

MROQC Bone Mets Data Elements Guide

60	Requires occasional assistance, but is able to care for most of his personal needs.
50	Requires considerable assistance and frequent medical care.
40	Disabled; requires special care and assistance.
30	Severely disabled; hospital admission is indicated although death not imminent.
20	Very sick; hospital admission necessary; active supportive treatment necessary.
10	Moribund; fatal processes progressing rapidly.
0	Dead

Toxicity Scoring (CTCAE v 4.0)

Grade						
	n/a	1	2	3	4	5
Gastrointestinal disorders						
Esophagitis		Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; altered eating/swallowing; oral supplements indicated	Severely altered eating/swallowing; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent operative intervention indicated	Death
Diarrhea		Increase of <4 stools per day over baseline; mild increase in ostomy output compared to baseline	Increase of 4 - 6 stools per day over baseline; moderate increase in ostomy output compared to baseline	Increase of >=7 stools per day over baseline; incontinence; hospitalization indicated; severe increase in ostomy output compared to baseline; limiting self-care ADL	Life-threatening consequences; urgent intervention indicated	Death
Nausea		Loss of appetite without alteration in eating habits	Oral intake decreased without significant weight loss, dehydration or malnutrition	Inadequate oral caloric or fluid intake; tube feeding, TPN, or hospitalization indicated		
Vomiting		1 - 2 episodes (separated by 5 minutes) in 24 hrs.	3 - 5 episodes (separated by 5 minutes) in 24 hrs.	>=6 episodes (separated by 5 minutes) in 24 hrs.; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent intervention indicated	Death
Fatigue						
Fatigue		Fatigue relieved by rest	Fatigue not relieved by rest; limiting instrumental ADL*	Fatigue not relieved by rest; limiting self-care ADL*		
Renal and Urinary Disorders						
Urinary Frequency		Present	Limiting instrumental ADL; medical management indicated			

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Urinary Urgency		Present	Limiting instrumental ADL; medical management indicated			
Skin						
Dermatitis		Faint erythema or dry desquamation	Moderate to brisk erythema; patchy moist desquamation, mostly confined to skin folds and creases; moderate edema	Moist desquamation in areas other than skin folds and creases; bleeding induced by minor trauma or abrasion	Life-threatening consequences; skin necrosis or ulceration of full thickness dermis; spontaneous bleeding from involved site; skin graft indicated	Death
<p>Was medication prescribed for any radiation treatment related toxicity?</p> <p>➤ If yes, note toxicity and medication:</p>				<ul style="list-style-type: none"> • Yes • No <p>_____ (free text)</p>		
<p>Was a clinical procedure performed due to radiation treatment related toxicity?</p> <p>➤ If yes, note toxicity and procedure:</p>				<ul style="list-style-type: none"> • Yes • No <p>_____ (free text)</p>		
<p>Since completing treatment, has the patient been hospitalized or seen in the ED for radiation treatment related toxicity?</p> <p>➤ If yes:</p> <p>➤ If yes, note toxicity:</p>				<ul style="list-style-type: none"> • Yes • No • ED • Hospitalization <p>_____ (free text)</p>		

M6 Patient: Pre-Treatment Bone Mets Questionnaire		
<i>Time points: Pre-Treatment</i>		
Data Elements	Options	
What is the treatment start date (RT start date) associated with this form?	_____ (mm/dd/yyyy)	
Do you have any trouble taking a short walk outside of the house?	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> Not at all A little Quite a bit Very much </div>	
Do you need to stay in bed or a chair during the day?		
Do you need help with eating, dressing, washing yourself or using the toilet?		
Were you short of breath?		
Have you had pain?		
I feel ill		
Have you had trouble sleeping?		
Have you felt weak?		
Have you lacked appetite?		
Have you felt nauseated?		<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> Not at all A little Quite a bit Very much </div>
Have you been constipated?		
Were you tired?		
Did pain interfere with your daily activities?		
Did you feel tense?		
Did you feel depressed?		
How would you rate your overall quality of life during the last 3 days?	_____ Scale (0-10)	

<p>Rate your pain at its worst at your treated site(s) within the last 3 days.</p>	<p>_____ Scale (0-10)</p>
<p>Have you ever, even once, used Cannabis?</p>	<ul style="list-style-type: none"> • Prefer not to answer • No • Yes
<p>Think specifically about the past 30 days up to and including today. What is your best estimate of the number of days you used Cannabis during the past 30 days?</p>	<ul style="list-style-type: none"> • 0 days • 1 or 2 days • 3 to 5 days • 6 to 9 days • 10 to 19 days • 20 to 29 days • All 30 days
<p>What is the highest level of education you have completed?</p>	<ul style="list-style-type: none"> • Grade School or less • Some College or Technical School • Some High School • Associate’s Degree • High School Graduate or G.E.D. • College Graduate (Bachelor’s Degree) • Graduate Degree
<p>Which of the following best describes your race?</p>	<ul style="list-style-type: none"> • American Indian/Alaska Native • Asian • Native Hawaiian or other Pacific Islander • Black or African American • White • Arab/Middle Eastern • Other (please specify) _____
<p>During the past 30 days, which one of the following ways did you use cannabis most often? Did you usually:</p>	<ul style="list-style-type: none"> • Smoke it (for example, in a joint, bong, pipe, or blunt) • Eat it (for example, in brownies, cakes, cookies, or candy) • Drink it (for example, in tea, cola, or alcohol) • Vaporize it (for example, in an e-cigarette-like vaporizer or another vaporizing device) • Dab it (for example, using waxes or concentrates) • Apply to skin (for example, using lotions or oils) • Administer rectally (for example, using suppositories).

	<ul style="list-style-type: none"> Use it some other way (please specify: _____)
What is the major active ingredient in the cannabis product that you use the most? (This information can often be found on the package label.)	<ul style="list-style-type: none"> THC –also called tetrahydrocannabinol CBD –also called cannabidiol Balanced levels of THC and CBD I don't know

M7 Patient: 6-week Follow-up Survey

Time points: Complete 6-weeks post-RT end date

Data Elements	Options
What is the treatment start date (RT start date) associated with this form?	_____ (mm/dd/yyyy)
Do you have any trouble taking a short walk outside of the house?	<div style="border: 1px solid black; padding: 10px; margin-bottom: 10px;"> <ul style="list-style-type: none"> Not at all A little Quite a bit Very much </div> <div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> Not at all A little Quite a bit Very much </div>
Do you need to stay in bed or a chair during the day?	
Do you need help with eating, dressing, washing yourself or using the toilet?	
Were you short of breath?	
Have you had pain?	
I feel ill	
Have you had trouble sleeping?	
Have you felt weak?	
Have you lacked appetite?	
Have you felt nauseated?	
Have you been constipated?	
Were you tired?	
Did pain interfere with your daily activities?	

Did you feel tense?	
Did you feel depressed?	
How would you rate your overall quality of life during the past week?	_____ Scale (0-7)
How would you rate your overall quality of life during the last 3 days?	_____ Scale (0-10)
Rate your pain at its worst at your treated site(s) within the last 3 days?	_____ Scale (0-10)
Thinking about your level of pain before starting treatment, did you experience an increase in pain after beginning treatment and up to 1 week following the end of treatment?	<ul style="list-style-type: none"> • Yes • No
Were you prescribed medication to treat side effects related to your radiation treatment?	<ul style="list-style-type: none"> • Yes • No
Were you prescribed steroids during treatment?	<ul style="list-style-type: none"> • Yes • No
<p>Have you been seen in the ED or hospitalized since completing radiation treatment?</p> <p>➤ If yes, how many times for the ED for Hospital?</p>	<ul style="list-style-type: none"> • Yes • No • ED _____ (free text) • Hospital _____ (free text)
Was radiation related side effects the reason for your emergency room visit or hospitalization?	<ul style="list-style-type: none"> • Yes • No • N/A

<p>➤ If yes, how many times?</p>	<p>_____ (free text)</p>
<p>Was pain a reason for your ED visit or hospitalization?</p> <p>➤ If yes, how many times?</p>	<ul style="list-style-type: none"> • Yes • No • N/A <p>_____ (free text)</p>

M8 CDA: Bone Mets Follow-up Medication Reconciliation Form

Time points: Complete 6-weeks post-RT end date

Data Elements	Options
<p>What is the treatment start date (RT start date) associated with this form?</p>	<p>_____ (mm/dd/yyyy)</p>
<p>List the current opioid medication(s) the patient was prescribed.</p> <ul style="list-style-type: none"> • Medication Name • Dose • Frequency <p>Check if the patient is not currently taking opioid medication</p>	<p>_____ (name)</p> <p>_____ (dose)</p> <p>_____ (frequency)</p> <ul style="list-style-type: none"> • Check box

SE2 CDA: Early Termination of MROQC Patient Participation Form

Data Elements	Options
<p>What is the treatment start date (RT start date) associated with this form?</p>	<p>_____ (mm/dd/yyyy)</p>
<p>Date of Early Termination:</p>	<p>_____ If the patient died this would be the date of death otherwise it is the last eval. date the patient had</p>

<p>Reason patient is no longer being followed /participating in MROQC:</p>	<ul style="list-style-type: none"> • Moved • To continue treatment elsewhere • Deceased • Hospice • Patient chose to stop treatment • Patient chose to not follow-up with department • Medical issues (i.e. CVA, MI) prevent further participation
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BONE METS Radiotherapy Technical Details Form	
Data Elements	Options
<p>What is the treatment start date (RT start date) associated with this form?</p>	<p>_____ (mm/dd/yyyy)</p>
<p>Select the planning type used for this plan:</p>	<ul style="list-style-type: none"> • Forward planning • Inverse planning • Hybrid technique (forward and inverse planning)
<p>What delivery technique(s) were used in this plan?</p>	<ul style="list-style-type: none"> • 2D • 3D • IMRT • Hybrid (3D and IMRT)
<p>Was this plan considered SBRT?</p>	<ul style="list-style-type: none"> • Yes • No
<p>Were standardized dose constraints used for organs at risk (OARs)?</p>	<ul style="list-style-type: none"> • Yes • No
<p>If any constraints were violated, was the rationale for their violation documented?</p>	<ul style="list-style-type: none"> • Yes • No • Not applicable – no constraint violations

<p>How was this plan billed?</p>	<ul style="list-style-type: none"> • 2D • 3D • IMRT • SBRT <p><i>Note: DICOM data upload is required for plans billed as IMRT or SBRT.</i></p>
<p>Was a simultaneous integrated boost included in this plan?</p>	<ul style="list-style-type: none"> • Yes • No
<p>Select the number of targets treated by this plan:</p>	<ul style="list-style-type: none"> • drop-down menu: 1-3
<p>TARGETS For each target, specify:</p> <p>➤ a. Enter the name of this target:</p> <p>➤ b. Choose all treatment sites included in this target:</p> <p>➤ c. Was a GTV structure contoured?</p>	<p>_____ free text</p> <ul style="list-style-type: none"> • Femur • Shoulder/Scapula • Hip • Skull • Humerus • Spine – select all levels treated: Cervical, Thoracic, Lumbar, Sacral • Pelvis • Other. Please specify: _____ • Rib/Sternum <ul style="list-style-type: none"> • Yes • No

<ul style="list-style-type: none"> ➤ d. Was a CTV structure contoured? ➤ e. What is the approximate margin between the GTV structure and CTV structure in cm? _____ cm ➤ f. Was a PTV structure contoured? ➤ g. What is the approximate margin between the CTV structure (or GTV structure if CTV structure was not defined) and PTV structure in cm? _____ cm ➤ h. Dose delivered to this target (Gy): _____ ➤ i. Number of fractions delivered to this target: _____ ➤ j. Did the target receive all of the planned dose? ➤ k. Was there any previous radiotherapy to the same target? 	<ul style="list-style-type: none"> • Yes • No • if Q6c = “Yes” and Q6d = “Yes” [between 0 and 5] • Yes • No • if Q6f = “Yes” and Q6c or Q6d = “Yes” [between 0 and 5] _____ [between 1 and 50] _____ [between 1 and 25] • Yes • No • Yes, to the entire target • Yes, some overlap with target • No
<p>Image Guidance</p> <p>What type of imaging was used to verify this patient’s setup?</p>	<ul style="list-style-type: none"> • kV/MV portal • CT (CBCT or TomoTherapy CT) • Other. Please specify: _____

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<p>For each imaging type, specify how often the patient was imaged during treatment.</p>	<ul style="list-style-type: none">• Daily• Less than daily but more than weekly• Weekly• Other. Please specify:
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