CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

DAY 0

MED-B GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC) ....

Hospital ..... Unit .....

Contact person: .....

e-mail .....

Date of this report .... - .... - ....
yyyy mm dd

STUDY/TRIAL

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

PATIENT

Unique Identification Code (UIC) .... *(to be entered only if patient previously reported)*

Hospital Unique <u>Patient</u> Number or Code (UPN): .....
Compulsory, registrations will not be accepted without this item.
All transplants performed in the same patient must be registered with the same patient identification number or code as this belongs to the patient and <u>not</u> to the transplant.

Initials .... (first name(s) – surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

ABO Group ....

Rh factor: ☐ Absent ☐ Present ☐ Not evaluated

DISEASE

Date of diagnosis : .... - .... - ....
yyyy mm dd

PRIMARY DISEASE DIAGNOSIS *(CHECK THE DISEASE FOR WHICH THIS TRANSPLANT WAS PERFORMED)*

- ☐ Acute Leukaemia
  - ☐ Acute Myelogenous Leukaemia (AML) & related Precursor Neoplasms
  - ☐ Precursor Lymphoid Neoplasms (old ALL)
- ☐ Therapy related myeloid neoplasms (old Secondary Acute Leukaemia)
- ☐ Chronic Leukaemia
  - ☐ Chronic Myeloid Leukaemia (CML)
  - ☐ Chronic Lymphocytic Leukaemia (CLL)
- ☐ Lymphoma
  - ☐ Non Hodgkin
  - ☐ Hodgkin's Disease
- ☐ Myeloma /Plasma cell disorder
- ☐ Solid Tumour
- ☐ Myelodysplastic syndromes / Myeloproliferative neoplasm
  - ☐ MDS
  - ☐ MDS/MPN
  - ☐ Myeloproliferative neoplasm
- ☐ Bone marrow failure including Aplastic anaemia
- ☐ Inherited disorders
  - ☐ Primary immune deficiencies
  - ☐ Metabolic disorders
- ☐ Histiocytic disorders
- ☐ Autoimmune disease
  - ☐ Juvenile Idiopathic Arthritis (JIA)
  - ☐ Multiple Sclerosis
  - ☐ Systemic Lupus
  - ☐ Systemic Sclerosis
- ☐ Haemoglobinopathy

☐ Other diagnosis, specify:_____

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): ……

DAY 0

MED-B
PLASMA CELL DISORDERS (INCLUDES MULTIPLE MYELOMA)

INITIAL DIAGNOSIS

Has the information requested in this section been submitted with a previous HSCT registration for this patient?

☐ Yes: go to page 4, *Pre HSCT Treatment* ☐ No: proceed with this section

SUBCLASSIFICATION (Main disease code 4)

	Heavy Chain	Light Chain
Select one	*Select one as applicable*	*Select one as applicable*
☐ Multiple myeloma	☐ IgG	☐ Kappa
☐ Heavy chain and light chain *(check light and heavy chain types)* →	☐ IgA	☐ Lambda
☐ Light chain only *(check light chain type only)* →	☐ IgD	
☐ Non secretory	☐ IgE	
☐ Plasma Cell Leukaemia	☐ IgM	
☐ Solitary plasmacytoma of bone		
☐ POEMS		
☐ Monoclonal light and heavy chain deposition disease (LCDD/HCDD)		
☐ Other		

STAGE AT DIAGNOSIS

Complete both staging systems

SALMON AND DURIE (MM)

	I	II	III
A	☐	☐	☐
B	☐	☐	☐

ISS

	β2 µglob *(mg/L)*	Albumin *(g/L)*		β2 µglob *(mg/L)*	Albumin *(g/L)*
☐ **I**	<3.5	≥35			
☐ **II**	<3.5	<35	***OR***	3.5 – ≤5.5	any
☐ **III**	>5.5	any			

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): …….

Chromosome analysis at diagnosis (All methods including FISH)

☐ Normal: number of metaphases examined: .....

☐ Abnormal:

Complex karyotype: ☐ No ☐ Yes ☐ Unknown
(3 or more abnormalities)

number of metaphases with abnormalities: ..... / number of metaphases examined: .....

☐ Not done or failed ☐ Unknown

You can transcribe the complete karyotype: .....……

OR

Indicate below those abnormalities that have been **evaluated** and whether they were **Absent** or **Present**

IF ABNORMAL, INDICATE ABNORMALITIES FOUND:

Del 13q14	☐ Absent	☐ Present	☐ Not evaluated
t(11;14)	☐ Absent	☐ Present	☐ Not evaluated
abn 17q	☐ Absent	☐ Present	☐ Not evaluated
17p del	☐ Absent	☐ Present	☐ Not evaluated
t(4:14)	☐ Absent	☐ Present	☐ Not evaluated
t(14:16)	☐ Absent	☐ Present	☐ Not evaluated
1q amplification	☐ Absent	☐ Present	☐ Not evaluated
myc rearrangement	☐ Absent	☐ Present	☐ Not evaluated
Other, specify	☐ Absent	☐ Present	☐ Not evaluated

☐ Other or associated abnormalities (specify).....……
.....……

☐ Not done or failed ☐ Unknown

Molecular analysis

☐ Absent ☐ Present (at least one) ☐ Not evaluated ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)*	....	☐ Not evaluated
Serum creatinine *(µmol/L)*	....	☐ Not evaluated
Serum calcium *(mmol/L)*	.... -	☐ Not evaluated
Serum albumin *(g/L)*	....	☐ Not evaluated
BM aspirate: % plasmacytosis	....	☐ Not evaluated
BM trephine: % plasmacytosis	....	☐ Not evaluated
Monoclonal Ig in serum *(g/L)*	....	☐ Not evaluated
Monoclonal Ig in urine *(g/24 h)*	....	☐ Not evaluated
Serum β2 microglobulin *(mg/L)*	.... -	☐ Not evaluated

INVOLVEMENT AT DIAGNOSIS

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

Extramedullary involvement ☐ No ☐ Yes, specify location .....…… ☐ Not evaluated

PRE-HSCT TREATMENT

If this registration pertains to a second or subsequent HSCT the therapy number should be counted since last reported HSCT.

WAS THE PATIENT TREATED BEFORE THE HSCT PROCEDURE?

☐ No
☐ Yes: **Date started** .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*
☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No
☐ Yes: **Date started** .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*
☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

☐ Unknown

ADDITIONAL PRE-HSCT TREATMENT?

☐ No
☐ Yes: **Date started** .... - .... - ....
yyyy mm dd

Sequential number of this treatment: .....
(counted from diagnosis, or last HSCT if applicable)

Modality: Chemo/Drugs ☐ No ☐ Yes: Chemo/Drug regimen .....
Radiotherapy ☐ No ☐ Yes

Response: *(see manual for full definition of each response)*
☐ sCR ☐ CR ☐ VGPR ☐ PR
☐ Stable disease ☐ Progression ☐ Not evaluated ☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): ……

HSCT

DATE OF HSCT : .... - .... - ....
yyyy *mm* *dd*

HSCT TYPE

☐ Allogeneic: *Proceed to* STATUS OF DISEASE AT START OF CONDITIONING *on page 6*

☐ Autologous: Date of 1st collection or aphaeresis: .... - .... - ....
yyyy *mm* *dd*

STATUS OF DISEASE AT COLLECTION (AUTOGRAFTS ONLY)

IMMEDIATELY PRIOR TO MOBILISING CHEMOTHERAPY AND/OR GROWTH FACTOR IF USED

SEE MANUAL FOR FULL DEFINITION OF EACH DISEASE STATUS

☐ At diagnosis *(untreated)*

☐ Stringent complete remission (sCR)

☐ Complete remission (CR) If sCR or CR: NUMBER OF THIS COMPLETE REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Very good PR (VGPR)

☐ PR If VGPR or PR: NUMBER OF THIS PARTIAL REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Relapse from CR *(untreated after the relapse)* NUMBER OF THIS RELAPSE
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Stable disease (*no change, includes old MR)*

☐ Progression

☐ Unknown

Plateau (**COMPLETE ONLY IF STATUS IS STABLE DISEASE OR PR**)
(not applicable for non secretory myeloma)
☐ No ☐ Yes ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)*	....	☐ Not evaluated	
Serum creatinine *(µmol/L)*	....	☐ Not evaluated	
Serum calcium *(mmol/L)*	.... -	☐ Not evaluated	
Serum albumin *(g/L)*	....	☐ Not evaluated	
BM aspirate: % plasmacytosis	....	☐ Not evaluated	
BM trephine: % plasmacytosis	....	☐ Not evaluated	
Monoclonal Ig in serum *(g/L)*	....	☐ Not evaluated	
Immunofixation of serum	☐ Negative ☐ Positive	☐ Not evaluated	☐ Unknown
Monoclonal Ig in urine *(g/24 h)*	....	☐ Not evaluated	
Immunofixation of urine	☐ Negative ☐ Positive	☐ Not evaluated	☐ Unknown
Serum β2 microglobulin *(mg/L)*	.... -	☐ Not evaluated	

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): ……

DISEASE STATUS AT HSCT

To be evaluated just before starting conditioning

SEE MANUAL FOR FULL DEFINITION OF EACH DISEASE STATUS

☐ At diagnosis *(untreated)*

☐ Stringent complete remission (sCR)

☐ Complete remission (CR) If sCR or CR: NUMBER OF THIS COMPLETE REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Very good PR (VGPR)

☐ PR If VGPR or PR: NUMBER OF THIS PARTIAL REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Relapse from CR *(untreated after the relapse)* NUMBER OF THIS RELAPSE
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Stable disease (*no change, includes old MR)*

☐ Progression

☐ Unknown

Plateau (**COMPLETE ONLY IF STATUS IS STABLE DISEASE OR PR**)
(not applicable for non secretory myeloma)

☐ No ☐ Yes ☐ Unknown

CLINICAL AND LABORATORY DATA

Hb *(g/dL)*	....	☐ Not evaluated		
Serum creatinine *(μmol/L)*	....	☐ Not evaluated		
Serum calcium *(mmol/L)*	.... -	☐ Not evaluated		
Serum albumin *(g/L)*	....	☐ Not evaluated		
BM aspirate: % plasmacytosis	....	☐ Not evaluated		
BM trephine: % plasmacytosis	....	☐ Not evaluated		
Monoclonal Ig in serum *(g/L)*	....	☐ Not evaluated		
Immunofixation of serum	☐ Negative	☐ Positive	☐ Not evaluated	☐ Unknown
Monoclonal Ig in urine *(g/24 h)*	....	☐ Not evaluated		
Immunofixation of urine	☐ Negative	☐ Positive	☐ Not evaluated	☐ Unknown
Serum β2 microglobulin *(mg/L)*	.... -	☐ Not evaluated		

Bone structure

Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF HSCT

☐ AUTOgraft, **proceed to Autograft day 0 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 0 form**

If ☐ Other : ..... , contact the EBMT Central Registry Office for instructions

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

DAY 100

MED-B
PLASMA CELL DISORDERS (INCLUDING MULTIPLE MYELOMA)

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Hospital Unique Patient Number .....

Date of this report .... - .... - ....
yyyy mm dd

Initials: ....._..... (first name(s)_surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of the most recent transplant before this follow up: ..... - ..... - .....
yyyy mm dd

BEST RESPONSE TO HSCT AT 100 DAYS

(see manual for full definition of each response)

☐ Stringent complete remission (sCR)
☐ Complete remission (CR) If sCR or CR: NUMBER OF THIS COMPLETE REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Very good PR (VGPR)
☐ PR If VGPR or PR: NUMBER OF THIS PARTIAL REMISSION
- ☐ 1st
- ☐ 2nd
- ☐ 3rd or higher

☐ Stable disease (*no change, includes old MR)*
☐ Progression
☐ Unknown

If complete response: Date of CR .... - .... - ....
yyyy mm dd

Otherwise: date of evaluation :..... ..... - .... - ....
yyyy mm dd

Plateau (*Complete only if status is Stable disease or PR*) ☐ No ☐ Yes ☐ Unknown
(not applicable for non secretory myeloma)

CLINICAL AND LABORATORY DATA

BM aspirate: % plasmacytosis .... ☐ Not evaluated
BM trephine: % plasmacytosis .... ☐ Not evaluated

Monoclonal Ig in serum *(g/L)* .... ☐ Not evaluated
Immunofixation of serum ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Monoclonal Ig in urine *(g/24 h)* .... ☐ Not evaluated
Immunofixation of urine ☐ Negative ☐ Positive ☐ Not evaluated ☐ Unknown

Serum β2 microglobulin *(mg/L)* .... - ..... ☐ Not evaluated

Bone structure
Lytic lesions: ☐ Normal ☐ Minor ☐ Major ☐ Not evaluated

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

☐ AUTOgraft, **proceed to Autograft day 100 form**

☐ ALLOgraft or Syngeneic graft, **proceed to Allograft day 100 form**

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

FOLLOW UP	MED-B PLASMA CELL DISORDERS (INCLUDING MULTIPLE MYELOMA)

Unique Identification Code (UIC) .... - .... - ..... *(if known)*

Hospital Unique Patient Number .....

Date of this report .... - .... - ....
yyyy mm dd

Patient following national / international study / trial: ☐ No ☐ Yes ☐ Unknown

Name of study / trial .....

Initials: ....._..... (first name(s)_surname(s))

Date of birth .... - .... - ....
yyyy mm dd

Sex: ☐ Male ☐ Female
(at birth)

Date of the most recent transplant before this follow up: ..... - ..... - .....
yyyy mm dd

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH: .... - .... - ....
yyyy mm dd

Complete haematological remission obtained after the HSCT in the absence of additional disease treatment

☐ Previously reported
☐ Yes, date .... - .... - ....
yyyy mm dd
☐ No
☐ Unknown

Complications after Transplant (Allografts)

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

Maximum grade ☐ grade 0 *(Absent)* ☐ grade I ☐ grade II ☐ grade III ☐ grade IV ☐ Not evaluated

If present: ☐ New onset ☐ Recurrent ☐ Persistent

Reason: ☐ Tapering ☐ DLI ☐ Unexplained

Date onset of this episode: ....- .... - ....
(if new or recurrent) *yyyy mm dd*
☐ Not applicable

Stage:

Skin	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Liver	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Lower GI tract	☐ 0 (none)	☐ I	☐ II	☐ III	☐ IV
Upper GI tract	☐ 0 (none)	☐ I			
Other site affected	☐ No	☐ Yes			

Resolution

☐ No ☐ Yes: Date of resolution: ....- .... - ....

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

yyyy mm dd

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

CHRONIC GRAFT VERSUS HOST DISEASE (CGVHD)

Presence of cGvHD

☐ No

☐ Yes: ☐ First episode
☐ Recurrence

Date of onset .... - .... - ....
yyyy mm dd

☐ Present continuously since last reported episode

Maximum extent during this period
☐ Limited ☐ Extensive ☐ Unknown

Maximum NIH score during this period
☐ Mild ☐ Moderate ☐ Severe ☐ Not evaluated

Organs affected ☐ Skin ☐ Gut ☐ Liver ☐ Mouth
☐ Eyes ☐ Lung ☐ Other, specify ..... ☐ Unknown

☐ Resolved: Date of resolution: .... - .... - ....
yyyy mm dd

OTHER COMPLICATIONS SINCE LAST REPORT

PLEASE USE THE DOCUMENT "DEFINITIONS OF INFECTIOUS DISEASES AND COMPLICATIONS AFTER STEM CELL TRANSPLANTATION" TO FILL THESE ITEMS.

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type	**Pathogen** *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	**Date** *Provide different dates for different episodes of the same complication if applicable.*
Bacteremia / fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		
ARDS		
Multiorgan failure due to infection		
ENDORGAN DISEASES		
Pneumonia		

Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		
Retinitis		
Other:		
		yyyy mm dd

DOCUMENTED PATHOGENS *(Use this table for guidance on the pathogens of interest)*

Type	**Pathogen**	**Type**	**Pathogen**
Bacteria		Viruses	
	S. pneumoniae		HSV
	Other gram positive *(i.e.: other streptococci, staphylococci, listeria …)*		VZV
	Haemophilus influenzae		EBV
	Other gram negative *(i.e.: E. coli klebsiella, proteus, serratia, pseudomonas …)*		CMV
	Legionella sp		HHV-6
	Mycobacteria sp		RSV
	Other:		Other respiratory virus *(influenza, parainfluenza, rhinovirus)*
Fungi			Adenovirus
	Candida sp		HBV
	Aspergillus sp		HCV
	Pneumocystis carinii		HIV
	Other:		Papovavirus
Parasites			Parvovirus
	Toxoplasma gondii		Other: .....
	Other:		

NON INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type *(Check all that are applicable for this period)*	**Yes**	**No**	**Unknown**	**Date**
Idiopathic pneumonia syndrome	☐	☐	☐	
VOD	☐	☐	☐	
Cataract	☐	☐	☐	
Haemorrhagic cystitis, non infectious	☐	☐	☐	
ARDS, non infectious	☐	☐	☐	
Multiorgan failure, non infectious	☐	☐	☐	
HSCT-associated microangiopathy	☐	☐	☐	
Renal failure requiring dialysis	☐	☐	☐	
Haemolytic anaemia due to blood group	☐	☐	☐	
Aseptic bone necrosis	☐	☐	☐	
Other: ……. VOTCOMPS	☐			

yyyy *mm* *dd*

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): ……

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

Graft loss

☐ No ☐ Yes ☐ Not evaluated

Overall chimaerism ☐ Full *(donor ≥95 %)* ☐ Mixed *(partial)*
☐ Autologous reconstitution *(recipient ≥95 %)* ☐ Aplasia
☐ Not evaluated

INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS.
SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE.
COPY THIS TABLE AS MANY TIMES AS NECESSARY.

Date of test	Identification of donor or Cord Blood Unit given by the centre	Number in the infusion order *(if applicable)*	Cell type on which test was performed	% Donor cells	Test used
.... - ..... - .... *yyyy mm dd*	.....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown
.... - ..... - .... *yyyy mm dd*	....	..... ☐ N/A	☐ BM ☐ PB mononuclear cells (PBMC) ☐ T-cell ☐ B-cells ☐ Red blood cells ☐ Monocytes ☐ PMNs (neutrophils) ☐ Lymphocytes, NOS ☐ Myeloid cells, NOS ☐ Other, specify:	..... % ..... …% ..... % ..... % ..... …% ..... % ..... % ..... …% ..... % ..... %	☐ FISH ☐ Molecular ☐ Cytogenetic ☐ ABO group ☐ Other: ..... ☐ unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

☐ Previously reported

☐ Yes, date of diagnosis: .... - .... - ....
yyyy mm dd

Diagnosis: ☐ AML ☐ MDS ☐ Lymphoproliferative disorder ☐ Other .....

IF THE PATIENT HAS RECEIVED AN ALLOGRAFT PRIOR TO THE DIAGNOSIS OF ACUTE LEUKAEMIA, ANSWER THE FOLLOWING QUESTION

Is this secondary malignancy a donor cell leukaemia**?** ☐ No ☐ Yes ☐ Not applicable

☐ No

ADDITIONAL TREATMENT SINCE LAST FOLLOW UP INCLUDING CELL THERAPY

Was any additional treatment given for the disease indication for transplant

☐ No

☐ Yes: Start date of the additional treatment since last report: ....
yyyy mm dd

☐ Unknown

-Cell therapy

Did the disease treatment include additional cell infusions ***(excluding a new HSCT)***

☐ No

☐ Yes: Is this cell infusion an allogeneic boost? ☐ No ☐ Yes
An allo boost is an infusion of cells from the same donor without conditioning, with no evidence of graft rejection.

Is this cell infusion an autologous boost? ☐ No ☐ Yes

⇨ **If cell infusion is <u>not</u> a boost, please complete CELLULAR THERAPY on the following page**

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy mm dd

Patient Number in EBMT database (if known): ……

CELLULAR THERAPY

One cell therapy regimen is defined as any number of infusions given within 10 weeks for the same indication. If more than one regimen of cell therapy has been given since last report, copy this section and complete it as many times as necessary.

Date of first infusion: ....
yyyy mm dd

Disease status before this cellular therapy ☐ CR ☐ Not in CR ☐ Not evaluated ☐ Unknown

Source of cells: ☐ Allo ☐ Auto
(check all that apply)

Type of cells *(check all that apply)*

☐ Donor lymphocyte infusion (DLI)

☐ Mesenchymal cells

☐ Fibroblasts

☐ Dendritic cells

☐ NK cells

☐ Regulatory T-cells

☐ Gamma/delta cells

☐ Other .....

☐ Unknown

Number of cells infused by type	
Nucleated cells (/kg*) *(DLI only)*	.... - .... x 10^8 ☐ Not evaluated ☐ unknown
CD 34+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
CD 3+ (cells/kg*) *(DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown
Total number of cells infused	
All cells (cells/kg*) *(non DLI only)*	.... - .... x 10^6 ☐ Not evaluated ☐ unknown

Chronological number of this cell therapy for this patient .....

Indication *(check all that apply)*

☐ Planned/protocol
☐ Prophylactic
☐ Treatment of GvHD
☐ Loss/decreased chimaerism
☐ Other, specify ....
☐ Treatment for disease
☐ Mixed chimaerism
☐ Treatment viral infection
☐ Treatment PTLD, EBV lymphoma

Number of infusions within 10 weeks .....
(count only infusions that are part of same regimen and given for the same indication)

Acute Graft Versus Host Disease *(after this infusion but before any further infusion / HSCT)*:

Maximum grade ☐ grade 0 (absent) ☐ grade 1 ☐ grade 2
☐ grade 3 ☐ grade 4 ☐ present, grade unknown

-Chemo / radiotherapy

ADDITIONAL DISEASE TREATMENT GIVEN EXCLUDING CELL INFUSION?

☐ No
☐ Yes: ☐ Preemptive / preventive *(planned before the transplant took place)*
☐ For relapse / progression or persistent disease *(not planned)*

Date started ..... - ..... - .....
yyyy mm dd

Chemo/drug/agent ..... ☐ Unknown
(including MoAB, vaccination, etc.)
Radiotherapy ☐ No ☐ Yes ☐ Unknown

Other treatment ☐ No ☐ Yes, specify: ..... ☐ Unknown
☐ Unknown

FIRST EVIDENCE OF RELAPSE OR PROGRESSION SINCE LAST HSCT

RELAPSE OR PROGRESSION

☐ Previously reported
☐ No
☐ Yes; date diagnosed: ..... - ..... - .....
yyyy mm dd
☐ Continuous progression since HSCT

LAST DISEASE AND PATIENT STATUS

LAST DISEASE STATUS

☐ Complete Remission
☐ Stable disease
☐ Relapse
☐ Progression

PREGNANCY AFTER HSCT

Has patient or partner become pregnant after this HSCT?

☐ No
☐ Yes: Did the pregnancy result in a live birth? ☐ No ☐ Yes ☐ Unknown
☐ Unknown

CIC: ..... Hospital UPN: ..... HSCT Date..... .... - ..... - .....
yyyy *mm* *dd*

Patient Number in EBMT database (if known): ……

SURVIVAL STATUS

- ☐ Alive
- ☐ Dead

PERFORMANCE SCORE *(if alive)*

Type of score used ☐ Karnofsky ☐ Lansky

SCORE ☐ 100 (Normal, NED) ☐ Not evaluated
☐ 90 (Normal activity) ☐ Unknown
☐ 80 (Normal with effort)
☐ 70 (Cares for self)
☐ 60 (Requires occasional assistance)
☐ 50 (Requires assistance)
☐ 40 (Disabled)
☐ 30 (Severely disabled)
☐ 20 (Very sick)
☐ 10 (Moribund)

MAIN CAUSE OF DEATH *(check only one main cause)*

- ☐ Relapse or progression / persistent disease
- ☐ Secondary malignancy *(including lymphoproliferative disease)*
- ☐ HSCT related cause
- ☐ Cell therapy (non HSCT) Related Cause *(if applicable)*
- ☐ Other: .....
- ☐ Unknown

Contributory Cause of Death *(check as many as appropriate)*:

	Yes	No	Unknown
GvHD *(if previous allograft)*	☐	☐	☐
Interstitial pneumonitis	☐	☐	☐
Pulmonary toxicity	☐	☐	☐
Infection	☐	☐	☐
bacterial	☐	☐	☐
viral	☐	☐	☐
fungal	☐	☐	☐
parasitic	☐	☐	☐
Rejection / poor graft function	☐	☐	☐
History of severe Veno-Occlusive disorder (VOD)	☐	☐	☐
Haemorrhage	☐	☐	☐
Cardiac toxicity	☐	☐	☐
Central nervous system toxicity	☐	☐	☐
Gastro intestinal toxicity	☐	☐	☐
Skin toxicity	☐	☐	☐
Renal failure	☐	☐	☐
Multiple organ failure	☐	☐	☐

Other: .....

ADDITIONAL NOTES IF APPLICABLE

COMMENTS .....

.....

....

IDENTIFICATION & SIGNATURE

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