Form 345 – LILAC Ovarian Cancer Abstraction Form   Ver. 3

CCC Coder ID: _______

Member ID: __ __ - __ __ __ __ __ - __   Case #: ____________   CCC ID: ____________

Other Case #s: ___________________   Date completed: __ __ /__ __ / __ __ (MM/DD/YY)

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1. Was any cancer-directed surgery done as part of primary treatment for ovarian cancer?

☐$_0$ No

☐$_9$ Unknown if cancer-directed surgery performed (e.g., death certificate ONLY)

☐$_1$ Yes

1.1 Type of surgery: (**Mark all that apply.**)

☐$_1$ Removal of tumor only

☐$_2$ One ovary

☐$_3$ Both ovaries (bilateral)

☐$_4$ One fallopian tube

☐$_5$ Both fallopian tubes

☐$_6$ With hysterectomy

☐$_8$ **Other surgery: ____________________________**

1.2 ☐$_1$ **Omentectomy/ Partial Omentectomy**

1.3 **Tumor debulking/ Cytoreductive surgery**

☐$_1$ Debulking colon and/or small intestine

☐$_2$ Debulking NOS

☐$_8$ Debulking other: ____________________________

1.4 Date of Surgery: __ __ /__ __ /__ __ (Month Day Year)   ☐$_1$ Exact   ☐$_2$ Estimated   ☐$_9$ Unknown

1.5 If hysterectomy was not performed as treatment for the primary cancer, did the participant have a prior hysterectomy (removal of uterus) noted in the records?

☐$_0$ No   ☐$_1$ Yes   ☐$_2$ Not Applicable   ☐$_9$ Unknown

1.6 If only one ovary was removed as treatment for the primary cancer, was a prior oophorectomy noted in the records?

☐$_0$ No   ☐$_1$ Yes   ☐$_2$ Not Applicable   ☐$_9$ Unknown

1.7 If only one fallopian tube was removed as treatment for the primary cancer, was prior fallopian tube removal noted in the records?

☐$_0$ No   ☐$_1$ Yes   ☐$_2$ Not Applicable   ☐$_9$ Unknown

2. Was there any residual disease noted at time of surgery?

☐$_0$ No   ☐$_2$ Not Applicable

☐$_9$ Unknown

☐$_1$ Yes

2.1 Residual Disease Volume

☐$_1$ Greater than 1 cm   ☐$_9$ Unknown

☐$_2$, Equal to or less than 1 cm

3. Was molecular testing documented in the medical records (e.g., CA-125 blood test) as part of diagnosis, treatment or surveillance?

☐0 No ☐2 Not Applicable
☐9 Unknown
☐1 Yes

3.1 CA-125 testing performed

FirstTest Date:____ / ____ / ___ ☐1 Exact ☐2 Estimated ☐9 Unknown Result: _________

Last test Date: ___ / ____ / ___ ☐1 Exact ☐2 Estimated ☐9 Unknown Result: _________

Highest Value recorded

Date: __ __ / __ __ / __ __ ☐1 Exact ☐2 Estimated ☐9 Unknown Result: _________

Total number of tests performed

Other testing performed

(Specify): ________________________

Date: __ __ / __ __ / __ __ ☐1 Exact ☐2 Estimated ☐9 Unknown Result: _________

(Specify): ________________________

Date: __ __ / __ __ / __ __ ☐1 Exact ☐2 Estimated ☐9 Unknown Result: _________

4. Was chemotherapy and/or other targeted or specialized therapy administered as part of the first course of therapy?

☐0 No ☐9 Unknown
☐1 Yes ☐2 Recommended, unknown if done

4.1 Regimen Name: ____ Code: ________

Type: ☐1 Adjuvant therapy ☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ ☐1 Exact ☐2 Estimated ☐9 Unknown
Month Day Year

Route: **(Mark all that apply.)** ☐1 Oral ☐2 IV ☐3 Intraperitoneal (IP)
☐9 Unknown

4.2 Regimen Name: ______________________ Code: ________

Type: ☐$_1$ Adjuvant therapy ☐$_2$ Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

Route: **(Mark all that apply.)** ☐$_1$ Oral ☐$_2$ IV ☐$_3$ Intraperitoneal (IP) ☐$_9$ Unknown

4.3 Regimen Name: ______________________ Code: ________

Type: ☐$_1$ Adjuvant therapy ☐$_2$ Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

Route: **(Mark all that apply.)** ☐$_1$ Oral ☐$_2$ IV ☐$_3$ Intraperitoneal (IP) ☐$_9$ Unknown

4.4 Regimen Name: ______________________ Code: ________

Type: ☐$_1$ Adjuvant therapy ☐$_2$ Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

Route: **(Mark all that apply.)** ☐$_1$ Oral ☐$_2$ IV ☐$_3$ Intraperitoneal (IP) ☐$_9$ Unknown

4.5 Regimen Name: ______________________ Code: ________

Type: ☐$_1$ Adjuvant therapy ☐$_2$ Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

Route: **(Mark all that apply.)** ☐$_1$ Oral ☐$_2$ IV ☐$_3$ Intraperitoneal (IP) ☐$_9$ Unknown

5. Was radiation therapy given as part of the first course of therapy?

☐$_0$ No ☐$_9$ Unknown

☐$_1$ Yes ☐$_2$ Recommended, unknown if done

5.1 **(Mark all that apply.)**

☐1 External beam radiation therapy (EBRT)
☐2 Internal radiation therapy (brachytherapy)
☐3 Radioactive isotopes
☐8 Other **(Specify)**: ____________________
☐9 Unknown

5.2 **(Mark all that apply.)**

Was radiation therapy neoadjuvant, or adjuvant and/or palliative treatment?

☐1 Neoadjuvant ☐3 Palliative
☐2 Adjuvant ☐9 Unknown

5.3 Start date: __ __ /__ __ /__ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

Stop date: __ __ /__ __ /__ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

Total dosage of radiation received: _______ cGy/Rad ☐9 Unknown

6. Was endocrine-targeted/hormonal therapy given?

☐0 No ☐9 Unknown
☐1 Yes ☐2 Recommended, unknown if done

6.1 Agent Name: ______________________ Code: ________

Use: ☐1 Intermittent use ☐2 Continuous use ☐9 Unknown

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date or
Last documented use: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐3 Current use ☐9 Unknown

6.2 Agent Name: ______________________ Code: ________

Use: ☐1 Intermittent use ☐2 Continuous use ☐9 Unknown

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date or
Last documented use: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐3 Current use ☐9 Unknown

7. Has the participant ever been disease free since her initial diagnosis/treatment?

☐1 Yes →
☐0 No
☐9 Unknown

7.1 Date as documented in the medical records *: __ __ / __ __ / __ __ (Month Day Year)

* If no evidence of recurrence or metastasis: Record **most recent** documented disease free date. If documented recurrence or metastasis: Record **first** known disease free date.

8. Was there a new or recurrent cancer diagnosed after a documented disease free interval?

☐1 Yes ☐0 No ☐9 Unknown

8.1 Site (with sub-site code): ______________________ ☐9 Unknown

Histology: ☐1 Same ☐2 Different ☐9 Unknown

Histology code: ______________________

Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

9. Did a metastasis occur outside the primary site after a documented disease free interval?

☐1 Yes ☐0 No ☐9 Unknown

9.1 Site: **(Mark all that apply.)**

☐1 Peritoneum ☐6 Bone ☐9 Ovary
☐2 Abdomen ☐7 Lung ☐10 Fallopian tube
☐3 Liver ☐8 Brain ☐99 Unknown
☐4 Retroperitoneal lymph node ☐88 Other site: ______________________
☐5 Other lymph node **(Specify)**: ______________________

9.2 Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

9.3 How was the diagnosis made? **(Mark all that apply.)**

☐1 CA-125 (or other lab)
☐2 Imaging
☐3 Physical Exam
☐4 Biopsy (Cytology or Pathology)
☐8 Other **(Specify):** ______________________
☐9 Unknown

Comments: