Form 2125 R2.0: Central Nervous System Tumor Post-HSCT Data

Center: CRID:

Key Fields

Sequence Number: _____

Date Received: __ __ __ __ - __ __- __ __

CIBMTR Center Number _____

CIBMTR Recipient ID: _____

Today's Date: __ __ __ __ - __ __- __ __

Date of HSCT for which this form is being completed: __ __ __ __ - __ __- __ __

HSCT type (check all that apply):

- Autologous
- Allogeneic, unrelated
- Allogeneic, related
- Syngeneic (identical twin)

Product type (check all that apply):

- Marrow
- PBSC
- Cord blood
- Other product

Specify: _____

Visit:

100 day 6 months 1 year 2 years > 2 years,

Specify: _____

Disease Assessment at the Time of Best Response to HSCT

Questions: 1 - 2

1 Compared to the disease status prior to the preparative regimen, what was the best response to HSCT since the date of the last report? (Include response to any planned post-HSCT surgical resection or irradiation.)

- continued complete response (CCR) - continued absence of all disease after a complete reponse from the pre-HSCT disease status
- complete reponse (CR) - complete disappearance of all sites of known disease for > 4 weeks
- complete response undetermined (CRU) - complete response with persistence of radiographic enhancing abnormalities of unknown significance
- partial response (PR) - ≥50% reduction in greatest diameter of all sites of known disease, and no new sites of disease for > 4 weeks
- no response (NR) - <50% reduction in greatest diameter of any known sites of disease, and no new sites of disease for 4 weeks
- progressive disease (PD)- increase in size of any site of know disease, or any new sites of disease
- Not assessed

2 Date best response first began: __ __ __ __ - __ __- __ __ date for the best response was previously reported

Relapse or Progression Post-HSCT

Questions: 3 - 100

3 Has the disease relapsed or progressed since the date of the last report?

yes no Unknown

4 Date of progression / relapse: __ __ __ __ - __ __- __ __ Date unknown

5 *Allogeneic HSCTs only:* Was there subsequent disease stability or regression without further therapy (so-called graft-versus-tumor effect)?

yes no Unknown

6 Did this change in disease status qualify as a partial response or better if compared to a post-HSCT imaging study? *(see page 1 for criteria to define partial response)*

yes no

7 Date of response: __ __ __ __ - __ __- __ __ Date unknown

Specify site(s) of tumor recurrence / progression:

8 Cerebrospinal fluid

yes no Unknown

9 Extraneural

yes no Unknown

10 Distant intracranial parenchymal

yes no Unknown

11 Intracranial leptomeningeal

yes no Unknown

12 Spinal leptomeningeal

yes no Unknown

13 Local primary site

yes no Unknown

14 Other site:

yes no Unknown

15 Specify site: _____

16 Was planned treatment given per protocol since the date of the last report? (Include any maintenance therapy, but exclude any treatment for persistent, progressive or recurrent disease.)

yes no

Post-HSCT Planned Treatment for CNS Disease (1) — Questions: 17 - 46

17 Radiation Therapy:

yes no

18 Date radiation therapy started: __ __ __ __ - __ __- __ __

19 Date radiation therapy stopped: __ __ __ __ - __ __- __ __

Specify radiation fields(s):

20 Whole brain

yes no

21 If yes, specify total dose: _____ cGy (rads)

22 Local cranial

yes no

23 If yes, specify total dose: _____ cGy (rads)

24 Craniospinal

yes no

25 If yes, specify total dose: _____ cGy (rads)

26 Gamma knife / radiosurgery

yes no

27 If yes, specify total dose: _____ cGy (rads)

28 Interstitial irradiation/brachytherapy

yes no

29 If yes, specify total dose: _____ cGy (rads)

30 Radioactive instillation

yes no

31 If yes, specify total dose: _____ cGy (rads)

32 Local spinal

yes no

33 If yes, specify total dose: _____ cGy (rads)

34 Other radiation field

yes no

35 If yes, specify total dose: _____ cGy (rads)

36 Specify other radiation field _____

37 Specify fractionation schedule:

single single daily multiple daily other schedule

38 Surgical Biopsy / Resection:

yes no

39 Date of surgery: __ __ __ __ - __ __- __ __

40 Type of surgery: _____

41 Size of residual tumor after surgery _____

42 Was the extent of the surgical resection confirmed radiographically?

yes no Unknown

43 Was any persistent, viable tumor detected?

yes no Unknown

44 Best Response to Line of Therapy: *(see definitions at question 1)* _____

45 If code 7, specify reason: _____

46 Date the best response, including planned post-HSCT treatment, was achieved: __ __ __ __ - __ __- __ __

47 Was treatment given for persistent, progressive or recurrent CNS disease since the dated of the last report?

yes no

Post-HSCT Treatment for Persistent, Progressive, or Recurrent CNS Disease (1) **Questions: 48 - 100**

48 Systemic therapy:

yes no

49 Date therapy started: __ __ __ __ - __ __- __ __

50 Date therapy stopped: __ __ __ __ - __ __- __ __

51 Number of cycles _____ unknown / not applicable

52 bleomycin (BLM, Blenoxane)

yes no

53 carboplatin (Paraplatin)

yes no

54 Cisplatin (Platinol, CDDP)

yes no

55 Corticosteroids

yes no

56 Cyclophosphamide (Cytoxan)

yes no

57 Etoposide (VP-16, VePesid)

yes no

58 ifosfamide (ifex)

yes no

59 melphalan (L-PAM, Alkeran)

yes no

60 methotrexate (MTX, Folex)

yes no

61 nitrosourea (carmustine)

yes no

62 procarbazine (Matulane)

yes no

63 temozolomide (Temodar)

yes no

64 thiotepa (Thioplex)

yes no

65 topotecan (Hycamtin)

yes no

66 Vincristine (VCR, Oncovin)

yes no

67 other therapy

yes no

68 Specify other therapy: _____

69 Hematopoietic growth factor?

yes no

70 # of chemo cycles used with:

< 5 >= 5 Unknown

71 **Radiation Therapy:**

yes no

72 Date radiation therapy started: __ __ __ __ - __ __- __ __

73 Date radiation therapy stopped: __ __ __ __ - __ __- __ __

Specify radiation field(s):

74 Whole brain

yes no

75 If yes, specify total dose: _____ cGy (rads)

76 Local cranial

yes no

77 If yes, specify total dose: _____ cGy (rads)

78 Craniospinal

yes no

79 If yes, specify total dose: _____ cGy (rads)

80 Gamma knife / radiosurgery

yes no

81 If yes, specify total dose: _____ cGy (rads)

82 Interstitial irradiation / brachytherapy

yes no

83 If yes, specify total dose: _____ cGy (rads)

84 Radioactive instillation

yes no

85 If yes, specify total dose: _____ cGy (rads)

86 Local Spinal

yes no

87 If yes, specify total dose: _____ cGy (rads)

88 Other radiation field

yes no

89 If yes, specify total dose: _____ cGy (rads)

90 Specify other radiation field _____

91 Specify fractionation schedule:

single single daily multiple daily other schedule

92 Surgical Biopsy / Resection:

yes no

93 Date of surgery: __ __ __ __ - __ __- __ __

94 Type of surgery: _____

95 Size of residual tumor after surgery *(see codes at left)* _____

96 Was the extent of the surgical resection confirmed radiographically?

yes no Unknown

97 Was any persistent, viable tumor detected?

yes no Unknown

98 Best Response to Line of Therapy: *(see definitions at question 1)* _____

99 Specify reason: _____

100 Date the best response to post HSCT treatment was achieved: __ __ __ __ - __ __- __ __

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Center: CRID:

Disease Status at the Time of Assessment for This Reporting Period

Questions: 101 - 102

101 What is the current disease status?

- complete remission
- Not in complete remission

102 Date the current disease status was established in this reporting period: __ __ __ __ - __ __- __ __

First Name: _____ Last Name: _____

Phone number: _____ Fax number: _____

E-mail address: _____