

Acute Myelogenous Leukemia Post-HSCT Data

Registry Use Only

Sequence
 Number:

Date
 Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: / / **20**

Month Day Year

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


Month Day Year

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


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

Visit: 100 day 6 month 1 year 2 years > 2 years,
specify: _____

To be completed in conjunction with a Form 2100 – 100 Days Post-HSCT Data, Form 2200 – Six Months to Two Years Post-HSCT Data, or Form 2300 – Yearly Follow-Up for Greater Than Two Years Post-HSCT Data. Information reported here should reflect the date of last contact as reported in the post-HSCT data collection form, or immediately prior to death.

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

Post-HSCT Planned Treatment for AML

1. Was planned treatment given per protocol since the date of the last report? (Include any treatment given for maintenance therapy, but exclude any treatment for relapse / progressive disease.) 

- 1 yes
- 2 no

Specify treatment(s) given:

2. Central nervous system irradiation

- 1 yes
- 2 no

3. Systemic / intrathecal therapy

- 1 yes
- 2 no

Specify systemic / intrathecal therapy given:

4. 1 yes 2 no aldesleukin (interleukin-2, IL-2)

5. 1 yes 2 no all-trans retinoic acid

6. 1 yes 2 no cytarabine

7. 1 yes 2 no daunorubicin (Cerubidine)

8. 1 yes 2 no doxorubicin (Adriamycin)

9. 1 yes 2 no etoposide (VP-16, VePesid)

10. 1 yes 2 no gemtuzumab (Mylotarg)

11. 1 yes 2 no idarubicin (Idamycin)

12. 1 yes 2 no interferon- α (Referon- α)

13. 1 yes 2 no intrathecal therapy

14. 1 yes 2 no mitoxantrone (Novantrone)

15. 1 yes 2 no thioguanine (6-TG)

16. 1 yes 2 no topotecan (Hycamtin)

17. 1 yes 2 no other therapy \rightarrow

19. Donor leukocyte infusions

- 1 yes
- 2 no

20. Other treatment

- 1 yes
- 2 no

21. Specify treatment: _____

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

CIBMTR Center Number:

CIBMTR Recipient ID:

Disease Assessment at the Time of Best Response to HSCT, Including Planned Therapy

22. Was a complete remission (CR) ever achieved in response to the HSCT? (Include any therapy planned as of Day 0, but exclude any change in therapy in response to a disease assessment.)

- 1 recipient was already in CR at the start of the preparative regimen
- 2 yes, post-HSCT CR was achieved →
- 3 no, CR was never achieved post-HSCT

Continue with 48

23. Specify the date the clinical / hematologic CR was achieved:

Month Day Year

date previously reported

24. Did molecular testing confirm the presence of the CR?

- 1 yes →
- 2 no
- 3 not tested

25. Date the molecular CR was determined:

Month Day Year

26. Did cytogenetic testing confirm the presence of the CR?

- 1 yes →
- 2 no
- 3 not tested

27. Was FISH used to determine cytogenetic CR status?

- 1 yes →
- 2 no

28. Date the cytogenetic CR was determined via FISH:

Month Day Year

29. Were conventional cytogenetics used to determine cytogenetic CR status?

- 1 yes →
- 2 no

30. Date the cytogenetic CR was determined via conventional cytogenetics:

Month Day Year

Disease Relapse Post-HSCT

31. Has the disease relapsed since the date of the last report?

- 1 yes →
- 2 no

Continue with 48

Specify the method(s) used to assess the disease relapse: (*report all concurrent assessments*)

32. Molecular assessment

- 1 yes →
- 2 no

33. Date of the molecular assessment:

Month Day Year

34. Was there evidence of disease?

- 1 yes →
- 2 no

35. Was the status considered a disease relapse or progression?

- 1 yes
- 2 no

CIBMTR Center Number:

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Post-HSCT Treatment for AML

48. Was any treatment given for relapsed, persistent, or progressive disease since the date of the last report?

- 1 yes
- 2 no

Specify treatment(s) given:

49. Central nervous system irradiation

- 1 yes
- 2 no

50. Systemic / intrathecal therapy

- 1 yes
- 2 no

Specify systemic / intrathecal therapy given:

- 51. 1 yes 2 no aldesleukin (interleukin-2, IL-2)
- 52. 1 yes 2 no all-trans retinoic acid
- 53. 1 yes 2 no cytarabine
- 54. 1 yes 2 no daunorubicin (Cerubidine)
- 55. 1 yes 2 no doxorubicin (Adriamycin)
- 56. 1 yes 2 no etoposide (VP-16, VePesid)
- 57. 1 yes 2 no gemtuzumab (Mylotarg)
- 58. 1 yes 2 no idarubicin (Idamycin)
- 59. 1 yes 2 no interferon- α (Referon- α)
- 60. 1 yes 2 no intrathecal therapy
- 61. 1 yes 2 no mitoxantrone (Novantrone)
- 62. 1 yes 2 no thioguanine (6-TG)
- 63. 1 yes 2 no topotecan (Hycamtin)
- 64. 1 yes 2 no other therapy

65. Specify therapy:

66. Donor leukocyte infusions

- 1 yes
- 2 no

67. Subsequent HSCT

- 1 yes
- 2 no

68. Other treatment

- 1 yes
- 2 no

69. Specify treatment:

Disease Status at the Time of Assessment for This Reporting Period

70. Was the disease status assessed since the date of the last report?

- 1 yes
- 2 yes, is the same assessment as 31-47, as no treatment was given
- 3 no

Specify the method(s) used to assess the disease status:

71. Current molecular assessment

- 1 yes
- 2 no

72. Date of the molecular assessment:

Month Day Year

73. Was there evidence of disease?

- 1 yes
- 2 no

74. Was the status considered a relapse or persistent disease?

- 1 yes
- 2 no

CIBMTR Center Number:

CIBMTR Recipient ID:

75. Current cytogenetic assessment

- 1 yes →
- 2 no

76. Was the disease status assessed via FISH?

- 1 yes →
- 2 no

77. Date of FISH test:

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

2 0

78. Was there evidence of disease?

- 1 yes →
- 2 no

79. Was the status considered a relapse or persistent disease?

- 1 yes
- 2 no

80. Was the disease status assessed via conventional cytogenetics?

- 1 yes →
- 2 no

81. Date of conventional cytogenetic test:

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

2 0

82. Was there evidence of disease?

- 1 yes →
- 2 no

83. Was the status considered a relapse or persistent disease?

- 1 yes
- 2 no

84. Current clinical / hematologic assessment

- 1 yes →
- 2 no

85. Date of the clinical / hematologic assessment:

| | | | | | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
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| Month | | Day | | Year | |

2 0

86. Was there evidence of disease?

- 1 yes
- 2 no

CIBMTR Center Number:

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87. What is the current disease status?

- 1 complete remission
- 2 not in complete remission

88. Date the current disease status was established in this reporting period:

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

89. Signed: _____

Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____