ARISTOTLE
RECURRENCE FORM

Trial Number | A | R | I | – | | | | **Patient Initials** | | | |

1. RECURRENCE

A) Is the recurrence ☐ Suspected ☐ Confirmed

B) Is the recurrence ☐ Locoregional ☐ Distant ☐ Both

i) Specify location of distant recurrence

☐ Liver ☐ Lung ☐ Lymph nodes ☐ Peritoneum ☐ Bone

☐ Brain ☐ Other, please specify _____

IF THERE IS A SUSPECTED RECURRENCE, PLEASE REVIEW AGAIN IN 6 MONTHS AS PER PROTOCOL

2. CONFIRMED RECURRENCE

A) Confirmed evidence of persisting disease following pre-operative CRT? ☐ Yes ☐ No

i) MDT decision that local extent of disease on post CRT pelvic MRI is not resectable ☐ Yes ☐ No

ii) Decision that at laparotomy after pre-operative CRT, local extent of disease is not resectable ☐ Yes ☐ No

iii) Incomplete resection of tumour at laparotomy during pre-operative CRT with biopsy proof of residual disease ☐ Yes ☐ No

B) Confirmed evidence of loco-regional recurrence *(any site below sacral promontory)*? ☐ Yes ☐ No

i) Clinical recurrence with biopsy proof of recurrence ☐ Yes ☐ No

ii) CEA elevation & enlarging or new mass (includes pelvic, nodal & peritoneal disease) Biopsy confirmation is contraindicated or not feasible ☐ Yes ☐ No

iii) CEA non-secretors: enlarging or new mass (includes pelvic, nodal & peritoneal disease). Biopsy confirmation is contraindicated or not feasible *(with or without PET/CT confirmation)* ☐ Yes ☐ No

C) Is there confirmed evidence of distant metastases? ☐ Yes ☐ No

i) Clinical recurrence with biopsy proof of recurrence ☐ Yes ☐ No

ii) CEA elevation & evidence of distant metastases. Biopsy confirmation is contraindicated or not feasible ☐ Yes ☐ No

Completed by:	**Signature:**	**Date completed** *(dd/mm/yyyy)*:

TRIALS OFFICE USE ONLY

Form received:	Form entered:	Form checked

ARISTOTLE

RECURRENCE FORM

Trial Number A R I – ☐☐☐ **Patient Initials** ☐☐☐

2. CONFIRMED RECURRENCE (continued)

iii) CEA non-secretors: evidence of distant metastases. Biopsy confirmation is contraindicated or not feasible (with or without PET/CT confirmation) ☐ Yes ☐ No

D) Date of confirmed recurrence d d / m m / y y y y

PLEASE SEND THE PATHOLOGY REPORT TO THE TRIALS CENTRE

3. SECOND MALIGNANCY

a) Date of diagnosis: d d / m m / y y y y

b) How was it confirmed?:

☐ CT scan ☐ Biospy ☐ Chest x-ray

☐ Other, please specify: _____

c) Site of second malignancy: _____

PLEASE SEND THE PATHOLOGY REPORT TO THE TRIALS CENTRE

Completed by:	**Signature:**	**Date completed** *(dd/mm/yyyy)*:

TRIALS OFFICE USE ONLY

Form received:	**Form entered:**	**Form checked**