

ERROR CORRECTION FORM

Sequence Number:

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CIBMTR Recipient ID:

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Initials:

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Today's Date:

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Month	Day	Year	Year		

Infusion Date:

		2	0		
Month	Day	Year	Year		

CIBMTR Center Number:

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Neuroblastoma Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

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CIBMTR Center Number:

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CIBMTR Recipient ID:

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Today's Date:

		2	0		
Month	Day	Year	Year		

Date of HSCT for which this form is being completed:

Month	Day	Year	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 post-HSCT treatment planned as of Day 0.)

- 1 complete response — no primary tumor, no metastatic sites, catecholamines normal; includes continued complete response
- 2 very good partial response — primary tumor decreased by 90-99%, no metastatic sites, catecholamines normal; residual ⁹⁹Tc bone changes allowed
- 3 partial response — primary tumor decreased by > 50%, all measurable metastatic sites decreased by > 50%, number of positive bone sites decreased by > 50%, no more than 1 positive bone marrow site allowed, 1 positive marrow aspirate or biopsy allowed if this represents a decrease from the number of positive sites at diagnosis →
- 4 minimal response — no new lesions; > 50% reduction of any measurable lesion (primary or metastases) with < 50% reduction in any other; < 25% increase in any existing lesion →
- 5 no response — no new lesions; < 50% reduction but < 25% increase in any existing lesion →
- 6 progressive disease — any new lesions; increase of any measurable lesion by > 25%; previous negative marrow positive for tumor →
- 7 not assessed
- 8 not tested / unknown

Specify the site(s) of persistent tumor:

- 2. 1 yes 2 no Adrenal gland
- 3. 1 yes 2 no Bone
- 4. 1 yes 2 no Bone marrow
- 5. 1 yes 2 no Cerebellum
- 6. 1 yes 2 no Cerebrospinal fluid (CSF)
- 7. 1 yes 2 no Cerebrum
- 8. 1 yes 2 no Cranial nerves
- 9. 1 yes 2 no Liver
- 10. 1 yes 2 no Lymph nodes
- 11. 1 yes 2 no Mediastinum
- 12. 1 yes 2 no Paraspinal ganglion
- 13. 1 yes 2 no Retro-orbital area
- 14. 1 yes 2 no Skin / subcutaneous tissue
- 15. 1 yes 2 no Elevated catecholamines
- 16. 1 yes 2 no Other site →

17. Specify: _____

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73. Did the neuroblastoma recur or progress since the date of the last report?

- 1 yes
2 no

Specify the known site(s) of disease progression / recurrence:		Date determined:										
		Month	Day	Year								
74. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Adrenal gland →	75.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
76. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Bone →	77.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
78. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Bone marrow →	79.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
80. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cerebellum →	81.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
82. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cerebrospinal fluid (CSF) →	83.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
84. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cerebrum →	85.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
86. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Cranial nerves →	87.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
88. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Liver →	89.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
90. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Lymph nodes →	91.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
92. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Mediastinum →	93.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
94. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Paraspinal ganglion →	95.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
96. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Retro-orbital area →	97.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
98. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Skin / subcutaneous tissue →	99.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
100. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other site →	101.	<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td></td><td></td></tr></table>			<table border="1" style="width: 20px; height: 20px;"><tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td></td><td></td></tr></table>	2	0		
2	0											
102. Specify other site: _____												
Specify the methods used to examine sites of disease recurrence / persistence / progression:		Specify disease status:										
103. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Biopsy →	104.	1 <input type="checkbox"/> positive	2 <input type="checkbox"/> negative									
105. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Bone scan →	106.	1 <input type="checkbox"/> positive	2 <input type="checkbox"/> negative									
107. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Radiology →	108.	1 <input type="checkbox"/> positive	2 <input type="checkbox"/> negative									
109. 1 <input type="checkbox"/> yes 2 <input type="checkbox"/> no Other method →	110.	1 <input type="checkbox"/> positive	2 <input type="checkbox"/> negative									
111. Specify other method: _____												

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112. Was the recipient given treatment for post-HSCT persistent, progressive or recurrent disease since the date of the last report?

- 1 yes
 2 no
 3 unknown

113. Was radiotherapy given?

- 1 yes
 2 no

Specify the site(s) of radiotherapy:

114. 1 yes 2 no Bone metastases

115. 1 yes 2 no Primary tumor

116. 1 yes 2 no Other →

117. Specify: _____

118. Specify the date radiotherapy was started:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"> </table>	<table border="1" style="width: 20px; height: 20px;"> </table>
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119. Number of fractions given:

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120. Dose per fraction:

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cGy (rads)

121. Was MIBG given?

- 1 yes
 2 no

Specify the radioisotope given:

122. 1 yes 2 no ¹³¹I-MIBG

123. 1 yes 2 no Other →

124. Specify: _____

125. Specify the date MBIG treatment was performed:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"> </table>	<table border="1" style="width: 20px; height: 20px;"> </table>
Month	Day	Year			

126. Were retinoids given?

- 1 yes
 2 no

Specify the retinoids given:

127. 1 yes 2 no Isotretinoin

128. 1 yes 2 no Other →

129. Specify: _____

130. Specify the date retinoid treatment was started:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"> </table>	<table border="1" style="width: 20px; height: 20px;"> </table>
Month	Day	Year			

131. Was immunotherapy given?

- 1 yes
 2 no

Specify the drug(s) given:

132. 1 yes 2 no α-interferon

133. 1 yes 2 no Anti-GD2 antibody CH14.18

134. 1 yes 2 no Interleukin-2 (IL-2)

135. 1 yes 2 no Other →

136. Specify: _____

137. Specify the date immunotherapy was started:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"> </table>	<table border="1" style="width: 20px; height: 20px;"> </table>
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138. Was chemotherapy given?

- 1 yes
 2 no

Specify the treatment(s) given:

139. 1 yes 2 no Adriamycin

140. 1 yes 2 no Cisplatin

141. 1 yes 2 no Cyclophosphamide

142. 1 yes 2 no Dacarbazine (DTIC)

143. 1 yes 2 no Etoposide (VP16)

144. 1 yes 2 no Ifosfamide

145. 1 yes 2 no Melphalan (L-PAM)

146. 1 yes 2 no Teniposide (VM26)

147. 1 yes 2 no Vincristine

148. 1 yes 2 no Other →

149. Specify: _____

150. Specify the date chemotherapy was started:

<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;">2</table>	<table border="1" style="width: 20px; height: 20px;">0</table>	<table border="1" style="width: 20px; height: 20px;"> </table>	<table border="1" style="width: 20px; height: 20px;"> </table>
Month	Day	Year			

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151. Was other treatment given?

- 1 yes
2 no

152. Specify other treatment: _____

153. Specify the date other treatment was started:

		2	0		
Month	Day	Year			

154. What is the current disease status?

- 1 complete remission
2 not in complete remission

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

		2	0		
Month	Day	Year			

156. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____