Post-Transplant Malignancy Fields

The Post-Transplant Malignancy record is generated after a malignancy has been reported in the Transplant Recipient Follow-up (TRF) record . The record should be completed by the transplant center responsible for follow-up of the recipient at the time the cancer was reported. If the patient has more than one follow-up record because of a multi-organ transplant, the malignancy only needs to be reported in one of the follow-up records. If it is reported in more than one, only one Post-Transplant Malignancy record will be generated.

If **Yes** was selected for Post Transplant Malignancies, along with one or more of the post transplant malignancies listed on the TRF record, the following sections will display in the Post-Transplant Malignancy record: Donor Related, Recurrence of Pretransplant Malignancy, Post Transplant De Novo Solid Tumor and/or Post Tx Lymphoproliferative Disease and Lymphoma. To change the section of the malignancy record that was generated, re-access the TRF record and select **No** to the section that is not needed, and select **Yes** to the section of the malignancy record that is needed. To delete the malignancy record, re-access the TRF record and select **No** in the Post Transplant Malignancies field.

Note: If no information is available about the malignancy except the fact that they were treated, contact the UNet Help Desk. They will work with the DMS department to have the Post Transplant Malignancy record validated.

View OPTN/UNOS Policy on Data Submission Requirements for additional information.

To correct information that is already displayed in an electronic record, call 1-800-978-4334.

Recipient Information

The following fields reported in the recipient's last completed TRF record will display.

Recipient name: Verify the last name, first name and middle initial of the transplant recipient.

Date of birth: Verify the recipient's date of birth.

Recipient SSN: Verify the recipient's social security number.

Recipient organ: Verify the type of organ transplanted.

TRF: Verify the Transplant Recipient Follow-up record number from which this malignancy record was generated.

Follow-up code: Verify the TRF Follow-up Code for the record from which this malignancy record was generated.

Transplant date: Verify that the displayed transplant date is the date of the beginning of the first anastomosis. If the operation started in the evening and the first anastomosis began early the next morning, the transplant date is the date that the first anastomosis began. The transplant is considered complete when the cavity is closed and the final skin stitch/staple is applied.

Follow-up center: Verify that the follow-up center listed is responsible for the follow-up of the recipient at the time the cancer was reported.

Recipient center: Verify that the transplant center listed is where the transplant procedure took place.

Donor Related

This section will only display if Yes was selected for Donor Related on post transplant malignancies listed in the TRF record.

Tumors transmitted from the donor

In most instances the donor does not have a history of cancer and transmission of cancer is unexpected. This occurrence is usually discovered when multiple recipients of organs from a single donor develop the same cancer (e.g. Melanoma). It may also occur when the clinical (not histological) diagnosis of primary brain cancer is made when, in fact, the donor had a metastatic brain cancer from an occult (concealed from observation) primary site.

Diagnosis Date: Enter the date of diagnosis. This date is in MM/DD/YYYY format and must fall within the follow-up period and after the transplant date that is displayed.

Immunosuppression: Select whether immunosuppression was stopped, reduced or if there was no adjustment. If the immunosuppression was changed or altered in any way, select **Immunosuppression Reduced**. This field is optional.

Immunosuppression Stopped
Immunosuppression Reduced
No Immunosuppression Adjustment

Type of Tumor: Select whether or not the cancer was primary to the transplanted organ.

Specify treatment: Select the type of treatment used for this type of tumor. This field is optional.

Surgical resection tumor: Select if surgical resection was used.

Chemotherapy: If chemotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

CHOP
MACOP-B
Pro-Mace-CytaBOM
M-BACOD
5FU/Gemzar
5FU/Leucovorin
5FU/Leucovorin/CPT-11
5FU/Mitomycin
ACDA
Adriamycin
Anedia
Bleomycin/Cisplatin/Etoposide
Carboplatin/Etoposide
Carboplatin/Taxol/Gemcitabine
Carboplatin/VP-16
Cisplatin/VP-16
Cyclophosphamide
Cyclophosphamide/Prednisone
Cytoxan
Cytoxan/Adriamycin
Cytoxan/Onkovin/Adriamycin/Prednisone
DHAP
Doxorubicin
Doxorubicin/and/Streptozocin
EPOCH
Etoposide/Doxorubicin/Vincristine
Etropralide/Ifosfamide
Eulexin/Lupron
Gemcitabine
Leucovorin/Methotrexate
Lupron
Melphazan/Prednisone
Methotrexate

Mitomycin/Carboplatin
Navelbine/Taxol
Nilandron
Tamoxifen
Taxol/5FU/Carb
Taxol/Adriamycin
Taxol/Carboplatin
Taxol/Carboplatin/Zofran
Topotecan
Vidarabine/Cisplatin/Dexamethasone
Vincristine
Vincristine/Prednisone
VP16
VP16/Etoposide
Carboplatin/Gemcitabine
Other, specify

Radiation: Select if radiation therapy was used.

Immunotherapy: If immunotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

Hormonal Therapy
Interferon Alpha
Prednisone
Rituximab
Other, specify

Other Treatment Specify: Enter the name of any other tumor treatment that was given.

Outcome: Select whether the recipient is **Alive**, **Free of Tumor**; **Alive with Tumor**; **Dead, due to tumor**; or **Dead, other causes**. This field is optional.

Recurrence of Pretransplant Malignancy

This section will only display if Yes was selected for Recurrence of Pretransplant Malignancy on post transplant malignancies listed in the TRF record.

The patient has a past history of cancer, and develops the same type of cancer post-transplantation. This does not apply to basal cell or squamous cell carcinoma of the skin, unless it recurs in the original site. The patient has a cancer in an explanted (removed) organ (usually liver or maybe kidney), and later develops a recurrence of the same type of cancer. For example, the patient has a hepatocellular carcinoma of the native liver (hepatoma), which is resected at the time of transplantation, and develops a recurrent hepatocellular carcinoma (at any site, at any time).

Type of pre-existing tumor: Select type of pre-existing tumor from the list provided.

Skin (Squamous, Basal Cell)
Skin - Melanoma
Genitourinary - Bladder
Genitourinary - Uterine Cervix
Genitourinary - Uterine Body (endometrial & choriocarcinoma)
Genitourinary - Vulva
Genitourinary - Ovarian
Genitourinary - Testicular
Genitourinary - Prostate
Genitourinary - Kidney
Gastrointestinal - Stomach
Gastrointestinal - Small Intestine

Gastrointestinal - Carcinoid
Gastrointestinal - Colo-Rectal
Gastrointestinal - Liver/Biliary Tract (incidental time of hepatectomy)
Gastrointestinal - Liver/Biliary tract, not incidental
Gastrointestinal - Pancreas
Thyroid
Breast
Tongue/Mouth,Pharynx
Larynx
Lung (include bronchial)
Leukemia
Lymphoma
Other Cancer, Specify

If skin, # of occurrences in follow-up period: Indicate the number of skin tumors during the follow-up period. This field is optional.

If Colo-rectal, Duke's Classification: If **Colo-rectal** is selected, provide the Duke's classification: This field is optional.

Duke's Classification:

Dukes A - Tumor is limited to the mucosa (Inner lining)
Dukes B - Tumor is limited to the muscularis (muscle wall)
Dukes C - Tumor extends through the bowel wall and has nodal metastasis.
Unknown

If Lymphoma, specify type: Specify the type of Lymphoma. This field is optional.

If Leukemia: Select the type of Leukemia. This field is optional.

AML (acute myelocytic leukemia)
ALL (acute lymphocytic leukemia)
MDS (myelodysplasia syndrome)
CML (chronic myelocytic leukemia)
CLL (chronic lymphocytic leukemia)
Other

If other cancer, specify - If **Other Cancer** is selected as the type of pre-existing tumor, specify in the space provided. This field is optional.

Treatments of pre-existing tumor: Indicate the type of treatment used for the pre-existing tumor. These fields are optional.

Treatment date: Enter the date of treatment of the pre-existing tumor. This date must be before or equal to the transplant date. The date is in MM/DD/YYYY format.

Surgery: If surgery was used, select the type of surgery. If **Other Specify** is selected, enter the type of the surgery in the space provided.

Biopsy
Resection
Limited Resection; debulking
Other, specify

Chemotherapy: If chemotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment that was given.

CHOP
MACOP-B
Pro-Mace-CytaBOM
M-BACOD
5FU/Gemzar

5FU/Leucovorin
5FU/Leucovorin/CPT-11
5FU/Mitomycin
ACDA
Adriamycin
Anedia
Bleomycin/Cisplatin/Etoposide
Carboplatin/Etoposide
Carboplatin/Taxol/Gemcitabine
Carboplatin/VP-16
Cisplatin/VP-16
Cyclophosphamide
Cyclophosphamide/Prednisone
Cytoxan
Cytoxan/Adriamycin
Cytoxan/Onkovin/Adriamycin/Prednisone
DHAP
Doxorubicin
Doxorubicin/and/Streptozocin
EPOCH
Etoposide/Doxorubicin/Vincristine
Etropralide/Ifosfamide
Eulexin/Lupron
Gemcitabine
Leucovorin/Methotrexate
Lupron
Melphazan/Prednisone
Methotrexate
Mitomycin/Carboplatin
Navelbine/Taxol
Nilandron
Tamoxifen
Taxol/5FU/Carb
Taxol/Adriamycin
Taxol/Carboplatin
Taxol/Carboplatin/Zofran
Topotecan
Vidarabine/Cisplatin/Dexamethasone
Vincristine
Vincristine/Prednisone
VP16
VP16/Etoposide
Carboplatin/Gemcitabine
Other, specify

Radiation: Select if radiation therapy was used.

Other treatment specify: Enter the name of any other tumor treatment.

Date of recurrence (post-tx): Enter the date the cancer recurred. This date must be after the transplant date and fall within the follow-up period that is displayed. The date is in MM/DD/YYYY format.

Site(s) affected: Select whether the cancer affected the **Primary organ**, **Adjacent organs**, **Regional lymph nodes** or **Distant metastases**. This field is optional.

Immunosuppression: Select whether immunosuppression was stopped, reduced or if there was no adjustment. If the immunosuppression was changed or altered in any way, select **Immunosuppression Reduced**. This field is optional.

Immunosuppression Stopped
Immunosuppression Reduced
No Immunosuppression Adjustment

Treatments of recurrent tumor: Indicate the type of treatment used for the recurrent tumor. These fields are optional.

Surgery: If surgery was used, select the type of surgery. If **Other Specify** is selected, enter the name of the surgery in the space provided.

Biopsy
Resection
Limited Resection; debulking
Other, specify

Chemotherapy: If chemotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

CHOP
MACOP-B
Pro-Mace-CytaBOM
M-BACOD
5FU/Gemzar
5FU/Leucovorin
5FU/Leucovorin/CPT-11
5FU/Mitomycin
ACDA
Adriamycin
Anedia
Bleomycin/Cisplatin/Etoposide
Carboplatin/Etoposide
Carboplatin/Taxol/Gemcitabine
Carboplatin/VP-16
Cisplatin/VP-16
Cyclophosphamide
Cyclophosphamide/Prednisone
Cytoxan
Cytoxan/Adriamycin
Cytoxan/Onkovin/Adriamycin/Prednisone
DHAP
Doxorubicin
Doxorubicin/and/Streptozocin
EPOCH
Etoposide/Doxorubicin/Vincristine
Etropralide/Ifosfamide
Eulexin/Lupron
Gemcitabine
Leucovorin/Methotrexate
Lupron
Melphazan/Prednisone
Methotrexate
Mitomycin/Carboplatin
Navelbine/Taxol
Nilandron
Tamoxifen

Taxol/5FU/Carb
Taxol/Adriamycin
Taxol/Carboplatin
Taxol/Carboplatin/Zofran
Topotecan
Vidarabine/Cisplatin/Dexamethasone
Vincristine
Vincristine/Prednisone
VP16
VP16/Etoposide
Carboplatin/Gemcitabine
Other, specify

Radiation: Select if radiation therapy was used.

Immunotherapy: If immunotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

Hormonal Therapy
Interferon Alpha
Prednisone
Rituximab
Other, specify

Other treatment, Specify: Enter the name of any other tumor treatment.

Outcome: Select whether the recipient is **Alive**, **Free of tumor**; **Alive with Tumor**; **Dead, due to tumor**; or **Dead, other causes**. This field is optional.

Post Transplant De Novo Solid Tumor

This section will only display if Yes was selected for Post Transplant De Novo Solid Tumor on post transplant malignancies listed in the TRF record.

This includes all new malignant tumors except Post Transplant Lymphoproliferative Disease. This includes all skin cancers, sarcomas, adenocarcinomas, hematological malignancies, and many cancers with special names. It does not include benign tumors such as nevi, adenomas, or fibromas. Usually, the description should include the type of cancer (e.g. squamous cell, adenocarcinoma), and the organ involved.

Select the type(s) of post-transplant tumor. Select all tumor types that apply to the patient:

Skin: If **Squamous Cell**, **Basal Cell** and/or **Melanoma** skin tumors are indicated, select the sites, either **Single** or **Multiple** and indicate the area by selecting **Lips/Head/Neck**, **Extremities** or **Trunk**. Indicate if the skin malignancy has spread by selecting **None**, **Nodes** and/or **Other specify**. If **Other specify** is selected, enter the location in the space provided. Enter the number of occurrences during the follow-up period. If the number of occurrences during the follow-up period is unavailable, select the appropriate status from the **ST** field **N/A**, **Not Done**, **Missing**, **Unknown**). These fields are optional.

Kaposi's Sarcoma: Cutaneous

Kaposi's Sarcoma: Visceral

Brain: Select the specific type of brain tumor. If **Other Specify** is selected, enter the type of tumor in the space provided.

Astrocytoma
Medulloblastoma
Glioblastoma Multiforme
Neuroblastoma
Meningioma,Malignant

Meningioma,Benign
Angioblastoma
Other Specify

Renal carcinoma - Specify Site(s): If Renal Carcinoma is selected, enter the site(s) in the space provided. This field is optional.

Carcinoma of Vulva, Perineum or Penis, Scrotum

Carcinoma of Uterus: Indicate either **Cervix**, **invasive**; **Cervix**, **in situ**; or **Body**, **Endometrium**. This field is optional.

Ovarian

Testicular

Esophagus

Stomach

Small Intestine

Pancreas

Larynx

Tongue, throat

Thyroid

Bladder

Breast

Prostate

Colo-rectal, Duke's Classification: If **Colo-rectal** is selected, provide the Duke's classification. This field is optional.

Duke's Classification:
Dukes A - Tumor is limited to the mucosa (Inner lining)
Dukes B - Tumor is limited to the muscularis (muscle wall)
Dukes C - Tumor extends through the bowel wall and has nodal metastasis.
Unknown

Primary Hepatic Tumor: If **Primary Hepatic Tumor** is indicated, select the type of tumor as it applies to this patient. If **Other** is selected, specify the name in the space provided. This field is optional.

Hepatocellular Carcinoma
Cholangiocarcinoma
Epithelioid-Hemangio-Endothelioma
Hepatoblastoma
Hemangiosarcoma
Other, specify

Metastatic Liver Tumor - Specify Original Site: If **Metastatic Liver Tumor** is indicated, select the original site as it applies to this patient. If **Other** is selected, enter the name in the space provided. This field is optional.

Stomach Adenocarcinoma
Colon Adenocarrcinoma
Breast Carcinoma
Pancreas Carcinoma
Bronchial Carcinoma

Carcinoid (Neuroendocrine)
Other

Lung (include bronchial): If **Lung** is selected, indicate either **Small Cell** or **Non-small Cell**. This field is optional.

Leukemia: If **Leukemia** is selected, choose one of the following: This field is optional.

AML (acute myelocytic leukemia)
ALL (acute lymphocytic leukemia)
MDS (myelodysplasia syndrome)
CML (chronic myelocytic leukemia)
CLL (chronic lymphocytic leukemia)
Other

Sarcomas (excluding Kaposi's)

If **Sarcoma** is selected, enter the Site(s) in the space provided. Select the type of sarcoma from those listed. This field is optional.

Fibrosarcoma
Liposarcoma
Leiomyosarcoma
Rhabdomyosarcoma
Angiosarcoma
Malignant Hemangiopericytoma
Neurofibrosarcoma
Neuroblastoma
Chondrosarcoma
Osteosarcoma
Ewing's sarcoma
Other, specify

If **Other Cancers** is selected, enter the Site(s) and the type of cancer in the spaces provided. This field is optional.

Primary Unknown: Select if the type of tumor is unknown.

Outcome: Select whether the recipient is **Alive**, **Free of tumor**; **Alive with Tumor**; **Dead, due to tumor**; or **Dead, other causes**. This field is optional.

Treatment Information

The Treatment Information must be completed when a type of tumor is selected from the Post Transplant De Novo Solid Tumor section of the record. All applicable fields must be completed.

Site(s) affected: Select whether the site(s) affected are **Primary organ**, **Adjacent organs**, **Regional lymph nodes** or **Distant metastases**. This field is optional.

Diagnosis date: Enter the date of diagnosis. This date is in MM/DD/YYYY format and must fall within the follow-up period and after the transplant date that is displayed.

Immunosuppression: Select whether immunosuppression was stopped, reduced or if there was no adjustment. If the immunosuppression was changed or altered in any way, select **Immunosuppression Reduced**. This field is optional.

Immunosuppression Stopped
Immunosuppression Reduced
No Immunosuppression Adjustment

Specify Treatment: Indicate the type of treatment used for the tumor. These fields are optional.

Surgery: If surgery was used, select the type of surgery. If **Other Specify** is selected, enter the type of the surgery in the space provided.

Biopsy
Resection
Limited Resection; debulking
Other, specify

Cryotherapy (skin cancers): Indicate if cryotherapy was used.

Chemotherapy: If chemotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

CHOP
MACOP-B
Pro-Mace-CytaBOM
M-BACOD
5FU/Gemzar
5FU/Leucovorin
5FU/Leucovorin/CPT-11
5FU/Mitomycin
ACDA
Adriamycin
Anedia
Bleomycin/Cisplatin/Etoposide
Carboplatin/Etoposide
Carboplatin/Taxol/Gemcitabine
Carboplatin/VP-16
Cisplatin/VP-16
Cyclophosphamide
Cyclophosphamide/Prednisone
Cytoxan
Cytoxan/Adriamycin
Cytoxan/Onkovin/Adriamycin/Prednisone
DHAP
Doxorubicin
Doxorubicin/and/Streptozocin
EPOCH
Etoposide/Doxorubicin/Vincristine
Etropralide/Ifosfamide
Eulexin/Lupron
Gemcitabine
Leucovorin/Methotrexate
Lupron
Melphazan/Prednisone
Methotrexate
Mitomycin/Carboplatin
Navelbine/Taxol
Nilandron
Tamoxifen
Taxol/5FU/Carb
Taxol/Adriamycin
Taxol/Carboplatin
Taxol/Carboplatin/Zofran
Topotecan
Vidarabine/Cisplatin/Dexamethasone
Vincristine
Vincristine/Prednisone

VP16
VP16/Etoposide
Carboplatin/Gemcitabine
Other, specify

Immunotherapy: If immunotherapy was used, select the appropriate type of treatment. If **Other Specify** is selected, enter the name of the treatment in the space provided.

Hormonal Therapy
Interferon Alpha
Prednisone
Rituximab
Other, specify

Radiation: Select if radiation therapy was used.

Other treatment: Enter the name of any other tumor treatment.

Best treatment response: Select whether the best treatment response was a **Progressive Disease (PD)**, **Stable Disease (SD), Partial Response (PR)**, **Complete Response (CR), Too Early in Treatment to Evaluate (TE)** or **No Treatment (NT)**. This field is optional.

Post Transplant Lymphoproliferative Disease and Lymphoma

This section will only display if Yes was selected for Post TX Lymphoproliferative Disease and Lymphoma on post transplant malignancies listed in the TRF record.

Lymphoid growths which occur in organ transplant patients, in which evidence of Epstein-Barr virus (EBV) can be demonstrated. A family of lesions that straddle the border between infection and neoplasia (tumors). The spectrum runs from infectious mononucleosis to clonal proliferation of lymphoid cells to gross tumor formation and malignancy. PTLDs must be distinguished from sporadic lymphomas or non-EBV-associated lymphadenopathies, which may also be seen in the transplant population.

Diagnosis date: Enter the date of diagnosis. This date is in MM/DD/YYYY format and must fall within the follow-up period and after the transplant date that is displayed.

Pathology: Select the pathology of the disease. If **Other, Specify** is selected, enter the disease in the space provided.

Polymorphic Hyperplasia
Polymorphic PTLD(lymphoma)
Monomorphic PTLD(lymphoma)
Multiple Myeloma, Plasmacytoma
Hodgkin's Disease
Other, Specify

Clonality: Select the clonality of the disease. This field is optional.

Monoclonal
Polyclonal
Oligoclonal
Unknown

Predominant cell type: Select the predominant cell type. If **Other, Specify** is selected, enter the name in the space provided. This field is optional.

B Cell
T Cell
Other Specify
Unknown

Epstein-Barr virus (EBV) status of tumor: Select whether the Epstein-Barr Virus was **Positive**, **Negative**, or **Unknown**. This field is optional.

Anatomy: Select whether the anatomy was a **Single Site** or **Multiple Sites**. This field is optional.

Lymph nodes: Select **Yes** if lymph nodes are affected. If not, select **No**. If Extranodal sites are applicable (sites outside of the lymph nodes), select **Stomach**, **Small Intestine**, **Colon**, **Allograft**, **Lung**, **Bone Marrow**, **CNS** and/or **Liver**. Enter any other sites in the **Other Specify** space provided. These fields are optional.

Ann Arbor Stage:
Ann Arbor is a classification of Non-Hodgkin's Lymphomas. Indicate if the Ann Arbor stage is **I**, **II**, **III,** or **IV**. Select only one. If unknown, select **Unknown**. This field is optional.

Stage I - Involvement of a single lymph node group or a single extralymphatic organ or site.

Stage II - Involvement of two or more lymph node regions on the same side of diaphragm alone or with localized involvement of an extralymphatic organ or site (on the same side of the diaphragm)

Stage III - Involvement of lymph node regions on both sides of the diaphragm alone or with localized involvement of an extralymphatic organ or site, or spleen, or both (on both sides of the diaphragm).

Stage IV - Diffuse or disseminated involvement of one or more extralymphatic organs with or without associated lymph node involvement.

PTLD Treatment:
Select the Best Response for each question: **PD- Progressive Disease**, **SD - Stable Disease**, **PR - Partial Response, CR - Complete Response**, or **TE - Too Early in Treatment to Evaluate.**

1. **Reduction/Cessation of immunosuppression:** Select whether the Immunosuppression was reduced or discontinued. This field is optional.
2. **Surgery:** Indicate the type of surgery. If **Other Specify** is selected, enter the surgery type in the space provided. This field is optional.

   Biopsy
   Resection
   Limited Resection; debulking
   No Surgery
   Other, specify
3. **Anti-Viral Therapy (if yes, list drugs):** Select whether anti-viral therapy was used. If the first drug was used, select the drug from the Drug 1 list and the associated Best Response. If a second drug was used, select the drug used from the Drug 2 list and the associated Best Response. If a second drug was not used, leave the Drug 2 field and associated Best Response option blank. These fields are optional.

   Acyclovir
   Cytogam
   Cytovene
   Foscarnet
   Ganciclovir
   IVIG
   Valtrex
   Other, specify
4. **Chemotherapy:** Select whether chemotherapy was used. If the first drug/regimen was used, select the drug/regimen from the Drug/regimen 1 list and the associated Best Response. If a second drug/regimen was used, select the drug/regimen used from the

Drug/Regimen 2 list and the associated Best Response. If a second drug was not used, leave the Drug 2 field and associated Best Response option blank. These fields are optional.

CHOP
MACOP-B
Pro-Mace-CytaBOM
M-BACOD
5FU/Gemzar
5FU/Leucovorin
5FU/Leucovorin/CPT-11
5FU/Mitomycin
ACDA
Adriamycin
Anedia
Bleomycin/Cisplatin/Etoposide
Carboplatin/Etoposide
Carboplatin/Taxol/Gemcitabine
Carboplatin/VP-16
Cisplatin/VP-16
Cyclophosphamide
Cyclophosphamide/Prednisone
Cytoxan
Cytoxan/Adriamycin
Cytoxan/Onkovin/Adriamycin/Prednisone
DHAP
Doxorubicin
Doxorubicin/and/Streptozocin
EPOCH
Etoposide/Doxorubicin/Vincristine
Etropralide/Ifosfamide
Eulexin/Lupron
Gemcitabine
Leucovorin/Methotrexate
Lupron
Melphazan/Prednisone
Methotrexate
Mitomycin/Carboplatin
Navelbine/Taxol
Nilandron
Tamoxifen
Taxol/5FU/Carb
Taxol/Adriamycin
Taxol/Carboplatin
Taxol/Carboplatin/Zofran
Topotecan
Vidarabine/Cisplatin/Dexamethasone
Vincristine
Vincristine/Prednisone
VP16
VP16/Etoposide
Carboplatin/Gemcitabine
Other, specify

5. **Radiation Therapy:** Select if radiation therapy was used. This field is optional.

6. **Immunotherapy:** Select whether immunotherapy was used. If Yes is indicated, select the type of immunotherapy. If Other Specify is selected, enter the name of the treatment in the space provided. These fields are optional.

Hormonal Therapy
Interferon Alpha
Prednisone
Rituximab
Other, specify