Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control
Guidance for Cancer Client Database (CDB) Revised Form Completion: Colorectal Cancer Screening
Modifications to Form Dated 8/20/2009

PAGE #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD	REFERENCE IF PRIOR GUIDANCE
1	History	Client history of:	This is information addresses additional risk factors for CRC. History of ovarian and endometrial (uterine) cancer is collected under "Client history of any cancer" on page 3 of the core form; however, pelvic radiation is not captured on the core form. It is important to make sure that the data regarding history of cancer in the core is current and accurate when completing this field at the cycle level for the CRC module. It is also recommended that whoever is completing page 1 of the CRC screening form verifies the client's cancer history including the type of cancer and any treatment that was received.	Yes	CRC Risk Definitions in CDB Help Menu
		Ovarian or Endometrial Ca <age 50 yr	**Ovarian or Endometrial Ca <age 50 yr:** Selecting this field indicates that the client was diagnosed with ovarian or endometrial (uterine) cancer before age 50 years and is therefore at increased risk for CRC. If the age of diagnosis is unknown, please check 'yes' for this field.		
		Pelvic Radiation	**Pelvic Radiation:** Selecting this field indicates that the client has a history of pelvic radiation and is therefore at increased risk for CRC. Cancers that may be treated with pelvic radiation include CRC, anal, prostate, ovarian, uterine, cervical, and lymphoma.		
		None	**None:** If the client does not have a history of ovarian or endometrial (uterine) cancer that was diagnosed before age 50 years or a history of pelvic radiation, choose this option.		
2	Other Medical History	Does client have history of:	**None of the following:** If the client reported none of the medical history issues noted on the top of page 2 in the Other Medical History section of the CRC screening form, check “none of the following” to indicate you did ask the client about these items and the client confirmed that none of the seven items noted are issues for the client.	No	
3	Eligible Clients: Endoscopy or DCBE Results	Findings	**Suspected Hyperplastic Polyposis:** This should be checked in the findings for a colonoscopy if the doctor indicates a concern for hyperplastic polyposis based on the findings of procedure and/or if the findings are indicative of hyperplastic polyposis. The number of hyperplastic polyps can/should be summed over more than one procedure. As specified in the Minimal Elements, hyperplastic polyposis should be suspected if any of the following findings are noted: 1) At least five histologically diagnosed hyperplastic polyps proximal to the sigmoid colon of which 2 are greater than 1 cm in diameter, or; 2) Any number of hyperplastic polyps occurring proximal to the sigmoid colon in an individual who has a first-degree relative with hyperplastic polyposis, or; 3) Greater than 20 hyperplastic polyps of any size distributed throughout the colon. **Other Polyp: Polyp with unknown pathology:** This field should be checked if there are one or more polyps noted in the procedure report that are not accounted for on the pathology report. Examples are polyps that were not removed or biopsied or that were ablated without biopsy or lost to retrieval during the procedure.	Yes	

Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control
Guidance for Cancer Client Database (CDB) Revised Form Completion: Colorectal Cancer Screening
Modifications to Form Dated 8/20/2009

3	Eligible Clients: Endoscopy or DCBE Results	Findings	This may also occur when, per the pathology report, there are not enough tissue fragments to account for all the polyps noted in the procedure report, thus indicating that tissue was not received for all polyps noted.		
3	Eligible Clients: Endoscopy or DCBE Results	Findings	**Inflammatory Bowel Disease (IBD):** If IBD is noted as a finding on the colonoscopy report and is confirmed or still suspected by the doctor after review of the pathology report, then IBD should be checked and the type specified. It is best to try to get this diagnosis from the colonoscopist after he/she has had a chance to review the pathology findings. It is also important to document in the Comments on Findings section the extent of inflammation noted and the number and location of biopsies done. You can choose one of the four options: 1) Ulcerative colitis (UC): Check UC if the client is diagnosed by the endocscopist as having ulcerative colitis. This is a very specific finding and must be diagnosed and stated in the pathology report and/or in the doctor's notes or confirmed by the doctor, after reviewing the pathology findings, diagnoses UC. There may be "ulcers" noted during the exam, or "colitis," but this does not mean the diagnosis is UC unless specifically stated as such. 2) Crohn's colitis: This is similar to ulcerative colitis; see 1) above. 3) UC & Crohn's colitis: Check if both conditions apply as described in 1) and 2) above. 4) IBD type unknown: Check this if the path report or the doctor's notes, after path review, indicates that there is evidence of Inflammatory Bowel Disease but the type is not specified.	Yes	CCSC HO Memo 06-27-CRC Screening Form Guidance