

# YHHN Data Collection: T-cell lymphoma

Please enter data into boxes, and amend any incorrect or missing details:

**Patient Name:**

**HILIS ID:**

**Date of Birth:**

**NHS No:**

**HMDS Number:**

**Report Date:**

**Source:**

**Specimen:**

## Demographics:

<b>Gender:</b>	M / F	<b>Date of diagnosis:</b>	
<b>Address at diagnosis:</b>			
<b>GP address:</b>			
<b>1st appointment on:</b>		<b>Palliative date:</b>	
<b>Date of death:</b>			

## Antecedent / concurrent events:

<b>Event:</b>	
<b>Therapies:</b>	chemotherapy / radiotherapy / both

## Treatment history:

<b>Centre:</b>	[name]		
<b>Treatment:</b>	[treatment name]		
<b>Trial:</b>	[trial name]		
<b>Start date:</b>		<b>End date:</b>	
		<b>Response:</b>	

## Presentation data:

<b>ECOG:</b>	[0 - 4]	<b>Hb:</b>	[g/dL]
<b>BM biopsy:</b>	[Y/N]	<b>WBC:</b>	[x10 <sup>9</sup> /L]
<b>Sweats:</b>	[Y/N]	<b>Lymphs:</b>	[x10 <sup>9</sup> /L]
<b>Fever:</b>	[Y/N]	<b>Albumin:</b>	[g/L]
<b>Wt. loss:</b>	[Y/N]	<b>β<sub>2</sub>m:</b>	[mg/L]
<b>CT Scan:</b>	[Y/N]	<b>LDH:</b>	[range]
<b>Ann-Arbor:</b>	[I - IV]		

**Nodal involvement:**

Site	L   R
Waldeyer's ring:	<input type="checkbox"/>
Neck:	<input type="checkbox"/> <input type="checkbox"/>
Infraclavicular:	<input type="checkbox"/> <input type="checkbox"/>
Axillary/pectoral:	<input type="checkbox"/> <input type="checkbox"/>
Arm:	<input type="checkbox"/> <input type="checkbox"/>
Thymus:	<input type="checkbox"/>
Hilar:	<input type="checkbox"/> <input type="checkbox"/>
Mediastinal:	<input type="checkbox"/>
Para-aortic:	<input type="checkbox"/>
Spleen:	<input type="checkbox"/>
Mesenteric:	<input type="checkbox"/>
Iliac:	<input type="checkbox"/> <input type="checkbox"/>
Inguinal/femoral:	<input type="checkbox"/> <input type="checkbox"/>
Popliteal:	<input type="checkbox"/> <input type="checkbox"/>
Bulky disease:	<input type="checkbox"/>

**Extranodal involvement:**

Site	L   R
Blood:	<input type="checkbox"/>
Bone:	<input type="checkbox"/>
CNS:	<input type="checkbox"/>
GIT:	<input type="checkbox"/>
GU:	<input type="checkbox"/>
Liver:	<input type="checkbox"/>
Marrow:	<input type="checkbox"/>
Muscle:	<input type="checkbox"/>
Orbit:	<input type="checkbox"/> <input type="checkbox"/>
Pericardium:	<input type="checkbox"/>
Pulmonary:	<input type="checkbox"/> <input type="checkbox"/>
Salivary gland:	<input type="checkbox"/> <input type="checkbox"/>
Skin:	<input type="checkbox"/>
Thyroid:	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Extensive disease:	<input type="checkbox"/>

**Comments:**