

Pediatric Heart Transplant Study

Form 07r: Malignancy/Lymphoproliferative Disease

ID#	P	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
P	Institution Code	Sequential Patient Number	Patient Initials		

1. Date of Diagnosis (mon-day-yr): - -

2. Initial Diagnosis
 Recurrence of previously diagnosed malignancy thought to be "cured".
 If recurrence, date of previous diagnosis (month-year): ____ - ____

3. Nature of Malignancy (check only one, complete additional form(s) for other malignancies):

<input type="checkbox"/> Lymphoproliferative Disease/Lymphoma	<input type="checkbox"/> Sarcoma
<input type="checkbox"/> Skin: Basal Cell Carcinoma	<input type="checkbox"/> Prostate carcinoma
<input type="checkbox"/> Skin: Squamous cell carcinoma	<input type="checkbox"/> Renal Cell Carcinoma
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Lung Carcinoma
<input type="checkbox"/> Hepatoma (primary liver)	<input type="checkbox"/> Colon Carcinoma
<input type="checkbox"/> Endometrial	<input type="checkbox"/> Gastric Carcinoma
<input type="checkbox"/> Cervical	<input type="checkbox"/> Breast Carcinoma
<input type="checkbox"/> CNS, specify: _____	
<input type="checkbox"/> Other, specify: _____	

4. Site(s) of involvement at initial diagnosis (check all that apply):

<input type="checkbox"/> CNS	<input type="checkbox"/> Pulmonary (lung)	<input type="checkbox"/> Breast
<input type="checkbox"/> Bone Marrow	<input type="checkbox"/> Bone	<input type="checkbox"/> Muscle
<input type="checkbox"/> Skin, non-facial	<input type="checkbox"/> Skin, facial/scalp	<input type="checkbox"/> Hepatic
<input type="checkbox"/> GI, Stomach	<input type="checkbox"/> GI, Small Bowel	<input type="checkbox"/> GI, Large Bowel
<input type="checkbox"/> GI, Rectal	<input type="checkbox"/> Mucous Membranes, craniofacial	<input type="checkbox"/> Mucous membranes, genital/anal
<input type="checkbox"/> Lymph nodes, subcutaneous	<input type="checkbox"/> Lymph nodes, deep	<input type="checkbox"/> Prostate
<input type="checkbox"/> Other, specify: _____		

5. If Lymphoproliferative / Lymphoma:

a. Epstein-Barr Seroconversion (negative to positive titer post transplant)? No Yes

b. If "5a" is Yes: Date Last Negative EBV titer: ____ - ____ - ____
 Date Last Positive EBV titer: ____ - ____ - ____

c. Was clonal analysis performed: No Yes, if yes: monoclonal polyclonal

d. Multiple sites and/or locations at presentation: Yes No

6. Diagnosis made histologically? (either ante or post mortem): Yes No. If no, describe means of diagnosis

7. Immunotherapy at time of malignancy and any changes made due to diagnosis within 30 days of dx (specify):

	Initial Dose/Units	Date Reduced	New Dose/Units
<input type="checkbox"/> Cyclosporine:	_____	____ - ____ - ____	_____
<input type="checkbox"/> Tacrolimus (FK-506)	_____	____ - ____ - ____	_____
<input type="checkbox"/> Azathioprine	_____	____ - ____ - ____	_____
<input type="checkbox"/> Mychophenolate (Cellcept)	_____	____ - ____ - ____	_____
<input type="checkbox"/> Steroids	_____	____ - ____ - ____	_____
<input type="checkbox"/> Other, specify _____	_____	____ - ____ - ____	_____

8. Additional therapeutic measures started within 30 days of diagnosis (check all that apply):

Ganciclovir (DHPG)

Chemotherapy

Radiation therapy

Surgery (excision, not performed solely for diagnostic purposes)

Other, specify: _____

Person Completing this form: _____ Date Original Form Mailed (do not send copy) _____

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