ERROR CORRECTION FORM

Sequence Number:

CIBMTR Recipient ID:

Visit:
☐ 100 day
☐ 6 month
☐ year

Today's Date: Month Day 20 Year

Infusion Date: Month Day 20 Year

CIBMTR Center Number:

Initials:

CIBMTR®
CENTER FOR INTERNATIONAL BLOOD & MARROW TRANSPLANT RESEARCH

Central Nervous System Tumor Post-HSCT Data

Registry Use Only

Sequence Number:

Date Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

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 ☐ multiple cord blood units infused ☐ 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 ☐ continued complete response (CCR) — continued absence of all disease after a complete response from the pre-HSCT disease status
   - 2 ☐ complete response (CR) — complete disappearance of all sites of known disease for > 4 weeks
   - 3 ☐ complete response undetermined (CRU) — complete response with persistence of radiographic enhancing abnormalities of unknown significance
   - 4 ☐ partial response (PR) — ≥ 50% reduction in greatest diameter of all sites of known disease, and no new sites of disease for > 4 weeks
   - 5 ☐ no response (NR) — < 50% reduction in greatest diameter of any known sites of disease, and no new sites of disease for > 4 weeks
   - 6 ☐ progressive disease (PD) — increase in size of any site of known disease, or any new sites of disease
   - 7 ☐ not assessed
2. Date best response first began: Month Day Year ☐ date for the best response was previously reported

Relapse or Progression Post-HSCT

3. Has the disease relapsed or progressed since the date of the last report?
   - 1 ☐ yes →
   - 2 ☐ no
   - 3 ☐ unknown

   4. Date of progression / relapse: Month Day 20 Year ☐ date unknown

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 414-805-0714 or Minneapolis 612-627-5895).

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5. *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

6. 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

7. Date of response: Month Day Year
☐ date unknown

Specify site(s) of tumor recurrence / progression:

8. 1 ☐ yes 2 ☐ no 3 ☐ unknown Cerebrospinal fluid
9. 1 ☐ yes 2 ☐ no 3 ☐ unknown Extraneural
10. 1 ☐ yes 2 ☐ no 3 ☐ unknown Distant intracranial parenchymal
11. 1 ☐ yes 2 ☐ no 3 ☐ unknown Intracranial leptomeningeal
12. 1 ☐ yes 2 ☐ no 3 ☐ unknown Spinal leptomeningeal
13. 1 ☐ yes 2 ☐ no 3 ☐ unknown Local primary site
14. 1 ☐ yes 2 ☐ no 3 ☐ unknown Other site →
15. Specify site: _____

Post-HSCT Planned Treatment for CNS Disease

16. Was planned treatment given per protocol since the date of the last report? (Include any maintenance therapy, but exclude any treatment for persistent, progressive or recurrent disease.)
1 ☐ yes →
2 ☐ no

Radiation Therapy: 17. 1 ☐ yes 2 ☐ no → cont. with q. 38

Date radiation therapy started: 18. Month Day Year

Date radiation therapy stopped: 19. Month Day Year

Specify radiation field(s):

Whole brain	20. 1 ☐ yes 2 ☐ no	21. If yes, specify total dose:		cGy (rads)
Local cranial	22. 1 ☐ yes 2 ☐ no	23. If yes, specify total dose:		cGy (rads)
Craniospinal	24. 1 ☐ yes 2 ☐ no	25. If yes, specify total dose:		cGy (rads)
Gamma knife / radiosurgery	26. 1 ☐ yes 2 ☐ no	27. If yes, specify total dose:		cGy (rads)
Interstitial irradiation / brachytherapy	28. 1 ☐ yes 2 ☐ no	29. If yes, specify total dose:		cGy (rads)
Radioactive instillation	30. 1 ☐ yes 2 ☐ no	31. If yes, specify total dose:		cGy (rads)
Local spinal	32. 1 ☐ yes 2 ☐ no	33. If yes, specify total dose:		cGy (rads)
Other radiation field	34. 1 ☐ yes 2 ☐ no	35. If yes, specify total dose:		cGy (rads)

Specify other radiation field 36. _____

Specify fractionation schedule: 37. 1 ☐ single 2 ☐ single daily 3 ☐ multiple daily 4 ☐ other schedule

Surgical Biopsy / Resection: 38. 1 ☐ yes 2 ☐ no → cont. with q. 44

Date of surgery: 39. Month Day Year

Type of surgery: *(see codes at left)* 40.

Codes for Type of Surgery

1 Gross total resection – > 95% resection, no radiographic residual tumor
2 Near total resection – 90-95% resection, minimal radiographic residual tumor
3 Subtotal resection – 51-89% resection, moderate radiographic residual tumor
4 Partial resection – 10-50% resection, significant radiographic residual tumor
5 Biopsy only – < 10% resection, no radiographic change post-op from pre-op

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Today's Date: Month ___ Day ___ Year 20___

Infusion Date: Month ___ Day ___ Year 20___

CIBMTR Center Number:

Initials:

CIBMTR Center Number:

CIBMTR Recipient ID:

Codes for Size of Residual Tumor after Surgery

1 None (no radiographic residual tumor)
2 Less than 1.5 cm, with radiographic residual tumor
3 1.5 to less than 3.0 cm
4 3.0 to 6.0 cm
5 > 6.0 cm
6 Not evaluable
7 Unknown

Size of residual tumor after surgery *(see codes at left* 41. ☐

Was the extent of the surgical resection confirmed radiographically? 42. 1 ☐ yes 2 ☐ no 3 ☐ unknown

Was any persistent, viable tumor detected? 43. 1 ☐ yes 2 ☐ no 3 ☐ unknown

Best Response to Line of Therapy: *(see definitions at question 1)* 44. 1 ☐ CCR 2 ☐ CR 3 ☐ CRU 4 ☐ PR 5 ☐ NR 6 ☐ PD 7 ☐ not assessed → 45. If code 7, specify reason: 1 ☐ toxic death before disease evaluation 2 ☐ other reason

Date the best response, including planned post-HSCT treatment, was achieved: 46. Month ___ Day ___ Year ____

Copy this page to report more than one line of therapy; check here ☐ if additional pages are attached.

Post-HSCT Treatment for Persistent, Progressive, or Recurrent CNS Disease

47. Was treatment given for persistent, progressive or recurrent CNS disease since the date of the last report?

1 ☐ yes →
2 ☐ no

Systemic therapy: 48. 1 ☐ yes 2 ☐ no → cont. with q. 71

Date therapy started: 49. Month ___ Day ___ Year ____

Date therapy stopped: 50. Month ___ Day ___ Year ____

Number of cycles: 51. ___ ☐ unknown / not applicable

bleomycin (BLM, Blenoxane) 52. 1 ☐ yes 2 ☐ no

carboplatin (Paraplatin) 53. 1 ☐ yes 2 ☐ no

cisplatin (Platinol, CDDP) 54. 1 ☐ yes 2 ☐ no

corticosteroids 📖 55. 1 ☐ yes 2 ☐ no

cyclophosphamide (Cytoxan) 56. 1 ☐ yes 2 ☐ no

etoposide (VP-16, VePesid) 57. 1 ☐ yes 2 ☐ no

ifosfamide (Ifex) 58. 1 ☐ yes 2 ☐ no

melphalan (L-PAM, Alkeran) 59. 1 ☐ yes 2 ☐ no

methotrexate (MTX, Folex) 60. 1 ☐ yes 2 ☐ no

nitrosourea (carmustine) 61. 1 ☐ yes 2 ☐ no

procarbazine (Matulane) 62. 1 ☐ yes 2 ☐ no

temozolomide (Temodar) 63. 1 ☐ yes 2 ☐ no

thiotepa (Thioplex) 64. 1 ☐ yes 2 ☐ no

topotecan (Hycamtin) 65. 1 ☐ yes 2 ☐ no

vincristine (VCR, Oncovin) 66. 1 ☐ yes 2 ☐ no

other therapy 67. 1 ☐ yes 2 ☐ no

specify other therapy 68. _____

Hematopoietic growth factor? 69. 1 ☐ yes 2 ☐ no

# of chemo cycles used with: 70. 1 ☐ < 5 2 ☐ ≥ 5 3 ☐ unknown

Radiation Therapy: 71. 1 ☐ yes 2 ☐ no → cont. with q. 92

Date radiation therapy started: 72. Month ___ Day ___ Year ____

Date radiation therapy stopped: 73. Month ___ Day ___ Year ____

Specify radiation field(s):

Whole brain 74. 1 ☐ yes 2 ☐ no 75. If yes, specify total dose: ____ cGy (rads)

Local cranial 76. 1 ☐ yes 2 ☐ no 77. If yes, specify total dose: ____ cGy (rads)

Craniospinal 78. 1 ☐ yes 2 ☐ no 79. If yes, specify total dose: ____ cGy (rads)

CIBMTR Form 2125 (CNS) v1.0 (3–4) July 2007

For internal use only: Document F00523 version 1.0 Replaces: n/a

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☐ ___ year

Today's Date: Month ___ Day ___ Year 20__

Infusion Date: Month ___ Day ___ Year 20__

CIBMTR Center Number:

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Codes for Type of Surgery

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Codes for Size of Residual Tumor after Surgery

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2 Less than 1.5 cm, with radiographic residual tumor
3 1.5 to less than 3.0 cm
4 3.0 to 6.0 cm
5 > 6.0 cm
6 Not evaluable
7 Unknown

Gamma knife / radiosurgery 80. 1 ☐ yes 2 ☐ no 81. If yes, specify total dose: ____ cGy (rads)

Interstitial irradiation / brachytherapy 82. 1 ☐ yes 2 ☐ no 83. If yes, specify total dose: ____ cGy (rads)

Radioactive instillation 84. 1 ☐ yes 2 ☐ no 85. If yes, specify total dose: ____ cGy (rads)

Local spinal 86. 1 ☐ yes 2 ☐ no 87. If yes, specify total dose: ____ cGy (rads)

Other radiation field 88. 1 ☐ yes 2 ☐ no 89. If yes, specify total dose: ____ cGy (rads)

Specify other radiation field 90. _____

Specify fractionation schedule: 91. 1 ☐ single 2 ☐ single daily 3 ☐ multiple daily 4 ☐ other schedule

Surgical Biopsy / Resection: 92. 1 ☐ yes 2 ☐ no → cont. with q. 98

Date of surgery: 93. Month ___ Day ___ Year ____

Type of surgery: *(see codes at left)* 94. ___

Size of residual tumor after surgery *(see codes at left)* 95. ___

Was the extent of the surgical re-section confirmed radiographically? 96. 1 ☐ yes 2 ☐ no 3 ☐ unknown

Was any persistent, viable tumor detected? 97. 1 ☐ yes 2 ☐ no 3 ☐ unknown

Best Response to Line of Therapy: *(see definitions at question 1)* 98. 1 ☐ CCR 2 ☐ CR 3 ☐ CRU 4 ☐ PR 5 ☐ NR 6 ☐ PD 7 ☐ not assessed → 99. If code 7, specify reason: 1 ☐ toxic death before disease evaluation 2 ☐ other reason

Date the best response to post-HSCT treatment was achieved: 100. Month ___ Day ___ Year ____

Copy this page to report more than one line of therapy; check here ☐ if additional pages are attached.

Disease Status at the Time of Assessment for This Reporting Period

101. What is the current disease status?
1 ☐ complete remission
2 ☐ not in complete remission

102. Date the current disease status was established in this reporting period: Month ___ Day ___ Year 20__

103. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

CIBMTR Form 2125 (CNS) v1.0 (4–4) July 2007

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