LUNG FORMS

The guidelines and figures below are specific to Lung studies. The information in this manual does NOT represent a complete set of required forms for any lung study. Please refer to the most recent version of the appropriate protocol for complete forms and submission requirements.

Lung Carcinoma Prestudy or Onstudy Form

Please note the information below is a guideline to the "standard" subset of data that will be documented on most lung prestudy or onstudy forms regardless of disease type or extent. Additional eligibility items may also be required to be documented on the prestudy or onstudy form. Please refer to Section 5.0 of the protocol for an explanation of the criteria.

Patient and Disease Description

This section is designed to record descriptive information regarding the patient and the current disease process. The information recorded here is based on that available at the time of registration on the protocol.

**Histology:** The information recorded here should reflect the sign-out diagnosis of the most definitive pathology report. This is usually best determined from a specimen obtained at resection or biopsy of the primary site. Because radiation and chemotherapy can alter some histologic aspects of a tumor, the biopsy specimen taken before such therapy may represent a more accurate picture of the histology. For patients who received prior treatment, record histologic type according to the best information available in the patient’s records. For example, the histologic types of non-small cell lung cancer are as follows:

* **Squamous:** when the diagnosis was squamous cell carcinoma or any subtype of squamous cell carcinoma.
* **Adenocarcinoma:** when the diagnosis was adenocarcinoma or any subtype of adenocarcinoma.
* **Large cell:** when the diagnosis was large cell carcinoma or any subtype of large cell carcinoma.
* **Bronchioloalveolar:** when the diagnosis was bronchioloalveolar carcinoma (BAC).
* **Other non small cell (mixed, not specified):** when the histology was other than those listed. If checking Other non small cell, verify that the histologic type is eligible for the protocol.

For background information on study specific histological definitions refer to the protocol Section 2.0.

*Tumor and Node Status:* Code the T-stage and N-stage according to the International Coding System of the AJCC. Use the version cited in Section 4.0 of the protocol.
Staging and Diagnostic Procedures: The following is a list of the diagnostic and staging procedures for evaluation of patients with carcinoma of the lung.

**Needle aspiration** is a biopsy procedure which uses a needle and syringe to obtain a small sample from the primary tumor, mediastinal nodes, supraclavicular nodes or distant metastatic sites.

**Bronchoscopy** is a procedure used to inspect the interior of the tracheobronchial tree by means of an electrically lighted endoscope.

**Mediastinoscopy** is the exploration of the mediastinal structures using a scope (mediastinoscope) and a surgical incision made in the suprasternal notch.

**Chamberlain Procedure:** Also known as a left anterior mediastinotomy. A procedure that allows sampling of lymph nodes in the aorto-pulmonary window and left hilar masses.

**VATS** is video assisted thorascoscopic surgery.

**Thoracotomy/sternotomy** is a surgical approach to the thoracic cavity.

**Supraclavicular node biopsy** is a surgical excision of supraclavicular nodes used to obtain material for microscopic examination.

**Chest X-ray** includes any standard radiologic exam of the chest, heart and lungs.

**CT/CAT Scan** is an x-ray procedure utilizing the aid of a computer to generate cross-sectional views and if needed three-dimensional images of internal organs and structures of the body. Synonyms for CT are computed tomography or computed axial tomography (CAT scan).

**MRI or Magnetic Resonance Imaging Scan** is a radiology technique that uses magnetism, radio waves and a computer to produce images of body structures and tissue.

**Bone scan** is a radioisotope study of the bones. Synonyms for bone scan are gallium scan, bone scintigram, or skeletal scintigram.

**Indirect Laryngoscopy** is inspection of vocal cords with a mirror.

**FDG (fludeoxyglucose) PET scan** is another type of computerized evaluation using measurements of metabolic activity. Synonyms for PET are positron emission tomography.
**Primary Tumor Location:** Indicate the location of the primary tumor. Abbreviations are as follows:

- RUL = Right upper lobe
- LUL = Left upper lobe
- RML = Right middle lobe
- LLL = Left lower lobe
- RLL = Right lower lobe

**Number of Metastatic Sites:** Record the number of disease sites other than the ipsilateral lung. "Multiple lesions in multiple organs" means that multiple organs each have at least one lesion. Contralateral = opposite lung. Ipsilateral = same lung.

Some examples clarifying the proper coding of single versus multiple sites of disease:

- Right Upper Lobe (RUL) lung lesion and Right adrenal lesion: 1 – Single lesion in single organ (i.e. adrenal).
- RUL lung lesion and Right Lower Lobe (RLL) lung lesion (ipsilateral lung) and Right adrenal lesion: 1 – Single lesion in single organ (i.e. adrenal).
- RUL lung lesion, Right adrenal lesion and Left adrenal lesion: 1 – Multiple lesions in single organ.
- RUL lung lesion and RL liver lesion and LL liver lesion: 1 – Multiple lesions in single organ (i.e. liver).
- RLL lung lesion, rib involvement and spine metastasis: 1 – Multiple lesions in single organ (i.e. bone).
- RUL lung lesion and RL liver lesion and bone metastases: 2 – Multiple lesions in multiple organs (i.e. liver and bone).
- RLL lung lesion, LUL lung lesion, RL liver lesion: 2 – Multiple lesions in multiple organs (i.e. opposite lung and liver).
- Right Upper Lobe (RUL) lung lesion: 3 - None

**Pleural/Pericardial Effusion:** Please record whether the patient has any pleural/pericardial effusions at the time of registration. If yes, please record whether they were malignant.
Small Cell Lung Cancer: SWOG protocols in small cell lung cancer usually use extent of disease (limited vs. extensive) to define stage groupings as follows:

**Limited disease**: Tumor confined to one hemithorax, mediastinal, hilar or supraclavicular area that could be encompassed within a single radiation port.

**Extensive disease**: Extension of disease beyond the areas defined for limited disease. Note: Malignant pleural effusion constitutes extensive stage disease.

Smoking History: Record the smoking history based on the definitions below:

- Never = less than 100 cigarettes in lifetime
- Former = no smoking for one year or more
- Current = all others

Current Laboratory Values: This section is used to record the laboratory values for prestudy and eligibility requirements. Labs should be performed prior to registration within the time frames noted in the protocol sections 5.0, 7.0 and 9.0. Document values in the units noted on the form. Some definitions are provided below:

Pulmonary Function Tests: Record information about pulmonary function tests that were performed. For example:

- **Forced Expiratory Volume (FEV1)**: Record the FEV1 (one second forced expiratory volume) in liters.

- **Predicted Forced Expiratory Volume (FEV1) of the contralateral lung**: Record the predicted FEV1 of contralateral lung based on the quantitative split function testing, (predicted FEV1 = FEV1 x % perfusion to uninvolved Lung V/Q scan report).

Diffusing Capacity Corrected for Hemoglobin: Record the diffusing capacity from the pulmonary function tests. Be sure to record the value that has been corrected for the patient's hemoglobin.

Arterial Blood Gases on Room Air: Record the results of the arterial blood studies taken while the patient was breathing room air.

- **pO2**: Record the partial pressure of oxygen present in the arterial blood in mm of mercury.

- **pCO2**: Record the partial pressure of carbon dioxide present in the arterial blood in mm of mercury.

- **pH**: Record the pH of the arterial blood.

Prior Treatment Related to This Cancer: Prior treatment refers to any disease-related treatment that the patient received prior to registration on the current protocol. Prior treatment
pertains only to the cancer being treated on the protocol, not other diseases or malignancies the patient may have had.

**Prior Surgery**: Please indicate whether this patient had any prior surgery related to this cancer. Prior surgery excludes any biopsy done only for diagnostic purposes, e.g., incisional biopsies and needle biopsies are excluded. An excisional biopsy is reported only when it is the most extensive surgical resection performed.

**Prior Radiation Therapy**: Please indicate whether this patient had any prior radiation therapy related to this cancer.

**Prior Systemic Therapy**: Please indicate whether this patient had any prior systemic therapy related to this cancer. The therapy must be administered with the intent of affecting, destroying, controlling or changing malignant tissue. Systemic therapy includes chemotherapy agents, hormones, antihormones, endocrine surgery/ablation, immunotherapy agents, or biologic response modifiers.

For purposes of SWOG, the term systemic therapy applies to therapies administered by any route including, but not limited to, the following: oral, intraarterial, intramuscular, intravenous, regional perfusion, intralesional or local application.

### Surgeon’s Post-Operative Assessment Form

This form must be completed by the surgeon.

**Description of Surgery**
Indicate whether patient had:
- Open thoracotomy
- VATS (Video assisted thorascopic surgery)

Mark all boxes that apply in the Extent of Pulmonary Resection and Additional Components of Resection.

**Surgical Pathological Staging**: Be sure that all nodal stations are addressed by marking one of the boxes. Either the ‘Not biopsied’, ‘Histologically negative’ or ‘Histologically positive’ box must be marked for each site. This information should come from the final pathology report.

**Post-Operative Complications**: Document complications occurring within 30 days of resection.

**Surgeon’s signature**: Have surgeon sign the completed form prior to submission.
Lung Carcinoma First Site of Progression or Relapse Form

**Date of last contact or death:** If patient is alive, record the month, day and year the patient was last known to be alive. If the patient is dead, code the date of death. If patient is dead a Notice of Death Form must also be submitted, and if the patient is off treatment submit the Follow-up Form.

**Date of progression or relapse:** Record the first date a progression or relapse was noted based on the criteria specified in the study protocol Section 10.0. Even if microscopically confirmed later, this date is the date of the first clinical diagnosis, and not the date of microscopic confirmation. For further details on coding date of progression or relapse, please see the instruction for the Follow-up Form in the General Forms and Guidelines chapter.

**Site(s) of progression or relapse:** Check all known sites of progression or relapse at the time of detection of progression or relapse.