# Caisis – Neuro(Brain) Customization

**Patient Data Section – Show following fields for following records for Neuro dataset**

| Records | Fields | Metadata Values | Data Entry Description |
|---|---|---|---|
| **Demographics** | All fields (except MRN and patient's Last Name, if pt not in Caisis) | | |
| **Actions** | All fields | | **Only** for Lost follow-up Patients |
| **Family Members** | | | **For future use** |
| **Protocols** | All fields | | |
| **Social Histories** | | | **For future use** |
| | | | |
| **Absent Events** (All fields) | Table | | General type of Treatment not given |
| | Field | | Specific type of Treatment not given |
| | Specific Value | | Name of Treatment not given |
| | Reason | | Why Treatment not given |
| | Absent Date | | Most recent known date that Treatment was not given (update with Status->Alive Date) |
| | Notes | | |
| | Data Quality | | |
| | | | |
| | | | |
| **Encounters** | Date | | Date of initial New Visit to/or Internal Referrals within the institution; Also Neurology appointment date at time(s) of progression |
| | Type | Standard | Initial New Visit to/or Internal Referral within the institution ("NV"/"IR") |
| | Physician | Values from "ApptPhysician" → Neuro attribute | First and last name of physician |
| | KPS | | % rating to classify pt's functional impairment (*only captured by Neurology and Radiation Oncology) |
| | Height | | Height (*only captured by Neurology and Radiation Oncology) |
| | Weight | | Weight (*only captured by Neurology and Radiation Oncology) |
| | BSA | | BSA (auto-calculated) |
| | BMI | | BMI (auto-calculated) |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | Notes | | |
| | | | |

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|---|---|---|---|
| **Operating Room Details** | Pending | | |
| | Date | | Date of surgery/operation |
| | Institution | Standard | Name of institution where surgery took place |
| | Service | Standard | What department did the surgeon work for |
| | Case Surgeon | Standard | Name of Attending surgeon |
| | OR In Time | | |
| | OR Out Time | | |
| | Operating Time | | |
| | Anesthesia Type | Standard | |
| | Location | Standard | Was it done in the MRI Suite? (In-house only) |
| | Intraop Monitoring | Standard | Was Intraop Monitoring done? (In-house only) |
| | Notes | | |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | | | |
| **Procedures** | Pending | | |
| | During Operation On | | Date of surgery/operation |
| | Date | | Date of surgery/operation |
| | Procedure | Values from "ProcName" → Neuro attribute | Type of surgery (i.e. Craniotomy) |
| | Start Time | | |
| | End Time | | |
| | Side | Standard | Side surgery was performed (i.e. Right, Left, Bilat) |
| | Site | Values from "DxTarget" → Neuro attribute | Specific site (i.e. Frontal, Temporal) |
| | Subsite | Standard | |
| | CPT code | | Procedure code for the surgery |
| | CPT Description | | Standard description of the CPT code |
| | Surgeon | Values from "OpSurgeon" → Neuro attribute | |
| | Surgeon Type | Standard | |
| | Institution | Standard | Name of institution where surgery took place |
| | Service | Standard | What department did the surgeon work for |
| | Notes | | |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | | | |
| **Pathology** | From operation On | | Date of surgery/operation |

| | | | |
|---|---|---|---|
| | Source Procedure | | From which surgery was this pathology specimen taken |
| | Date | | Date path report signed out |
| | Path # | | Specific # and letters given to specimen |
| | Specimen Type | | Description of specimen as written on path report (i.e. Left frontal brain tumor) |
| | Site | Values from "DxTarget" → Neuro attribute | Specific site (i.e. Frontal, Temporal) |
| | Subsite | Standard | |
| | Side | Standard | Side surgery was performed |
| | Histology | Values from "PathHistology" Neuro attribute | Diagnosis determined by pathologist as written on path report |
| | Sec. Histology | Standard | More description of path (i.e. Diffuse large B-cell, Marginal Zone, Pituitary Adenoma-Prolactinoma) |
| | Institution | Standard | Where pathology was reviewed |
| | Pathologist | Standard | Name of Pathologist who signed out report |
| | Notes | | "N/A" if no Cytogenetic Report (In-house only) |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | | | |
| **Pathology Stages** | Disease | | Type of disease |
| | Grade | Standard | WHO grades: G1, G1/2, G2, G2/3, G3, G3/4, G4. Also Varies or Not Applicable. Determined by pathologist on path report. |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | Notes | | |
| | | | |
| **Pathology Tests** | Date | | Sign out date |
| | Time | | Sign out time |
| | Test | Standard | Type of test (i.e. EGFR, MGMT, EGFRvIII, 1p/19q, IDH-1/IDH-2, and also Pituitary Adenoma immunohistochemistry results) |
| | Result | Standard | Positive, Negative, Deletion, Pending, Invalid, Amplified, Not Amplified, None |
| | Units | | |
| | Notes | | If further description necessary; Protocol # entered here (i.e. 05-079 MGMT) |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | | | |
| **Specimen Accessions** | Collection Date | | |

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|---|---|---|---|
| | Collection Time | | |
| | Received Condition | | |
| | # EDTA Tubes | | |
| | Date Frozen | | |
| | Time Frozen | | |
| | Institution | | |
| | Department | | |
| | Notes | | |
| | | | |
| **Specimens** | All fields | | |
| | | | |
| **Medical Tx** | Protocol # | Standard | **Only** if pt was involved in a protocol, enter # |
| | During Operation On | | **Only** if MedTx was given during a Procedure |
| | Pending | | |
| | Start Date | | Date MedTx initiated (prefer date 1st dose given) |
| | Stop Date | | Date MedTx was discontinued (not date of last dose given) |
| | Agent | Standard | Name of MedTx (i.e. Temozolomide) |
| | Type | Standard | Specific type of Agent (i.e. Chemo) |
| | Disease | | Type of disease |
| | Dose | | *If Normalized Dose not provided; prescribed daily dose of med |
| | Total Dose | | Normalized Dose of the Agent (i.e. 75mg/m2) |
| | Units | Standard | |
| | Route | Standard | How Agent was administered (i.e. orally, IVPB, intrathecal) |
| | Schedule | Standard | How Agent was prescribed (i.e. 5/28, Concurrent RT, q2 weeks) |
| | Total Cycles | | Total # of Cycles or Dosages a pt received |
| | Total Weeks | | |
| | Institution | Standard | |
| | Notes | | Any additional info, i.e. outside protocol # |
| | Data Source | Standard | |
| | Data Quality | Standard | |
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| **Med Tx Administrations** | All fields | | |
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| **Medications** (All fields) | Start Date | | Date Med started |
| | Stop Date | | Date Med ended/discontinued |
| | Type | | What category is the medication (i.e. Hormone Replacement) |
| | Medication | | Name of Medication |

| | | | |
|---|---|---|---|
| | Dose | | Dose prescribed |
| | Total Dose | | Normalized dose |
| | Units | | |
| | Route | | How was it administered |
| | Schedule | | How was it prescribed |
| | Indication | | |
| | Notes | | |
| | Data Source | | |
| | Data Quality | | |
| | | | |
| **Radiation Tx** | Pending | | |
| | Start Date | | Date RT initiated |
| | Stop Date | | Date RT completed |
| | Disease | | Type of disease |
| | Type | | Specific type of RT (i.e. External Beam IMRT) |
| | Target | | Area RT was focused on (i.e. Left frontal lobe) |
| | Isotope | | Only if 'Type' is High-Dose Brachytherapy |
| | Total Dose | | Total dose of RT |
| | Units | | |
| | # Fractions | | Total # of fractions completed |
| | Physician | Values from “RadiationOncologist” → Neuro attribute | Name of Radiation Oncologist |
| | Institution | Standard | Where RT was performed |
| | Notes | | |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| | | | |
| **Diagnostics** | Pending | | |
| | Date | | Date of scan. CT/MRI to be entered only for pre/postoperative MRIs and for progression(s); all PET Scans |
| | Disease | Standard | Type of disease |
| | Type | Standard | MRI, CT, PET Scan, MRI Perfusion |
| | Target | | Enter only if site is not brain, i.e. Spine MRI |
| | Result | Standard | Brief summary of results (i.e. CT/MRI= Abnormal, Abnormal POD, Status post GTR, Status post subtotal resection, 1st-10th Progression; for PET= Hyper/Hypometabolic, Mixed)) |
| | Notes | | |
| | Data Source | Standard | |
| | Data Quality | Standard | |
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| **Other Image Findings** | All fields | | |
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| **LabTests** (All fields) | Date | | Date lab test performed |
| | Time (if applicable) *(for Pituitary Adenomas only)* | | Time lab test performed (can be important for Cortisol or other fasting labs) |
| | Lab Test | | Name of test |
| | Result | | Result |
| | Units | | Units |
| | Normal Range | | Normal range for that test, if provided |
| | | | |
| **Status** | Date | | Date of Diagnosis is defined as 1) 1st Abnormal MRI if no histology in >6 months; or 2) Tissue confirmation/Histology/OR Date |
| | Disease | Standard | "Brain", "Spine", "Pituitary Adenoma" (for Pits, subcategories available to specify type, i.e. Prolactinoma) |
| | Status | Standard | "Diagnosis Date" |
| | Notes | | Specify how pt was diagnosed ("OR" or "MRI". For the latter, include presumed diagnosis, i.e. "MRI, Low Grade Glioma", as there is no path to refer to.) |
| | | | *for multiple Diseases, enter EACH Diagnosis Date as per corresponding Histology or Scan date. Example "MRI, Lung Mets", "OR" and include same date Path. |
| | | | (OR if < 6months from scan; otherwise MRI, CT or LP; include suspected diagnosis) |
| | Data Source | Standard | |
| | Data Quality | Standard | |
| **Status (continued)** | Date | Last known alive date; also Progression date(s) | |
| | Disease | Type of disease, "Brain" | |
| | Status | Alive; 1st-10th Progression | |
| | Data Source | Standard | |
| | Data Quality | Standard | |
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| **Toxicities** | All fields (Auto-feed all complications occurred 30-days after to **only** procedures that are | | |

| | | | |
|---|---|---|---|
| | auto-fed to Caisis) | | |
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***Notes :***

- **"Data Source"=** Where was data found? Most often is "Medical Record".
- **"Data Quality"=** "STD" for done at this institution; "OUT" for done outside of this institution, "REV" for reviewed at this institution (i.e. path slides)
- **If Missing or No Data found in the EMR= "N/A" entered (**do not leave blank fields**)
- Auto-fed
- Fields not relevant for all patients
- Used for banking specimens. Not part of usual clinical data entry