**REPORTER IDENTIFICATION**

FACILITY NAME: ABSTRACTOR INITIALS:

PHYSICIAN’S NATIONAL PROVIDER ID (NPI) #:

FACILITY ID # (Assigned by MCR, if known) :

MEDICAL RECORD # (if applicable):

**PATIENT** **DEMOGRAPHICS**

PATIENT NAME:

SOC SEC #: DATE OF BIRTH: / /

YYYY MM DD

Patient Residential Address:

Patient Residential Address:

City/State/Zip: , ,

County of Residence:

**GENDER (check one):** Male  Female  Other **PLACE (Country or U.S. State) OF BIRTH** (if known):

**RACE** (check one):  White  Black  American Indian  Asian Indian

Asian/Pacific Islander (specify country if known)

Other, specify  Unknown

**SPANISH/HISPANIC ORIGIN** (include country of origin if Hispanic):  Hispanic/Latino

Non-Hispanic Unknown

**OCCUPATION:**

**DIAGNOSIS/TUMOR INFORMATION**

**Date of Initial Diagnosis**: / / **Site of Tumor***:***Prostate – C619**

YYYY MM DD

**Size of Tumor** (enter tumor size in cm): ●

**Type of Tumor (Histology)**:

**Behavior**:  Benign  Borderline Tumor  In-situ  Malignant  Unknown

**Grade** (if stated):  Grade I  Grade II  Grade III  Grade IV  Unknown/not stated in report

**Metastatic Disease**:  Yes Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Unknown

**AJCC 7 STAGING**

If physician staging information was available, please provide the following:

**T** \_\_\_\_\_\_\_\_ **N**  **M**  **Stage**

**PROSTATE Tumor Characteristics** (for Staging). Check ‘Yes’ box if condition is present and/or described in the pathology report:

**DRE Performed**:  Yes  No Date:       **Imaging Studies**:  Yes  No Date:       Describe:

**Total Number of Core Needle Biopsies: Total Number of Core Needle Biopsies Positive:**

**PSA Level:**  ● **Gleasons Score:** + = **or total**

Positive  Yes  No  Unknown Please indicate method Gleason score was decided:

Prostectomy  Autopsy  TURP  Needle Core Biopsy

**Choose only one that best describes the tumor, then skip to TREATMENT INFORMATION.**

In situ: noninvasive; intraepithelial  Yes  No Date:

***If the prostate cancer is considered “clinically Inapparent”, choose the selection that best describes the tumor:***

Number of foci or percent involved tissue not specified  Yes  No Date:

Incidental histologic finding in **5% or les**s of tissue resected  Yes  No Date:

Incidental histologic finding **more than 5%** of tissue resected  Yes  No Date:

Tumor identified by needle biopsy, e.g., for elevated PSA  Yes  No Date:

***If the prostate cancer is considered “clinically apparent”, choose the selection that best describes the tumor:***

Involvement in one lobe, NOS  Yes  No Date:

Involves one half of one lobe or less  Yes  No Date:

Involves more than one half of one lobe, but not both lobes  Yes  No Date:

Involves both lobes  Yes  No Date:

Clinically apparent tumor confined to prostate, NOS or Localized, NOS, Confined to prostate, NOS,

Intracapsular involvement only  Yes  No Date:

Extension to periprostatic tissue; or Extracapsular extension (beyond prostatic capsule),

NOS; or Through capsule, NOS; or Periprostatic extension, NOS (Unknown if

seminal vesicle(s) involved)  Yes  No Date:

Extension to seminal vesicles (s) with or without microscopic bladder neck involvement  Yes  No Date:

Unilateral extracapsular extension; or Bilateral extracapsular extension; or extension to

seminal vesicle(s)  Yes  No Date:

Extension to or fixation to adjacent structures

other than seminal vesicles: Bladder neck; Bladder, NOS; Fixation, NOS;

Rectovesical (Denonvillier's) fascia; Rectum; external sphincter; extraprostatic

urethra (membranous urethra); Levator muscles; Skeletal muscle; NOS, Ureter(s)  Yes  No Date:

Extension to or fixation to pelvic wall or pelvic bone  Yes  No Date:

Further contiguous extension (Stage D2) including to:  Yes  No Date:        
    Bone, Other organs, Penis, Sigmoid colon, Soft Tissue other than periprostatic

No evidence of primary tumor  Yes  No Date:

Extension unknown, Primary tumor cannot be assessed  Yes  No Date:

Not documented in patient record

**TREATMENT INFORMATION**

Check response to indicate procedures were completed. **Check as many as apply**. If response is ‘Yes’ please indicate date of procedure.

**SURGERY**

None; no cancer-directed surgery of primary site **Reason**

Date:

Local tumor destruction or excision, NOS  Yes  No Date:

Transurethral resection (TURP), NOS  Yes  No Date:

TURP patient has suspected/known cancer  Yes  No Date:

Cryoprostatectomy  Yes  No Date:

Laser  Yes  No Date:

Hyperthermia  Yes  No Date:

Other method of local resection or destruction  Yes  No Date:

Subtotal or simple prostatectomy, NOS  Yes  No Date:

Less than total prostatectomy, NOS  Yes  No Date:

Radical prostatectomy, NOS; total prostatectomy, NOS  Yes  No Date:

Prostatectomy **with** en bloc resection of other organs;

pelvic exenteration  Yes  No Date:

Prostatectomy, NOS  Yes  No Date:

Surgery, NOS  Yes  No Date:

Lymph Node Dissection  Yes  No Date:

If Lymph Nodes were involved, please describe name of lymph nodes or area, total number examined, and total number positive.

Total Number Nodes Examined:       Total Number Nodes Positive:

***Was a Pelvic Lymph Nodes Dissection performed?***   Yes  No  Unknown

**OTHER TREATMENT** Choose all that apply, if yes – indicate starting date.

Watchful Waiting/Active Surveillance  Yes  No Unknown Date:

Orchiectomy  Yes  No Unknown Date:

Prednisone  Yes  No Unknown Date:

**Drug Therapy**

leuprolide (Lupron, Viadur, Eligard)  Yes  No Unknown Date:

goserelin (Zoladex)  Yes  No Unknown Date:

triptorelin (Trelstar)  Yes  No Unknown Date:

histrelin (Vantas)  Yes  No Unknown Date:

Casodex  Yes  No Unknown Date:

Eulexin  Yes  No Unknown Date:

Nilandron  Yes  No Unknown Date:

Abarelix (Plenaxis)  Yes  No Unknown Date:

docetaxel (Taxotere)  Yes  No Unknown Date:

mitoxantrone (Novantrone)  Yes  No Unknown Date:

estramustine (Emcyt)  Yes  No Unknown Date:

doxorubicin (Adriamycin)  Yes  No Unknown Date:

etoposide (VP-16)  Yes  No Unknown Date:

vinblastine (Velban)  Yes  No Unknown Date:

paclitaxel (Taxol)  Yes  No Unknown Date:

carboplatin (Paraplatin)  Yes  No Unknown Date:

vinorelbine (Navelbine)  Yes  No Unknown Date:

**Radiation Therapy**  Yes  No Unknown Date: Describe:

Indicate the type(s) of Radiation received: External Beam  Brachytherapy  CyberKnife

**Provide additional Information or referral information if the patient was referred to another physician for further treatment or care (if available):**

**NAME: SPECIALTY: \_\_\_\_\_\_\_\_**

**Please: ATTACH AND SEND A COPY OF THE PATHOLOGY/CYTOLOGY REPORT TO THIS MEDICAL RECORD ABSTRACT**

**Mail or Fax report to:**

**Myriddian, LLC., Maryland Cancer Registry**

**6711 Columbia Gateway Drive, Suite 475**

**Columbia, MD 21046**

**Fax: 240-833-4111**

**Questions? Call 1-866-986-6575 or 410-344-2851**