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

Langerhans Cell Histiocytosis 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 ☐ 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.

1. What was the best response to HSCT, excluding any planned post-HSCT therapy, since the date of the last report?
   1 ☐ complete response — absence of all signs and/or symptoms of Langerhans cell histiocytosis
   2 ☐ partial response — regression of signs and/or symptoms of disease without appearance of new lesions
   3 ☐ stable disease — persistence of signs and/or symptoms of disease without appearance of new lesions
   4 ☐ mixed response — regression of some signs and/or symptoms of disease with appearance of new lesions
   5 ☐ progressive disease — progression of signs and/or symptoms of disease initially detected and/or reappearance of old and/or appearance of new lesions
   6 ☐ unknown
   7 ☐ not evaluable → 2. Specify reason: _____

3. Specify the date best response was determined: Month Day Year

4. Did the disease recur or progress since the date of the last report?
   1 ☐ yes →
   2 ☐ no
   3 ☐ unknown

   Specify the organ(s) involved in the disease recurrence or progression:
   5. 1 ☐ yes 2 ☐ no 3 ☐ unknown Bone
   6. 1 ☐ yes 2 ☐ no 3 ☐ unknown Bone marrow
   7. 1 ☐ yes 2 ☐ no 3 ☐ unknown Central nervous system
   8. 1 ☐ yes 2 ☐ no 3 ☐ unknown Gastrointestinal tract
   9. 1 ☐ yes 2 ☐ no 3 ☐ unknown Liver
   10. 1 ☐ yes 2 ☐ no 3 ☐ unknown Lung
   11. 1 ☐ yes 2 ☐ no 3 ☐ unknown Lymph nodes
   12. 1 ☐ yes 2 ☐ no 3 ☐ unknown Skin
   13. 1 ☐ yes 2 ☐ no 3 ☐ unknown Spleen
   14. 1 ☐ yes 2 ☐ no 3 ☐ unknown Other organ → 15. Specify: _____

   16. Specify the date disease recurrence or progression was determined: Month Day 20 Year

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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17. Was any additional treatment specifically for LCH given since the date of the last report?
1 ☐ yes →
2 ☐ no

18. Specify the date treatment started: Month Day Year ☐ date unknown

Specify any additional drugs given since the date of the last report:

19. 1 ☐ yes 2 ☐ no 3 ☐ unknown 2 CdA (cladribine)
20. 1 ☐ yes 2 ☐ no 3 ☐ unknown Chlorambucil (Leukeran)
21. 1 ☐ yes 2 ☐ no 3 ☐ unknown Cyclosporin-A (CsA)
22. 1 ☐ yes 2 ☐ no 3 ☐ unknown Etoposide (VP-16)
23. 1 ☐ yes 2 ☐ no 3 ☐ unknown Mercaptopurine (6-MP, Purinethol)
24. 1 ☐ yes 2 ☐ no 3 ☐ unknown Steroids
25. 1 ☐ yes 2 ☐ no 3 ☐ unknown Vinblastine (Velban)
26. 1 ☐ yes 2 ☐ no 3 ☐ unknown Other drug →

27. Specify: _____

28. Was radiation given since the date of the last report?
1 ☐ yes →
2 ☐ no
3 ☐ unknown

Specify the site(s) of radiation: Total cGy (rads) given:

29. 1 ☐ yes 2 ☐ no Bone → 30.
31. 1 ☐ yes 2 ☐ no Central nervous system → 32.
33. 1 ☐ yes 2 ☐ no Gastrointestinal tract → 34.
35. 1 ☐ yes 2 ☐ no Liver → 36.
37. 1 ☐ yes 2 ☐ no Lung → 38.
39. 1 ☐ yes 2 ☐ no Lymph nodes → 40.
41. 1 ☐ yes 2 ☐ no Skin → 42.
43. 1 ☐ yes 2 ☐ no Spleen → 44.
45. 1 ☐ yes 2 ☐ no Other site → 46.

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

48. Was any other treatment for LCH administered?
1 ☐ yes →
2 ☐ no
3 ☐ unknown

49. Specify other treatment: _____

50. Are any of the additional treatments still currently being administered?
1 ☐ yes
2 ☐ no
3 ☐ unknown

CIBMTR Form 2140 (LCH) v1.0 (2–3) July 2007

For internal use only: Document F00553 version 1.0 Replaces: n/a

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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 Number:

CIBMTR Recipient ID:

51. What is the current status of Langerhans cell histiocytosis? (*For recipients who died since the date of the last report, report the disease status at the time of death.)*

1 ☐ complete response — absence of all signs and/or symptoms of Langerhans cell histiocytosis
2 ☐ partial response — regression of signs and/or symptoms of disease without appearance of new lesions
3 ☐ stable disease — persistence of signs and/or symptoms of disease without appearance of new lesions
4 ☐ mixed response — regression of some signs and/or symptoms of disease with appearance of new lesions
5 ☐ progressive disease — progression of signs and/or symptoms of disease initially detected and/or reappearance of old and/or appearance of new lesions
6 ☐ unknown
7 ☐ not evaluable → 52. Specify reason: _____

53. Specify the date the current disease status was determined: Month ____ Day ____ 20__ Year

54. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____

CIBMTR Form 2140 (LCH) v1.0 (3–3) July 2007

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