Renal Disease		Drop-down	Yes	Chronic renal disease (CRD), chronic renal failure (CRF), chronic renal insufficiency
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Congestive heart failure		Drop-down	Yes	enlarged heart, cardiomyopathy
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Connective Tissue Disease		Drop-down	Yes	Polymyalgia rheumatica, ankylosing spondylitis, rheumatic fever, polio, systemic lupus erythematosis, lupus (SLE), rheumatoid arthritis (RA), fibromyalgia
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	

			earliest recorded in MR	
Coronary Heart disease		Drop-down	Yes	Coronary artery disease, athlerosclerosis, athlerosclerotic cardiovascular disease (ASCVD) *NOT including congestive heart failure (captured above) or MI (captured below)
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Diabetes		Drop-down	Yes	Diabetes mellitus (DM), Type I diabetes (juvenile onset or insulin-dependent), Type II diabetes (adult onset or non-insulin dependent, NIDDM)
			No	Borderline diabetes
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
	End-organ damage?	Drop-down	Yes	
			No	
			X=NS	
Dementia		Drop-down	Yes	Alzheimer's disease, senile dementia, TIA Memory Deficit
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Family history of prostate cancer		Drop-down	Yes	
			No	If at a prostate-related MD visit (e.g., visit with urologist; visit with family MD due to urological symptoms such as bladder control), and family history is recorded as "noncontributory"
			X=NS	

	Person	Drop-down	Brother	*If 2 people in the patient's family had CaP, create 2 separate entries (even if both are the same type person – e.g., 2 brothers)
			Father	
			Grandfather	
			Uncle	
			Cousin	
			Son	
			Nephew	
			Grandson	
			X=NS	
High blood pressure		Drop-down	Yes	Hypertension (HTN)
			No	Borderline hypertension
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
MI		Drop-down	Yes	Myocardial infarction, heart attack
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Paralysis		Drop-down	Yes	Paraplegia, hemiplegia, paralysis associated with prior injuries, quadraplegia, Brown-Sequard's syndrome (hemiparalysis)
			No	
			X=NS	*temporary paralysis (e.g., Bell's palsy) should NOT be abstracted
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	

Peripheral Vascular Disease		Drop-down	Yes	Aneurysm, peripheral artery disease (PAD), peripheral venous disease (PVD), varicose veins, deep vein thrombosis (DVT), pulmonary embolism, chronic venous insufficiency, lymphedema, aortic aneurism, vein blockage in leg, carotid blockage, Wegener granulomatosis, brain aneurysms, thrombosis, vascular problems, poor circulation, circulation issues
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	

Tab 9: Other Cancers

- If a comorbid cancer is diagnosed twice (e.g., a 2nd primary diagnosis of colorectal cancer), create 2 entries for that.

Malignant solid tumor		Drop-down	Yes	NOT including lymphoma, leukemia and skin cancer (captured below)
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
	Type	Drop-down	Bone	
			Bladder	
			Colon and rectum	
			Lung	
			Liver	
			Other – specify	
			X=NS	
	Other type	Text		
	Has the cancer metastasized?	Drop-down	Yes	
			No	
			X=NS	
	Is this a metastasis of their CaP?	Drop-down	Yes	
			No	
			X=NS	
Leukemia		Drop-down	Yes	*Any leukemia or cancer of the blood or bone marrow (lymphocytic leukemias) should be classified here instead of with lymphomas (per CCI)
			No	
			X=NS	
	Type	Drop-down	Acute lymphocytic	
			Acute myeloid	
			Children's	
			Chronic lymphocytic	
			Chronic myeloid	
			Chronic myelomonocytic	
			X=NS	
	Date	Date	MM/DD/YY	

	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
Lymphoma		Drop-down	Yes	
			No	
			X=NS	
	Type	Drop-down	Non-Hodgkin's	
			Hodgkin's	
			Skin	Sezary's disease
			X=NS	
	Has it metastasized ?	Drop-down	Yes	
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
	Other type	Text		
Skin cancer		Drop-down	Yes	
			No	
			X=NS	
	Date	Date	MM/DD/YY	
	Estimate?	Check box	Blank	Exact date is known
			Checkmark	Date of occurrence/diagnosis was estimated
	Date type	Drop-down	occurrence/diagnosis	
			earliest recorded in MR	
	Type	Drop-down	Basal cell carcinoma	
			Squamous cell carcinoma	
			Melanoma	
			X=NS	
	Has it metastasized?	Drop-down	Yes	
			No	
			X=NS	

FAQ

URINE

If something is described as "medium" we can consider that to be the same as "moderate" which is typically considered normal - e.g., MOP already says "moderate FOS" = Weak Stream = No, thus "medium stream" also = Weak Stream = No.

If they list **overactive bladder** as a urinary symptom, put it in other.

PSA

Non legible PSA. Example, it was 0.x32 (or something like that), where you couldn't make out the 1st number past the decimal point. Enter it as <1.