

ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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Initials:

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Today's Date:

Month	Day	20		Year															

Infusion Date:

Month	Day	20		Year															

CIBMTR Center Number:

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Small Cell Lung Cancer Post-HSCT Data

Registry Use Only

Sequence Number:

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Date Received:

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Today's Date:

Month	Day	20		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: _____

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.

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 planned post-HSCT surgical resection or irradiation.)

- 1 complete response – no tumor; no metastatic sites
- 2 very good partial response – primary tumor decreased by 90–99%; no metastatic sites; scar may be present, mediastinal nodes ≤ 1.5 cm diameter; residual ⁹⁹Tc bone changes allowed →
- 3 partial response – primary tumor decreased by ≥ 50%; all measurable metastatic sites decreased by > 50% →
- 4 no response / stable disease – no new lesions; < 50% reduction but < 25% increase in any existing lesion →
- 5 progressive disease – any new lesion; increase of any measurable lesion by ≥ 25%; previously negative bone marrow positive for tumor →
- 6 not assessed

Specify the site(s) of persistent tumor:

- 2. 1 yes 2 no Adrenal glands
- 3. 1 yes 2 no Bone
- 4. 1 yes 2 no Bone marrow
- 5. 1 yes 2 no Brain parenchyma
- 6. 1 yes 2 no Cerebrospinal fluid (CSF)
- 7. 1 yes 2 no Liver
- 8. 1 yes 2 no Lymph nodes
- 9. 1 yes 2 no Mediastinum
- 10. 1 yes 2 no Pericardium
- 11. 1 yes 2 no Pleura (includes pleural effusion)
- 12. 1 yes 2 no Primary tumor
- 13. 1 yes 2 no Skin / subcutaneous
- 14. 1 yes 2 no Other site →

15. Specify site:

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16. Specify the date best response first began:

Month	Day	Year																	

date previously reported

CIBMTR Form 2121 (SCL) v1.0 (1–6) July 2007
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Mail this form to your designated campus (Milwaukee or Minneapolis). Retain the original at the transplant center.

Fax this form to your designated campus (Milwaukee 414-456-6165 or Minneapolis 612-627-5895).

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Relapse or Progression Post-HSCT

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

- 1 yes →
 2 no
 3 unknown

18. Date of relapse / progression:

		2	0		
Month	Day	Year			

 date unknown

19. *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

20. 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

21. Date of response:

		2	0		
Month	Day	Year			

date unknown

Post-HSCT Planned Treatment for Small Cell Lung Cancer

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

- 1 yes →
 2 no

Specify therapy given:

23. 1 yes 2 no Chemotherapy

24. 1 yes 2 no Radiation →

25. Specify radiation field:

- 1 central nervous system
 2 thorax
 3 other field →

26. Specify radiation field:

27. 1 yes 2 no Surgery →

28. Specify surgery site:

- 1 brain
 2 lung
 3 other site →

29. Specify surgery site:

30. 1 yes 2 no Other therapy →

31. Specify other therapy: _____

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32. Did the small cell lung cancer relapse or progress since the date of the last report?

- 1 yes
2 no

		Date of Relapse / Progression				Date unknown												
		Month	Day	Year	Year													
33.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Adrenal glands	→	34.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
35.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Bone	→	36.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
37.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Bone marrow	→	38.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
39.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Brain parenchyma	→	40.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
41.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Cerebrospinal fluid	→	42.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
43.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Liver	→	44.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
45.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Lung (primary tumor)	→	46.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
47.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Lymph nodes	→	48.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
49.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Mediastinum	→	50.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
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Month	Day	Year																
51.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Pericardium	→	52.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
53.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Pleura (includes pleural effusion)	→	54.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
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Month	Day	Year																
55.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Skin / subcutaneous	→	56.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
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Month	Day	Year																
57.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Other site	→	58.	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td>2</td><td>0</td><td></td><td></td></tr> <tr><td>Month</td><td>Day</td><td colspan="2">Year</td><td> </td><td> </td></tr> </table>			2	0			Month	Day	Year				<input type="checkbox"/>
		2	0															
Month	Day	Year																
59. Specify site: _____																		
Specify the method(s) used to establish the diagnosis of disease relapse or progression:																		
60.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Biopsy	→	61. Was small cell lung cancer detected? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no														
62.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Diagnostic radiology (x-ray, CT scan, bone scan)	→	63. Was small cell lung cancer detected? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no														
64.	1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no	Other test	→	65. Specify test: _____ 66. Was small cell lung cancer detected? 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no														

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	<p>86. Date therapy started:</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 60%;"><table border="1" style="width: 20px; height: 20px; text-align: center;">20</table></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> </tr> </table> <p>87. Number of fractions: <table border="1" style="width: 30px; height: 20px;"></table></p> <p>88. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other site →</p> <p>89. Specify total dose: <table border="1" style="width: 60px; height: 20px;"></table> cGy (rads)</p> <p>90. Specify site(s): _____</p> <p>91. Date therapy started:</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 60%;"><table border="1" style="width: 20px; height: 20px; text-align: center;">20</table></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> </tr> </table> <p>92. Number of fractions: <table border="1" style="width: 30px; height: 20px;"></table></p>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	Month	Day	Year	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	Month	Day	Year
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Month	Day	Year											
<p>93. Was chemotherapy given?</p> <p>1 <input type="checkbox"/> yes →</p> <p>2 <input type="checkbox"/> no</p>	<p>94. Specify the date the first cycle of chemotherapy began:</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 60%;"><table border="1" style="width: 20px; height: 20px; text-align: center;">20</table></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> </tr> </table> <p>95. Specify the date the last cycle of chemotherapy began:</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 20%;"><table border="1" style="width: 20px; height: 20px;"></table></td> <td style="width: 60%;"><table border="1" style="width: 20px; height: 20px; text-align: center;">20</table></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> </tr> </table> <p>96. Specify the total number of chemotherapy cycles given: <table border="1" style="width: 30px; height: 20px;"></table></p> <p>Specify the chemotherapeutic agent(s) used:</p> <p>97. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Carboplatin</p> <p>98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cisplatin</p> <p>99. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cyclophosphamide</p> <p>100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Doxorubicin</p> <p>101. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Etoposide (VP16)</p> <p>102. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Ifosfamide</p> <p>103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Taxol</p> <p>104. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Topotecan</p> <p>105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Vinblastine</p> <p>106. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Vincristine</p> <p>107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Vinorelbine</p> <p>108. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other agent →</p> <p>109. Specify agent: <table border="1" style="width: 100%; height: 20px;"></table></p>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	Month	Day	Year	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px; text-align: center;">20</table>	Month	Day	Year
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Disease Status at the Time of Assessment for This Reporting Period

110. What is the current disease status?

- 1 complete remission
2 not in complete remission

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

				2	0		
Month	Day	Year					

112. Signed: _____
Person completing form

Please print name: _____

Phone number: (_____) _____

Fax number: (_____) _____

E-mail address: _____