Disease Assessment at the Time of Best Response to HSCT

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.)

<table>
<thead>
<tr>
<th>Response</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>continued complete response (CCR)</td>
<td>Continued absence of all disease after a complete response from the pre-HSCT disease status</td>
</tr>
<tr>
<td>complete response (CR)</td>
<td>Complete disappearance of all sites of known disease for &gt; 4 weeks</td>
</tr>
<tr>
<td>complete response undetermined (CRU)</td>
<td>Complete response with persistence of radiographic enhancing abnormalities of unknown significance</td>
</tr>
<tr>
<td>partial response (PR)</td>
<td>ñ 50% reduction in greatest diameter of all sites of known disease, and no new sites of disease for &gt; 4 weeks</td>
</tr>
<tr>
<td>no response (NR)</td>
<td>&lt; 50% reduction in greatest diameter of any known sites of disease, and no new sites of disease for &gt; 4 weeks</td>
</tr>
<tr>
<td>progressive disease (PD)</td>
<td>Increase in size of any site of known disease, or any new sites of disease</td>
</tr>
<tr>
<td>not assessed</td>
<td></td>
</tr>
</tbody>
</table>

2. Date best response first began: Month Day Year

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.”

Relapse or Progression Post-HSCT

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>no</td>
<td></td>
</tr>
<tr>
<td>unknown</td>
<td></td>
</tr>
</tbody>
</table>

4. Date of progression / relapse: Month Day Year

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.
### 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

<table>
<thead>
<tr>
<th>Radiation Therapy:</th>
<th>Date radiation therapy started:</th>
<th>Date radiation therapy stopped:</th>
</tr>
</thead>
</table>

Specify radiation field(s):
- Whole brain
- Local cranial
- Craniospinal
- Gamma knife / radiosurgery
- Local spinal
- Other radiation field

Specify fractionation schedule:
- Single dose
- Single daily
- Multiple daily
- Other schedule

Surgical Biopsy / Resection:
38. [ ] yes 2. [ ] no 3. unknown

<table>
<thead>
<tr>
<th>Date of surgery:</th>
<th>Type of surgery:</th>
<th>cont. with q. 44</th>
</tr>
</thead>
</table>

Specify site(s) of tumor recurrence / progression:
- Cerebrospinal fluid
- Extraneural
- Distant intracranial parenchymal
- Intracranial leptomeningeal
- Spinal leptomeningeal
- Local primary site
- Other site

Specify site:

<table>
<thead>
<tr>
<th>Site:</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

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

Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
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

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
cyclophosphamide (Ifex) 58. 1  yes 2  no
corticosteroids 59. 1  yes 2  no
cyclophosphamide (Cytoxan) 60. 1  yes 2  no
etoposide (VP-16, VePesid) 61. 1  yes 2  no
}

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Fax this form to your designated campus (Milwaukee 414-805-0714 or Minneapolis 612-627-5895).
Gamma knife / radiosurgery

If yes, specify total dose: cGy (rads)

Interstitial irradiation / brachytherapy

If yes, specify total dose: cGy (rads)

Radioactive instillation

If yes, specify total dose: cGy (rads)

Local spinal

If yes, specify total dose: cGy (rads)

Other radiation field

If yes, specify total dose: cGy (rads)

Specify other radiation field

Specify fractionation schedule:

Surgical Biopsy / Resection:

Date of surgery:

Type of surgery:

Size of residual tumor after surgery

Was the extent of the surgical resection confirmed radiographically?

Was any persistent, viable tumor detected?

Best Response to Line of Therapy:

Date the best response to post-HSCT treatment was achieved:

Disease Status at the Time of Assessment for This Reporting Period

What is the current disease status?

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

Signed:

Person completing form

Please print name:

Phone: (________) __________________________

Fax: (________) __________________________

E-mail address: __________________________

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