Pediatric Heart Transplant Study

Form 0799: **Malignancy/Lymphoproliferative Disease**

ID# P [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

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):

- ❑ Lymphoproliferative Disease/Lymphoma
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Squamous cell carcinoma
- ❑ Melanoma
- ❑ Hepatoma (primary liver, not metastatic to liver)
- ❑ Endometrial
- ❑ Cervical
- ❑ Sarcoma
- ❑ Prostate carcinoma
- ❑ Renal Cell Carcinoma
- ❑ Lung Carcinoma
- ❑ Colon Carcinoma
- ❑ Gastric Carcinoma
- ❑ Breast Carcinoma
- ❑ CNS, specify: ____________________
- ❑ Other, specify: ____________________

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

- ❑ CNS
- ❑ Bone Marrow
- ❑ Skin, non-facial
- ❑ GI, Stomach
- ❑ GI, Rectal
- ❑ Lymph nodes, subcutaneous
- ❑ Pulmonary (lung)
- ❑ Bone
- ❑ Skin, facial/scalp
- ❑ GI, Small Bowel
- ❑ Mucous Membranes, craniofacial
- ❑ Lymph nodes, deep
- ❑ Breast
- ❑ Muscle
- ❑ Hepatic
- ❑ GI, Large Bowel
- ❑ Mucous membranes, genital/anal
- ❑ Prostate
- ❑ Other, specify:____________________

5. If Lymphoproliferative/ Lymphoma:

a Ebstein-Barr Seroconversion (negative pre transplant 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	Not Changed	Discontinued	New Dose/Units
❑ Cyclosporine (❑Sandimmune ❑Neoral)	________	❑	❑	________
❑ Tacrolimus (FK-506):	________	❑	❑	________
❑ Azathioprine	________	❑	❑	________
❑ Mychophenolate (Cellcept)	________	❑	❑	________
❑ Steroids, specify:__________	________	❑	❑	________
❑ Other, specify__________	________	❑	❑	________

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

- ❑ Ganciclovir (Cytovene)
- ❑ 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):__________

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS FROM January 1, 1999.

2/14/99 RCB