



BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

TESTIS CANCER STAGING DIAGRAM

Pure seminoma Nonseminoma

UNIT	
AGENCY CHART No.	
SURNAME	GIVEN NAME
D.O.B.	HEALTH CARE PLAN No.

<input type="checkbox"/> New Referred as part of definitive treatment (initial treatment of disease)	<input type="checkbox"/> Recurrent Disease Definitive treatment already received (referred at recurrence)	<input type="checkbox"/> Referred for Follow-up Previously treated and followed elsewhere before referral
Primary Gonadal <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/>	Primary Retroperitoneal <input type="checkbox"/>	Primary Mediastinal <input type="checkbox"/>

TNM 2009*	T	<input checked="" type="checkbox"/>						
Clinical	N	X	0	1	2	3		
	M	X	0	1	1a	1b		
Pathological	T	X	0	pTis	1	2	3	4
	N	X	0	1	2	3		
	M	X	0	1	1a	1b		

IGCCCG Risk Group* Good Intermediate Poor

Histologic components (check all that apply)	Seminoma <input type="checkbox"/>	Yolk Sac <input type="checkbox"/>	Metastatic sites (check all that apply)	Retroperitoneum <input type="checkbox"/>
	Embryonal <input type="checkbox"/>	other <input type="checkbox"/>		Mediastinum <input type="checkbox"/>
	Choriocarcinoma <input type="checkbox"/>			Other LN <input type="checkbox"/>
	Mature teratoma <input type="checkbox"/>			Lung <input type="checkbox"/> Liver <input type="checkbox"/>
	Immature teratoma <input type="checkbox"/>			Bone <input type="checkbox"/> Brain <input type="checkbox"/>
	Transformation <input type="checkbox"/>			Other: <input type="checkbox"/> which _____
				Other: <input type="checkbox"/> which _____
Lymphovascular invasion	Yes <input type="checkbox"/> No <input type="checkbox"/>		Tumor marker pre-orchietomy	HCG <input type="checkbox"/> if yes: _____ IU/l
Predominant embryonal (> 50% embryonal)	Yes <input type="checkbox"/> No <input type="checkbox"/>			AFP <input type="checkbox"/> if yes: _____ ng/l
Invasion of the Rete testis	Yes <input type="checkbox"/> No <input type="checkbox"/>			LDH <input type="checkbox"/> if yes: _____ IU/l
Tumor size			Tumor markers post-orchietomy	HCG <input type="checkbox"/> if yes: _____ IU/l
Tunica albuginea invasion	Yes <input type="checkbox"/> No <input type="checkbox"/>			AFP <input type="checkbox"/> if yes: _____ ng/l
Spermatic cord invasion	Yes <input type="checkbox"/> No <input type="checkbox"/>			LDH <input type="checkbox"/> if yes: _____ IU/l

Completed by: _____ Date: _____

Diagnosis/Stage amended to: _____

Reason: _____

By: _____ Date: _____

NOTIFY DATA QUALITY AND REGISTRY IF DIAGNOSIS/STAGE IS AMENDED