## CLL4 - ENTRY FORM [A]

Please return completed form to:
FREEPOST RLUJ-UUUU-UUAC, CTSU, Richard Doll Building, Old Road, Headington, Oxford OX3 7LF
or Fax: +44-(0)1865-743986

### Please complete this section before phoning for randomisation

Consultant .......................................... Hospital ............................................

Patient’s full name .......................................................... Sex ..........................

Date of birth....../....../........ Date of diagnosis....../....../........

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb (g/dl)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets (x10^9/l)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BM lymphocytes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any enlargement of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spleen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes in:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axillae</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please telephone CTSU for randomisation (+44-(0)1865-765615) and note the information given:

Stage  A  B  C  CLL trial number .................

Treatment allocated:  Chlorambucil  Fludara  Fludara plus Cyclo

Date phoned ....../....../........

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>+ve</th>
<th>-ve</th>
<th>not done</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBC (x10^9/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphocytes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>β2 microglobulin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAG test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDH: Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For stage A, indicate features of progression:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Value</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphocyte doubling &lt;12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in nodes/spleen, etc</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop in Hb/plat/PMN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please provide patient with QOL questionnaire.
CLL4 - FIRST TREATMENT FORM [B]

Please return after completion of first treatment (about 6mths (F DR) or one year (Chl)) to:
FREEPOST RLUJ-UUUU-UUAC, CTSU, Richard Doll Building, Old Road, Headington, Oxford OX3 7LF or
FAX: +44-(0)1865-743986

Consultant ................................................................. Hospital .............................................

Patient’s full name ............................................... CLL trial number .............................

<table>
<thead>
<tr>
<th>Treatment given</th>
<th>Chlorambucil</th>
<th>Fludara</th>
<th>Fludara plus Cyclo</th>
<th>Oral or IV Fludara</th>
</tr>
</thead>
</table>

Date started ........../........./.......... No. of courses .................

Was full dose given? ☐ Yes ☐ No Date completed ........../........./.......... 

Response Date of best response ........../........./.......... All data recorded in this section should be at this date

Best response ☐ CR ☐ NPR ☐ PR ☐ NR ☐ PD ☐ Not assessable

Hb (g/dl) ....................... Platelets (x10^9/l) ..............

WBC (x10^9/l) .............. Lymphocytes ..........% Neutrophils ..........% 

BM lymphocytes ..........% BM biopsy? ☐ Yes ☐ No 

DAG test ☐ +ve ☐ -ve ☐ not done

Any enlargement of: Spleen ☐ Yes ☐ No Liver ☐ Yes ☐ No

Lymph nodes in: Neck ☐ Yes ☐ No Axillae ☐ Yes ☐ No 

Groin ☐ Yes ☐ No 

TOXICITY DURING THIS TREATMENT PERIOD

Neutropenia (<1x10^9/l) ☐ Yes ☐ No Non-haematological (with WHO toxicity grade, see back of form)

Thrombocytopenia (<50x10^9/l) ☐ Yes ☐ No Grade 

Haemolytic anaemia ☐ Yes ☐ No Nausea/vomiting .......... 

Alopecia .......... 

Number of days in hospital ............... Mucositis .......... 

Diarrhoea .......... 

Number of febrile episodes requiring antibiotics ............... Other ☐ Yes ☐ No 

If Yes specify: Type ....................... Grade ........ 

PATIENT STATUS

Performance status (WHO; see back of form) ............... Vital status ☐ Alive ☐ Dead 

If died: Date of death ........../........./......... Cause of death ................................................ 

Autopsy done? ☐ Yes ☐ No 

Revised protocol - 27th February 2001
WHO TOXICITY GRADING AND PERFORMANCE STATUS

WHO toxicity grading

<table>
<thead>
<tr>
<th>Grade</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea / Vomiting</td>
<td>Nausea</td>
<td>Transient vomiting</td>
<td>Vomiting requiring therapy</td>
<td>Intractable vomiting</td>
</tr>
<tr>
<td>Alopecia</td>
<td>Minimal hair loss</td>
<td>Moderate, patchy alopecia</td>
<td>Severe alopecia</td>
<td>Total alopecia</td>
</tr>
<tr>
<td>Oral</td>
<td>Soreness / erythema</td>
<td>Erythema, ulcers, can eat solids</td>
<td>Ulcers, requires liquid diet</td>
<td>Feeding not possible</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>Transient &lt; 2 days</td>
<td>Tolerable but &gt; 2 days</td>
<td>Intolerable, requiring therapy</td>
<td>Haemorrhagic dehydration</td>
</tr>
<tr>
<td>Cardiac Function</td>
<td>Asymptomatic, but abnormal cardiac sign</td>
<td>Transient symptomatic dysfunction, no therapy required</td>
<td>Symptomatic dysfunction, responsive to therapy</td>
<td>Symptomatic dysfunction, not responsive to therapy</td>
</tr>
</tbody>
</table>

WHO Performance Status

**Grade 0** - Able to carry out all normal activity without restriction.

**Grade 1** - Restricted in physically strenuous activity but able to walk and do light work.

**Grade 2** - Able to walk and capable of all self-care, but unable to carry out any work. Up and about more than 50% of waking hours.

**Grade 3** - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.

**Grade 4** - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
**CLL4 - FOLLOW-UP FORM [C]**

Please complete this form yearly for the first 5 years from entry and return to:
FREEPOST RLUJ-UUU-UUAC, CTSU, Richard Doll Building, Old Road, Headington, Oxford OX3 7LF
or
Fax: +44-(0)1865-743986

Date ........../........./........

Consultant .................................................................................................................... Hospital ..........................................................

Patient’s full name .................................................. CLL trial number ..................................

<table>
<thead>
<tr>
<th>Disease status</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Never responded</td>
</tr>
<tr>
<td>□ Stable disease</td>
</tr>
<tr>
<td>□ Relapse (progression requiring therapy)</td>
</tr>
</tbody>
</table>

**If progression:** Date when documented ........../........./........

Evidence of progression:

□ Downward trend Hb/plt

□ Lymphocyte doubling time <12 months

□ Progressive organomegaly

Have you initiated further therapy? □ Yes □ No

If yes, treatment:

□ Chlorambucil          □ Fludara

□ Fludara plus Cyclo □ CHOP

□ Other. Specify .............................................

<table>
<thead>
<tr>
<th>Vital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Alive □ Dead</td>
</tr>
</tbody>
</table>

If died: Date of death ........../........./........  Cause of death ..........................................................

Autopsy done? □ Yes □ No
CLL4 - 2ND LINE TREATMENT FORM [D]

Please complete this form for all patients treated with 2nd line therapy (different from initial treatment) at the end of this phase of treatment, and return to:
FREEPOST RLUJ-UUUU-UUAC, CTSU, Richard Doll Building, Old Road, Headington, Oxford OX3 7LF
or Fax: +44-(0)1865-743986

Date ....../....../........
Consultant ........................................... Hospital ..............................................
Patient’s full name ........................................ CLL trial number .........................

Second randomisation
Was second randomisation done?   □ Yes □ No
If No, reason
□ Patient refusal
□ Clinical, please specify ........................................
□ Other, please specify ........................................
If Yes, was recommended treatment given?   □ Yes □ No
If No, reason:
□ Patient refusal
□ Clinical, please specify ........................................
□ Other, please specify ........................................

Treatment given
□ CHOP   □ Fludara   □ Fludara plus Cyclo
□ Other. Please specify ..........................................................
Date initiated ....../....../........   No. of courses given .........................
Response □ CR □ NPR □ PR □ NR □ PD □ Not assessable

Vital status
□ Alive □ Dead
If died: Date of death ....../....../........   Cause of death ...................................................
   Autopsy done? □ Yes □ No

Revised protocol - 27th February 2001