International Registry on Recurrent VTE in Patients with Cancer
Registry Form – Inclusion
Fax this form to: Dr. Sam Schulman, 1-905-521-1551
(Thrombosis Service, McMaster Clinic, HHS-General Hospital, Hamilton, Canada)

Center No. ☐☐☐ **Patient**: Year of birth ☐☐ **Date of recurrent VTE** ☐☐/☐☐☐/☐☐
(the twelve digits above constitute the registry identification for this patient) YY / MMM / DD

Patient sex M ☐ F ☐ **Body weight** (kg) ☐☐☐ **Creatinine** (µmol/L) ☐☐☐

Cancer Dx ☐☐/☐☐☐/☐☐ **Extent** (last known) Metastatic ☐ Local ☐ Remission/ or no evidence ☐ **ECOG** score (0 – 4) ☐
YY / MMM / DD

Site Breast ☐ Lung ☐ Colorectal ☐ GU ☐ Gyne ☐ Brain ☐ Pancreas ☐ Hematopoetic ☐ Other ☐

Histology Adeno ☐ Squamous ☐ Sarcoma ☐ Leukemia ☐ Lymphoma ☐ Myeloma ☐ Other ☐

Cancer treatment (at VTE recurrence) None ☐ Chemotherapy ☐ Hormone therapy ☐ Immunotherapy ☐
Surgery within past 4 weeks ☐ Radiotherapy ☐ Growth factors ☐ Anti-angiogenesis ☐ Other ☐

HISTORY OF VENOUS THROMBOEMBOLISM (VTE)

Number of symptomatic and objectively confirmed VTE events prior to break-through: ☐

	Present VTE = Break-through Event (same as on 1st line)	**Previous VTE Event** (most recent prior to this)
Date of diagnosis:	- see 1st line -	☐☐/☐☐☐/☐☐ YY / MMM / DD
DVT (1), PE (2), both (3)	☐	☐
Diagnostic method: Ultrasound (1); Venography (2); Ventilation-perfusion lung scan (3); Spiral CT of pullmonary arteries (4); Pulmonary angiogram (5); Other (6). **Please fax all reports**	☐☐☐☐☐☐	☐☐☐☐☐☐
	Treatment at time of Break-through	**Treatment for Previous VTE**
Unfractionated heparin:	(iv ☐/ sc ☐ dose)_____U/24h	(iv ☐/ sc☐ dose)____U/24h
APTT at break-through	☐☐☐ s – Provide normal range: ☐☐☐ s - ☐☐☐ s	
Low-molecular-weight heparin:	_____ (generic name) _____	
Dose and unit of LMWH	_____ (mg ☐/ IU ☐)/24 h	_____ (mg ☐/ IU ☐)/24 h
Anti-Xa level at break-through	☐.☐☐ IU/mL	
Fondaparinux :	dose _____ mg / 24 h	dose _____ mg / 24 h
Vitamin K antagonist:	_____ (generic name) _____	
INR at break-through	☐☐.☐☐	
IVC filter:	Permanent ☐ Retrievable ☐	Permanent ☐ Retrievable ☐

Date completed and faxed:_____ Signature of Investigator_____

*Provide treatment on day of diagnosis of break-through VTE and lab results as close as available

International Registry on Recurrent VTE in Patients with Cancer
Registry Form – 3-month follow-up
Fax this form to: Dr. Sam Schulman, 1-905-521-1551
(Thrombosis Service, McMaster Clinic, HHS-General Hospital, Hamilton, Canada)

Registry Identification Number □□□-□□-□□□□□□□ Center + Year of birth + Date of break-through VTE

A. Treatments given to treat break-through VTE:

Unfractionated heparin:

(iv □ / sc □) dose___ U/24 h from Date□□/□□□/□□ to Date□□/□□□/□□ (YY / MMM / DD)

aPTT results □□□s; □□□s; □□□s; □□□s; □□□s; □□□s; □□□s; □□□s; □□□s

Low-molecular-weight heparin: _____ (generic name)

Dose or unit _____(mg □/ IU □)/24 h from Date □□/□□□/□□ to Date □□/□□□/□□
YY / MMM / DD YY / MMM / DD

Anti-Xa levels (IU/mL) □.□□; □.□□; □.□□; □.□□; □.□□; □.□□; □.□□; □.□□

Fondaparinux: _____mg/ 24 h from Date □□/□□□/□□ to Date □□/□□□/□□
YY / MMM / DD YY / MMM / DD

Vitamin K antagonist: _____ from Date □□/□□□/□□ to Date □□/□□□/□□
YY / MMM / DD YY / MMM / DD

INR results □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□;
□□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□;
□□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□; □□.□□;

IVC filter: None □ Permanent □ Retrievable □

B. Major bleeding complications: None □ 1 or more bleeds □ Indicate type of bleeding below

_____Date □□/□□□/□□ _____Date □□/□□□/□□

_____Date □□/□□□/□□ _____Date □□/□□□/□□

C. Outcome of break-through VTE: No further recurrent VTE □ More recurrent VTE □

	1st VTE event after Break-through	**2nd VTE event after Break-through**
Date of diagnosis	□□/□□□/□□	□□/□□□/□□
DVT (1), PE (2), both (3)	□	□

Diagnostic method: Ultrasound (1), venography (2); ventilation-perfusion lung scan (3), spiral CT of pulmonary arteries (4); pulmonary angiogram (5), other (6). **Please fax all reports**

□ □ □ □ □ □	□ □ □ □ □ □

D. Most recent status of patient: date: □□/□□□/□□

Alive with no symptoms of VTE □ Alive with post-thrombotic syndrome □

Dead: Date of death □□/□□□/□□ Cause of death _____

Date completed and faxed:_____ Signature of Investigator _____

Version: 25 May 2006

International Registry on Recurrent VTE in Patients with Cancer
Registry Form – Center information
Fax this form to: Dr. Sam Schulman, 1-905-521-1551
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(This form is only to be completed once at the latest with submission of data for the first patient.)

Name of primary contact person for missing data:_____

Fax:_____ Phone:_____

e-mail:_____

Address of your centre: _____

_____

_____

Type of hospital: (University/District/Local etc.)_____

Where is the closest oncology clinic?

Same building ☐ Same hospital ☐ Same town/city ☐

How many patients with VTE does your clinic/service treat per year? ☐☐☐

What is your standard treatment for patients without cancer

	DVT	PE
Unfractionated heparin:	iv ☐/ sc☐	iv ☐/ sc☐
aPTT –therapeutic range:	☐☐☐s - ☐☐☐s	☐☐☐s - ☐☐☐s

Low-molecular-weight heparin: _____ (generic name) _____

mainly as inpatient ☐ or outpatient ☐

Fondaparinux: _____ (generic name) _____

mainly as inpatient ☐ or outpatient ☐

Vitamin K antagonist: _____ (generic name)

Information for reimbursement. $100 (US) will be paid for each completed registration of a patient – Inclusion & 3-month follow-up; payments will be done every 4 months. Bank charges will be on the recipient. Do you prefer to accumulate the reimbursements to a payment at the end of recruitment (200 patients) to reduce bank charges? If yes, then tick in this box: ☐

Payment ☐ By cheque to
Name_____
Address _____
_____
_____
_____
_____

☐ By money transfer to
Name _____
Bank _____
Branch address_____
_____
Account number _____
SWIFT code _____
IBAN number _____

Date completed and faxed:_____ Signature of Investigator _____