Pediatric Heart Transplant Study

FORM 07$_{05}$: Malignancy/Lymphoproliferative Disease

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ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐

P	Institution Code	Sequential Patient Number	Patient Initials

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

2. Weight at time of diagnosis: _____ ☐lb ☐kg

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

4. Nature of Malignancy (check only one, complete additional form(s) for other malignancies):
- ☐ Lymphoproliferative Disease/Lymphoma
- ☐ Sarcoma
- ☐ Skin
- ☐ Other, specify: _____

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

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

6. If Lymphoproliferative/Lymphoma:
a. Ebstein-Barr Seroconversion (negative pre transplant to positive titer post transplant)? ☐ No ☐ Yes
b. If "6a" is Yes: Date Last Negative EBV titer: __ __ - __ __ - __ __ ☐ Not Done
Date Last Positive EBV titer: __ __ - __ __ - __ __ ☐ Not Done
c. Was clonal analysis performed: ☐ No ☐ Yes, if yes: ☐ monoclonal ☐ polyclonal ☐ T cell ☐ B cell
d. EBV PCR: ☐ Positive ☐ Negative ☐ Quantitative _____ DNA copies/ml
Is tumor EBV positive: ☐ Yes ☐ No
WHO classification:
i. Polymorphic PTLD
ii. Monomorphic PTLD, if yes check boxes for: ☐ diffuse large B cell ☐ Burkitts ☐ Other
iii. Hodgkin's/Hodgkin's-like
iv. Other _____

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

	Initial Dose (mg/day)	Not Changed	Discontinued	New Dose 30 days after diagnosis
☐ Acyclovir	_____	☐	☐	_____mg/day
☐ Azathioprine (Imuran)	_____	☐	☐	_____ mg/day
☐ Cyclosporine: ☐Sandimmune ☐Neoral ☐Gengraf	_____	☐	☐	_____ mg/day
☐ Mycophenolate (Cellcept)	_____	☐	☐	_____ mg/day
☐ Sirolimus (Rapamycin)	_____	☐	☐	_____ mg/day
☐ Steroids, specify: _____	_____	☐	☐	_____ mg/day
☐ Tacrolimus (Prograf, FK506)	_____	☐	☐	_____ mg/day
☐ Other, specify: _____	_____	☐	☐	_____ mg/day

8. Additional therapeutic measures started within 30 days of diagnosis (check all that apply):
- ☐ Chemotherapy
- ☐ Ganciclovir or Valganciclovir
- ☐ Radiation therapy
- ☐ Rituximab
- ☐ 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 AFTER JANUARY 1, 2005