

<h1>DAY 0</h1>	<h1>MED-B</h1> <h1>GENERAL INFORMATION</h1>
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TEAM

EBMT Centre Identification Code (CIC)

Hospital Unit

Contact person:

e-mail

Date of this report
yyyy mm dd

STUDY/TRIAL

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

Name of study / trial

PATIENT

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

Hospital Unique Patient Number or Code (UPN):

Compulsory, registrations will not be accepted without this item.

All transplants performed in the same patient must be registered with the same patient identification number or code as this belongs to the patient and not to the transplant.

Initials (first name(s) – surname(s))

Date of birth Sex: Male Female
yyyy mm dd

ABO Group Rh factor: Absent Present Not evaluated

DISEASE

Date of diagnosis :
yyyy mm dd

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

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

Other diagnosis, specify:

DAY 0	MED-B AL AMYLOIDOSIS
INITIAL DIAGNOSIS	

Has the information requested in this section been submitted with a previous HSCT registration for this patient?
 Yes: go to page 4, *Pre-HSCT Treatment* No: proceed with this section.

EVIDENCE OF UNDERLYING PLASMA CELL DISORDER

- | | | |
|---|--|---|
| <input type="checkbox"/> No
<input type="checkbox"/> Yes | <i>Select one as applicable</i>
<input type="checkbox"/> IgG
<input type="checkbox"/> IgA
<input type="checkbox"/> IgD
<input type="checkbox"/> IgE
<input type="checkbox"/> IgM
<input type="checkbox"/> Absent
<input type="checkbox"/> Not evaluated | <i>Select one as applicable</i>
<input type="checkbox"/> Kappa
<input type="checkbox"/> Lambda
<input type="checkbox"/> Absent
<input type="checkbox"/> Not evaluated |
| <input type="checkbox"/> Monoclonal Gammopathy
<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Other B-cell malignancy, specify
..... | | |

If Multiple myeloma
Stage Untreated (Salmon and Durie)

	I	II	III
A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSIS OF AMYLOIDOSIS

- Methods**
- | | | | |
|-------------------------------|-----------------------------------|--|--|
| Hereditary Amyloidosis | <input type="checkbox"/> Excluded | <input type="checkbox"/> Not evaluated | |
| Positive immunohistochemistry | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not evaluated |

CLINICAL AND LABORATORY DATA

Hb (g/dL)	<input type="checkbox"/> Not evaluated
Serum creatinine	Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL <input type="checkbox"/> Not evaluated
Creatinine clearance (mL/min)	<input type="checkbox"/> Not evaluated
Total urinary protein excretion (mg/24 h)	<input type="checkbox"/> Not evaluated
Total urinary albumin excretion (mg/24 h)	<input type="checkbox"/> Not evaluated
Serum calcium (mmol/L)	<input type="checkbox"/> Not evaluated
Serum albumin (g/L)	<input type="checkbox"/> Not evaluated
Serum alkaline phosphatase (IU/L)	<input type="checkbox"/> Not evaluated
Serum bilirubin	Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL <input type="checkbox"/> Not evaluated
Serum NT-pro-BNP (ng/L)	<input type="checkbox"/> Not evaluated
Serum c-Troponin T ($\mu\text{g/L}$)	<input type="checkbox"/> Not evaluated

Bone marrow investigations

- | | |
|------------------------------------|--|
| BM aspirate: % plasmacytosis | <input type="checkbox"/> Not evaluated |
| BM trephine: % plasmacytosis | <input type="checkbox"/> Not evaluated |

Immunoglobulins

Monoclonal Ig in serum (g/L)

Immunofixation of serum Negative Positive Not evaluated Unknown

Free light chains in serum:

 Kappa light chains (mg/L) Not evaluated.

 Lambda light chains (mg/L) Not evaluated

Immunofixation of urine Negative Positive Not evaluated Unknown

 Monoclonal light chains in urine (g/24 h)

Serum β2 microglobulin (mg/L)

Bone structure (X-ray) Normal Lytic lesion present Not evaluated Unknown

Typical clinical symptoms

Macroglossy Absent Present Not evaluated Unknown

Periorbital bleeding Absent Present Not evaluated Unknown

Shoulder pad sign Absent Present Not evaluated Unknown

ORGAN INVOLVEMENT UNTREATED

	Dominant organ(s) involved	Additional organ involvement	Biopsy	No involvement
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Tract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autonomic nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify

ORGAN-SPECIFIC DATA UNTREATED

Liver

Liver span in ultrasound or CT scan (cm craniocaudal diameter) Not evaluated

Heart

NYHA class I II III IV Unknown

Left ventricular ejection fraction (%) Not evaluated

Interventricular septal wall thickness (mean number of mm in echocardiogram) Not evaluated

Gastrointestinal

Weight loss No Yes Not evaluated Unknown

Malabsorption No Yes Not evaluated Unknown

GI bleeding No Yes Not evaluated Unknown

Other evidence of gastrointestinal involvement:

Peripheral neuropathy

Neurological exam Normal Abnormal Not evaluated or failed Unknown

If abnormal:
 Specify abnormality

PNP severity grade I grade II grade III grade IV

Autonomic neuropathy

Orthostatic hypotension Yes No Not evaluated Unknown

Intractable diarrhoea Yes No Not evaluated Unknown

Inflexible pulse rate Yes No Not evaluated Unknown

Other sites

Clinical evidence for involvement of other sites:.....

PRE-HSCT TREATMENT

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

WAS THE PATIENT TREATED BEFORE THE HSCT PROCEDURE?

- No
 Yes:

Date started
yyyy mm dd

Modality: Chemotherapy No Yes: Chemotherapy regimen
Number of cycles
Other

HSCT

DATE OF HSCT :
yyyy mm dd

HSCT TYPE

- Allogeneic: *proceed to "Status at Start of Conditioning" on page 5*
Autologous: Date of 1st collection or aphaeresis:
yyyy mm dd

STATUS OF DISEASE AT COLLECTION (AUTOGRAFTS ONLY)

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

Haematological status

- Untreated / At diagnosis
 Complete remission (CR) NUMBER OF THIS COMPLETE REMISSION
 1st
 2nd
 3rd or higher
 PR NUMBER OF THIS PARTIAL REMISSION
 1st
 2nd
 3rd or higher
 Minimal response
 Stable disease (*no change*)
 Progression
 Unknown

Organ status Untreated Response No change Progression Unknown

STATUS OF DISEASE AT START OF CONDITIONING FOR BMT

Haematological status

- Untreated / At diagnosis
- Complete remission (CR) NUMBER OF THIS COMPLETE REMISSION
 - 1st
 - 2nd
 - 3rd or higher
- PR NUMBER OF THIS PARTIAL REMISSION
 - 1st
 - 2nd
 - 3rd or higher
- Minimal response
- Stable disease (*no change*)
- Progression
- Unknown

- Organ status** Untreated Response No change Progression Unknown

CLINICAL AND LABORATORY DATA

- | | |
|---|--|
| Hb (g/dL) | <input type="checkbox"/> Not evaluated |
| Serum creatinine | Units: <input type="checkbox"/> μmol/L <input type="checkbox"/> mg/dL <input type="checkbox"/> Not evaluated |
| Creatinine clearance (mL/min) | <input type="checkbox"/> Not evaluated |
| Total urinary protein excretion (mg/24 h) | <input type="checkbox"/> Not evaluated |
| Total urinary albumin excretion (mg/24 h) | <input type="checkbox"/> Not evaluated |
| Serum calcium (mmol/L) | <input type="checkbox"/> Not evaluated |
| Serum albumin (g/L) | <input type="checkbox"/> Not evaluated |
| Serum alkaline phosphatase (IU/L) | <input type="checkbox"/> Not evaluated |
| Serum bilirubin | Units: <input type="checkbox"/> μmol/L <input type="checkbox"/> mg/dL <input type="checkbox"/> Not evaluated |
| Serum NT-pro-BNP (ng/L) | <input type="checkbox"/> Not evaluated |
| Serum c-Troponin T (μg/L) | <input type="checkbox"/> Not evaluated |

Bone marrow investigations

- BM aspirate: % plasmacytosis Not evaluated
- BM trephine: % plasmacytosis Not evaluated

Immunoglobulins

- Monoclonal Ig in serum (g/L)
- Immunofixation of serum Negative Positive Not evaluated Unknown
- Free light chains in serum:
 - Kappa light chains (mg/L) Not evaluated.
 - Lambda light chains (mg/L) Not evaluated
- Immunofixation of urine Negative Positive Not evaluated Unknown
 - Monoclonal light chains in urine (g/24 h)
- Serum β2 microglobulin (mg/L)

ORGAN INVOLVEMENT AT HSCT

	Dominant organ(s) involved	Additional organ involvement	Biopsy	No involvement
Soft Tissues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Tract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autonomic nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify

ORGAN-SPECIFIC DATA AT HSCT

Liver

Liver span in ultrasound or CT scan (cm craniocaudal diameter) Not evaluated

Heart

NYHA class I II III IV Unknown

Left ventricular ejection fraction (%) Not evaluated

Interventricular septal wall thickness Not evaluated
 (mean number of mm in echocardiogram)

Gastrointestinal

Weight loss No Yes Not evaluated Unknown

Malabsorption No Yes Not evaluated Unknown

GI bleeding No Yes Not evaluated Unknown

Other evidence of gastrointestinal involvement:

Peripheral neuropathy

Neurological exam Normal Abnormal Not evaluated or failed Unknown

If abnormal:

Specify abnormality

PNP severity grade I grade II grade III grade IV Unknown

Autonomic neuropathy

Orthostatic hypotension Yes No Not evaluated Unknown

Intractable diarrhoea Yes No Not evaluated Unknown

Inflexible pulse rate Yes No Not evaluated Unknown

Other sites

Clinical evidence for involvement of other sites:.....

FORMS TO BE FILLED IN

TYPE OF HSCT

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

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

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

DAY 100	MED-B AL AMYLOIDOSIS
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Unique Identification Code (UIC) (if known)

Date of this report
yyyy mm dd

Hospital Unique Patient Number

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

Date of birth
yyyy mm dd

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

STATUS OF DISEASE AT 100 DAYS AFTER HSCT

BEST HAEMATOLOGICAL RESPONSE TO HSCT AT 100 DAYS

- | | | | |
|------------------------------------|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> CR1 | <input type="checkbox"/> CR2 | <input type="checkbox"/> >CR2_ | |
| <input type="checkbox"/> PR1 | <input type="checkbox"/> PR2 | <input type="checkbox"/> >PR2 | <input type="checkbox"/> MR |
| <input type="checkbox"/> No change | <input type="checkbox"/> Progression | <input type="checkbox"/> Not evaluable | <input type="checkbox"/> Unknown |

DATE RESPONSE ACHIEVED OR ASSESSED :.....
yyyy mm dd

CLINICAL AND LABORATORY DATA

- | | |
|---|--|
| Hb (g/dL) | <input type="checkbox"/> Not evaluated |
| Serum creatinine Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL | <input type="checkbox"/> Not evaluated |
| Creatinine clearance (mL/min) | <input type="checkbox"/> Not evaluated |
| Total urinary protein excretion (mg/24 h) | <input type="checkbox"/> Not evaluated |
| Total urinary albumin excretion (mg/24 h) | <input type="checkbox"/> Not evaluated |
| Serum calcium (mmol/L) | <input type="checkbox"/> Not evaluated |
| Serum albumin (g/L) | <input type="checkbox"/> Not evaluated |
| Serum alkaline phosphatase (IU/L) | <input type="checkbox"/> Not evaluated |
| Serum bilirubin Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL | <input type="checkbox"/> Not evaluated |
| Serum NT-pro-BNP (ng/L) | <input type="checkbox"/> Not evaluated |
| Serum c-Troponin T ($\mu\text{g/L}$) | <input type="checkbox"/> Not evaluated |

Bone marrow investigations

- BM aspirate: % plasmacytosis Not evaluated
- BM trephine: % plasmacytosis Not evaluated

Immunoglobulins

Monoclonal Ig in serum (g/L)

Immunofixation of serum Negative Positive Not evaluated Unknown

Free light chains in serum:

 Kappa light chains (mg/L) Not evaluated.

 Lambda light chains (mg/L) Not evaluated

Immunofixation of urine Negative Positive Not evaluated Unknown

 Monoclonal light chains in urine (g/24 h)

Serum β2 microglobulin (mg/L)

ORGAN-SPECIFIC RESPONSES AT 100 DAYS AFTER HSCT

Kidney

Renal response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Liver

Liver span in ultrasound or CT scan (cm craniocaudal diameter) Not evaluated

Hepatic response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Heart

NYHA class I II III IV Unknown

Left ventricular ejection fraction (%) Not evaluated

Interventricular septal wall thickness Not evaluated
(mean number of mm in echocardiogram)

Cardiac response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Gastrointestinal

Weight loss No Yes Not evaluated Unknown

Malabsorption No Yes Not evaluated Unknown

GI bleeding No Yes Not evaluated Unknown

GI response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Peripheral neuropathy

(Compare current situation to situation before HSCT)

Neurological exam Improved Worsened Unchanged Unknown

PNP severity grade I grade II grade III grade IV

PN response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Autonomic neuropathy

AN response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

CIC: Hospital Unique Patient Number (UPN): HSCT Date.....
yyyy mm dd

Evidence of new organ involvement

Clinical evidence for involvement of new sites:.....

KARNOFSKY :

FORMS TO BE FILLED IN

TYPE OF HSCT

- AUTOgraft, **proceed to Autograft day 100 form**
- ALLOgraft or Syngeneic graft, **proceed to Allograft day 100 form**

Patient Number in EBMT database (if known):

FOLLOW UP	MED-B AL AMYLOIDOSIS
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Please use this form for annual follow up only and not data at 100 days, which is already included in the first report

Unique Identification Code (UIC) (if known)

Date of this report
yyyy mm dd

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

Name of study / trial

Hospital Unique Patient Number

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

Date of birth
yyyy mm dd

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

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH:
yyyy mm dd

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

Previously reported

Yes, date
yyyy mm dd

No

Unknown

Complications after Transplant (Allografts)

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME

ACUTE GRAFT VERSUS HOST DISEASE (AGVHD)

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

If present: New onset Recurrent Persistent

Reason: Tapering DLI Unexplained

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

Stage:

Skin	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV
Liver	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV
Lower GI tract	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV
Upper GI tract	<input type="checkbox"/> 0 (none)	<input type="checkbox"/> I			
Other site affected	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

Resolution

No Yes: Date of resolution:
yyyy mm dd

ANSWER IF PATIENT HAS HAD AN ALLOGRAFT AT ANY TIME
CHRONIC GRAFT VERSUS HOST DISEASE (cGVHD)

Presence of cGVHD

- No
 Yes: First episode
 Recurrence

Date of onset - -
yyyy mm dd

- Present continuously since last reported episode

Maximum extent during this period

- Limited Extensive Unknown

Maximum NIH score during this period

- Mild Moderate Severe Not evaluated

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

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

OTHER COMPLICATIONS SINCE LAST REPORT

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

INFECTION RELATED COMPLICATIONS

- No complications
 Yes

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

Patient Number in EBMT database (if known):

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

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

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

NON INFECTION RELATED COMPLICATIONS

- No complications
- Yes

Type (Check all that are applicable for this period)	CTC grade					Date	Comments
	0	1	2	3	4		
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dermatologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Renal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other: VOTHCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

dd mm yyyy

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM
 (ALLOS ONLY)

Graft loss
 No Yes Not evaluated

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

INDICATE THE DATE(S) AND RESULTS OF ALL TESTS DONE FOR ALL DONORS.

SPLIT THE RESULTS BY DONOR AND BY THE CELL TYPE ON WHICH THE TEST WAS PERFORMED IF APPLICABLE.

COPY THIS TABLE AS MANY TIMES AS NECESSARY.

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

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

- Previously reported
- Yes, date of diagnosis:
yyyy mm dd
- Diagnosis: AML MDS Lymphoproliferative disorder Other

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

ADDITIONAL THERAPIES SINCE LAST FOLLOW UP

ADDITIONAL TREATMENT

Treatment given since last report

- No
- Yes: Date started:
yyyy mm dd
- Unknown

Cell therapy

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

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

Is this cell infusion an autologous boost? No Yes

⇒ If cell infusion is not a boost, please complete **CELLULAR THERAPY** on the following page

Patient Number in EBMT database (if known):

CELLULAR THERAPY

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

- No
- Yes: Disease status before this cellular therapy CR Not in CR Not evaluated
- Unknown

Type of cells (check all that apply)

- Donor lymphocyte infusion (DLI)
- Mesenchymal cells
- Fibroblasts
- Dendritic cells
- NK cells
- Regulatory T-cells
- Gamma/delta cells
- Other
- Unknown

Number of cells infused by type	
Nucleated cells (/kg*) (DLI only) - x 10 ⁸ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
CD 34+ (cells/kg*) (DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
CD 3+ (cells/kg*) (DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown
Total number of cells infused	
All cells (cells/kg*) (non DLI only) - x 10 ⁶ <input type="checkbox"/> Not evaluated <input type="checkbox"/> unknown

Chronological number of this cell therapy for this patient

Indication (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Planned/protocol | <input type="checkbox"/> Treatment for disease |
| <input type="checkbox"/> Prophylactic | <input type="checkbox"/> Mixed chimaerism |
| <input type="checkbox"/> Treatment of GvHD | <input type="checkbox"/> Treatment viral infection |
| <input type="checkbox"/> Loss/decreased chimaerism | <input type="checkbox"/> Treatment PTLD, EBV lymphoma |
| <input type="checkbox"/> Other, specify | |

Number of infusions within 10 weeks

(count only infusions that are part of same regimen and given for the same indication)

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

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

Patient Number in EBMT database (if known):
 -Chemo / radiotherapy

ADDITIONAL DISEASE TREATMENT GIVEN EXCLUDING CELL INFUSION?

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

Date started - -
yyyy mm dd

Chemo/drug/agent Unknown
 (including MoAB, vaccination, etc.)

Radiotherapy No Yes Unknown

Other treatment No Yes, specify: Unknown

Unknown

FIRST EVIDENCE OF DISEASE WORSENING SINCE LAST HSCT

EVIDENCE OF DISEASE ACTIVITY

- Previously reported
 No
 Yes; date first noted: - -
yyyy mm dd
 Continuous worsening since HSCT
 Unknown

LAST DISEASE AND PATIENT STATUS

HAEMATOLOGICAL DISEASE STATUS

- Complete remission
 Partial remission
 Stable disease
 Progression
 Not evaluable
 Unknown

ORGAN RESPONSE

- Response
 Non Response
 Progression
 Not evaluable
 Unknown

CLINICAL AND LABORATORY DATA

Hb (g/dL)		<input type="checkbox"/> Not evaluated
Serum creatinine	Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL	<input type="checkbox"/> Not evaluated
Creatinine clearance (mL/min)		<input type="checkbox"/> Not evaluated
Total urinary protein excretion (mg/24 h)		<input type="checkbox"/> Not evaluated
Total urinary albumin excretion (mg/24 h)		<input type="checkbox"/> Not evaluated
Serum calcium (mmol/L)		<input type="checkbox"/> Not evaluated
Serum albumin (g/L)		<input type="checkbox"/> Not evaluated
Serum alkaline phosphatase (IU/L)		<input type="checkbox"/> Not evaluated
Serum bilirubin	Units: <input type="checkbox"/> $\mu\text{mol/L}$ <input type="checkbox"/> mg/dL	<input type="checkbox"/> Not evaluated
Serum NT-pro-BNP (ng/L)		<input type="checkbox"/> Not evaluated
Serum c-Troponin T ($\mu\text{g/L}$)		<input type="checkbox"/> Not evaluated

Bone marrow investigations

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

Immunoglobulins

Monoclonal Ig in serum (g/L)
 Immunofixation of serum Negative Positive Not evaluated Unknown
 Free light chains in serum:
 Kappa light chains (mg/L) Not evaluated.
 Lambda light chains (mg/L) Not evaluated
 Immunofixation of urine Negative Positive Not evaluated Unknown
 Monoclonal light chains in urine (g/24 h)
 Serum β2 microglobulin (mg/L)

ORGAN-SPECIFIC RESPONSES AT THIS FOLLOW UP

Renal response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Liver

Liver span in ultrasound or CT scan (cm craniocaudal diameter) Not evaluated
 Hepatic response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Heart

NYHA class I II III IV Unknown
 Left ventricular ejection fraction (%) Not evaluated
 Interventricular septal wall thickness Not evaluated
 (mean number of mm in echocardiogram)
 Cardiac response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Gastrointestinal

Weight loss No Yes Not evaluated Unknown
 Malabsorption No Yes Not evaluated Unknown
 GI bleeding No Yes Not evaluated Unknown
 GI response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Peripheral neuropathy

(Compare current situation to situation before HSCT)
 Neurological exam Not done Improved Worsened Unchanged Unknown
 PNP severity grade I grade II grade III grade IV
 PN response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Autonomic neuropathy

AN response Response No response/stable disease Progressive disease
 Not evaluable Not evaluated Not applicable Unknown

Evidence of new organ involvement

Clinical evidence for involvement of new sites:.....

PREGNANCY AFTER HSCT

Has patient or partner become pregnant after this HSCT?

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

SURVIVAL STATUS

- Alive
- Dead

PERFORMANCE SCORE *(if alive)*

- | | | | | |
|---------------------------|------------------------------------|--------------|--|--|
| Type of score used | <input type="checkbox"/> Karnofsky | SCORE | <input type="checkbox"/> 100 (Normal, NED) | <input type="checkbox"/> Not evaluated |
| | <input type="checkbox"/> Lansky | | <input type="checkbox"/> 90 (Normal activity) | <input type="checkbox"/> Unknown |
| | | | <input type="checkbox"/> 80 (Normal with effort) | |
| | | | <input type="checkbox"/> 70 (Cares for self) | |
| | | | <input type="checkbox"/> 60 (Requires occasional assistance) | |
| | | | <input type="checkbox"/> 50 (Requires assistance) | |
| | | | <input type="checkbox"/> 40 (Disabled) | |
| | | | <input type="checkbox"/> 30 (Severely disabled) | |
| | | | <input type="checkbox"/> 20 (Very sick) | |
| | | | <input type="checkbox"/> 10 (Moribund) | |

Patient Number in EBMT database (if known):

MAIN CAUSE OF DEATH (check only one main cause)

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

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

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

Other:

ADDITIONAL NOTES IF APPLICABLE

COMMENTS

IDENTIFICATION & SIGNATURE