

HAEMATOPOIETIC CELL TRANSPLANTATION (HCT) --- Day 100 Follow-Up ---

SURVIVAL STATUS

Date of follow-up: ____/____/____ (YYYY/MM/DD)
 (if died: date of death, if lost to follow up: date last seen)

Survival status:

- Alive
- Dead
- Lost to follow-up

Main cause of death:
 (check only one main cause)

<input type="checkbox"/> Relapse or progression/persistent disease	
<input type="checkbox"/> Secondary malignancy	
<input type="checkbox"/> CT-related	Select treatment related cause: <i>(select all that apply)</i> <input type="checkbox"/> Graft versus Host Disease <input type="checkbox"/> Non-infectious complication <input type="checkbox"/> Infectious complication:
<input type="checkbox"/> HCT-related	<i>(select all that apply)</i> <input type="checkbox"/> Bacterial infection <input type="checkbox"/> Viral infection <input type="checkbox"/> Fungal infection <input type="checkbox"/> Parasitic infection <input type="checkbox"/> Infection with unknown pathogen
<input type="checkbox"/> GT-related	
<input type="checkbox"/> IST-related	
<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other; specify: _____	

Autopsy performed:

- No
- Yes
- Unknown

BEST RESPONSE

Not applicable for Inborn Errors

Best clinical/biological response after HCT* (observed before any subsequent treatment): _____

Date best response first observed: ____/____/____ (YYYY/MM/DD) Unknown

* Indicate the best clinical/biological response after HCT corresponding to indication diagnosis by selecting from the list provided in Appendix 1



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

RECOVERY

Absolute neutrophil count (ANC) recovery (*neutrophils* $\geq 0.5 \times 10^9/L$):

- No : **Date of the last assessment:** ____/____/____ (YYYY/MM/DD) Unknown
- Yes: **Date of ANC recovery:** ____/____/____ (YYYY/MM/DD) Unknown
(first of 3 consecutive values after 7 days without transfusion containing neutrophils)
- Never below
- Unknown

Platelet reconstitution (*platelets* $\geq 20 \times 10^9/L$):

- No: **Date of the last assessment:** ____/____/____ (YYYY/MM/DD) Unknown
- Yes: **Date of platelet reconstitution:** ____/____/____ (YYYY/MM/DD) Unknown
(first of 3 consecutive values after 7 days without platelet transfusion)
- Never below
- Unknown
- Date of the last platelet transfusion:** ____/____/____ (YYYY/MM/DD) Not applicable
(not transfused) Unknown



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Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

GRAFT FUNCTION

Poor graft function (defined as: frequent dependence on blood and/or platelet transfusions and/or growth factor support in the absence of other explanations, such as disease relapse, drugs, or infection):

- No
 Yes; **Date of poor graft function:** ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

Complete for every chimaerism test performed:
(complete only if patient received an allogeneic HCT)

Chimaerism test date: ____/____/____ (YYYY/MM/DD) Unknown

Source of cells tested: Peripheral blood
 Bone marrow

Select cell type and complete relevant test results:

- Global: _____ % donor Unknown
 Myeloid cells (i.e. CD33, CD15 or CD14): _____ % donor Unknown
 T-cells (CD3): _____ % donor Unknown
 B-cells (CD19 or CD20): _____ % donor Unknown
 CD34+ cells: _____ % donor Unknown
 Other cell type; specify cells; _____ % donor Unknown

copy and fill-in this table as many times as necessary.

PREVENTIVE THERAPIES

(Complete only if the patient received an alloHCT)

Immunosuppression:

- No
 Yes; **Immunosuppression stopped:**
 No
 Yes; **End date:** ____/____/____ (YYYY/MM/DD) Unknown
 Unknown
 Unknown

Letermovir used as CMV prophylaxis:

- No
 Yes; **Start date:** ____/____/____ (YYYY/MM/DD) Unknown
Letermovir treatment stop? No
 Yes; **End date:** ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

Extended dataset

Antimicrobial prophylaxis

Did the patient receive prophylaxis for bacterial, viral or fungal infection? No Yes

If yes, what type of prophylaxis? Antibacterial Antifungal Antiviral
 (select all that apply and complete the relevant section)

Antibacterial

Antibiotic <i>(select all that were administered)</i>	Phase
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Antimicrobial prophylaxis

Extended dataset

Antibacterial

Antibiotic <i>(select all that were administered)</i>	Phase
<input type="checkbox"/> Non-absorbable antibiotic	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown

Final date antibacterial prophylaxis was discontinued: ____/____/____ (YYYY/MM/DD) Ongoing Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Antimicrobial prophylaxis continued

Extended dataset

Antiviral

Did the patient receive CMV prophylaxis other than or in addition to letermovir?

- No (i.e. no prophylaxis or only letermovir)
- Yes: **Which drugs were used?** High-dose acyclovir
(select all that apply) High-dose valacyclovir
- Note: letermovir is not included as this is requested on the core dataset. Do not consider letermovir for 'Other drug'.* Gancyclovir intravenous
 Valgancyclovir
 Foscarnet
 Other drug

Final date CMV prophylaxis was discontinued: ____/____/____ (YYYY/MM/DD) Ongoing Unknown

Did the patient receive prophylaxis for varicella-zoster virus (VZV) or herpes simplex virus (HSV) with either acyclovir or valacyclovir? (Only for allo-HCT, not auto-HCT)

- No
- Yes: **Final date VZV or HSV prophylaxis was discontinued:** ____/____/____ (YYYY/MM/DD) Ongoing Unknown

Did the patient receive rituximab or another anti-CD20 monoclonal drug as prophylaxis for Epstein-Barr virus post-transplant lymphoproliferative disorder (EBV-PTLD)? (Only for allo-HCT, not auto-HCT)

- No
 Yes

Did the patient receive prophylaxis for hepatitis B virus (HBV)?

- No
- Yes:
- Which drugs were used?** Lamivudine
(select all that apply) Entecavir
 Tenofovir
 Other drug

Final date HBV prophylaxis was discontinued: ____/____/____ (YYYY/MM/DD) Ongoing Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Antimicrobial prophylaxis continued

Extended dataset

Antifungal

Antifungal <i>(select all that were administered)</i>	Phase
<input type="checkbox"/> Fluconazole	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Voriconazole	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Posaconazole	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Itraconazole	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Antimicrobial prophylaxis continued

Extended dataset

Antifungal

Antifungal <i>(select all that were administered)</i>	Phase
<input type="checkbox"/> Caspofungin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Micafungin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Anidulafungin	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown
<input type="checkbox"/> Ambisome (IV or inhalations)	<input type="checkbox"/> Pre-engraftment <input type="checkbox"/> Post-engraftment; specify: <input type="checkbox"/> Only post-engraftment <input type="checkbox"/> Started pre-engraftment and continued into post-engraftment <input type="checkbox"/> Started and stopped in pre-engraftment phase and restarted in post-engraftment phase <input type="checkbox"/> Unknown

Final date antifungal prophylaxis was discontinued: ____/____/____ (YYYY/MM/DD) Ongoing Unknown



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

Antimicrobial prophylaxis continued

Extended dataset

Antifungal

Did the patient receive prophylaxis for *Pneumocystis jirovecii* pneumonia (PJP)?

- No
- Yes: **Which drugs were used?** Trimethoprim-sulfamethoxazole
(select all that apply)
- Dapsone
- Atovaquone
- Pentamidine inhaled
- Pentamidine intravenous
- Other drug

Final date prophylaxis was discontinued: ____/____/____ (YYYY/MM/DD) Ongoing Unknown

Unknown



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

Extended dataset

Pre-emptive viral therapy

Did the patient receive pre-emptive therapy for a viral infection? No Yes

If yes, for what virus? CMV EBV
(select all that apply)

Specify the pre-emptive therapy for each CMV episode that occurred

CMV treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used:
(Select all that apply)

- Valgancyclovir
- Gancyclovir intravenous
- Foscarnet
- Cidofovir
- Maribavir
- Specific CMV T-cell
- Other drug

Was this episode of CMV infection due to a resistant CMV strain?

- No Yes Unknown

Copy as often as necessary to reflect all episodes that occurred

Specify the pre-emptive therapy for each EBV episode that occurred

EBV treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used:
(Select all that apply)

- Rituximab
- Specific EBV T-cells
- Other drug

Copy as often as necessary to reflect all episodes that occurred

COMPLICATIONS POST HCT TREATMENT

-- GvHD --

Allogeneic HCT only

Did graft versus host disease (GvHD) occur?

No (proceed to 'Complications since the last report - Non-infectious complications')

Yes: **Did the patient receive a systemic/immunosuppressive treatment for GvHD?**

No

Yes: **Date treatment started:** ____/____/____ (YYYY/MM/DD) Unknown

Treatment stopped: No

Yes; **Stop date of treatment:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

Unknown

Unknown (proceed to 'Complications since the last report - Non-infectious complications')

Did acute GvHD occur during this follow-up period?

No

Yes: **Date of onset:** ____/____/____ (YYYY/MM/DD) Unknown

Maximum observed organ severity score:

Skin:	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Liver:	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Lower GI tract:	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Upper GI tract:	<input type="checkbox"/> 0 (none)		<input type="checkbox"/> 1	<input type="checkbox"/> Not evaluated		<input type="checkbox"/> Unknown	
Other site affected:	<input type="checkbox"/> No		<input type="checkbox"/> Yes; specify: _____				

Overall maximum grade observed: 1 2 3 4 Unknown Not evaluated

Steroid-refractory acute GvHD: No

Yes: **Date of onset:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

aGvHD resolved: No

Yes; **Date of aGvHD resolution:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

Unknown

COMPLICATIONS POST HCT TREATMENT

-- GvHD --

Allogeneic HCT only

Extended dataset

aGvHD first line treatment

Did the patient receive steroids as first line treatment of aGvHD? No Yes Unknown

Steroid details :

Name of steroid	Treatment started date (YYYY/MM/DD)	Initial dose (mg/kg/day)	Treatment stopped / date (YYYY/MM/DD)
<input type="checkbox"/> Prednisolone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other; specify: _____	____/____/____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Prednisolone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other; specify: _____	____/____/____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Copy and print this table as many times as needed, or enter the data directly into the EBMT Registry

Were other systemic drugs/strategies used to treat aGvHD in the first line: No Yes Unknown
 (other than steroids)

If yes, select the drugs below:
 (select all that apply)

Name of drug/strategy
<input type="checkbox"/> ECP
<input type="checkbox"/> Ruxolitinib
<input type="checkbox"/> MMF
<input type="checkbox"/> Cyclosporin A
<input type="checkbox"/> Tacrolimus
<input type="checkbox"/> Sirolimus
<input type="checkbox"/> Other; specify: _____

COMPLICATIONS POST HCT TREATMENT

-- GvHD --

Allogeneic HCT only

Extended dataset

aGvHD first line treatment continued

Steroid refractory definition covers other subtypes, such as dependent and intolerant, but 'Steroid Refractory' (SR) will be used as an umbrella term in this form

Refractory: progression in any organ within 3, 4 or 5 days of therapy onset with ≥ 2 mg/Kg/day of prednisone equivalent, or failure to improve within 5 to 7 days of treatment initiation, or incomplete response after more than 28 days of immunosuppressive treatment including steroids.

Dependent: Inability to taper prednisone under 2 mg/Kg/day after an initially successful treatment of at least 7 days or as the recurrence of aGvHD activity during steroid tapering.

How did aGvHD respond to steroids ? (according to the definitions above)

Steroid sensitive: No Yes Unknown

If steroid sensitive, please continue at 'Complications since the last report'

Steroid refractory: No Yes Unknown

Steroid dependent: No

Yes: **Date of onset:** ____/____/____ Unknown
 (YYYY/MM/DD)

Unknown

Steroid refractory/dependent aGvHD

Did the patient receive treatment for SR/SD aGvHD ? No Yes Unknown
 (after steroid refractoriness/dependence was established)

if SR/SD aGvHD treatment started :

Overall aGvHD grade at start of SR/SD GvHD treatment: 0 1 2 3 4 Not evaluated Unknown

Organ(s) involved at start of SR/SD GvHD treatment:

Organ	Stage (Glucksberg scale)
Skin	<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Liver	<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Lower GI tract	<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Upper GI tract	<input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage 1 <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown

Extended dataset

Steroid refractory/dependent aGvHD continued
Drugs given during the line of treatment

Line of treatment . _____

Name of drug (select all that applies)	Started date (YYYY/MM/DD)	Stopped / date (YYYY/MM/DD)
<input type="checkbox"/> ECP	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Ruxolitinib	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> MMF	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Cyclosporin A	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Tacrolimus	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Sirolimus	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Other; specify: ____	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

If there were more lines of treatment, copy the page as often as necessary or enter the data directly into the EBMT Registry

Extended dataset

**Steroid refractory/dependent aGvHD
continued**

Organ involved during the course of treatment and response to the line of treatment :

Organ involved during the course of treatment	Organ(s) involved during the course of treatment and Best response achieved	Date best response assessed (YYYY/MM/DD)
Skin	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Liver	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Lower GI tract	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Upper GI tract	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Overall (if organ specific is not available)	<input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown

If there were more lines of treatment, copy the page as often as necessary or enter the data directly into the EBMT Registry

COMPLICATIONS SINCE THE LAST REPORT

-- GvHD --

Allogeneic HCT only

Did chronic GvHD occur during this follow-up period?

 No

 Yes: **Date of onset:** ____/____/____ (YYYY/MM/DD) Unknown

Maximum NIH score:

- Mild
- Moderate
- Severe
- Unknown
- Not evaluated

Date of maximum NIH score: ____/____/____ (YYYY/MM/DD) Unknown

Maximum observed organ severity score:

Skin:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Oral:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Gastrointestinal:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Eyes:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Liver:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Joints and fascia:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Lungs:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Genitalia:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Other site affected:	<input type="checkbox"/> No	<input type="checkbox"/> Yes; specify: _____				

Steroid-refractory chronic GvHD: No

Yes: **Date of onset:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

cGvHD resolved: No

Yes; **Date of cGvHD resolution:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

Was overlap syndrome observed: No Yes Unknown

(features of both chronic and acute GvHD)

 Unknown

Extended dataset

cGvHD first line treatment

Did the patient receive steroids as first line treatment of cGvHD ? No Yes Unknown

Steroid details :

Name of steroid	Treatment started date (YYYY/MM/DD)	Initial dose (mg/kg/day)	Treatment stopped / date (YYYY/MM/DD)
<input type="checkbox"/> Prednisolone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other; specify: _____	_____/____/____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Prednisolone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other; specify: _____	_____/____/____ <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Copy and print this table as many times as needed, or enter the data directly into the EBMT Registry

Were other systemic drugs/strategies used to treat cGvHD in the first line? No Yes Unknown
 (other than steroids)

If yes, select the drugs below:
 (select all that apply)

Name of drug/strategy
<input type="checkbox"/> ECP <input type="checkbox"/> Ruxolitinib <input type="checkbox"/> MMF <input type="checkbox"/> Cyclosporin A <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Sirolimus <input type="checkbox"/> Other; specify: _____

Steroid refractory definition covers other subtypes, such as dependent and intolerant, but 'Steroid Refractory' (SR) will be used as an umbrella term in this form

Refractory: progression of GvHD while on prednisone at ≥ 1 mg/Kg/day for 1-2 weeks or stable GvHD while on ≥ 0.5 mg/Kg/day (or 1 mg/Kg every other day) of prednisone for 1-2 months.

Dependent: inability to control GVHD symptoms while tapering prednisone below 0.25 mg/Kg/day (or 0.5 mg/Kg every other day) in at least two individual attempts, separated by at least 8 weeks.

Intolerant: Includes avascular necrosis, severe myopathy, uncontrolled diabetes mellitus, systemic viral or fungal infections.

How did cGvHD respond to steroids ? (according to the definitions above)

Steroid sensitive: No Yes Unknown

If steroid sensitive, please continue at 'Complications since the last report'

Steroid refractory: No Yes Unknown

Steroid dependent: No

Yes: **Date of onset:** _____/____/____ Unknown
 (YYYY/MM/DD)
 Unknown

Steroid intolerant: No

Yes: **Date of onset:** _____/____/____ Unknown
 (YYYY/MM/DD)
 Unknown

Extended dataset

Steroid refractory/dependent/intolerant cGvHD

Did the patient receive treatment for SR/SD/SI cGvHD ? No Yes Unknown
 (after steroid refractoriness/dependence/intolerance was established)

Overall cGvHD grade at start of SR/SD/SI GvHD treatment: Mild Moderate Severe Not evaluated Unknown

Organ(s) involved at start of SR/SD/SI GvHD treatment:

Skin:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Oral:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Gastrointestinal:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Eyes:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Liver:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Joints and fascia:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Lungs:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Genitalia:	<input type="checkbox"/> 0 (<i>none</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Other site affected:	<input type="checkbox"/> No	<input type="checkbox"/> Yes; specify: _____				

Extended dataset

Steroid refractory/dependent/intolerant cGvHD

Drugs given during the line of treatment

Line of treatment _____

Name of drug/ strategy (select all that applies)	Started date (YYYY/MM/DD)	Stopped / date (YYYY/MM/DD)
<input type="checkbox"/> ECP	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Ruxolitinib	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> MMF/CellCept	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Belumosudil	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Ibrutinib	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Everolimus	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Sirolimus	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Cyclosporin A	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Tacrolimus	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Other; specify: _____	_____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: _____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

If there were more lines of treatment, copy the page as often as necessary or enter the data directly into the EBMT Registry

Steroid refractory/dependent/intolerant cGvHD

Extended dataset

Organ involved during the course of treatment and response to the line of treatment :

Organ involved during the course of treatment	Organ(s) involved during the course of treatment and Best response achieved	Date best response assessed (YYYY/MM/DD)
Skin	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Oral	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Gastrointestinal	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Liver	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Joints and fascia	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Genitalia	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown
Overall (if organ specific is not available)	<input type="checkbox"/> CR <input type="checkbox"/> PR <input type="checkbox"/> Progression <input type="checkbox"/> Stable/no change <input type="checkbox"/> Unknown	____/____/____ <input type="checkbox"/> Unknown

If there were more lines of treatment, copy the page as often as necessary or enter the data directly into the EBMT Registry

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --

Did non-infectious complications occur during the follow-up period?

(Please only report toxic events here that are above Grade 2 and not linked to GvHD and/or infections)

- No (proceed to 'Complications since the last report - Infectious complications')
 Yes (report in the table below)
 Unknown

Secondary graft failure

- Complication observed?** No
 Yes
 Unknown

Maximum grade observed during this period: Non-fatal Fatal

Onset date (YYYY/MM/DD): ____/____/____ Unknown

- Resolved:** No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Cardiac event

- Complication observed?** No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

- Resolved:** No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Central nervous system (CNS) toxicity

- Complication observed?** No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

- Resolved:** No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Gastrointestinal (GI) Toxicity (non-GvHD and non-infectious related)

- Complication observed?** No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

- Resolved:** No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

* Grade 0-2

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --
continued

Liver disorder

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown
 Unknown

Renal failure (chronic kidney disease, acute kidney injury)

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown
 Unknown

Respiratory disorders

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown
 Unknown

Skin Toxicity (non-GvHD and non-infectious related)

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown
 Unknown

* Grade 0-2

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --
continued

Vascular event

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Avascular necrosis (AVN)

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Cerebral haemorrhage

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Haemorrhage (other than cerebral haemorrhage)

Complication observed? No*
 Yes:
 Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

* Grade 0-2

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --
continued

Cerebral thrombosis

Complication observed? No*

Yes:

Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown

Unknown

Cytokine release syndrome (CRS)

Complication observed? No*

Yes:

Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown

Unknown

Haemophagocytic lymphohistiocytosis (HLH)

Complication observed? No*

Yes:

Unknown

Maximum CTCAE grade observed: 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown

Unknown

Pure red cell aplasia (PRCA)

Complication observed? No

Yes:

Unknown

Maximum grade observed: Non-fatal Fatal

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown

Unknown

* Grade 0-2

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --
continued

Posterior reversible encephalopathy syndrome (PRES)

Complication observed? No
 Yes:
 Unknown

Maximum grade observed: Non-severe Severe Fatal Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

Transplant-associated microangiopathy (TMA)

Complication observed? No*
 Yes:
 Unknown

Maximum grade observed: Non-severe Severe Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No
 Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown
 Unknown

* Grade 0-2

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --

Extended dataset

Was TA-TMA treatment given : No Yes Unknown

Line of TA-TMA treatment given :

Line of treatment _____

Name of drug	Start date (YYYY/MM/DD)	Stopped / date (YYYY/MM/DD)
<input type="checkbox"/> Defibrotide	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Eculizumab	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Narsoplimab	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Pegcetacoplan	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Iptacopan	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Danicopan	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Ravulizumab	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Other; specify: _____	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Other TA-TMA treatment given in this line of treatment :

Renal replacement therapy performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first renal replacement therapy: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
Mechanical ventilation performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first mechanical ventilation: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
Exchange plasmapheresis performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first exchange plasmapheresis : ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Response to this line of TA-TMA treatment :

Did the patient achieve complete response? No Yes Unknown

Defined as normal LDH, no organ manifestations, high-risk TA-TMA harmonisation criteria not fulfilled anymore

If yes, date of complete response: ____/____/____ Unknown

If no, did the patient achieve partial response? No Yes Unknown

Defined as LDH decreased, residual organ manifestations, high-risk TA-TMA harmonisation criteria not fulfilled anymore

If yes, date of partial response: ____/____/____ Unknown

Copy and print this table as many times as needed, or enter the data directly into the EBMT Registry

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --

Veno-occlusive disease (VOD)

Complication observed? No* Yes Unknown

Maximum CTCAE grade observed Mild Moderate Severe Very severe Fatal Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; **Stop date (YYYY/MM/DD):** ____/____/____ Unknown

Unknown

Extended dataset

Was VOD treatment given: No Yes Unknown

Line of VOD treatment given :

Line of treatment _____

Name of drug	Start date (YYYY/MM/DD)	Stopped / date (YYYY/MM/DD)
<input type="checkbox"/> Defibrotide	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
<input type="checkbox"/> Other; specify: _____	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Other VOD treatment given in this line of treatment :

Renal replacement therapy performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first renal replacement therapy: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
Mechanical ventilation performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first mechanical ventilation: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
Extracorporeal membrane oxygenation performed:	<input type="checkbox"/> No <input type="checkbox"/> Yes: date of first extracorporeal membrane oxygenation : ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown

Response to this line of VOD treatment :

Did the patient achieve complete response? No Yes Unknown

Defined as serum bilirubin <2 mg/dL, no oxygen support, eGFR >50% from baseline before VOD and no renal replacement therapy

If yes, date of complete response: ____/____/____ Unknown

If no, did the patient achieve partial response? No Yes Unknown

Defined as serum bilirubin increased, but >2 mg/dL, or pulmonary dysfunction, or eGFR ≤50% from baseline before VOD

If yes, date of partial response: ____/____/____ Unknown

Copy and print this table as many times as needed, or enter the data directly into the EBMT Registry



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

COMPLICATIONS SINCE THE LAST REPORT

-- Non-infectious complications --

Other complication observed? No* Yes Unknown

Specify: _____ *Consult appendix 4 for a list of complications that should not be reported*

(Indicate CTCAE term)

Maximum CTCAE grade observed 3 4 5 (fatal) Unknown

Onset date (YYYY/MM/DD): ____/____/____ Unknown

Resolved: No

Yes; Stop date (YYYY/MM/DD): ____/____/____ Unknown

Unknown

* Grade 0-2 *If more other complications occurred, copy and fill-in this table as many times as necessary.*

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications --

Do not report infections that were already reported as resolved on the previous assessment and did not reoccur.

Did infectious complications occur during the follow-up period?

- No *Consult appendix 4 for a list of complications that should not be reported*
 Yes (report all infection-related complications below)
 Unknown

Bacterial infection: No Yes Unknown

1) **Start date:** ____/____/____ (YYYY/MM/DD)

- Gram-positive Gram-negative Other

Pathogen*: _____

- Infection with clinical implications:** No
 Yes: (select all that apply during this period)
 Symptoms/signs of disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

- Intravascular catheter-related infection:** No
 Yes; specify***: _____
 Unknown

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

2) **Start date:** ____/____/____ (YYYY/MM/DD)

- Gram-positive Gram-negative Other

Pathogen*: _____

- Infection with clinical implications:** No
 Yes: (select all that apply during this period)
 Symptoms/signs of disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

- Intravascular catheter-related infection** No
 Yes; specify***: _____
 Unknown

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 2 bacterial infections, copy and fill-in this table as many times as necessary.

* Indicate the pathogen and sub-type (if applicable) by choosing from the list of pathogens provided in Appendix 2

** Indicate CTCAE term by choosing from the list provided in Appendix 3

*** If intravascular catheter-related infection, specify it by choosing from the list provided in Appendix 5

COMPLICATIONS SINCE THE LAST REPORT
 -- Infectious complications -- continued

Viral infection: No Yes Unknown

1) **Start date:** ____/____/____ (YYYY/MM/DD)

Pathogen*: _____

If the pathogen was CMV/EBV: **Was this infection a reactivation?** No
 Yes

Infection with clinical implications: No
 Yes: *(select all that apply during this period)*
 Symptoms/signs of disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

2) **Start date:** ____/____/____ (YYYY/MM/DD)

Pathogen*: _____

If the pathogen was CMV/EBV: **Was this infection a reactivation?** No
 Yes

Infection with clinical implications: No
 Yes: *(select all that apply during this period)*
 Symptoms/signs of disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 2 viral infections, copy and fill-in this table as many times as necessary.

* Indicate the pathogen and sub-type (if applicable) by choosing from the list of pathogens provided in Appendix 2

** Indicate CTCAE term by choosing from the list provided in Appendix 3

*** If intravascular catheter-related infection, specify it by choosing from the list provided in Appendix 5

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications -- continued

Parasitic infection: No Yes Unknown

1) **Start date:** ____/____/____ (YYYY/MM/DD)

Protozoa Helminths

Pathogen*: _____

Infection with clinical implications: No

Yes: *(select all that apply during this period)*

Symptoms/signs or disease

Administration of pathogen-directed therapy

Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

2) **Start date:** ____/____/____ (YYYY/MM/DD)

Protozoa Helminths

Pathogen*: _____

Infection with clinical implications: No

Yes: *(select all that apply during this period)*

Symptoms/signs or disease

Administration of pathogen-directed therapy

Unknown

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 2 parasitic infections, copy and fill-in this table as many times as necessary.

* Indicate the pathogen and sub-type (if applicable) by choosing from the list of pathogens provided in Appendix 2

** Indicate CTCAE term by choosing from the list provided in Appendix 3

*** If intravascular catheter-related infection, specify it by choosing from the list provided in Appendix 5

COMPLICATIONS SINCE THE LAST REPORT
 -- Infectious complications -- continued

Infection with unknown pathogen: No Yes Unknown
 (for clinical infections without microbiological documentation, like pneumonia, cellulitis, etc.)

1) **Start date:** ____/____/____ (YYYY/MM/DD)

Infection with clinical implications: No Yes: (select all that apply)
 Symptoms/signs or disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location:

Localisation 1 (CTCAE term)*: _____
Localisation 2 (CTCAE term)*: _____
Localisation 3 (CTCAE term)*: _____

Intravascular catheter-related infection: No
 Yes; specify** : _____
 Unknown

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

2) **Start date:** ____/____/____ (YYYY/MM/DD)

Infection with clinical implications: No Yes: (select all that apply)
 Symptoms/signs or disease
 Administration of pathogen-directed therapy
 Unknown

Indicate at least 1 location:

Localisation 1 (CTCAE term)*: _____
Localisation 2 (CTCAE term)*: _____
Localisation 3 (CTCAE term)*: _____

Intravascular catheter-related infection: No
 Yes; specify** : _____
 Unknown

Resolved: No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 2 infections with unknown pathogen, copy and fill-in this table as many times as necessary.

* Indicate CTCAE term by choosing from the list provided in Appendix 3 at page 25

** If intravascular catheter-related infection, specify it by choosing from the list provided in Appendix 5 at page 25



EBMT Centre Identification Code (CIC): _____

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

Treatment Type HCT

Treatment Date ____/____/____ (YYYY/MM/DD)

ADDITIONAL TREATMENTS

Did the patient receive any additional disease treatment?

No

Yes: **complete the "Treatment — non-HCT/CT/GT/IST form and/or the Cell infusion sheet"**

Unknown

ADDITIONAL CELL INFUSIONS

Did the patient receive additional cell infusions during this period?

(excluding a new HCT and CT)

No

Yes; **Is this cell infusion an allogeneic boost* ?** No Yes

** An allogeneic boost is an infusion of cells from the same donor without conditioning, with no evidence of graft rejection.*

Date of the allogeneic boost: ____/____/____ (YYYY/MM/DD)

Is this cell infusion an autologous boost? No Yes

Date of the autologous boost: ____/____/____ (YYYY/MM/DD)

Unknown

If this cell infusion is not a boost, attach the Cell Infusion (CI) sheet available in Appendix 6, completing as many sheets as episodes of cell infusion that took place during this interval; then continue below.

Did the patient receive subsequent HCT/CT (either at your or another centre)?

No

Yes

If the patient had a subsequent HCT/CT, please, make sure that this subsequent treatment is registered using the appropriate treatment form before proceeding.

RELAPSE, PROGRESSION, RECURRENCE OF DISEASE OR SIGNIFICANT WORSENING
(not relevant for Inborn errors)

Was there a relapse, progression, recurrence of disease or significant worsening of organ function related to the primary disease after HCT? *(detected by any method)*

- No
- Yes; *for every relapse, progression, recurrence, significant worsening complete the questions below*

Type: Relapse / Recurrence of disease
 (Continuous) progression / Significant worsening

Date of relapse/progression/recurrence/worsening: ____/____/____ (YYYY/MM/DD) Unknown

Extended dataset

In case of relapse or progression (CML only)

Type of relapse: *(select worst detected at this time point)* Haematological; **Disease status at relapse:** Chronic phase
 Accelerated phase
 Blast crisis
 Unknown

Cytogenetic
 Molecular
 Unknown

In case of relapse or progression (MPN only)

Type of relapse: *(select worst detected at this time point)* Haematological
 Molecular
 Unknown

Malignant disorders only:

Type of relapse/progression:

Medullary: No Yes Unknown

Extramedullary: No Yes Unknown

If the relapse/progression was extramedullary or both medullary and extramedullary:

Involvement at time of relapse/progression:

Skin: No Yes Not evaluated

CNS: No Yes Not evaluated

Testes/Ovaries: No Yes Not evaluated

Other: No Yes; specify: _____

copy and fill-in this table as many times as necessary.

Unknown



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

DISEASE STATUS

Disease status after HCT or at time of death*: _____

* Indicate the disease status at this follow-up or at time of death corresponding to indication diagnosis by selecting from the list provided in Appendix 1



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Best Response and Disease Status (Disease Specific)

Complete only one section with the main indication diagnosis for which HCT was given.

ACUTE LEUKAEMIAS	Go to page 39
CHRONIC LEUKAEMIAS	Go to page 39
PLASMA CELL NEOPLASMS (PCN)	Go to page 40
MPN, MDS, MDS / MPN OVERLAP SYNDROMES	Go to page 42
LYMPHOMAS	Go to page 43
SOLID TUMOURS	Go to page 43
BONE MARROW FAILURE SYNDROMES (BMF) including APLASTIC ANAEMIA (AA)	Go to page 43
AUTOIMMUNE DISORDERS	Go to page 44
HAEMOGLOBINOPATHIES	Go to page 44
OTHER DIAGNOSIS	Go to page 45
Inborn Errors	Go to page 46

Appendix 1
 Best Response and Disease Status (Disease Specific)

Acute leukaemias (AML, PLN, Other)

<input type="checkbox"/> Complete remission (CR)
<input type="checkbox"/> Not in complete remission
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Proceed to next page for Diseases Status section

Chronic leukaemias (CML, CLL, PLL, Other)

Chronic Myeloid Leukaemia (CML):

<input type="checkbox"/> Chronic phase (CP); Number: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd or higher <input type="checkbox"/> Unknown Haematological remission: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown Cytogenetic remission: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
<p><i>Extended dataset</i></p> <p>In case of NO cytogenetic remission</p> <p>Cytogenetic details: t(9;22) positive metaphases: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>t(9;22) positive cells detected by FISH: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>Molecular remission: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p>

<p><i>Extended dataset</i></p> <p>In case of NO molecular remission</p> <p>BCR::ABL1 variant allele frequency (VAF): _____% <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p>

<input type="checkbox"/> Accelerated phase; Number: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd or higher <input type="checkbox"/> Unknown
<p><i>Extended dataset</i></p> <p>Cytogenetic details: t(9;22) positive metaphases: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>t(9;22) positive cells detected by FISH: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>BCR::ABL1 variant allele frequency (VAF): _____% <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p>

<input type="checkbox"/> Blast crisis; Number: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd or higher <input type="checkbox"/> Unknown
<p><i>Extended dataset</i></p> <p>Cytogenetic details: t(9;22) positive metaphases: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>t(9;22) positive cells detected by FISH: _____ (%) <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p> <p>BCR::ABL1 variant allele frequency (VAF): _____% <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown</p>

<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Proceed to next page for Diseases Status section

Appendix 1
Best Response and Disease Status (Disease Specific)
Chronic Lymphocytic Leukaemia (CLL), Prolymphocytic Leukaemia (PLL) and other chronic leukaemias:

<input type="checkbox"/> Complete remission (CR)
<input type="checkbox"/> Partial remission (PR)
<input type="checkbox"/> Progression: <input type="checkbox"/> Resistant to last regimen <input type="checkbox"/> Sensitive to last regimen <input type="checkbox"/> Unknown
<input type="checkbox"/> Stable disease (no change, no response/loss of response)
<input type="checkbox"/> Relapse
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Proceed to next page for Diseases Status section

Plasma cell neoplasms (PCN)

<input type="checkbox"/> Complete remission (CR)	Number: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd or higher <input type="checkbox"/> Unknown
<input type="checkbox"/> Stringent complete remission (sCR)	
<input type="checkbox"/> Very good partial remission (VGPR)	
<input type="checkbox"/> Partial remission (PR)	
<input type="checkbox"/> Relapse	
<input type="checkbox"/> Progression	
<input type="checkbox"/> Stable disease (no change, no response/loss of response)	
<input type="checkbox"/> Not evaluated	
<input type="checkbox"/> Unknown	

Extended dataset

Immunoglobulin-related (AL) Amyloidosis only

Organ response

Heart	<input type="checkbox"/> Response <input type="checkbox"/> No change <input type="checkbox"/> Progression <input type="checkbox"/> Not involved <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Kidney	<input type="checkbox"/> Response <input type="checkbox"/> No change <input type="checkbox"/> Progression <input type="checkbox"/> Not involved <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Liver	<input type="checkbox"/> Response <input type="checkbox"/> No change <input type="checkbox"/> Progression <input type="checkbox"/> Not involved <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Peripheral nervous system	<input type="checkbox"/> Response <input type="checkbox"/> No change <input type="checkbox"/> Progression <input type="checkbox"/> Not involved <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown

Proceed to next page for Diseases Status section



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Best Response and Disease Status (Disease Specific)
continued

Complete only for PCN Disease Status

Was the patient on dialysis after HCT?

- No
 Yes; **Start date:** ____/____/____ (YYYY/MM/DD) Unknown

Did dialysis stop? No

- Yes; **End date:** ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

Unknown

Complete only for leukaemias (AL, CLL) and PCN Disease Status

Leukaemias (AL, CLL) and PCN (complete only for patient in CR or sCR)

Minimal residual disease (MRD):

- Negative
 Positive;
 Increasing (>1log10 change) Stable (<1log10 change) Decreasing (>1log10 change) Unknown
 Not evaluated
 Unknown

Date MRD status evaluated: ____/____/____ (YYYY/MM/DD) Unknown

Sensitivity of MRD assay:

- $\leq 10^{-6}$
 $\leq 10^{-5}$
 $\leq 10^{-4}$
 $\leq 10^{-3}$
 Other; specify: _____
 Unknown

Method used:

- (select all that apply)
 PCR
 Flow cytometry
 NGS
 Other; specify: _____
 Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Best Response and Disease Status (Disease Specific)
continued

Myeloproliferative neoplasms (MPN), Myelodysplastic neoplasms (MDS), MDS/MPN overlap syndromes

<input type="checkbox"/> Complete remission (CR)	<u>Number:</u> <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd or higher <input type="checkbox"/> Unknown
<input type="checkbox"/> Improvement but no CR	
<input type="checkbox"/> Primary refractory phase (no change)	
<input type="checkbox"/> Relapse	<u>Number:</u> <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd or higher <input type="checkbox"/> Unknown
<input type="checkbox"/> Progression/Worsening	
<input type="checkbox"/> Not evaluated	
<input type="checkbox"/> Unknown	

Appendix 1
Best Response and Disease Status (Disease Specific)
continued
Lymphomas

<input type="checkbox"/> Chemorefractory relapse or progression, including primary refractory disease
<input type="checkbox"/> Complete remission (CR): <input type="checkbox"/> Confirmed <input type="checkbox"/> Unconfirmed (CRU*) <input type="checkbox"/> Unknown
<input type="checkbox"/> Partial remission (PR)
<input type="checkbox"/> Stable disease (no change, no response/loss of response)
<input type="checkbox"/> Untreated relapse (from a previous CR) or progression (from a previous PR)
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

* CRU: Complete response with persistent scan abnormalities of unknown significance

Solid tumours

<input type="checkbox"/> Complete remission (CR): <input type="checkbox"/> Confirmed <input type="checkbox"/> Unconfirmed <input type="checkbox"/> Unknown
<input type="checkbox"/> First partial remission
<input type="checkbox"/> Partial remission (PR)
<input type="checkbox"/> Progressive disease
<input type="checkbox"/> Relapse: <input type="checkbox"/> Resistant <input type="checkbox"/> Sensitive <input type="checkbox"/> Unknown
<input type="checkbox"/> Stable disease (no change, no response/loss of response)
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Bone marrow failures (incl. AA)

<input type="checkbox"/> Complete remission (CR)
<input type="checkbox"/> Partial remission (PR)
<input type="checkbox"/> Haematological improvement (HI); <i>NIH partial response</i>
<input type="checkbox"/> Stable disease (no change, no response/loss of response)
<input type="checkbox"/> Relapse / Progression
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Complete only for Bone marrow failures (incl. AA) Disease Status

Did transfusions stop during the follow-up period? Patient was never transfusion dependent

No

Yes; **Did the patient return to transfusion dependency afterwards?**

No

Yes; **First transfusion date:** ____/____/____ (YYYY/MM/DD) Unknown
(after transfusion free period)

Unknown

Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Best Response and Disease Status (Disease Specific)
continued

Autoimmune disorders

<input type="checkbox"/> No evidence of disease
<input type="checkbox"/> Improved
<input type="checkbox"/> Unchanged
<input type="checkbox"/> Worse
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Haemoglobinopathies

Thalassaemia:

Complete only for **Thalassemia Best Response**

<input type="checkbox"/> Transfusion independent; Date of last transfusion: ____/____/____ (YYYY/MM/DD) <input type="checkbox"/> Unknown <i>(after HCT)</i>
<input type="checkbox"/> Transfusions required; Date of first transfusion: ____/____/____ (YYYY/MM/DD) <input type="checkbox"/> Unknown <i>(after HCT)</i>
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Complete only for **Thalassemia Disease Status**

Patient requires transfusions during follow-up period:

No

Yes; **Date of first transfusion:** ____/____/____ (YYYY/MM/DD) Unknown
(after HCT)

Number of units: ____ Unknown
(during follow-up period)

Did transfusions stop? No

Yes; **Date of last transfusion:** ____/____/____ (YYYY/MM/DD) Unknown

Unknown

Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Best Response and Disease Status (Disease Specific)
continued

Haemoglobinopathies

Sickle cell disease:

Complete only for Sickle cell disease Best Response

<input type="checkbox"/> No return of sickling episodes
<input type="checkbox"/> Return of sickling episodes; Date of first episode: ____/____/____ (YYYY/MM/DD) <input type="checkbox"/> Unknown (after HCT)
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown

Complete only for Sickle cell disease Disease Status

Sickling episodes occur during follow-up period:

<input type="checkbox"/> No
<input type="checkbox"/> Yes; <input type="checkbox"/> First return of sickling episodes after HCT Date of first episode : ____/____/____ (YYYY/MM/DD) <input type="checkbox"/> Unknown (after HCT)
<input type="checkbox"/> Ongoing presence of sickling episodes
Number of SCD episodes: ____ <input type="checkbox"/> Unknown (after HCT)
<input type="checkbox"/> Unknown

Other diagnosis

<input type="checkbox"/> No evidence of disease
<input type="checkbox"/> Improved
<input type="checkbox"/> No response
<input type="checkbox"/> Worse
<input type="checkbox"/> Not evaluated
<input type="checkbox"/> Unknown



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT

Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Disease Status
Inborn errors only

Extended dataset

Inborn errors

Patient height after HCT: _____ cm Not evaluated Unknown

Patient weight after HCT: _____ kg Not evaluated Unknown

Patient is attending:

- Regular school/work
- Alternative school/adapted work
- Patient is not able to attend work/school
- Unknown

(Only for Inborn errors of Immunity)

Immune profiling done: No Yes Unknown

Test date: ____/____/____ (YYYY/MM/DD) Unknown

Cell type and test results		Units (for CD4 and CD8, select unit)
CD3 T-cells: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Cells/ μ l
CD4 T-cells: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Cells/ μ l
CD8 T-cells: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Cells/ μ l
B-cells (i.e. CD19): _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Cells/ μ l
NK-cells (CD16/CD56): _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Cells/ μ l
Naive CD4 T-cells (CD4/CD45RA): _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	<input type="checkbox"/> % of CD4 <input type="checkbox"/> Cells/ μ l
Naive CD8 T-cells (CD8/CD45RA): _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	<input type="checkbox"/> % of CD8 <input type="checkbox"/> Cells/ μ l
IgG: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Gram/l
IgA: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Gram/l
IgM: _____	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	Gram/l



EBMT Centre Identification Code (CIC): _____
Hospital Unique Patient Number (UPN): _____
Patient Number in EBMT Registry: _____

Treatment Type HCT
Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Disease Status
(Only for Inborn errors of immunity)

Extended dataset

Inborn errors

Select the immunomodulatory treatments the patient received within 100 days post HCT

Only report treatments administered within 100 days post HCT. Do not report report treatments for GvHD or HCT/CT related complications, only report the treatments for the underlying disease

- No treatment given
- IVIG
- SCIG
- Steroids (>0.5 mg/kg/day prednison equivalent)
- Cyclosporine A
- Tacrolimus
- Sirolimus
- Ruxolitinib
- Baricitinib
- Other JAK-inhibitor, specify: _____
- Leniolisib
- Abatacept
- Anakinra
- Canakinumab
- Etoposide
- Interferon gamma
- Etanercept
- Infliximab
- Vedolizumab
- Dupilumab
- Emapalumab
- PEG-ADA
- Other drug; specify: _____

Appendix 1
Disease Status
Inborn errors only

Extended dataset

Comorbidities after HCT
Inborn errors of Immunity only

Indicate in the table below if the comorbidities de novo, resolved, improved, stabilised or worsened since the treatment.

Inflammatory bowel disease	Crohn's disease or ulcerative colitis	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Rheumatologic	SLE, RA, polymyositis, mixed CTD or polymyalgia rheumatica	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Renal: moderate/severe	Serum creatinine > 2 mg/dL or >177 µmol/L, on dialysis, or prior renal transplantation	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Hepatic: mild	Chronic hepatitis, bilirubin between Upper Limit Normal (ULN) and 1.5 x ULN, or AST/ALT between ULN and 2.5 x ULN	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Hepatic: moderate/severe	Liver cirrhosis, bilirubin greater than 1.5 x ULN, or AST/ALT greater than 2.5 x ULN	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Chronic lung disease	Bronchiectasis, interstitial pneumonitis, GLILD, oxygen dependency, structural lung disease (e.g. pneumatoceles)	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Pre-HCT malignancy	Leukaemia, lymphoma, myelodysplastic syndrome (MDS)	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> In remission <input type="checkbox"/> Stable disease <input type="checkbox"/> Relapsed <input type="checkbox"/> Not evaluated <input type="checkbox"/> Not evaluated
Failure to thrive	Weight <3 rd percentile or requirement for (par)enteral feeding	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated
Active infection at HCT	Any infection requiring therapy in the immediate pre HCT period	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> Not evaluated
Lymphoproliferation	I.e. splenomegaly, organ specific lymphoproliferation	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> De novo <input type="checkbox"/> Not evaluated



EBMT Centre Identification Code (CIC): _____
 Hospital Unique Patient Number (UPN): _____
 Patient Number in EBMT Registry: _____

Treatment Type HCT
 Treatment Date ____/____/____ (YYYY/MM/DD)

Appendix 1
Disease Status
Inborn errors only

Extended dataset

Comorbidities after HCT
Inborn errors of Immunity only

Indicate in the table below if the comorbidities de novo, resolved, improved, stabilised or worsened since the treatment.

Pre-HCT organ impairment	Infectious or non-infectious (including neurologic)	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> Not evaluated
Autoimmunity/ autoinflammation	Pre HCT/CT (includes patients in remission but on immunomodulatory treatment within 3 months before HCT/CT)	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Resolved <input type="checkbox"/> Improved <input type="checkbox"/> Stabilised <input type="checkbox"/> Worsened <input type="checkbox"/> Not evaluated

Was the patient admitted to ICU after HCT? No Yes Unknown

Appendix 2
 -- Pathogens as per EBMT Registry database --

**As defined by the IDSA (Mermel LA, Allon M, Bouza E, Craven DE, Flynn P, O'Grady NP, et al. Clinical practice guidelines for the diagnosis and management of intravascular catheter-related infection: 2009 Update by the Infectious Diseases Society of America. Clin Infect Dis. 2009;49(1):1-45)*

Bacterial infections

Gram-positive:

- Clostridioides difficile
- Enterococcus faecalis (vancomycin-susceptible)
- Enterococcus faecalis (vancomycin-resistant)
- Enterococcus faecium (vancomycin-susceptible)
- Enterococcus faecium (vancomycin-resistant)
- Listeria monocytogenes
- Nocardia spp (specify)
- Staphylococcus aureus MSSA (methicillin-susceptible)
- Staphylococcus aureus MRSA (methicillin-resistant) vancomycin-susceptible
- Staphylococcus aureus MRSA (methicillin-resistant) vancomycin not tested
- Staphylococcus aureus MRSA and VISA (vancomycin-intermediate, MIC 4-8 µg/ml)
- Staphylococcus aureus MRSA and VRSA (vancomycin-resistant, MIC ≥ 16 µg/ml)
- Staphylococcus coagulase-negative spp (at least two positive blood cultures)
- Streptococcus pneumoniae
- Streptococcus viridans
- Streptococcus other spp (specify)
- Gram-positive bacteria other spp (specify)

Gram-negative:

- Acinetobacter baumannii
- Campylobacter jejuni
- Citrobacter freundii
- Enterobacter cloacae
- Enterobacter other spp (specify)
- Escherichia coli
- Haemophilus influenzae
- Helicobacter pylori
- Klebsiella aerogenes (carbapenem-susceptible)
- Klebsiella pneumoniae (carbapenem-susceptible)
- Klebsiella (any species) (carbapenem-resistant) (specify)
- Legionella pneumophila
- Morganella morganii
- Neisseria gonorrhoeae
- Neisseria meningitidis
- Proteus vulgaris
- Providencia spp
- Pseudomonas aeruginosa (carbapenem-susceptible)
- Pseudomonas aeruginosa (carbapenem-resistant)
- Salmonella spp (specify)
- Serratia marcescens
- Shigella spp
- Stenotrophomonas maltophilia
- Treponema pallidum
- Gram-negative bacteria other spp (specify)

Other bacteria:

- Chlamydia spp
- Chlamydomphila
- Mycobacterium other spp (specify)
- Mycobacterium tuberculosis
- Mycoplasma pneumoniae
- Rickettsia spp
- Bacteria other (specify)

Viral infections:

- Adenovirus
- Gastrointestinal viruses:
 - o Norovirus
 - o Rotavirus
- Hepatotropic viruses:
 - o HAV
 - o HBV
 - o HCV
 - o HEV
- Herpes group:
 - o CMV
 - o EBV
 - o HHV6
 - o HHV7
 - o HHV8
 - o HS
 - o VZ
- HIV
- Human papilloma viruses (HPV)
- Parvovirus
- Polyomaviruses:
 - o BK
 - o JC
 - o Merkel cell
 - o Other polyomavirus (specify)
- Respiratory viruses:
 - o Enterovirus
 - o Human coronavirus
 - o Influenza A
 - o Influenza B
 - o Metapneumovirus
 - o Parainfluenza
 - o Rhinovirus
 - o RSV
 - o SARS-CoV-2
 - o Respiratory virus other (specify)
- Viruses other (specify)

Appendix 2**-- Pathogens as per EBMT Registry database -- continued**

**As defined by the IDSA (Mermel LA, Allon M, Bouza E, Craven DE, Flynn P, O'Grady NP, et al. Clinical practice guidelines for the diagnosis and management of intravascular catheter-related infection: 2009 Update by the Infectious Diseases Society of America. Clin Infect Dis. 2009;49(1):1-45)*

Fungal infections:**Yeasts:**

- Candida albicans
- Candida auris
- Candida other (specify)
- Cryptococcus neoformans
- Trichosporon (specify)
- Pneumocytis jiroveci
- Yeasts other (specify)

Moulds:

- Aspergillus flavus
- Aspergillus fumigatus
- Aspergillus other spp (specify)
- Aspergillus terreus
- Fusarium other spp (specify)
- Fusarium solani
- Lomentospora prolificans (formerly Scedosporium prolificans)
- Order Mucorales (specify)
- Dematiaceous fungi (Phaeohyphomycosis) (specify)
- Scedosporium spp (specify)
- Moulds other spp (specify)
- Mould infection diagnosed based on positive galactomannan only, without microbiological confirmation
- Blastomyces spp
- Histoplasma spp (specify)
- Coccidioides spp
- Paracoccidioides spp

Parasitic infections:**Protozoa:**

- Babesia spp (specify)
- Cryptosporidium
- Giardia spp
- Leishmania spp (specify)
- Plasmodium spp (specify)
- Toxoplasma gondii
- Trypanosoma cruzi
- Protozoa other spp (specify)

Helminths:

- Strongyloides stercoralis
- Other helminths

Appendix 3
 -- CTCAE term --

CTCAE terms related to infections and infestations (version 5.0.)
https://ctep.cancer.gov/protocoldevelopment/electronic_applications/ctc.htm#ctc_50

Respiratory tract infections

- Pneumonia
- Other respiratory tract infections, please specify:

- Upper respiratory tract infection
- Tracheobronchitis
- Pleural infection

Intra-abdominal infections

- Esophagus or gastric infection
- Liver site infection (including biliary tract and gallbladder), please specify:

- Biliary tract or gallbladder infection
- Liver infection

- Lower gastrointestinal infection, please specify:

- Anorectal infection
- Appendicitis infective
- Duodenal infection
- Enterocolitis infective
- Small intestine infection
- Typhlitis infective

- Other intra-abdominal infection, please specify:

- Pancreas infection
- Peritoneal infection
- Splenic infection

Skin, soft tissue and muscle infections

- Lymph gland infection
- Skin, soft tissue or muscle infection, please specify:

- Breast infection
- Muscle infection
- Papulo/pustular rash
- Periorbital infection
- Skin infection (other than periorbital)
- Soft tissue infection (other than periorbital)

Blood infections

- Bacteremia
- Fungemia
- Viremia (including DNAemia)
- DNAemia for parasitic infection

Other infections

- Device-related infection (other than intravascular catheter)

Uro-genital tract infections

- Genital infection, please specify:

- Deep genital infection(including cervicitis infective, ovarian/ pelvic/ prostate/ uterine infection)
- Superficial genital infection(including penile/ scrotal / vaginal / vulvai infection)

- Urinary tract infection, please specify:

- Cystitis or urethritis infective
- Upper urinary tract infection (e.g. kidney infection)

Nervous system infection

- Central nervous system infection, please specify:

- Encephalitis infective (including abscess)
- Isolated meningitis infective

- Other nervous system infection, please specify:

- Cranial nerve infection
- Myelitis infective

Cardiovascular infections

- Endocarditis infective
- Other cardiovascular infection, please specify:

- Arteritis infective
- Mediastinal infection

Head and neck infections (excluding lymph gland)

- Conjunctivitis infective
- Corneal infection
- Ear infection
- Endophthalmitis infective
- Oral cavity infection, please specify:

- Salivary gland infection
- Other oral cavity structure infection

- Retinitis infective
- Sinusitis infective

Osteoarticular infections

- Joint infection
- Bone infection

Appendix 5
 -- Non-infectious and infectious Complications CTCAE term -- **No Reporting Required**

Non-infectious complications

- Allergic reaction
- All laboratory abnormalities
- All types of pain
- Alopecia
- Blurred vision
- Dry mouth
- Dyspepsia
- Dysphagia
- Edema
- Esophageal stenosis
- Fatigue
- Flashes
- Gastritis
- Hematologic toxicities
- Hematoma
- Hypertension
- Injection site reaction
- Malaise
- Mucositis
- Sore throat
- Tinnitus
- Vertigo
- Weight loss

Infectious complications

- Minor ophthalmologic bacterial infections
- External otitis treated topically
- Otitis media treated with oral antibiotics
- Isolated lip herpes simplex
- Bacterial tonsillitis or pharyngitis treated orally
- Laryngitis without viral identification managed at home by inhalations or without any intervention
- URTI without viral/bacterial identification managed at home
- Bilateral cervical lymph node enlargement concurrent with URTI that resolved without specific treatment, together with the resolution of URTI
- Local superficial wound infection resolved under topical antibiotics (incl. impetigo)
- Minor skin bacterial infections
- Minor fungal skin infection
- Diaper rash treated with local antifungals
- Candidal balanitis treated topically
- Vaginal candidiasis treated topically or with a single oral dose
- Asymptomatic bacteriuria due to a pathogen not multi-resistant
- Single low urinary tract infection treated orally without need for hospitalisation
- Phlebitis following peripheral intravascular infusion that resolved after intravascular removal without treatment with antibiotics
- Any isolate that is considered part of the normal flora of the place (oral cavity, vagina, skin, stools) except if it carries an antimicrobial resistance that has clinical implications (induce isolation precautions or a pathogen-directed therapy)
- Positive culture without clinical implications
- Neutropenic fever and sepsis of unknown origin

Appendix 5
 -- Intravascular catheter-related infections --

CVC infections:

- Catheter colonization
- Tunnel infection
- Phlebitis
- Pocket infection
- Exit site infection
- Bloodstream infection

Appendix 6
 Cell Infusion Sheet

Chronological number of CI episode for this patient: _____

Date of the first infusion (after HCT): ____/____/____ (YYYY/MM/DD)

Number of infusions within this episode (10 weeks): _____
 (Count only infusions that are part of the same regimen and given for the same indication.)

Source of cells:

- Allogeneic
 Autologous

Type of cells:

- Lymphocytes (DLI)
 Mesenchymal
 Fibroblasts
 Dendritic cells
 NK cells
 Regulatory T-cells
 Gamma/delta cells
 Virus-specific T-cells; specify virus: _____
 Other; specify: _____

Not applicable for Inborn Errors

Disease status at time of this cell infusion*: _____

* Indicate the disease status corresponding to indication diagnosis by selecting from the list provided in Appendix 1

Indication:

(check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Planned/protocol | <input type="checkbox"/> Poor graft function |
| <input type="checkbox"/> Prophylactic | <input type="checkbox"/> Infection prophylaxis |
| <input type="checkbox"/> Treatment of acute GvHD | <input type="checkbox"/> Other; specify: _____ |
| <input type="checkbox"/> Treatment of chronic GvHD | |
| <input type="checkbox"/> Treatment PTLD, EBV lymphoma | |
| <input type="checkbox"/> Treatment for primary disease | |
| <input type="checkbox"/> Mixed chimaerism | |
| <input type="checkbox"/> Loss/decreased donor chimaerism | |
| <input type="checkbox"/> Treatment of viral infection other than EBV | |

Acute GvHD -- maximum grade (after this infusion episode but before any subsequent cell infusion/HCT/CT):

- 0 (none)
 1
 2
 3
 4
 Present but grade unknown

Date Acute GvHD onset after cell infusion: ____/____/____ (YYYY/MM/DD)

Unknown