



Ovarian Cancer Post-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, 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.

Disease Assessment at the Time of Best Response to HSCT

Best response is based on response to the HSCT, but does NOT include response to any therapy given for disease relapse or progression post-HSCT. When determining the best response to HSCT, compare the post-HSCT disease status to the status immediately prior to the preparative regimen, regardless of time since HSCT. This comparison is meant to capture the BEST disease status in response to HSCT that occurred in the reporting interval, even if a subsequent disease relapse or progression occurred during the same reporting interval. If a recipient already achieved their best response in a previous reporting interval, confirm the best response and check the box to indicate “date previously reported.”

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 post-HSCT treatment planned as of Day 0.)

- 1 CR
- 2 CRU
- 3 PR
- 4 SD
- 5 PD
- 6 NA
- 7 NETD

2. Date the best response first began: / /
Month Day Year

Response Evaluation Criteria in Solid Tumors (RECIST)

- 1 complete response (CR) – disappearance of all target lesions for a period of at least one month
- 2 complete response with persistent imaging abnormalities of unknown significance (CRU)
- 3 partial response (PR) – at least 30% decrease in the sum of the longest diameter of measured lesions (target lesions) taking as reference the baseline sum of longest diameters
- 4 stable disease (SD) – neither sufficient shrinkage to qualify for PR nor sufficient increase to qualify for PD, taking as reference the smallest sum of the longest diameters since the treatment started
- 5 progressive disease (PD) – at least a 20% increase in the sum of the longest diameter of measured lesions (target lesions), taking as reference the smallest sum of the longest diameters recorded since the treatment started or the appearance of one or more new lesions
- 6 not assessed (NA)
- 7 not evaluable, toxic death (NETD)

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3. Was the best response documented surgically?

- 1 yes
- 2 no
- 3 unknown

4. Specify the type of surgery performed:

- 1 total resection with microscopic residual disease only
- 2 optimal cytoreduction with largest residual tumor size < 1 cm
- 3 suboptimal resection with largest residual tumor size ≥ 1 cm
- 4 resection, diameter of residual disease unknown
- 5 biopsy only (not debulking)
- 6 removal of extra-abdominal metastatic lesion
- 7 second look surgery only
- 8 other abdominal surgery

5. Specify surgery:

Relapse or Progression Post-HSCT

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

- 1 yes
- 2 no
- 3 unknown

7. Date of progression / relapse:

Month Day Year

date unknown

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

- 1 yes
- 2 no
- 3 unknown

9. 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)

- 1 yes
- 2 no

10. Date of response:

Month Day Year

date unknown

Specify site(s) of disease progression / recurrence:

- 11. 1 yes 2 no 3 unknown Bone marrow
- 12. 1 yes 2 no 3 unknown Central nervous system (CNS)
- 13. 1 yes 2 no 3 unknown Diffuse abdominal
- 14. 1 yes 2 no 3 unknown Liver
- 15. 1 yes 2 no 3 unknown Lungs
- 16. 1 yes 2 no 3 unknown Lymph nodes – distant
- 17. 1 yes 2 no 3 unknown Lymph nodes – regional
- 18. 1 yes 2 no 3 unknown Skin
- 19. 1 yes 2 no 3 unknown Other site

20. Specify site:

Post-HSCT Treatment for Ovarian Cancer

21. Was therapy given since the date of the last report?

- 1 yes →
 2 no

Line of Therapy:	1st Line of Therapy	2nd Line of Therapy
Was post-HSCT therapy planned as of Day 0?	22. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Systemic Therapy:	23. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 65	85. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 127
Date therapy started:	24. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	86. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Date therapy stopped:	25. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	87. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Number of cycles:	26. <input type="text"/> <input type="text"/> <input type="checkbox"/> unknown/not applicable	88. <input type="text"/> <input type="text"/> <input type="checkbox"/> unknown/not applicable
aldesleukin (interleukin-2)	27. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	89. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
altretamine (Hexalen)	28. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
anastrozole (Arimidex)	29. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	91. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
bevacizumab (Avastin)	30. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	92. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
capecitabine (Xeloda)	31. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	93. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
carboplatin (Paraplatin)	32. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
cisplatin (CDDP, Platinol)	33. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	95. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
cyclophosphamide (CTX)	34. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	96. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
cytarabine (Ara-C, Cytosar-U)	35. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	97. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
docetaxel (Taxotere)	36. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
doxorubicin (Adriamycin)	37. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
doxorubicin liposomal (Doxil)	38. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
epirubicin (Ellence)	39. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	101. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
erlotinib (Tarceva)	40. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
etoposide (VP-16, VePesid)	41. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
exemestane (Aromasin)	42. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
fluorouracil (5-FU, Adrucil)	43. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
fulvestrant (Faslodex)	44. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
gemcitabine (Gemzar)	45. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
ifosfamide (Ifex)	46. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
imatinib (Gleevec)	47. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
interferon-α (Roferon-α)	48. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	110. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
irinotecan (Camptosar)	49. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	111. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
lapatinib (Tykerb)	50. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	112. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
letrozole (Femara)	51. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	113. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
mitoxantrone (Novantrone)	52. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	114. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
oxaliplatin (Eloxatin)	53. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	115. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
paclitaxel (Taxol)	54. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	116. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
prednisone (Sterapred)	55. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	117. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
sorafenib (Bayer)	56. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	118. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
sunitinib (Sutent, SU11248)	57. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	119. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
tamoxifen (Nolvadex)	58. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	120. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
thiotepa (Thioplex)	59. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	121. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
topotecan (Hycamtin)	60. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	122. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
vinblastine (Velban, VLB)	61. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	123. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
vinorelbine (Navelbine)	62. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	124. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
other therapy	63. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	125. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
specify other therapy	64. _____	126. _____
Radiation Therapy:	65. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 75	127. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 141
Date therapy started:	66. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	128. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Date therapy stopped:	67. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	129. <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Local / regional	68. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 70	130. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 132
Specify total dose	69. <input type="text"/> <input type="text"/> cGy (rads)	131. <input type="text"/> <input type="text"/> cGy (rads)
Sites of non-contiguous extra-abdominal metastases	70. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 73	132. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 134
Specify total dose	71. <input type="text"/> <input type="text"/> cGy (rads)	133. <input type="text"/> <input type="text"/> cGy (rads)

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Other radiotherapy site	72. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 75	134. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 137
Specify other radiation site	73. _____	135. _____
Specify total dose	74. <input type="text"/> cGy (rads)	136. <input type="text"/> cGy (rads)
Abdominal Surgery:	75. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 79	137. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no → cont. with q. 141
Date of surgery:	76. <input type="text"/> / <input type="text"/> / <input type="text"/>	138. <input type="text"/> / <input type="text"/> / <input type="text"/>
Type of abdominal surgery (see options at question 4)	77. <input type="text"/>	139. <input type="text"/>
Specify surgery (option 8)	78. _____	140. _____
Best Response to Line of Therapy: (see definitions on page 1)	79. 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> CRU 3 <input type="checkbox"/> PR 4 <input type="checkbox"/> SD 5 <input type="checkbox"/> PD 6 <input type="checkbox"/> NA 7 <input type="checkbox"/> NETD 8 <input type="checkbox"/> unknown / not tested	141. 1 <input type="checkbox"/> CR 2 <input type="checkbox"/> CRU 3 <input type="checkbox"/> PR 4 <input type="checkbox"/> SD 5 <input type="checkbox"/> PD 6 <input type="checkbox"/> NA 7 <input type="checkbox"/> NETD 8 <input type="checkbox"/> unknown / not tested
Date response evaluated:	80. <input type="text"/> / <input type="text"/> / <input type="text"/>	142. <input type="text"/> / <input type="text"/> / <input type="text"/>
Did patient relapse/progress following this line of therapy?	81. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	143. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no
Date of relapse/progression:	82. <input type="text"/> / <input type="text"/> / <input type="text"/>	144. <input type="text"/> / <input type="text"/> / <input type="text"/>
Specify site(s) of relapse:	83. _____	145. _____

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

Disease Status at the Time of Assessment for This Reporting Period

Specify imaging performed:	Specify imaging method:	Specify results:	Was tumor present?
	yes no	normal abnormal	
146. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Bone imaging →	147. 1 <input type="checkbox"/> 2 <input type="checkbox"/> Bone scan →	148. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	149. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
	150. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT →	151. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	152. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
	153. 1 <input type="checkbox"/> 2 <input type="checkbox"/> MRI →	154. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	155. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
	156. 1 <input type="checkbox"/> 2 <input type="checkbox"/> X-ray →	157. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	158. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
159. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Chest x-ray →	160. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	161. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk	
162. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of chest →	163. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	164. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk	
165. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of abdomen →	166. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	167. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk	
168. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no CT scan of pelvis →	169. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	170. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk	
171. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Head imaging →	172. 1 <input type="checkbox"/> 2 <input type="checkbox"/> CT →	173. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	174. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
	175. 1 <input type="checkbox"/> 2 <input type="checkbox"/> MRI →	176. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	177. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk
178. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no PET scan →	179. 1 <input type="checkbox"/> 2 <input type="checkbox"/> →	180. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no 3 <input type="checkbox"/> unk	

181. What is the current disease status?

- 1 complete remission
- 2 not in complete remission

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

Month Day Year

183. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____