

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

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: <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"/> Other treatment related cause of death; specify: _____
<input type="checkbox"/> HCT-related	
<input type="checkbox"/> GT-related	
<input type="checkbox"/> IST-related	
<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other cause of death; specify: _____	

Extended dataset

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

Primary graft failure?

- No
- Yes
- 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. This section is optional for malignant disorders)

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 primary CMV prophylaxis:

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



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

Extended dataset

PREVENTIVE THERAPIES continued
(Complete only if the patient received an alloHCT)

Was secondary letermovir prophylaxis given (after CMV reactivation leading to treatment or CMV disease regardless of whether primary letermovir prophylaxis was previously given during the course of the most recent HCT)?

- No
 Yes: **Start date secondary letermovir prophylaxis:** ____/____/____ (YYYY/MM/DD) Unknown
 Unknown

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 prophylaxis

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/Amoxycilline	<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): _____
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 Patient Number in EBMT Registry: _____

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

Antimicrobial prophylaxis

Extended dataset

Antibacterial prophylaxis

Antibiotic <i>(select all that were administered)</i>	Phase
<input type="checkbox"/> Ampicillin clavulonate	<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"/> 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 prophylaxis

Did the patient receive CMV prophylaxis other than or in addition to letermovir? (Only for allo-HCT, not auto-HCT)

- No (i.e. no prophylaxis or only letermovir)
- Yes: **Which drugs were used?** (select all that apply)
- Note: letermovir is not included as this is requested on the core dataset. Do not consider letermovir for 'Other drug'.*
- High-dose acyclovir (≥500 mg/m²/8h (IV) with normal renal function or ≥ 800 mg/6h (oral) with normal renal function)
 - High-dose valaciclovir (2 grams Q8 hours with normal renal function)
 - Ganciclovir intravenous
 - Valganciclovir
 - Foscarnet
 - Maribavir
 - CMV immunoglobulin
 - Standard immunoglobulin
 - CMV-specific T-cells (VST)
 - 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 valaciclovir? (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?** (select all that apply)
- Lamivudine
 - Entecavir
 - Tenofovir
 - HBV immunoglobulin
 - Other drug

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



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

Antimicrobial prophylaxis continued

Extended dataset

Antifungal prophylaxis

Antifungal (select all that were administered)	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
<input type="checkbox"/> Isavuconazole	<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 prophylaxis

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 prophylaxis

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)

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*Extended dataset***aGvHD resolved:** No

(Resolution of symptoms)

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



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

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

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 (MAGIC 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



EBMT Centre Identification Code (CIC): _____

Treatment Type HCT

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

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

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 (none)	<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 (none)	<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 (none)	<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 (none)	<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 (none)	<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 (none)	<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 (none)	<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 (none)	<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*Extended dataset***cGvHD resolved:** No

(Resolution of symptoms)

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

(Resolution of symptoms)

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

Extended dataset

- 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

Extended dataset

- 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

Extended dataset

- 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

Extended dataset

- 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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

Extended dataset

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

* Grade 0-2



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 --
 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

Extended dataset

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

Extended dataset

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 --

Sinusoidal obstruction syndrome/Veno-occlusive disease (SOS/VOD)

Complication observed? No* Yes Unknown

Maximum CTCAE grade observed Mild Moderate Severe Very severe Fatal Unknown

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

Extended dataset

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

Was SOS/VOD treatment given: No Yes Unknown

Line of SOS/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 SOS/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 SOS/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 SOS/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 SOS/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

Extended dataset

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

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

* Grade 0-2

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*: _____

Extended dataset

Carbapenem (any of imipenem, meropenem, doripenem) resistance/susceptibility:

(Only if pathogen 'Acinetobacter baumannii', 'Acinetobacter lwofii', 'Acinetobacter other', 'Citrobacter', 'Enterobacter', 'Escherichia coli', 'Klebsiella pneumoniae', 'Klebsiella other', 'Morganella', 'Proteus', 'Providencia', 'Pseudomonas aeruginosa', 'Pseudomonas other', 'Raoultella' or 'Serratia' is selected)

- Susceptible
 Resistant; **KPC:** Negative Positive Unknown
OXA-48: Negative Positive Unknown

New Delhi metallo-beta-lactamase (NDM)/VIM/IMP/Other metallo-beta-lactamase:

- Negative Positive Unknown

Only if pathogen 'Citrobacter', 'Enterobacter', 'Escherichia coli', 'Klebsiella pneumoniae', 'Klebsiella other', 'Morganella', 'Proteus', 'Providencia', 'Pseudomonas aeruginosa', 'Pseudomonas other', 'Raoultella' or 'Serratia' is selected

Ceftazidime avibactam (caz-avi, avycaz) resistance/susceptibility:

- Susceptible Resistant Susceptibility unknown

Ceftazidime avibactam+aztreonam resistance/susceptibility:

- Susceptible Resistant Susceptibility unknown

Meropenem vaborbactam resistance/susceptibility:

- Susceptible Resistant Susceptibility unknown

Imipenem-cilastatin-relebactam resistance/susceptibility:

- Susceptible Resistant Susceptibility unknown

Cefiderocol resistance/susceptibility:

- Susceptible Resistant Susceptibility unknown

- Susceptibility unknown

Trimethoprim/sulfamethoxazole resistance/susceptibility: *(Only if pathogen 'Stenotrophomas maltophilia' is selected)*

- Susceptible Resistant Susceptibility unknown

Sulbactam resistance/susceptibility: *(Only if pathogen 'Acinetobacter baumannii', 'Acinetobacter lwofii' or 'Acinetobacter other' is selected)*

- Susceptible Resistant Susceptibility unknown

Cefiderocol resistance/susceptibility: *(Only if pathogen 'Acinetobacter baumannii', 'Acinetobacter lwofii' or 'Acinetobacter other' is selected)*

- Susceptible Resistant Susceptibility unknown

Only if pathogen 'Pseudomonas aeruginosa' is selected

Ceftolozane tazobactam (zerbaxa) resistance/susceptibility: Susceptible Resistant Susceptibility unknown

Ceftazidime resistance/susceptibility: Susceptible Resistant Susceptibility unknown

Cefepime resistance/susceptibility: Susceptible Resistant Susceptibility unknown

Piperacillin tazobactam resistance/susceptibility: Susceptible Resistant Susceptibility unknown

Amikacin resistance/susceptibility: Susceptible Resistant Susceptibility unknown

Ciprofloxacin/levofloxacin resistance/susceptibility: Susceptible Resistant (if resistant to any of them) Susceptibility unknown

If more than 1 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

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications --

- 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):** _____

Extended dataset

- Were abnormalities detected upon radiological assessment?** *(Only if CTCAE term 'Central nervous system infection', 'Sinusitis infective', 'Liver site infection', 'Esophagus or gastric infection', 'Lower gastrointestinal infection', 'Enteritis infective', 'Other intra-abdominal infection', 'Splenic infection' or 'Urinary tract infection' is selected)*
- No
 Yes; **What diagnostic technique was used to detect abnormalities?**
 Unknown
- MRI
 CT
 PET
 PET CT
 Ultrasound
 Other; Specify: _____

Radiology showing new or worsening pulmonary infiltrates: *(Only if CTCAE term 'Pneumonia' is selected)*

- No
 Yes; **What diagnostic technique was used to show pulmonary infiltration?**
 Unknown
- CT
 PET
 Chest X-ray
 MRI

Was a biopsy performed? *(Not applicable if CTCAE term 'Bacteremia' is selected)*

- No
 Yes; **Date of biopsy:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in biopsy?** No
 Yes; **By what technique was the pathogen detected in biopsy?**
 Unknown
- Culture
 Histopathological or cytopathological demonstration
 Immunohistochemistry
 PCR
 Stain
 Unknown

Was bronchoalveolar lavage (BAL) performed? *(Only if CTCAE term 'Pneumonia' or 'Tracheobronchitis infective' is selected)*

- No
 Yes; **Date of BAL:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in BAL?** No
 Yes; **By what technique was the pathogen detected in BAL?**
 Unknown
- Culture
 PCR
 Stain
 Unknown

Was CSF obtained? *(Only if CTCAE term 'Central nervous system infection' is selected)*

- No
 Yes; **Date of CSF:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in CSF?** No
 Yes; **By what technique was the pathogen detected in CSF?**
 Unknown
- Culture
 PCR
 Stain
 Serology/antigen in CSF
 Unknown

If more than 1 bacterial infections, copy and fill-in this table as many times as necessary.

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



EBMT Centre Identification Code (CIC): _____

Treatment Type HCT

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

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

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications --

Extended dataset

Were typical lesions seen on the eye examination? *(Only if CTCAE term 'Other eye infection' is selected)*

No Yes Unknown

Was the patient transferred to the ICU due to this infection? No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 1 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

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications -- continued

Viral infection: No Yes Unknown

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

Pathogen*: _____

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

Indicate at least 1 location involved during this period:

Localisation 1 (CTCAE term):** _____

Localisation 2 (CTCAE term):** _____

Localisation 3 (CTCAE term):** _____

Extended dataset

Were abnormalities detected upon radiological assessment? (Only if CTCAE term 'Central nervous system infection', 'Liver site infection', 'Esophagus or gastric infection', 'Lower gastrointestinal infection', 'Enteritis infective', 'Other intra-abdominal infection' or 'Urinary tract infection' is selected)
 No
 Yes; **What diagnostic technique was used to detect abnormalities?**
 Unknown

MRI
 CT
 PET
 PET CT
 Ultrasound
 Other; Specify: _____

Radiology showing new or worsening pulmonary infiltrates: (Only if CTCAE term 'Pneumonia' is selected)
 No
 Yes; **What diagnostic technique was used to show pulmonary infiltration?**
 Unknown

CT
 PET
 Chest X-ray
 MRI

Was a biopsy performed? (Not applicable if CTCAE term 'Viremia including DNAemia' is selected)
 No
 Yes; **Date of biopsy:** ____/____/____ (YYYY/MM/DD) Unknown

Was this pathogen detected in biopsy? No
 Yes; **By what technique was the pathogen detected in biopsy?**
 Unknown

Histopathological or cytopathological demonstration
 Immunohistochemistry
 Quantitative PCR
 DNA hybridization

Was bronchoalveolar lavage (BAL) performed? (Only if CTCAE term 'Pneumonia' or 'Tracheobronchitis infective' is selected)
 No
 Yes; **Date of BAL:** ____/____/____ (YYYY/MM/DD) Unknown

Was this pathogen detected in BAL? No
 Yes; **By what technique was the pathogen detected in BAL?**
 Unknown

PCR
 Cytology and immunofluorescence (IF)

If more than 1 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

*** Also answer 'Yes' in case of pre-emptive therapy

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications -- continued

Extended dataset

Was CSF obtained? *(Only if CTCAE term 'Central nervous system infection' is selected)*

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

Was this pathogen detected in CSF? No

- Yes; **By what technique was the pathogen detected in CSF?**
 PCR
 Cytology and immunofluorescence (IF)
 Serology/antigen in CSF
 Unknown

Unknown

Was an endoscopy performed? *(Only if CTCAE term 'Lower gastrointestinal infection' or 'Esophagus or gastric infection' is selected)*

- No
 Yes; **Were gastrointestinal lesions documented?** No Yes Unknown
 Unknown

Were typical lesions seen on the eye examination? *(Only if CTCAE term 'Retinitis infective' or 'Other eye infection' is selected)*

- No Yes Unknown

Was haemorrhagic cystitis diagnosed? *(Only if CTCAE term 'Urinary tract infection' is selected)*

- No Yes Unknown

Was HSV resistance to antiviral drugs documented? *(Only if pathogen 'Herpes simplex virus (HSV)' is selected)*

- No Yes Unknown

Was the patient transferred to the ICU due to this infection? No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 1 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

Pre-emptive viral therapy

Extended dataset

(If 'Viral infection' is 'Yes')

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

If yes, for what virus? *(Please make sure this viral infection has also been registered in the core dataset viral infection-part above (select all that apply) and the CTCAE term 'Viremia including DNAemia' was chosen)*

- CMV
- EBV
- BKV
- ADV
- JCV
- HHV-6

Specify each pre-emptive therapy modality administered for each CMV treatment course

(a new pre-emptive therapy course is defined either as a relapse of CMV after at least 2 weeks without antiviral therapy (success of previous treatment) or change of antiviral therapy due to failure of any reason (see definition at 'Response'-question below))

CMV pre-emptive therapy start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used:

(Select all that apply)

- Valganciclovir
- Ganciclovir intravenous
- Foscarnet
- Cidofovir
- Maribavir
- CMV-specific T-cells (VST) *(Please fill in the additional Cell Infusion Sheet in the appendix)*
- CMV hyperimmune immunoglobulin
- Regular immunoglobulin
- Leflunomide
- Artesunate
- Other drug

In case of refractory CMV, was a resistance test performed? *(please see definition in the completion guidelines)*

- No
- Yes: **Which mutation(s) were identified?**
 - UL97
 - UL54
 - UL56
 - UL27
 - No mutation identified
- Unknown

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success: *(stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)*
- Failure: *(progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)*

Viral load at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
--	-------------	---	--

Viral load at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
--	-------------	---	--

Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred

Pre-emptive viral therapy continued

Extended dataset

Specify each pre-emptive therapy modality administered for each EBV treatment course

(a new pre-emptive therapy course is defined either as a relapse of EBV after at least 2 weeks without therapy (success of previous treatment) or change of therapy due to failure of any reason (see definition at 'Response'-question below))

EBV pre-emptive therapy start date: ____/____/____ (YYYY/MM/DD) Unknown

Therapy used: (EBV)

(Select all that apply)

- Rituximab or anti-CD20 antibody
- EBV-specific T-cells (VST) *(Please fill in the additional Cell Infusion Sheet in the appendix)*
- Reduction of immunosuppression (defined as a sustained decrease of at least 20% of the daily dose of immunosuppressive drugs with the exception of low-dose corticosteroid therapy)
- Other drug

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success:** (stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)
- Failure:** (progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)

Viral load at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Viral load at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Specify each pre-emptive therapy modality administered for each BKV treatment course

(a new pre-emptive therapy course is defined either as a relapse of BKV after at least 2 weeks without antiviral therapy (success of previous treatment) or change of antiviral therapy due to failure of any reason (see definition at 'Response'-question below))

BKV pre-emptive therapy start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (BKV)

(Select all that apply)

- Cidofovir
- BKV-specific T-cells (VST) (please fill in the additional Cell Infusion Sheet in the appendix)

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success:** (stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)
- Failure:** (progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)

Viral load in blood at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Viral load in blood at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred

Pre-emptive viral therapy continued

Extended dataset

Specify each pre-emptive therapy modality administered for each ADV treatment course

(a new pre-emptive therapy course is defined either as a relapse of ADV after at least 2 weeks without antiviral therapy (success of previous treatment) or change of antiviral therapy due to failure of any reason (see definition at 'Response'-question below))

ADV pre-emptive therapy start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (ADV)

(Select all that apply)

- Cidofovir
- Brincidofovir
- Ribavirin
- Immunoglobulin as treatment (not for replacement)
- ADV-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success:** (stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)
- Failure:** (progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)

Viral load in stool at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
--	-------------	--	------------------------------------	--

Viral load in blood at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
--	-------------	--	------------------------------------	--

Viral load in stool at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
--	-------------	--	------------------------------------	--

Viral load in blood at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
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Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Specify each pre-emptive therapy modality administered for each JCV treatment course

(a new pre-emptive therapy course is defined either as a relapse of JCV after at least 2 weeks without antiviral therapy (success of previous treatment) or change of antiviral therapy due to failure of any reason (see definition at 'Response'-question below))

JCV pre-emptive therapy start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (JCV)

(Select all that apply)

- Cidofovir
- JCV-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success:** (stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)
- Failure:** (progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)

Viral load at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
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Viral load at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL	<input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated
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Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred

Pre-emptive viral therapy continued

Extended dataset

Specify each pre-emptive therapy modality administered for each HHV-6 treatment course

(a new pre-emptive therapy course is defined either as a relapse of HHV-6 after at least 2 weeks without antiviral therapy (success of previous treatment) or change of antiviral therapy due to failure of any reason (see definition at 'Response'-question below))

HHV-6 pre-emptive therapy treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (HHV-6)

(Select all that apply)

- Cidofovir
- HHV-6-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)
- Ganciclovir
- Valganciclovir
- Foscarnet

Was HHV-6 subtyping done?

- No
- Yes; **What HHV-6 subtype was identified?** HHV-6A HHV-6B Unknown
- Unknown

Was testing for chromosomally integrated HHV-6 done?

- No
- Yes; **Was chromosomally integrated HHV-6 present?** No Yes Unknown
- Unknown

Response to pre-emptive therapy (address response to this specific treatment modality):

- Success:** (stopping pre-emptive therapy without need for restarting therapeutic dose of the same or another antiviral agent within 2 weeks)
- Failure:** (progression of viremia or stable viral load requiring change or addition of therapy, response followed by rebound (during treatment or in the 2 weeks after end of therapy), progression to disease (during treatment or in the 2 weeks after end of therapy), or unacceptable toxicity)

Viral load at the start (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Viral load at the discontinuation (+/- 3 days) of pre-emptive therapy: _____	Unit	
	<input type="checkbox"/> log 10 IU/mL <input type="checkbox"/> IU/mL <input type="checkbox"/> copies/mL	<input type="checkbox"/> Not evaluated

Date of discontinuation of pre-emptive therapy: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred

Treatment of end-organ viral disease

Extended dataset

(If 'Viral infection' is 'Yes')

Did the patient receive treatment for end-organ viral disease? No Yes
If yes, for what virus? *(Please make sure this viral infection has also been registered in the core dataset viral infection-part above)*
(select all that apply)

- CMV
- EBV
- BKV
- ADV
- JCV
- HHV-6
- CARVs (community acquired respiratory viruses)

Specify each treatment modality given for each occurrence of CMV disease or change in antiviral therapy due to failure (see definition at 'Response'-question below) that occurred

End-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used:

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Valganciclovir
- Ganciclovir intravenous
- Foscarnet
- Cidofovir
- Maribavir
- CMV-specific T-cells (VST) *(Please fill in the additional Cell Infusion Sheet in the appendix)*
- CMV hyperimmune immunoglobulin
- Regular immunoglobulin
- Leflunomide
- Artesunate
- Other drug

In case of refractory CMV , was a resistance test performed? *(please see definition in the completion guidelines)*

- No
- Yes: **Which mutation(s) were identified?**
 - UL97
 - UL54
 - UL56
 - UL27
 - No mutation identified
- Unknown

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success: *(Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)*
- Failure: *(Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))*

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Specify each treatment modality given for each occurrence of EBV disease or change in therapy due to failure (see definition at 'Response'-question below) that occurred

EBV end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Therapy used: (EBV)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Rituximab or anti-CD20 antibody
- EBV-specific T-cells (VST) *(Please fill in the additional Cell Infusion Sheet in the appendix)*
- Reduction of immunosuppression *(defined as a sustained decrease of at least 20% of the daily dose of immunosuppressive drugs with the exception of low-dose corticosteroid therapy)*
- Other drug

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success: *(Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)*
- Failure: *(Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))*

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Treatment of end-organ viral disease continued

Extended dataset

Specify each treatment modality given for each occurrence of BKV disease or change in antiviral therapy due to failure (see definition at 'Response'-question below) that occurred

BKV end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (BKV)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Cidofovir
- BKV-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success:** (Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)
- Failure:** (Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Specify each treatment modality given for each occurrence of ADV disease or change in antiviral therapy due to failure (see definition at 'Response'-question below) that occurred

ADV end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (ADV)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Cidofovir
- Brincidofovir
- Ribavirin
- Immunoglobulin as treatment (not for replacement)
- ADV-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success:** (Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)
- Failure:** (Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Specify each treatment modality given for each occurrence of JCV disease or change in therapy due to failure (see definition at 'Response'-question below) that occurred

JCV end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Therapy used: (JCV)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Cidofovir
- JCV-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)
- Mirtazapine
- Checkpoint inhibitors

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success:** (Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)
- Failure:** (Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred



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

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

Treatment of end-organ viral disease continued

Extended dataset

Specify each treatment modality given for each occurrence of HHV-6 disease or change in antiviral therapy due to failure (see definition at 'Response'-question below) that occurred

HHV-6 end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (HHV-6)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Cidofovir
- HHV-6-specific T-cells (VST) (Please fill in the additional Cell Infusion Sheet in the appendix)
- Ganciclovir
- Valganciclovir
- Foscarnet

Was HHV-6 subtyping done?

- No
- Yes; **What HHV-6 subtype was identified?** HHV-6A HHV-6B Unknown
- Unknown

Was testing for chromosomally integrated HHV-6 done?

- No
- Yes; **Was chromosomally integrated HHV-6 present?** No Yes Unknown
- Unknown

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success: (Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)
- Failure: (Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Specify each treatment modality given for each occurrence of community acquired respiratory virus (CARV) disease or change in antiviral therapy due to failure (see definition at 'Response'-question below) that occurred

CARV end-organ disease treatment start date: ____/____/____ (YYYY/MM/DD) Unknown

Antiviral(s) used: (CARV)

(Select all that apply (More than one modality can be added if the intention is combination therapy and the modalities are started no more than 48 hours apart))

- Oseltamvir
- Zanamivir
- Baloxavir
- Peramivir
- Ribavirin
- Intravenous immunoglobulin (IVIG) for treatment
- Remdesivir
- Nirmatrel-Ritonavir

Response to end-organ disease treatment (address response to this/these specific treatment modality/modalities):

- Success: (Defined as stopping end-organ disease treatment without the need for restarting the same or other treatment)
- Failure: (Defined as progression requiring change or addition of end-organ disease treatment, response followed by rebound (worsening symptoms after initial improvement, death or unacceptable toxicity))

Date of discontinuation of end-organ disease treatment: ____/____/____ (YYYY/MM/DD) Unknown

Copy as often as necessary to reflect all episodes that occurred

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

Invasive fungal infection: No Yes Unknown

Start date: ____/____/____ (YYYY/MM/DD)
 Yeasts Moulds
Pathogen*: _____

Extended dataset

Voriconazole resistance/susceptibility: Susceptible Resistant Susceptibility unknown
(Only if pathogen 'Aspergillus flavus', 'Aspergillus fumigatus', 'Aspergillus terreus' or 'Aspergillus other' is selected)

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):** _____

Extended dataset

Were abnormalities detected upon radiological assessment? *(Only if CTCAE term 'Central nervous system infection', 'Sinusitis infective', 'Liver site infection', 'Esophagus or gastric infection', 'Lower gastrointestinal infection', 'Enteritis infective', 'Other intra-abdominal infection', 'Splenic infection' or 'Urinary tract infection' is selected)*
 No
 Yes; **What diagnostic technique was used to detect abnormalities?**
 Unknown

MRI
 CT
 PET
 PET CT
 Ultrasound
 Other; Specify: _____

Radiology showing new or worsening pulmonary infiltrates: *(Only if CTCAE term 'Pneumonia' is selected)*
 No
 Yes; **What diagnostic technique was used to show pulmonary infiltration?**

CT
 PET
 Chest X-ray
 MRI

Were at least one of the following detected: Nodular lesion/Halo sign/Reverse halo sign/Cavity/Tree in bud/Ground glass/Wedge-shaped and segmental or lobal consolidation: No
 Yes
 Unknown

Unknown

Was PCR in blood performed? No Yes, negative Yes, positive Unknown
(If Yes, negative/Yes, positive)
Date of PCR in blood performed: ____/____/____ (YYYY/MM/DD)
(If Yes, positive)

Was the result confirmed by a second test? No, second PCR in blood not taken
 No, second PCR in blood taken and negative
 Yes
 Unknown

If more than 1 fungal 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

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications -- continued

Extended dataset

Was a biopsy performed? *(Not applicable if CTCAE term 'Fungemia' is selected)*

- No
 Yes; **Date of biopsy:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in biopsy?** No
 Yes; **By what technique was the pathogen detected in biopsy?**
- Unknown
- Culture
 - Histopathological or cytopathological demonstration
 - Immunohistochemistry
 - PCR
 - Fungal stain
- Unknown

Was bronchoalveolar lavage (BAL) performed? *(Only if CTCAE term 'Pneumonia' or 'Tracheobronchitis infective' is selected)*

- No
 Yes; **Date of BAL:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in BAL?** No
 Yes; **By what technique was the pathogen detected in BAL?**
- Unknown
- Culture
 - PCR
 - Stain
 - BAL Galactomannan assay
- Unknown

Was CSF obtained? *(Only if CTCAE term 'Central nervous system infection' is selected)*

- No
 Yes; **Date of CSF:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this pathogen detected in CSF?** No
 Yes; **By what technique was the pathogen detected in CSF?**
- Unknown
- Culture
 - PCR
 - Beta D glucan galactomannan
 - Stain
 - Serology/antigen in CSF
- Unknown

Was sinus fluid sampled? *(Only if CTCAE term 'Sinusitis infective' is selected)*

- No
 Yes; **Date of sinus fluid sampling:** ____/____/____ (YYYY/MM/DD) Unknown
- Was this fungus detected in sinus fluid?** No
 Yes; **By what technique was the fungus detected in sinus fluid?**
- Unknown
- Culture
 - PCR
 - Fungal stain
- Unknown

Was an endoscopy performed? *(Only if CTCAE term 'Lower gastrointestinal infection' or 'Esophagus or other gastric infection' is selected)*

- No
 Yes; **Were gastrointestinal lesions documented?** No Yes Unknown
 Unknown

Were typical lesions seen on the eye examination? *(Only if CTCAE term 'Retinitis infective' or 'Other eye infection' is selected)*

- No Yes Unknown

Was the patient transferred to the ICU due to this infection? No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 1 fungal 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

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):** _____

Extended dataset

Were abnormalities detected upon radiological assessment?

No

Yes; **What diagnostic technique was used to detect abnormalities?**

Unknown

MRI

CT

PET

PET CT

Ultrasound

Other; Specify: _____

(Only if CTCAE term 'Central nervous system infection', 'Sinusitis infective', 'Liver site infection', 'Esophagus or gastric infection', 'Lower gastrointestinal infection', 'Enteritis infective', 'Other intra-abdominal infection', 'Splenic infection' or 'Urinary tract infection' is selected)

Radiology showing new or worsening pulmonary infiltrates: (Only if CTCAE term 'Pneumonia' is selected)

No

Yes; **What diagnostic technique was used to show pulmonary infiltration?**

Unknown

CT

PET

Chest X-ray

MRI

Was a biopsy performed? (Not applicable if CTCAE term 'DNAemia for parasitic infection' is selected)

No

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

Was this pathogen detected in biopsy? No

Yes; **By what technique was the pathogen detected in biopsy?**

Culture

Histopathological or cytopathological demonstration

Immunohistochemistry

PCR

Stain

Unknown

Unknown

If more than 1 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

COMPLICATIONS SINCE THE LAST REPORT

-- Infectious complications -- continued

Extended dataset

Was bronchoalveolar lavage (BAL) performed? *(Only if CTCAE term 'Pneumonia' or 'Tracheobronchitis infective' is selected)*

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

Was this pathogen detected in BAL? No

Yes; **By what technique was the pathogen detected in BAL?**

- Culture
 PCR
 Stain

Unknown

Unknown

Was CSF obtained? *(Only if CTCAE term 'Central nervous system infection' is selected)*

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

Was this pathogen detected in CSF? No

Yes; **By what technique was the pathogen detected in CSF?**

- Culture
 PCR
 Stain
 Serology/antigen in CSF

Unknown

Unknown

Were typical lesions seen on the eye examination? *(Only if CTCAE term 'Retinitis infective' or 'Other eye infection' is selected)*

- No Yes Unknown

Was the patient transferred to the ICU due to this infection? No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 1 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

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)*: _____

Extended dataset

Were abnormalities detected upon radiological assessment? (Only if CTCAE term 'Central nervous system infection', 'Sinusitis infective', 'Liver site infection', 'Esophagus or gastric infection', 'Lower gastrointestinal infection', 'Enteritis infective', 'Other intra-abdominal infection', 'Splenic infection' or 'Urinary tract infection' is selected)
 No
 Yes; **What diagnostic technique was used to detect abnormalities?**
 Unknown

MRI
 CT
 PET
 PET CT
 Ultrasound
 Other; Specify: _____

Radiology showing new or worsening pulmonary infiltrates: (Only if CTCAE term 'Pneumonia' is selected)
 No
 Yes; **What diagnostic technique was used to show pulmonary infiltration?**
 Unknown

CT
 PET
 Chest X-ray
 MRI

Was the patient transferred to the ICU due to this infection? No Yes Unknown

(if patient died)

Contributory cause of death: No Yes Unknown

If more than 1 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

VACCINATIONS

Extended dataset

Was the patient vaccinated with recombinant zoster vaccine (RZV; Shingrix® - GlaxoSmithKline (GSK)) during this follow-up period after the HCT took place? *(Only if allogeneic HCT)*

- No
- Yes; **Date of first RZV (Shingrix®) vaccination:** ____/____/____ (YYYY/MM/DD) Unknown
- Date of last RZV (Shingrix®) vaccination:** ____/____/____ (YYYY/MM/DD) Unknown
- Number of doses RZV (Shingrix®) vaccine:** _____
- Unknown

Was the patient vaccinated against Respiratory syncytial virus (RSV) during this follow-up period after the HCT took place?

- No
- Yes; **What type of RSV vaccine did the patient receive?**
- Adjuvant subunit vaccine (Arexvy® - GlaxoSmithKline (GSK))
 - Unadjuvanted bivalent recombinant RSV vaccine (Abrysvo® - Pfizer)
 - mRNA-based vaccine (mResvia® - Moderna)
- Date of RSV vaccination :** ____/____/____ (YYYY/MM/DD) Unknown
- Unknown

Did the patient receive monoclonal antibody against RSV during this follow-up period after the HCT took place?

- No
- Yes; **What type of RSV antibody did the patient receive?**
- Clesrovimab (Enflonsia® - Merck)
 - Palivizumab (Synagis® - AstraZeneca)
 - Nirsevimab (Beyfortus® - Sanofi)
 - Unknown
- Date of monoclonal antibody given:** ____/____/____ (YYYY/MM/DD) Unknown
- Unknown

SECONDARY MALIGNANCIES AND AUTOIMMUNE DISORDERS

Did a secondary malignancy or autoimmune disorder occur after HCT?

- No
- Yes: **Was it a secondary malignancy or autoimmune disorder?**
- Secondary malignancy
 - Autoimmune disorder

Date of diagnosis: ____/____/____ (YYYY/MM/DD)

Was this disease an indication for a subsequent HCT/CT/IST/GT?

- No *(complete the non-indication diagnosis form)*
 - Yes *(complete the relevant indication diagnosis form)*
- Unknown



EBMT Centre Identification Code (CIC): _____

Treatment Type HCT

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

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)

MRD detectable (with any method): (only for Acute leukaemia)

- No
 Yes: **Date of first detectable MRD:** ____/____/____ (YYYY/MM/DD) Unknown
 Not evaluated
 Unknown

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

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	<i>Go to page 49</i>
CHRONIC LEUKAEMIAS	<i>Go to page 49</i>
PLASMA CELL NEOPLASMS (PCN)	<i>Go to page 50</i>
MPN, MDS, MDS / MPN OVERLAP SYNDROMES	<i>Go to page 52</i>
LYMPHOMAS	<i>Go to page 53</i>
SOLID TUMOURS	<i>Go to page 53</i>
BONE MARROW FAILURE SYNDROMES (BMF) including APLASTIC ANAEMIA (AA)	<i>Go to page 53</i>
AUTOIMMUNE DISORDERS	<i>Go to page 54</i>
HAEMOGLOBINOPATHIES	<i>Go to page 54</i>
OTHER DIAGNOSIS	<i>Go to page 55</i>
Inborn Errors	<i>Go to page 56</i>

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
<i>Extended dataset</i> In case of NO cytogenetic remission Cytogenetic details: t(9;22) positive metaphases (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown t(9;22) positive cells detected by FISH (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Molecular remission: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
<i>Extended dataset</i> In case of NO molecular remission BCR::ABL1 variant allele frequency (VAF) (%) : _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
<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
<i>Extended dataset</i> Cytogenetic details: t(9;22) positive metaphases (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown t(9;22) positive cells detected by FISH (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown BCR::ABL1 variant allele frequency (VAF) (%) : _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
<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
<i>Extended dataset</i> Cytogenetic details: t(9;22) positive metaphases (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown t(9;22) positive cells detected by FISH (%): _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown BCR::ABL1 variant allele frequency (VAF) (%) : _____ <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
<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)

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

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
- Not evaluated
- Unknown

Extended dataset

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"/> 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

Technique used for disease assessment:

CT scan
 PET-CT
 MRI
 Clinical assessment (for continuous CR)
 Other; specify: _____
 Unknown

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 (after HCT)
<input type="checkbox"/> Transfusions required;	Date of first transfusion: ____/____/____ (YYYY/MM/DD) <input type="checkbox"/> Unknown (after HCT)
<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

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:

- . Bacillus (in blood: report only if ≥2 positive separately taken cultures)
- . Clostridioides difficile (c difficile/CDT/CDI)
- . Clostridium other (NOT difficile)
- . Corynebacterium jeikeium
- . Corynebacterium other (NOT jeikeium) (in blood: report only if ≥2 positive separately taken cultures)
- . Enterococcus faecalis (vancomycin-susceptible)
- . Enterococcus faecalis (vancomycin-resistant)
- . Enterococcus faecium (vancomycin-susceptible)
- . Enterococcus faecium (vancomycin-resistant)
- . Listeria monocytogenes
- . Nocardia (specify)
- . Propionibacterium (in blood: report only if ≥2 positive separately taken cultures)
- . Rothia
- . Staphylococcus aureus (s aureus/staph aureus) MSSA (methicillin-susceptible)
- . Staphylococcus aureus (s aureus/staph aureus) MRSA (methicillin-resistant) vancomycin-susceptible
- . Staphylococcus coagulase-negative (in blood: report only if ≥2 positive separately taken cultures)
- . Staphylococcus lugdunensis
- . Streptococcus pneumoniae (pneumococcus)
- . Streptococcus viridans
- . Streptococcus other (specify)
- . Gram-positive bacteria other (specify)

Gram-negative:

- . Acinetobacter baumannii
- . Acinetobacter lwoffii (in blood: report only if ≥2 positive separately taken cultures)
- . Acinetobacter other (NOT baumannii, NOT lwoffii)
- . Bacteroides fragilis
- . Bordetella pertussis
- . Borrelia
- . Brucella
- . Campylobacter jejuni
- . Citrobacter freundii
- . Coxiella burnetii (Q fever)
- . Enterobacter cloacae
- . Enterobacter other
- . Escherichia coli (e coli)
- . Fusobacterium
- . Haemophilus influenzae (haemophilus influenzae type B/Hib/hemophilus influenzae)
- . Haemophilus other (hemophilus)
- . Helicobacter pylori
- . Klebsiella pneumoniae (carbapenem-susceptible)
- . Klebsiella other (NOT pneumoniae) (carbapenem-susceptible)
- . Klebsiella (any species) (carbapenem-susceptibility not checked)
- . Klebsiella (any species) (carbapenem-resistant)
- . Legionella pneumophila
- . Morganella morganii
- . Micrococcus (in blood: report only if ≥2 positive separately taken cultures)
- . Moraxella catarrhalis
- . Neisseria gonorrhoeae (gonococcus)
- . Neisseria meningitidis (meningococcus)
- . Proteus vulgaris
- . Providencia
- . Pseudomonas aeruginosa (PSA) (carbapenem-susceptible)
- . Pseudomonas aeruginosa (PSA) (carbapenem-resistant)
- . Pseudomonas aeruginosa (PSA) (carbapenem-susceptibility not checked)
- . Pseudomonas other (NOT aeruginosa)
- . Raoultella
- . Salmonella (specify)
- . Serratia marcescens
- . Shigella
- . Stenotrophomonas maltophilia
- . Treponema pallidum (syphilis/lues)
- . Yersinia
- . Gram-negative bacteria other (specify)

Other bacteria:

- . Chlamydia
- . Chlamydomphila
- . Mycobacterium other (specify)
- . Mycobacterium tuberculosis (TB)
- . Mycoplasma pneumoniae
- . Rickettsia
- . Ureoplasma
- . Bacteria other (specify)

Viral infections:

- . Adenovirus (ADV)
- . Chikungunya virus
- . Crimean-Congo haemorrhagic fever virus (CCHFV)
- . Dengue virus
- . Gastrointestinal viruses:
 - o Norovirus
 - o Rotavirus
 - o Sapovirus
 - o Astrovirus
- . Hepatotropic viruses:
 - o Hepatitis A virus (HAV)
 - o Hepatitis B virus (HBV)
 - o Hepatitis C virus (HCV)
 - o Hepatitis D virus (HDV)
 - o Hepatitis E virus (HEV)
- . Herpes group:
 - o Cytomegalovirus (CMV)
 - o Epstein-Barr virus (EBV)
 - o Herpes simplex virus (HS/HSV)
 - o Herpesvirus 6 (HHV6)
 - o Herpesvirus 7 (HHV7)
 - o Herpesvirus 8 (HHV8/Kaposi's sarcoma-associated herpesvirus/KSHV/Kaposi)
 - o Varicella zoster virus (VZV/VZV/HZV/shingles/zoster/chickenpox)
- . Human immunodeficiency virus (HIV)
- . Human papilloma viruses (HPV)
- . Human T-lymphotropic virus 1 (HTLV-1)
- . Human T-lymphotropic virus 2 (HTLV-2)
- . Measles virus
- . Mumps virus
- . Parechovirus
- . Parvovirus (parvovirus B-19/B-19)
- . Poliovirus
- . Polyomaviruses:
 - o BK polyomavirus (BKV)
 - o JC virus (JCV)
 - o Merkel cell virus
- . Respiratory viruses:
 - o Bocavirus
 - o Enterovirus
 - o Human coronavirus (excluding SARS-CoV-2 or COVID-19)
 - o Influenza A virus (including birdflu)
 - o Influenza B virus
 - o Human metapneumovirus (hMPV)
 - o Parainfluenza
 - o Rhinovirus
 - o Respiratory syncytial virus (RSV)
 - o SARS-CoV-2 virus (COVID-19)
- . Rubella virus
- . Sandfly viruses (Naples virus/Sicilian virus/Toscana virus/Cyprus virus/Turkey virus/Tehran virus/phlebovirus)
- . Tick-borne encephalitis virus (TBE)
- . West Nile virus (WNV)
- . Yellow fever virus
- . Zika virus (ZIKV)
- . 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
- Geotrichum
- Magnusiomyces
- Pneumocystis jirovecii
- Saccharomyces
- Saprochaete
- Trichosporon
- Yeasts other (specify)

Moulds:

- Aspergillus flavus
- Aspergillus fumigatus
- Aspergillus other (NOT flavus, NOT fumigatus, NOT terreus)
- Aspergillus terreus
- Blastomyces
- Coccidioides
- Dematiaceous fungi / phaeohyphomycosis (specify)
- Fusarium solani
- Fusarium other (NOT solani)
- Galactomannan positive in blood or BAL, without microbiological confirmation of fungal infection
- Histoplasma
- Lomentospora prolificans / scedosporium prolificans
- Mucorales (mucor/rhizomucor/rhizopus/lichteinia) (specify)
- Paracoccidioides
- Scedosporium other (NOT prolificans) (specify)
- Moulds other (specify)

Parasitic infections:**Protozoa:**

- Amoeba
- Babesia
- Cryptosporidium
- Giardia
- Leishmania
- Plasmodium (malaria)
- Toxoplasma gondii
- Trypanosoma cruzi
- Protozoa other

Helminths:

- Schistosoma
- Strongyloides stercoralis
- Helminths other

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 infective
- 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
- Typhlitis infective

- Enteritis infective, please specify:

- Duodenal infection
- Enterocolitis infective
- Small intestine infection

- 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
- Papulo/pustular rash
- Periorbital infection
- Skin infection (other than periorbital)
- Soft tissue infection (other than periorbital) and muscle infection

Blood infections

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

Other infections

- Device-related infection (other than intravascular catheter)
- Post-transplant lymphoproliferative disorder (PTLD)**

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 / vulval 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
- Progressive multifocal leukoencephalopathy (PML)*
- Myelitis infective

- Other nervous system infection, please specify:

- Cranial nerve infection
- Other nervous system infection

Cardiovascular infections

- Endocarditis infective
- Other cardiovascular infection, please specify:

- Arteritis infective
- Mediastinal infection
- Myocarditis infective

Head and neck infections (excluding lymph gland)

- Ear infection
- Oral cavity infection, please specify:

- Salivary gland infection
- Other oral cavity structure infection

- Retinitis infective
- Sinusitis infective

- Other eye infection, please specify:

- Conjunctivitis infective
- Corneal infection
- Endophthalmitis infective

Osteoarticular infections

- Joint infection
- Bone infection

* Only if pathogen 'JC virus' is selected

** Only if pathogen 'Epstein-Barr virus' is selected

Appendix 4
 -- Non-infectious and infectious Complications CTCAE term -- **No Reporting Required**

Non-infectious complications

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

- 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 6 Cell Infusion Sheet

Chronological number of CI episode for this patient: _____

Date of the first infusion (within this episode): ____/____/____ (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 (VST)
 Other; specify: _____

(Only if 'Type of cells: = Virus-specific T-cells (VST))'

Specificity of VST product: Single-virus specific Multi-virus specific

If single-virus specific, to which virus? *(Please register this virus in the Infectious complications - Viral infection part and fill in the VST in the 'Pre-emptive viral therapy' or 'Treatment of end-organ viral disease' section)*

- EBV
 CMV
 ADV
 BKV or JCV
 HHV-6

If multi-virus specific, to which viruses? *(Please register these viruses in the Infectious complications - Viral infection part and fill in the VST in the 'Pre-emptive viral therapy' or 'Treatment of end-organ viral disease' section)*

- (Select all that apply)** EBV
 CMV
 ADV
 BKV or JCV
 HHV-6

Extended dataset

Product origin: In-house manufactured
 Commercial product;

Tabelecleucel
Donor source: *(Only if 'Source of cells: = Allogeneic')*

- Stem cell donor
 Third-party donor;
 Related (family)
 Unrelated

Manufacturing method: In vitro expansion
 Cytokine capture system (CCS)
 Multimer sorting

Number of doses per infection episode: 1 dose
 >1 dose; **Total number of doses:** _____

Dosing interval (in days): _____



EBMT Centre Identification Code (CIC): _____

Treatment Type HCT

Hospital Unique Patient Number (UPN): _____

Patient Number in EBMT Registry: _____

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

Appendix 6
Cell Infusion Sheet continued

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 | |

Only for Acute leukemia donor lymphocyte infusions:

Response to DLI:

- Complete remission (CR) **MRD status:** MRD negative MRD positive Not evaluated Unknown
- Not in CR
- Not evaluated
- Unknown