ERROR CORRECTION FORM

Sequence Number: ______________ CIBMTR Recipient ID: ______________

Visit: ☐ 100 day ☐ 6 month ☐ ___ year

Today's Date: Month __ Day __ Year 20__ Infusion Date: Month __ Day __ Year 20__ CIBMTR Center Number: ______ Initials: ______

Neuroblastoma Post-HSCT Data

Registry Use Only

Sequence Number: ______

Date Received: ______

CIBMTR Center Number: ______

CIBMTR Recipient ID: ______

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

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 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 ^{99}Tc 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 exisiting 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 catecholemines
16. 1 ☐ yes 2 ☐ no Other site ➤ 17. Specify: ______

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

ERROR CORRECTION FORM

Sequence Number: CIBMTR Recipient ID:

Visit: ☐ 100 day ☐ 6 month ☐ __ year

Today's Date: __ __ 20__ (Month, Day, Year) Infusion Date: __ __ 20__ (Month, Day, Year) CIBMTR Center Number: Initials:

CIBMTR Center Number: CIBMTR Recipient ID:

18. Specify the date best response was determined: __ __ __ (Month, Day, Year) ☐ date previously reported

19. Were tumor markers evaluated for the best response post-HSCT determination?
   1 ☐ yes → Specify the following tumor marker analyses performed:
   2 ☐ no

Date of best response determination: Month Day Year

20. Homovanillic acid (HVA):
   1 ☐ known → ___ . _ µg/mg creatinine 21. __ __ __
   2 ☐ not known

22. Neuron specific enolase:
   1 ☐ known → __ . __ ng/mL 23. __ __ __
   2 ☐ not known

24. Serum ferritin:
   1 ☐ known → ____ ng/mL or µg/L 25. __ __ __
   2 ☐ not known

26. Vanilmandelic acid (VMA):
   1 ☐ known → ___ . _ µg/mg creatinine 27. __ __ __
   2 ☐ not known

28. Other tumor marker analysis:
   1 ☐ known → 29. Specify other analysis: ______ 30. Specify level and units: ______
   2 ☐ not known

31. Was the recipient given planned per protocol post-HSCT treatment for neuroblastoma?
   1 ☐ yes →
   2 ☐ no

32. Was radiotherapy given?
   1 ☐ yes → Specify the site(s) of radiotherapy:
   2 ☐ no

33. 1 ☐ yes 2 ☐ no Bone metastases
34. 1 ☐ yes 2 ☐ no Primary tumor
35. 1 ☐ yes 2 ☐ no Other site → 36. Specify: ______
37. Specify the date radiotherapy was started: __ __ __ (Month, Day, Year)
38. Number of frations given: __
39. Dose per fraction: ____ cGy (rads)

40. Was MIBG given?
   1 ☐ yes → Specify the radioisotope given:
   2 ☐ no

41. 1 ☐ yes 2 ☐ no ^{131}I-MIBG
42. 1 ☐ yes 2 ☐ no Other → 43. Specify: ______
44. Specify the date MIBG treatment was performed: __ __ __ (Month, Day, Year)

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ERROR CORRECTION FORM

Sequence Number: | | | | | | | | | | | | | | |

CIBMTR Recipient ID: | | | | | | | | | | |

Visit:
- ☐ 100 day
- ☐ 6 month
- ☐ ___ year

Today's Date: ___ ___ Month ___ ___ Day 2 0 ___ ___ Year

Infusion Date: ___ ___ Month ___ ___ Day 2 0 ___ ___ Year

CIBMTR Center Number: | | | | | |

Initials: ______

CIBMTR Center Number: | | | | | | CIBMTR Recipient ID: | | | | | | | | | | |

45. Were retinoids given?
    - 1 ☐ yes → Specify the retinoids given:
      - 46. 1 ☐ yes 2 ☐ no Isotretinoin
      - 47. 1 ☐ yes 2 ☐ no Other → 48. Specify: ______
      - 49. Specify the date retinoid treatment was started: ___ ___ Month ___ ___ Day ___ ___ ___ ___ Year
    - 2 ☐ no

50. Was immunotherapy given?
    - 1 ☐ yes → Specify the drug(s) given:
      - 51. 1 ☐ yes 2 ☐ no α-interferon
      - 52. 1 ☐ yes 2 ☐ no Anti-GD2 antibody CH14.18
      - 53. 1 ☐ yes 2 ☐ no Interleukin-2 (IL-2)
      - 54. 1 ☐ yes 2 ☐ no Other → 55. Specify: ______
      - 56. Specify the date immunotherapy was started: ___ ___ Month ___ ___ Day ___ ___ ___ ___ Year
    - 2 ☐ no

57. Was chemotherapy given?
    - 1 ☐ yes → Specify the treatment(s) given:
      - 58. 1 ☐ yes 2 ☐ no Adriamycin
      - 59. 1 ☐ yes 2 ☐ no Cisplatin
      - 60. 1 ☐ yes 2 ☐ no Cyclophosphamide
      - 61. 1 ☐ yes 2 ☐ no Dacarbazine (DTIC)
      - 62. 1 ☐ yes 2 ☐ no Etoposide (VP16)
      - 63. 1 ☐ yes 2 ☐ no Ifosfamide
      - 64. 1 ☐ yes 2 ☐ no Melphalan (L-PAM)
      - 65. 1 ☐ yes 2 ☐ no Teniposide (VM26)
      - 66. 1 ☐ yes 2 ☐ no Vincristine
      - 67. 1 ☐ yes 2 ☐ no Other → 68. Specify: ______
      - 69. Specify the date chemotherapy was started: ___ ___ Month ___ ___ Day ___ ___ ___ ___ Year
    - 2 ☐ no

70. Was other treatment given?
    - 1 ☐ yes →
      - 71. Specify other treatment: ______
      - 72. Specify the date other treatment was started: ___ ___ Month ___ ___ Day ___ ___ ___ ___ Year
    - 2 ☐ no

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ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Visit: ☐ 100 day ☐ 6 month ☐ __ year

Today's Date: Month / Day / Year 20__ | Infusion Date: Month / Day / Year 20__ | CIBMTR Center Number: | Initials:

CIBMTR Center Number: | CIBMTR Recipient ID:

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)

Question	Site	Date determined (Month / Day / Year)
74. 1 ☐ yes 2 ☐ no	Adrenal gland →	75. __ __ 20__
76. 1 ☐ yes 2 ☐ no	Bone →	77. __ __ 20__
78. 1 ☐ yes 2 ☐ no	Bone marrow →	79. __ __ 20__
80. 1 ☐ yes 2 ☐ no	Cerebellum →	81. __ __ 20__
82. 1 ☐ yes 2 ☐ no	Cerebrospinal fluid (CSF) →	83. __ __ 20__
84. 1 ☐ yes 2 ☐ no	Cerebrum →	85. __ __ 20__
86. 1 ☐ yes 2 ☐ no	Cranial nerves →	87. __ __ 20__
88. 1 ☐ yes 2 ☐ no	Liver →	89. __ __ 20__
90. 1 ☐ yes 2 ☐ no	Lymph nodes →	91. __ __ 20__
92. 1 ☐ yes 2 ☐ no	Mediastinum →	93. __ __ 20__
94. 1 ☐ yes 2 ☐ no	Paraspinal ganglion →	95. __ __ 20__
96. 1 ☐ yes 2 ☐ no	Retro-orbital area →	97. __ __ 20__
98. 1 ☐ yes 2 ☐ no	Skin / subcutaneous tissue →	99. __ __ 20__
100. 1 ☐ yes 2 ☐ no	Other site →	101. __ __ 20__

102. Specify other site: ____________________

Specify the methods used to examine sites of disease recurrence / persistence / progression: | Specify disease status:

Question	Method	Disease status
103. 1 ☐ yes 2 ☐ no	Biopsy →	104. 1 ☐ positive 2 ☐ negative
105. 1 ☐ yes 2 ☐ no	Bone scan →	106. 1 ☐ positive 2 ☐ negative
107. 1 ☐ yes 2 ☐ no	Radiology →	108. 1 ☐ positive 2 ☐ negative
109. 1 ☐ yes 2 ☐ no	Other method →	110. 1 ☐ positive 2 ☐ negative

111. Specify other method: ____________________

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Today's Date: Month __ Day __ Year 2 0 __ | Infusion Date: Month __ Day __ Year 2 0 __ | CIBMTR Center Number: | Initials:

CIBMTR Center Number: | CIBMTR Recipient ID:

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: Month __ Day __ Year 2 0 __

119. Number of fractions given: __

120. Dose per fraction: ____ cGy (rads)

121. Was MIBG given?
- 1 ☐ yes →
- 2 ☐ no

Specify the radioisotope given:
- 122. 1 ☐ yes 2 ☐ no ^{131}I-MIBG
- 123. 1 ☐ yes 2 ☐ no Other → 124. Specify: ______

125. Specify the date MBIG treatment was performed: Month __ Day __ Year 2 0 __

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: Month __ Day __ Year 2 0 __

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: Month __ Day __ Year 2 0 __

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: Month __ Day __ Year 2 0 __

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- ☐ ___ year

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

Infusion Date: Month ___ Day ___ Year 20__

CIBMTR Center Number:

Initials:

CIBMTR Center Number:

CIBMTR Recipient ID:

151. Was other treatment given?
   1 ☐ yes →
   2 ☐ no

152. Specify other treatment: ___

153. Specify the date other treatment was started: Month ___ Day ___ Year 20__

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

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

156. Signed: ___
Person completing form

Please print name: ___

Phone: (___) ___

Fax: (___) ___

E-mail address: ___

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