Lung proforma

Patient Name: _____ **Patient No:** _____ **Date of Birth:** _____

REPORTING PRO FORMA FOR CT STAGING: LUNG CANCER

(SECTIONS SHOWN IN BLUE ARE OPTIONAL)

TUMOUR

Primary tumour: ☐ solid ☐ part solid / part GG ☐ entirely GG

☐ cavitating ☐ necrotic

☐ spiculated ☐ irregular ☐ lobulated

☐ air bronchograms

Located in: ☐ RUL apical seg ☐ RUL anterior seg ☐ RUL posterior seg

☐ RML medial seg ☐ RML lateral seg

☐ RLL apical basal seg ☐ RLL ant basal seg

☐ RLL lateral basal seg ☐ RLL posterior basal seg ☐ RLL medial basal seg

☐ LUL apicoposterior seg ☐ LUL anterior seg ☐ Lingula

☐ LLL apicobasal seg ☐ LLL anterior basal seg

☐ LLL lateral basal seg ☐ LLL posterior basal seg

Tumour dimensions: _____ x _____ x _____ mm

Tumour difficult to differentiate from adjacent consolidation ☐

Endobronchial disease: Present/absent ☐ Trachea ☐ main bronchus ☐ lobar
☐ segmental ☐ subsegmental

Tumour locally invades: ☐ visceral pleura

☐ parietal pleura

☐ mediastinal fat

☐ mediastinal structures - ☐ SVC/Aorta/Oesophagus/Heart/Trachea

☐ diaphragm

☐ rib(s)

☐ vertebral body/ies ☐ One ☐ More than one

☐ neural foramina/spinal canal

☐ into pleural apex, involving vessel(s)/nerves

☐ main bronchus within 2cm of carina

Distal lung/lobar atelectasis : ☐ present lung/lobe ☐ absent lung/lobe

Other features:_____

Change from previous imaging: _____

Potential for percutaneous lung biopsy: ☐ yes ☐ no

Distance from pleura ____ cm
Cross fissure/bulla ☐ yes ☐ no

REGIONAL LYMPH NODES Nodes > 10mm short axis diameter

Ipsilateral bronchial or hilar LN: ☐ None ☐ present _____ mm

Ipsilateral mediastinal or Subcarinal LN: ☐ None ☐ present _____ mm

Contralateral mediastinal or Hilar, supraclavicular or scalene LN: ☐ None ☐ present _____ mm

Other distant LN: ☐ None ☐ present _____ mm

Site _____

METASTATIC DISEASE

Metastatic disease in liver: ☐ no evidence ☐ indeterminate ☐ definite evidence

Incidental note: ☐ cysts ☐ haemangioma

☐ equivocal low density lesion

☐ for characterisation by MRI

☐ for characterisation by US

☐ requires follow up

☐ unlikely to represent metastatic disease

Pulmonary nodule(s): ☐ No CT evidence

☐ CT evidence ☐ Ipsilateral ☐ Contralateral

☐ Indeterminate solitary nodule requires follow up Size _____ mm

☐ Indeterminate multiple nodules require follow up. Number _____

Lymphangitis carcinomatosis: ☐ Possible ☐ Definite

☐ Unilobar ☐ Multilobar

Other Details _____

Adrenal metastatic disease: ☐ no evidence

☐ definite metastases

☐ definite adenomas

☐ equivocal lesion requires other investigation

Bone metastatic disease: ☐ no evidence

☐ CT evidence

☐ equivocal – requires further investigation

Cerebral metastatic disease: ☐ no evidence

☐ CT evidence

☐ not assessed

Pleural disease	☐ Present	☐ Absent	
	☐ Ipsilateral	☐ Contralateral	☐ Bilateral
	☐ Effusion	☐ Thickening	☐ Nodule(s)
Pericardial effusion	☐ present	☐ absent	
Other sites of metastases:	☐ no evidence		
	☐ CT evidence		

_____

SUMMARY

Overall stage T _____ N _____ M _____

Discussion points for imaging case:

Prostate proforma

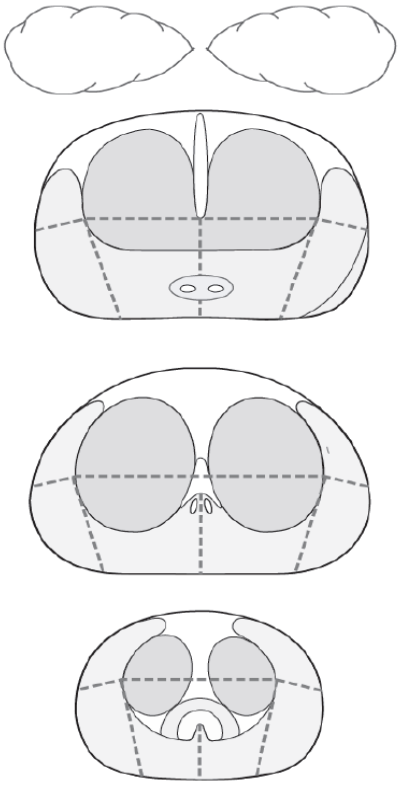
Hospital Name

REPORTING PROFORMA FOR STAGING PROSTATE CANCER *(SECTIONS SHOWN IN BLUE ARE OPTIONAL)*

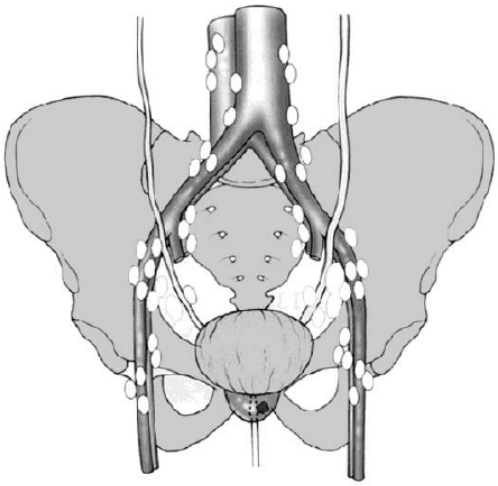
Patient label

Surname		**Forenames**		**Birth date**			
Hospital		**Hospital no**		**NHS no**			
Examination date		**MDT date**		**Consultant**			
Clinical stage		**PSA/date**		**TRUS date**	**Lt**		**Rt**
Treatments received							
Examinations dates	**MRI**	**US**	**CT**	**Bone scan**		**Other (specify)**	
Prostate gland dimensions (XYZ)				Volume (ml)			
BPH	None □ Mild □ Moderate □ Marked □						

Lesion locations & ECE (upto 3 lesions; including index cancer; lesion size; probability of clinically significant cancer 1-5 (Clinically significant disease - highly unlikely (1) ↔ clinically significant disease - unlikely (2) ↔ indeterminate ↔ clinically significant cancer likely (4) ↔ clinically significant disease - highly likely (5))



Organ confined	Yes	□	Indeterminate	□	No	□		
Beyond prostate (state side)	Yes	□	Indeterminate	□	No	□	Bilateral	□
Into seminal vesicle(s) (state side)	Yes	□	Indeterminate	□	No	□	Bilateral	□
Into bladder neck	Yes	□	Indeterminate	□	No	□		
Fixed or into adjacent organs or pelvic wall.	Yes	□	Indeterminate	□	No	□	Specify:	
Neurovascular bundle invasion	Yes	□	Indeterminate	□	No	□	Bilateral	□

Nodal status (draw sites of positive nodes	**Node positive**	□		Number (positive nodes/total)	
	Node negative	□		Right side	Left side
	Indeterminate	□		Maximum short axis dimension mm	Maximum short axis dimension mm

Metastases	Yes □	Indeterminate □	No □	Locations

TNM stage	**N**	**M**
□ Tx (cannot be assessed; should not be used for uncertainty in other T categories) □ T1 (invisible by imaging) □ T2a (tumour involves one half of one lobe or less) □ T2a (tumour involves more than one half of one lobe but not both lobes) □ T2c (bilateral disease) □ T3a (EPE; unilateral or bilateral) □ T3b (SV positive; unilateral or bilateral) □ T4 (other organs involved)	□ Nx □ N0 □ N1	□ Mx (cannot be assessed) □ M0 (No distant metastasis) □ M1 (Distant metastasis) □ M1a (Non regional node(s)) □ M1b (Bones) □ M1c (Other site(s) with or without bone disease When more than one site of metastasis, the most advanced category is used. M1c is most advanced.

Additional comments
Recommendations of further imaging CT □ MRI □ PET-CT □ Bone scan □

Signature …… **Date**……..

Radiologist Name:

Cervical proforma

REPORTING PROFORMA FOR MRI STAGING IN PRIMARY CERVICAL CANCER

(SECTIONS SHOWN IN BLUE ARE OPTIONAL)

Surname…… Forenames…… Date of birth……

Hospital…… Hospital no……

Pre MRI clinical information (if available)

Previous biopsy No biopsy ☐
Yes ☐ Date: _____ Cone ☐ LLEZT ☐

Type: squamous carcinoma ☐ adenosquamous carcinoma ☐ adenocarcinoma ☐
neuroendocrine carcinoma ☐ other ☐ specify……

Differentiation: well/grade 1 ☐ moderate/grade 2 ☐ poor/grade 3 ☐
not applicable ☐

Description of uterus

Dimensions of uterus: length…….mm transverse……...mm anteroposterior…….mm

Cervix:

No tumour seen ☐

Maximum dimensions of tumour:……..mm x ……mm x……mm

Tumour volume: **(V=d1×d2×d3×π/6).** ……

Position of cervical tumour: anterior ☐ posterior ☐ right ☐ left ☐ circumferential ☐

Morphology: ectocervix/exophytic ☐ endocervix ☐ barrel-shaped ☐

Depth of transverse invasion:

Confined to cervix ☐ Deep stromal invasion ☐
Parametrial invasion Rt ☐ Parametrial invasion Lt ☐
Anterior paracervical invasion ☐ Posterior paracervical invasion ☐

Vagina Vaginal involvement Yes ☐ No ☐
Anterior fornix involved ☐ Posterior fornix involved ☐
Lower third of vagina involved ☐

Pelvic side-wall Involved No ☐ Yes ☐
Side of involvement: Right ☐ Left ☐

Depth of involvement: Visceral ☐ Muscle ☐ Bone ☐
Hydronephrosis No ☐ Right ☐ Left ☐

Bladder
No involvement ☐
Serosal invasion ☐ Muscle invasion ☐ Mucosal invasion☐

Rectum
No involvement ☐
Serosal invasion ☐ Muscle invasion ☐ Mucosal invasion☐

Ascites
No ☐ small volume ☐ moderate volume ☐ large volume ☐

Nodes

Pelvis:
Suspicious node >10mm SA yes ☐ no ☐
Suspicious node <10 mm SA yes ☐ no ☐
Necrosis ☐ Extra-nodal spread ☐

Para-aortic
Suspicious node > 10mm SA yes ☐ no ☐
Suspicious node <10 mm SA yes ☐ no ☐
Necrosis ☐ Extra-nodal spread ☐

Position of suspicious nodes:

Along external iliac vessels	Rt short axis .....mm	Lt short axis .....mm
Obturator fossa	Rt short axis .....mm	Lt short axis .....mm
Common iliac	Rt short axis .....mm	Lt short axis .....mm
Left para-aortic	Short axis .....mm	
Aorto-caval	Short axis .....mm	
Other	.....	

Other tissues and organs:	Normal	Abnormal (describe)
Endometrium	☐	.....
Myometrium	☐	.....
Right adnexum	☐	.....
Left adnexum	☐	.....
Kidneys	☐	.....
Liver	☐	.....
Lungs	☐	

Provisional radiological FIGO stage*……

iTNM stage: iT……iN……iM…….

Further recommendation/comments

: **……**

Need for: CT chest/abdomen ☐ No ☐ Yes Already available ☐

PET/CT ☐ No ☐ Yes Already available ☐

Signature of Radiologist: …….. Date……..

Endometrial proforma

REPORTING PROFORMA: MRI STAGING IN PRIMARY ENDOMETRIAL CANCER

(SECTIONS SHOWN IN BLUE ARE OPTIONAL)

Surname…… Forenames…… Date of birth……
Hospital…… Hospital no……..

Pre MRI clinical information (if available)

Previous biopsy No biopsy ☐ Yes ☐ Date: _____

Type: endometriod adenocarcinoma ☐
adenosquamous carcinoma ☐
Serous papillary carcinoma ☐ Clear cell carcinoma ☐
Mixed Mullerian Tumour ☐ other ☐ specify……..…

Differentiation: well/grade 1 ☐ moderate/grade 2 ☐ poor/grade 3 ☐
not available/applicable ☐

Description of uterus

Dimensions of uterus: length…….mm transverse……mm anteroposterior…....mm
Endometrial thickness: .....mm
Maximum dimensions of tumour:……....mm x .....……mm x.....……mm
Maximum depth of myometrial invasion Less than 50% ☐ Greater than 50% ☐
Position of tumour (predominant) fundal ☐ mid uterine body ☐ lower uterine body ☐
Position of maximum myometrial invasion .....

Benign myometrial pathology: No ☐ Adenomyosis ☐ Bulky fibroids ☐

Uterine serosal involvement No ☐ Yes ☐

Cervix: No invasion ☐ Stromal invasion ☐ Parametrial invasion ☐

Ovarian involvement No ☐ Right ovarian involvement ☐ Left ovarian involvement ☐

Peritoneal involvement No ☐ Pelvic peritoneal deposits ☐ Abdominal peritoneal deposits ☐

Vagina Vaginal involvement No ☐ Upper third ☐ Middle third ☐Lower third ☐

Bladder	No involvement ☐ Serosal invasion ☐ Muscle invasion ☐ Mucosal invasion☐
Rectum	No involvement ☐ Serosal invasion ☐ Muscle invasion ☐ Mucosal invasion☐
Hydronephrosis	No ☐ Right ☐ Left ☐
Ascites	No ☐ small volume ☐ moderate volume ☐ large volume ☐

Nodes

Pelvis:	Suspicious node >10mm SA	yes ☐	no ☐
	Suspicious node <10 mm SA	yes ☐	no ☐
	Necrosis ☐ Extra-nodal spread ☐		
Para-aortic	Suspicious node > 10mm SA	yes ☐	no ☐
	Suspicious node <10 mm SA	yes ☐	no ☐
	Necrosis ☐ Extra-nodal spread ☐		

Position of suspicious nodes:

Along external iliac vessels	Rt short axis .....mm	Lt short axis .....mm
Obturator fossa	Rt short axis .....mm	Lt short axis .....mm
Common iliac	Rt short axis .....mm	Lt short axis .....mm
Left para-aortic	Short axis .....mm	
Aorto-caval	Short axis .....mm	
Other	.....	

Other tissues and organs:	Normal	Abnormal (describe)
Liver	☐	.....
Kidneys	☐	.....
Lungs	☐	.....
Other.....	☐	.....

Radiological FIGO stage.....

iTNM stage: iT.....iN.....iM.....

Further recommendation/ Comments

: **……..……**

Need for CT chest/abdomen ☐ No ☐ Yes Already available ☐

Signature of Radiologist: …….. Date……..

Rectal proforma

REPORTING PRO FORMA FOR RECTAL CANCER

(SECTIONS SHOWN IN BLUE ARE OPTIONAL)

Patient Name:_____ **Patient No:**_____ **Date of Birth:**_____

Primary tumour: ☐ Annular ☐ Semi-annular ☐ Ulcerating ☐ Polypoidal ☐ Mucinous ☐ Not seen
Height from anal verge: _____ mm

Distal edge lies: ____mm ☐ Above puborectalis sling ☐ At puborectalis sling ☐ below puborectalis sling

Extends craniocaudally over: _____ mm
Lies: ☐ Above the peritoneal reflection ☐ Below the peritoneal reflection ☐ At the peritoneal reflection

Invading edge of tumour: From _____ O'clock To _____ O'clock

Muscularis propria: ☐ Confined to ☐ Extends through

Extramural spread: _____ mm

T stage: ☐ T1 ☐ T2 ☐ T3a ☐ T3b ☐ T3c ☐ T3d ☐T4 visceral ☐T4 peritoneal

For low rectal tumours at or below the puborectalis sling
☐ Submucosal layer/part thickness of muscularis propria : intersphincteric plane/mesorectal plane is safe intersphincteric APE or ultra low TME possible, CRM is safe
☐ Full thickness of muscularis propria : intersphincteric plane/mesorectal plane is **unsafe**, Extralevator APE.
☐ Into intersphincteric plane : intersphincteric plane/mesorectal plane is **unsafe**, for extralevator APE.
☐ Into External sphincter : intersphincteric plane/mesorectal plane is **unsafe**.
☐ Beyond External sphincter into ischiorectal tissue : intersphincteric plane / mesorectal plane is **unsafe**.

Free Text Additional comments:

Lymph nodes:
☐ None ☐ Only benign reactive ☐ Present number _____ mixed signal/irregular border

Extramural venous invasion: ☐ No evidence ☐ Evidence
☐ Small ☐ Medium ☐ Large

Closest circumferential resection margin: _____ O'clock
The closest CRM is from ☐ Direct spread of tumour ☐ Extramural venous invasion ☐ Tumour deposit

Minimum tumour distance to mesorectal fascia: _____mm ☐ CRM clear ☐ CRM involved

Peritoneal deposits: ☐ No evidence ☐ Evidence

Pelvic side wall lymph nodes: ☐ None ☐ Benign ☐ Malignant mixed signal/irreg border
Location: Obturator fossa ☐ R ☐L . External Iliac Nodes☐ R ☐L. Inf Hypogastric ☐ R ☐L

Summary: MRI Overall stage: T _____ N _____ M_____

☐ CRM clear ☐ CRM involved ☐ EMVI positive ☐ EMVI negative

☐ No adverse features eligible for primary surgery ☐ Poor prognosis safe margins for preoperative therapy
☐ Poor prognosis unsafe margins eligible for preoperative chemoradiotherapy

Post Treatment Assessment MRI Rectal Cancer

☐ The treated tumour: shows no fibrosis,TRG5
☐ Less than <25% fibrosis, predominant tumour signal, TRG4
☐ 50% tumour/fibrosis, TRG 3
☐>75% fibrosis, minimal tumour signal intensity,TRG2
☐low signal fibrosis only no intermediate tumour signal TRG1

Height from anal verge:_____ mm

Treated tumour distal edge is: ____mm ☐Above puborectalis sling ☐ At puborectalis sling ☐ below PR sling

Extends craniocaudally over: _____ mm
Lies: ☐ Above the peritoneal reflection ☐ Below the peritoneal reflection ☐ At the peritoneal reflection

Invading edge of treated tumour: From _____ O'clock To _____ O'clock

Tumour signal is ☐ Confined to ☐ Extends through the muscularis propria.
Fibrotic signal is ☐ Confined to ☐ Extends through muscularis propria.
Extramural spread: _____ mm for tumour signal _____ for fibrotic stroma _____

yMR T stage: ☐ T1 ☐ T2 ☐ T3a ☐ T3b ☐ T3c ☐ T3d ☐T4 visceral ☐T4 peritoneal

For low rectal tumours at or below the puborectalis sling tumour signal/fibrosis extends into
☐ Submucosal layer/part thickness of muscularis propria : intersphincteric plane/mesorectal plane is safe intersphincteric APE or ultra low TME possible, CRM is safe
☐ Full thickness of muscularis propria : intersphincteric plane/mesorectal plane is **unsafe**, Extralevator APE.
☐ Into intersphincteric plane : intersphincteric plane/mesorectal plane is **unsafe**, for extralevator APE.
☐ Into External sphincter : intersphincteric plane/mesorectal plane is **unsafe**.
☐ Beyond External sphincter into ischiorectal tissue : intersphincteric plane / mesorectal plane is **unsafe**.

Free Text Additional comments:

Lymph nodes:

☐ None ☐ Only benign reactive ☐ Present number _____ mixed signal/irregular border

Extramural venous invasion: ☐ No evidence ☐ Evidence
☐ Small ☐ Medium ☐ Large

Closest circumferential resection margin: _____ O'clock
Closest CRM is from ☐ Direct spread of tumour ☐ Extramural venous invasion ☐ Tumour deposit

Minimum tumour distance to mesorectal fascia: _____mm ☐ CRM clear ☐ CRM involved

Peritoneal deposits: ☐ No evidence ☐ Evidence

Pelvic side wall lymph nodes: ☐ None ☐ Benign ☐ Malignant
Location: Obturator fossa ☐ R ☐L . External Iliac Nodes☐ R ☐L. Inf Hypogastric ☐ R ☐L

Summary: y MRI Overall stage ymrT _____ ymr N _____ M_____ , TRG _____

☐ CRM clear ☐ CRM fibrosis only ☐ CRM involved
☐ EMVI positive ☐ EMVI negative
☐ Good prognosis, CRM clear, TRG 1-3, EMVI –ve ☐ Poor prognosis

Colon proforma

REPORTING PRO FORMA FOR COLON CANCER

(SECTIONS SHOWN IN BLUE ARE OPTIONAL)

Patient Name:_____ Patient No:_____ Date of Birth:_____

Primary tumour: ☐ Annular ☐ Ulcerating ☐ Polypoidal ☐ Villous ☐ Eroding
☐ Mucinous ☐ Not easily shown

Located in colon: ☐ Caecum ☐ Ascending ☐ Hepatic flexure ☐ Transverse ☐ Descending
☐ Sigmoid ☐ Rectum ☐ Has been demonstrated on MRI scan, pls see report

Advancing edge tumour (border): ☐ Mesenteric ☐ Peritoneal ☐ N/A

To bowel wall: ☐ Confined ☐ Extends through
Peritoneal infiltration: ☐ No evidence ☐ Evidence
Tumour extension: ☐ <5mm ☐ >5mm Tumour
Diameter: _____ mm Tumour Thickness:_____ mm

Lymph nodes in colonic mesentery: ☐ Benign ☐ Reactive ☐ Malignant

Extramural venous invasion: ☐ No evidence ☐ Evidence

Peritoneal disease: ☐ Absent ☐ Present

Retroperitoneal lymphadenopathy: ☐ Absent ☐ Present

Incidental note: ☐ Intra-abdominal pathology ☐ Pelvic pathology

Metastatic disease in liver: ☐ No evidence ☐ Evidence Details:
☐ Segmental sparing ☐ No segmental sparing

Incidental note: ☐ Cysts ☐ Haemangioma ☐ Equivocal low density lesion
☐ For characterisation by MRI ☐ Follow-up
☐ Unlikely to represent metastatic disease

Pulmonary metastatic disease:	☐ No CT evidence	☐ CT evidence
Details:		

Summary:	Overall stage:	T _____	N _____	
	☐ Resectable	☐ Irresectable	☐ EMVI positive	☐ EMVI negative
	☐ M0	☐ M1	☐ Good prognosis	☐ Poor prognosis
Discussion points for imaging case:				
Radiologically Eligible for :				