PEDIATRIC HEART TRANSPLANT STUDY

FORM 07: 2010: **Malignancy/Lymphoproliferative Disease** (PG 1 of 1)
To be filled out post-transplant

ID# **P** ☐☐☐ ☐☐☐☐ ☐☐☐ ☐

P	Instituitional Code	Sequential Patient Number	Patient Initials	Tran #

1. Date of Diagnosis: (MO | 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 ☐ Skin
☐ Sarcoma ☐ 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 ☐ Unknown

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 *or* ☐ polyclonal | ☐ T cell *or* ☐ 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):

	No dose change	Dose decreased	Drug discontinued	Drug added
☐ Acyclovir	☐	☐	☐	☐
☐ Azathioprine (Imuran)	☐	☐	☐	☐
☐ Cyclosporine: ☐ Sandimmune ☐ Neoral ☐ Gengraf	☐	☐	☐	☐
☐ Mycophenolate (Cellcept, Myfortic)	☐	☐	☐	☐
☐ Sirolimus (Rapamycin)	☐	☐	☐	☐
☐ Steroids, specify: _____	☐	☐	☐	☐
☐ Tacrolimus (Prograf, FK506)	☐	☐	☐	☐
☐ Other, specify: _____	☐	☐	☐	☐

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

☐ Chemotherapy ☐ Rituximab
☐ Ganciclovir or Valganciclovir ☐ Surgery (excision, not performed solely for diagnostic purposes)
☐ Radiation therapy ☐ Other, specify: _____

Person completing this form: _____ Date original form mailed (do not send copy) _____

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