



Langerhans Cell Histiocytosis Pre-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date:

Month Day Year

Date of HSCT for which this form is being completed:

Month Day Year

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.

If this is a report of a second (or subsequent) transplant, check here and continue with question 120.

1. What was the date of diagnosis of Langerhans cell histiocytosis (LCH)?

Month Day Year

Specify the known organ involvement at diagnosis:

			Site:	Confirmed by biopsy?			If confirmed by biopsy, histologic diagnosis: (see below)		
Yes	No	Unknown		Yes	No	Unknown	Presumptive	Designated	Definitive
2. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Bone →	3. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Bone marrow →	6. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	7. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Central nervous system →	9. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	10. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
11. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Gastrointestinal tract →	12. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	13. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
14. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Liver →	15. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	16. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
17. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Lung →	18. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	19. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
20. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Lymph nodes →	21. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	22. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
23. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Skin →	24. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	25. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
26. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Spleen →	27. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	28. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
29. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	Other organ →	30. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	31. 1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

32. Specify other organ:

33. Is a copy of the biopsy report attached?

- 1 yes
- 2 no

34. Did the recipient develop diabetes insipidus at any time prior to the preparative regimen?

- 1 yes
- 2 no
- 3 unknown

Histologic Diagnosis

- 1 Presumptive diagnosis — light microscopy only
- 2 Designated diagnosis — LM+ at least 2 supplemental stains: ATPase, S100, alpha-D-mannosidase, peanut lectin
- 3 Definitive diagnosis — CD1a and/or Birbeck granules on electronmicroscopy

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

CIBMTR Center Number:

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Disease Status Immediately Prior to the Preparative Regimen

120. What was the disease status immediately prior to the preparative regimen?

- 1 complete response — absence of all signs and/or symptoms of Langerhans cell histiocytosis
- 2 partial response — regression of signs and/or symptoms of disease without appearance of new lesions →
- 3 stable disease — persistence of signs and/or symptoms of disease without appearance of new lesions →
- 4 mixed response — regression of some signs and/or symptoms of disease with appearance of new lesions →
- 5 progressive disease — progression of signs and/or symptoms of disease initially detected and/or reappearance of old and/or appearance of new lesions →
- 6 unknown / not tested
- 7 not evaluable →

Specify any organ involvement immediately prior to the preparative regimen:

121. 1 yes 2 no 3 unknown Bone

122. 1 yes 2 no 3 unknown Bone marrow

123. 1 yes 2 no 3 unknown Central nervous system

124. 1 yes 2 no 3 unknown Gastrointestinal tract

125. 1 yes 2 no 3 unknown Liver

126. 1 yes 2 no 3 unknown Lung

127. 1 yes 2 no 3 unknown Lymph nodes

128. 1 yes 2 no 3 unknown Skin

129. 1 yes 2 no 3 unknown Spleen

130. 1 yes 2 no 3 unknown Other organ →

131. Specify: _____

132. Specify reason: _____

133. What was the percent of monocytes immediately prior to the preparative regimen?

- 1 known → %
- 2 not known

134. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____