



Acute Lymphoblastic Leukemia Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: / / (20)

Date of HSCT for which this form is being completed: / / (20)

HSCT type: autologous allogeneic, unrelated allogeneic, related syngeneic (identical twin)

Product type: marrow PBSC cord blood other product, specify: _____

This form must be accompanied by Form 2000 – Recipient Baseline Data. All information in the box above, including the date, should be identical with the corresponding Form 2000. Information should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HSCT, or abstraction of the recipient’s medical records.

Questions followed by the symbol indicate additional information necessary to complete the question is referenced in the forms instruction manual.

If this is a report of a second or subsequent transplant, check here and continue with question 121.

Disease Assessment at Diagnosis

1. What was the date of diagnosis of Acute Lymphoblastic Leukemia? / / (Month Day Year)

2. Did the recipient have a predisposing condition prior to the diagnosis of leukemia?

- 1 yes
- 2 no

3. Specify condition:

- 1 aplastic anemia → Also complete CIBMTR Form 2028 — APL
- 2 Bloom syndrome
- 3 Down syndrome
- 4 Fanconi anemia → Also complete CIBMTR Form 2029 — FAN
- 5 other condition → 4. Specify condition: _____

5. Was extramedullary disease present at diagnosis?

- 1 yes
- 2 no

Specify site(s) of disease:

- 6. 1 yes 2 no Central nervous system (CNS)
- 7. 1 yes 2 no Mediastinum
- 8. 1 yes 2 no Testes
- 9. 1 yes 2 no Other site → 10. Specify site: _____

Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Laboratory Studies at Diagnosis

11. Were cytogenetics tested (conventional or FISH)?

- 1 yes
- 2 no
- 3 unknown

12. Results of test at diagnosis:

- 1 yes abnormalities identified
- 2 no evaluable metaphases
- 3 no abnormalities

13. Results of tests after diagnosis to prior to the preparative regimen:

- 1 yes abnormalities identified
- 2 no evaluable metaphases on any tests
- 3 no abnormalities on any tests after diagnosis and before the preparative regimen

Specify abnormalities identified:

Cytogenetic abnormality	At diagnosis	Any test result between diagnosis and preparative regimen
Monosomy		
-7	14. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	39. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Trisomy		
+4	15. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	40. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
+8	16. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
+17	17. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
+21	18. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Translocation		
t(1;19)	19. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(4;11)	20. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(5;17)	21. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(8;14)	22. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(9;22)	23. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	48. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
translocation 9p	24. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	49. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(10;14)	25. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	50. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(11;14)	26. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(v;11q23)	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	52. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
t(12;21)	28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	53. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
translocation 12p	29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	54. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Deletion		
del(6q) / 6q-	30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	55. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
del(9p) / 9p-	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
del(12p) / 12p-	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	57. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Addition		
add(14q)	33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	58. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Other		
hyperdiploid (> 50)	34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	59. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
hypodiploid (< 46)	35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	60. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
complex (≥ 3 distinct abnormalities)	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
other abnormality	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	62. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
specify other abnormality:	38. _____	63. _____

64. Is a copy of the cytogenetic or FISH report attached?

- 1 yes
- 2 no

CIBMTR Center Number: [] [] [] [] [] []

CIBMTR Recipient ID: []

Pre-HSCT Treatment for Acute Lymphoblastic Leukemia

65. Was central nervous system prophylaxis given at any time prior to the preparative regimen?

- 1 yes
- 2 no

Specify prophylaxis:

- 66. 1 yes 2 no Cranial irradiation
- 67. 1 yes 2 no High-dose cytarabine
- 68. 1 yes 2 no Intrathecal chemotherapy
- 69. 1 yes 2 no Spinal irradiation
- 70. 1 yes 2 no Other prophylaxis

71. Specify prophylaxis: _____

72. Was therapy given between diagnosis and the start of the preparative regimen?

- 1 yes
- 2 no

Line of Therapy:	1st Line of Therapy	2nd Line of Therapy
Purpose of therapy:	73. 1 <input type="checkbox"/> induction 2 <input type="checkbox"/> consolidation 3 <input type="checkbox"/> maintenance 4 <input type="checkbox"/> treatment for relapse	97. 1 <input type="checkbox"/> induction 2 <input type="checkbox"/> consolidation 3 <input type="checkbox"/> maintenance 4 <input type="checkbox"/> treatment for relapse
Systemic / Intrathecal Therapy:	74. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 87	98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 111
Date therapy started:	75. [] [] [] [] [] [] Month Day Year	99. [] [] [] [] [] [] Month Day Year
Date therapy stopped:	76. [] [] [] [] [] [] Month Day Year	100. [] [] [] [] [] [] Month Day Year
Number of cycles:	77. [] [] <input type="checkbox"/> unknown/not applicable	101. [] [] <input type="checkbox"/> unknown/not applicable
aldesleukin (IL-2) chemotherapy	78. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
dasatinib (Sprycel)	79. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
imatinib (Gleevec)	80. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
interferon-α (Referon-α)	81. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
intrathecal drugs	82. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
nilotinib (AMN107, Tassigna)	83. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
other therapy	84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
specify other therapy	85. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
	86. _____	110. _____
Radiation Therapy:	87. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 93	111. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 117
Date therapy started:	88. [] [] [] [] [] [] Month Day Year	112. [] [] [] [] [] [] Month Day Year
Date therapy stopped:	89. [] [] [] [] [] [] Month Day Year	113. [] [] [] [] [] [] Month Day Year
central nervous system	90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	114. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
other site	91. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	115. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
specify other site	92. _____	116. _____
Best Response to Line of Therapy:	93. 1 <input type="checkbox"/> complete response 2 <input type="checkbox"/> no complete response	117. 1 <input type="checkbox"/> continuous complete response 2 <input type="checkbox"/> complete response 3 <input type="checkbox"/> no complete response
Date response established:	94. [] [] [] [] [] [] Month Day Year	118. [] [] [] [] [] [] Month Day Year
Did the recipient relapse following this line of therapy?	95. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	119. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Date of relapse:	96. [] [] [] [] [] [] Month Day Year	120. [] [] [] [] [] [] Month Day Year

Copy this page to report more than 2 lines of therapy; check here if additional pages are attached.

CIBMTR Center Number:

CIBMTR Recipient ID:

Laboratory Studies Prior to the Start of the Preparative Regimen

Report findings prior to any first treatment of the primary disease for which the HSCT is being performed.

121. WBC:

1 known → .

2 not known

Specify units:

1 $\times 10^9/L$ ($\times 10^3/mm^3$)
2 $\times 10^6/L$

122. Blasts in blood:

1 known → %

2 not known

123. Blasts in bone marrow:

1 known → %

2 not known

→ 124. Date of bone marrow examination:

Month

Day

2 0
Year

125. Were tests for BCR / ABL or other molecular markers performed at any time prior to the preparative regimen?

1 yes →

2 no

126. Was BCR / ABL testing performed?

1 yes →

2 no

127. Specify results:

1 positive
2 negative

128. Was TEL / AML / AML-1 testing performed?

1 yes →

2 no

129. Specify results:

1 positive
2 negative

130. Was any other molecular testing performed?

1 yes →

2 no

131. Specify test: _____

132. Specify results:

1 positive
2 negative

133. Did the recipient have central nervous system leukemia at any time or immediately prior to the preparative regimen?

1 yes →

2 no

3 unknown

Specify treatment(s) given:

134. 1 yes 2 no No treatment

135. 1 yes 2 no Cranial irradiation

136. 1 yes 2 no High-dose cytarabine

137. 1 yes 2 no Intrathecal chemotherapy

138. 1 yes 2 no Spinal irradiation

139. 1 yes 2 no Other treatment →

140. Specify treatment: _____

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Disease Status at the Last Assessment Prior to the Preparative Regimen

141. What was the status of ALL (based on hematological test results) at the last evaluation prior to the preparative regimen?

- 1 1st complete remission
(no previous marrow or extramedullary relapse) →
- 2 2nd complete remission →
- 3 ≥ 3rd complete remission →

142. Was the recipient in cytogenetic remission?

- 1 yes
- 2 no
- 3 unknown

143. Was the recipient in molecular remission?

- 1 yes
- 2 no
- 3 unknown

- 4 primary induction failure →
- 5 1st relapse →
- 6 2nd relapse →
- 7 ≥ 3rd relapse →
- 8 no treatment

Specify site(s) of active leukemia immediately prior to the preparative regimen:

- 144. 1 yes 2 no Bone marrow
- 145. 1 yes 2 no Central nervous system
- 146. 1 yes 2 no Cytogenetic / FISH test results
- 147. 1 yes 2 no Molecular test results
- 148. 1 yes 2 no Testes
- 149. 1 yes 2 no Other site →

150. Specify site:

151. Date of the most recent assessment for disease status prior to the preparative regimen:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year	

152. Signed: _____

Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____