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EBMT
European Society for Blood and Marrow Transplantation

Med A form: discussion forum

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Tuesday, 28th. March 2017; 9 - 10:30

Disease transformations in general

Q: How should I report transformed diseases?

- CLL to Richter transformation
- AML to MDS to AML
- One form of lymphoma to another

A: Richters: enter main diagnosis as CLL: Richter's. Enter "yes" to secondary/transformed. You will be asked the date of the original CLL. Sometimes it may be a primary Richter, so you answer "no" to the question on transformation.

Lymphomas – some scenarios in next slides

MED-AB MANUAL

For transformed diseases - at HSCT - you should register the pre-HSCT treatment (and response/status) given since the transformation, rather than the diagnosis prior to transformation.

ProMISe

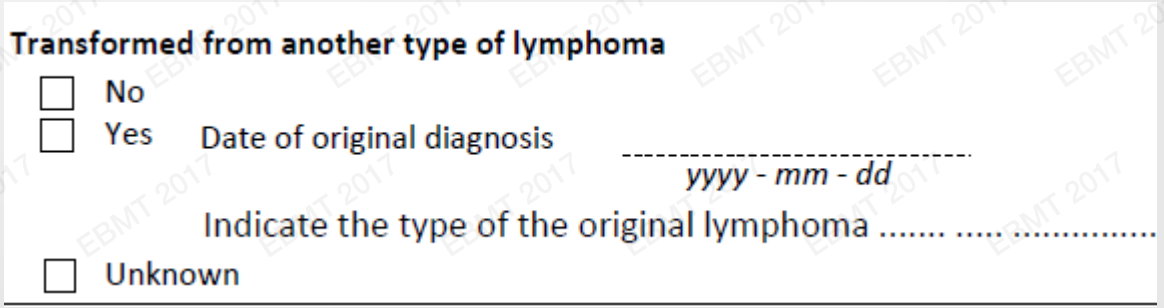
Relapse after HSCT: You should only record a relapse for the main diagnosis indication for transplant. A relapse of a different diagnosis has to go in the comments at the end.

Lymphoma (Med AB day 0) – Case 1

Q: How should the following patient be reported:
the disease sheet only allows for 1 transformation?

- Patient original diagnosis 2013 with Diffuse Large B-cell lymphoma (DLBCL)
- Relapse in 2015 to Follicular Lymphoma (FL)
- Relapse in 2016 back to DLBCL

A: Depends on date of HSCT and which diagnosis the HSCT is treating. If the transplant was for disease in 2016, then record as DLBCL but on the question of transformation say 'yes, diagnosis DLBCL, relapse FL'



Lymphoma (Med AB day 0) – Case 2

Q: How should I record the pathway for this transplant patient?

Diagnosed 2009/07/13

- 1. Skin from right side of scalp - follicular lymphoma.
- 2. Skin from left side of scalp - follicular lymphoma and DLBCL
- Chemo then CR in 2010
- Relapse 2011: follicular lymphoma
- 2014: Radiotherapy
- CR 2015
- Relapse 2016: DLBCL
- Treatment then VGPR
- **Auto Transplant 2017/02/01**

A: Over to the panel

Lymphoma (Med AB day 0) – Case 3

Q: How should I record the diagnosis for this patient?

A: Panel…..

- **2012/08** DLBCL - stage IV
- Treatment - CR

- **2016/1** Recurrent B-cell non-Hodgkin's lymphoma transformed from lymphoplasmacytoid lymphoma

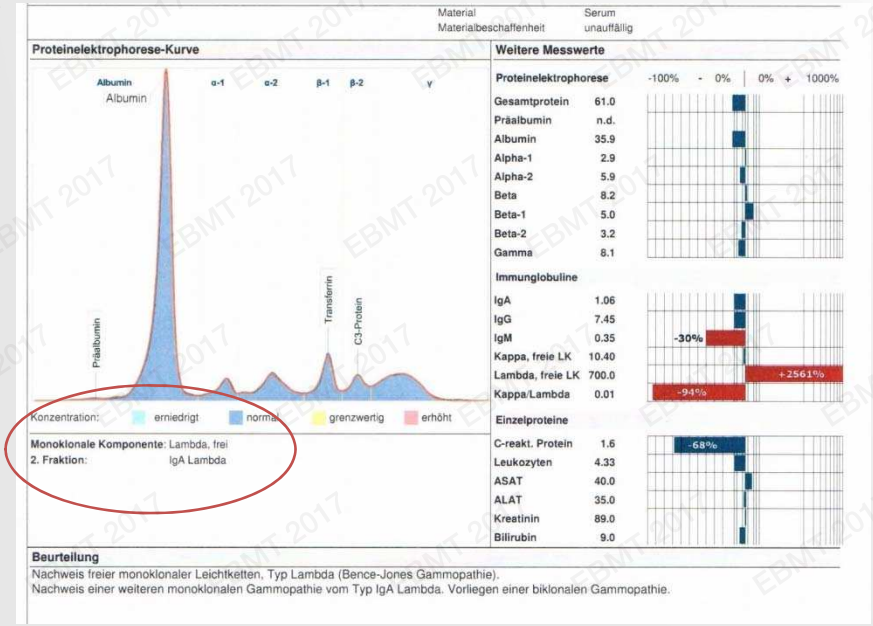
- No response to drug treatment

- **Allo Transplant 2016/07/06**

Complex results: MM

Q: Concerning the two images: How can I report these two results for the biclonal gammopathy?

A: Over to the panel



Material: Serum
Materialbeschaffenheit: unauffällig

Proteinelektrophorese-Kurve

Albumin, α-1, α-2, β-1, β-2, γ
Präalbumin, Transferrin, C3-Protein

Konzentration: erniedrigt, normal, grenzwertig, erhöht

Monoklonale Komponente: Lambda, frei
2. Fraktion: IgA Lambda

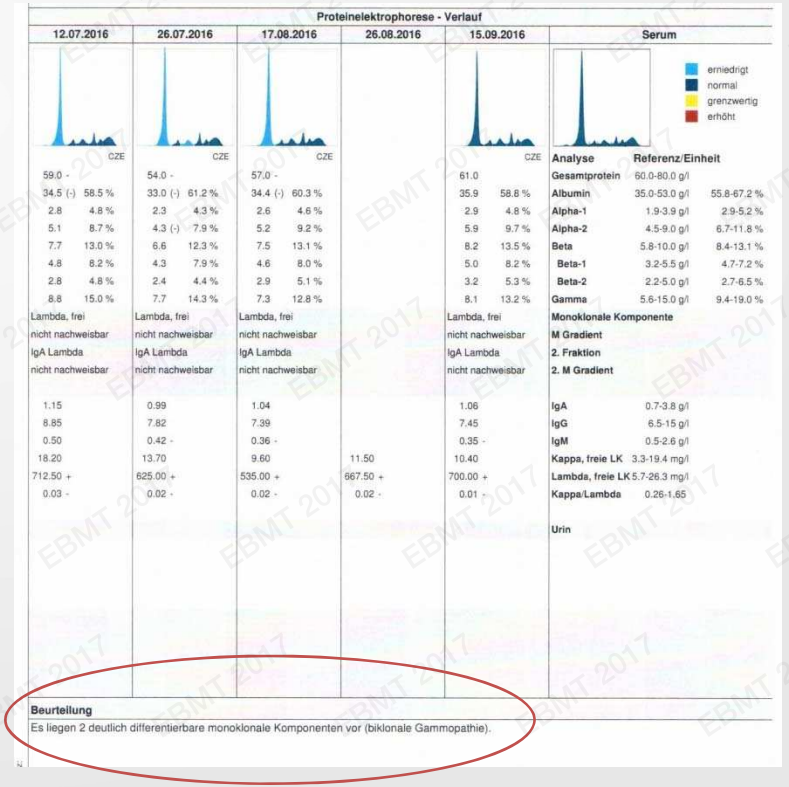
Weitere Messwerte

Proteinelektrophorese	-100% - 0% | 0% + 1000%
Gesamtprotein	61.0
Präalbumin	n.d.
Albumin	35.9
Alpha-1	2.9
Alpha-2	5.9
Beta	8.2
Beta-1	5.0
Beta-2	3.2
Gamma	8.1
Immunglobuline	
IgA	1.06
IgG	7.45
IgM	0.35
Kappa, freie LK	10.40
Lambda, freie LK	700.0
Kappa/Lambda	0.01
Einzelproteine	
C-reakt. Protein	1.6
Leukozyten	4.33
ASAT	40.0
ALAT	35.0
Kreatinin	89.0
Bilirubin	9.0

-30%, +2561%, -94%, -68%

Beurteilung

Nachweis freier monoklonaler Leichtketten, Typ Lambda (Bence-Jones Gammopathie).
Nachweis einer weiteren monoklonalen Gammopathie vom Typ IgA Lambda. Vorliegen einer biklonalen Gammopathie.



Proteinelektrophorese - Verlauf

12.07.2016	26.07.2016	17.08.2016	26.08.2016	15.09.2016	Serum
CZE	CZE	CZE		CZE	erniedrigt, normal, grenzwertig, erhöht
59.0 -	54.0 -	57.0 -		61.0	
34.5 (-) 58.5 %	33.0 (-) 61.2 %	34.4 (-) 60.3 %		35.9 58.8 %	
2.8 4.8 %	2.3 4.3 %	2.6 4.6 %		2.9 4.8 %	
5.1 8.7 %	4.3 (-) 7.9 %	5.2 9.2 %		5.9 9.7 %	
7.7 13.0 %	6.6 12.3 %	7.5 13.1 %		8.2 13.5 %	
4.8 8.2 %	4.3 7.9 %	4.6 8.0 %		5.0 8.2 %	
2.8 4.8 %	2.4 4.4 %	2.9 5.1 %		3.2 5.3 %	
8.8 15.0 %	7.7 14.3 %	7.3 12.8 %		8.1 13.2 %	
Lambda, frei	Lambda, frei	Lambda, frei		Lambda, frei	
nicht nachweisbar	nicht nachweisbar	nicht nachweisbar		nicht nachweisbar	
IgA Lambda	IgA Lambda	IgA Lambda		IgA Lambda	
nicht nachweisbar	nicht nachweisbar	nicht nachweisbar		nicht nachweisbar	
1.15	0.99	1.04		1.06	
8.85	7.82	7.39		7.45	
0.50	0.42 -	0.36 -		0.35 -	
18.20	13.70	9.60	11.50	10.40	
712.50 +	625.00 +	535.00 +	667.50 +	700.00 +	
0.03 -	0.02 -	0.02 -	0.02 -	0.01 -	

Analyse	Referenz/Einheit	
Gesamtprotein	60.0-80.0 g/l	
Albumin	35.0-53.0 g/l	55.8-67.2 %
Alpha-1	1.9-3.9 g/l	2.9-5.2 %
Alpha-2	4.5-9.0 g/l	6.7-11.8 %
Beta	5.8-10.0 g/l	8.4-13.1 %
Beta-1	3.2-5.5 g/l	4.7-7.2 %
Beta-2	2.2-5.0 g/l	2.7-6.5 %
Gamma	5.6-15.0 g/l	9.4-19.0 %
Monoklonale Komponente		
M Gradient		
2. Fraktion		
2. M Gradient		
IgA	0.7-3.8 g/l	
IgG	6.5-15 g/l	
IgM	0.5-2.6 g/l	
Kappa, freie LK	3.3-19.4 mg/l	
Lambda, freie LK	5.7-26.3 mg/l	
Kappa/Lambda	0.26-1.65	
Urin		

Beurteilung

Es liegen 2 deutlich differentierbare monoklonale Komponenten vor (biklonale Gammopathie).

Chromosome / Molecular Analysis

Q: Could we have a lookup table to see which molecular markers and cytogenetics are frequent for the different malignancies?

- And also for those malignancies which techniques are used (FISH etc)?

A: Over to the panel

- (For more specific questions on cytogenetics, Jordi Esteve will be presenting today at 15:15)

Donor Identification

Q: How important is “Donor Centre Name” and “Patient ID assigned by Donor Registry”? It takes time to look these up.

A: The “Donor Centre Name” is important to French & German centres so far. We can look into making this field visible only to those countries.

- The Patient ID used by Donor Registries is helpful to us when linking data from other registries

HLA matching – example 1

Q: When I only have one HLA value (eg by HLA A). Is this also a mismatch?

A: The 'A* 24' followed by ' – ', indicates that both alleles are the same:

A* 24

A* 24

Patient:

	A	B	C	KIR-Liganden	DRB1	DQB1	DPB1	Haplo typ
Erste Typisierung am 29.04.2015	A*24	B*39		Bw6	DRB1*08	DQB1*04		n.b.
Kommentar: typisiert in Bern	A*31	B*53		Bw4	DRB1*13	DQB1*06		n.b.
Re-Typisierung am 30.04.2015	A*24:02	B*39:06	C*07:02	Bw6 C1!	DRB1*08:01	DQB1*04:02	DPB1*03:01	n.b.
Kommentar: typisiert in Genf	A*31:01	B*53:01	C*16:01	Bw4 C1!	DRB1*13:02	DQB1*06:04	DPB1*04:01	n.b.

Spenderin:

	A	B	C	KIR-Liganden	DRB1	DQB1	DPB1	Haplo typ
Erste Typisierung am 16.07.2015	A*24	B*39		Bw6	DRB1*08	DQB1*04		n.b.
Kommentar: typisiert in Bern	-	B*53		Bw4	DRB1*13	DQB1*06		n.b.
Re-Typisierung am 14.08.2015	A*24	B*39:06	C*07	Bw6 C1!	DRB1*08:01	DQB1*04:02	DPB1*03:01	n.b.
Kommentar: typisiert in Genf	-	B*53:01	C*16	Bw4 C1!	DRB1*13:02	DQB1*06:04	DPB1*04:01	n.b.

HLA matching – example 2

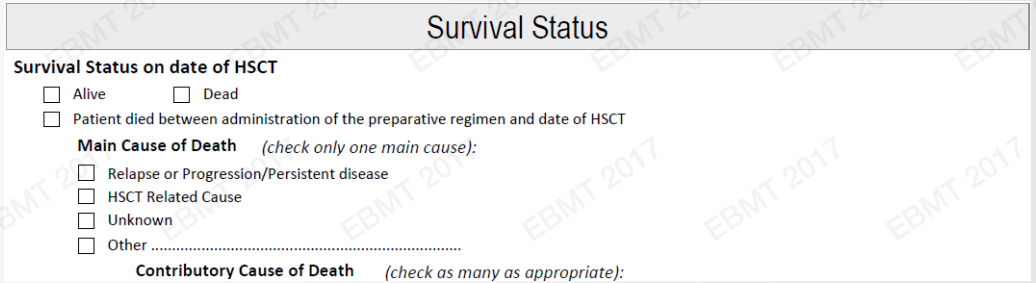
Q: What about a HLA mismatch 11/12? Is this a mismatch or identical?

A: Panel to clarify

(Johannes Schetelig will talk more on HLA this afternoon at 13:45)

General – Reporting a planned HSCT

Q: If a patient started a conditioning protocol for HSCT but died before the HSCT, do we need to enter his data? Because when we arrive at the HSCT date we have to put something there, but there was no HSCT.



A: Yes, the planned HSCTs (after start of conditioning) also need to be reported.
In Promise enter the date of death as the date of transplant
AND
Select 'Died before HSCT but after Conditioning was initiated' at survival status

Manual:
Patients who die after conditioning has started but before the transplant should be reported.
ProMISe users should register those patients entering the date of death as the date of HSCT. It is understood that this is not the date of HSCT since the transplant was never done.
When you finish entering the planned transplant you will be asked the Patient Status: please select code 3 - Died before HSCT but after Conditioning was initiated

General – Consent

Q: If a patient refused to consent to their data being stored in the Registry, is there a place to mark not signed ?

A: Yes, the Registry Office can mark the record as “not consented”. Minimal data can be entered so that the HSCT is still counted in your numbers. Before registering any data, contact the helpdesk first if you have a non consenting patient and we will advise.

ProMISe Guide : MED-AB

i) Entering a non consenting patient

For patients who have not consented for their data to be viewed by the Registry, you have 2 options.

1. You can enter the minimal data set (so it is counted in your centre numbers)
2. Enter the full report for your own centre records but ensure you mark them as “Not to be seen by EBMT” and/or “Not to be seen by National Registry” (if applicable) before saving the data.

General - Comorbidities

Q: In comorbid conditions, we only have yes/no options without being able to explain, why?

A: Need to keep to strict, standardised definitions as provided in the Comorbidity Index.

Q: Some conditions are not relevant to report. Could the panel give examples? E.g. should data managers record hypertension, hyperlipidemia in “Other” for comorbidities?

MED-AB MANUAL:

Comorbid conditions are those conditions which are likely to affect the outcome of the HSCT but which may not be directly related to the diagnosis indication for transplant.

Ensure an answer is only given if the comorbid condition fits the definition found in the form itself.

Do not give a positive answer if the condition exists in a milder way than defined (for example, minor obesity not reaching the required index)

General – TBI Dose

Q: Please could you give an example, how to enter a TBI dose?

A: as described in the TBI section in the Med AB manual

MED-AB Manual

TBI (total body irradiation)*: if present, almost always associated to chemo. Indicate the total dose in Gy, for instance; 2 days of 6Gy = total dose of 12 Gy. To transform cGy into Gy, multiply by 100.*

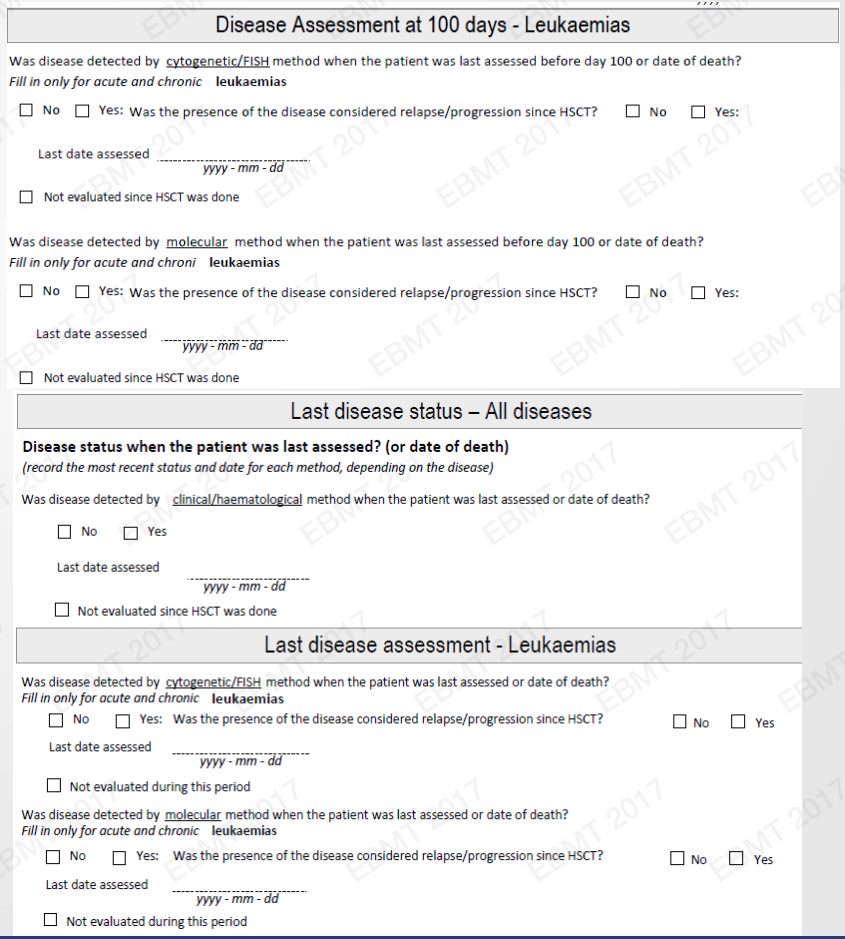
Number of fractions: …..

General: remission status

Q: For remission, some patients have tests such as PET-CT, MRI… but it asks only for cytogenetic remission. What should we do with those others tests?

A: Panel: which diagnosis would this relate to?

(There is a plan to add flow cytometry tests to the MED-A to help evaluate minimal residual disease (MRD)



Disease Assessment at 100 days - Leukaemias

Was disease detected by cytogenetic/FISH method when the patient was last assessed before day 100 or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes:

Last date assessed ..... *yyyy - mm - dd*

☐ Not evaluated since HSCT was done

Was disease detected by molecular method when the patient was last assessed before day 100 or date of death?
Fill in only for acute and chroni **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes:

Last date assessed ..... *yyyy - mm - dd*

☐ Not evaluated since HSCT was done

Last disease status – All diseases

Disease status when the patient was last assessed? (or date of death)
(record the most recent status and date for each method, depending on the disease)

Was disease detected by clinical/haematological method when the patient was last assessed or date of death?

☐ No ☐ Yes

Last date assessed ..... *yyyy - mm - dd*

☐ Not evaluated since HSCT was done

Last disease assessment - Leukaemias

Was disease detected by cytogenetic/FISH method when the patient was last assessed or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes

Last date assessed ..... *yyyy - mm - dd*

☐ Not evaluated during this period

Was disease detected by molecular method when the patient was last assessed or date of death?
Fill in only for acute and chronic **leukaemias**

☐ No ☐ Yes: Was the presence of the disease considered relapse/progression since HSCT? ☐ No ☐ Yes

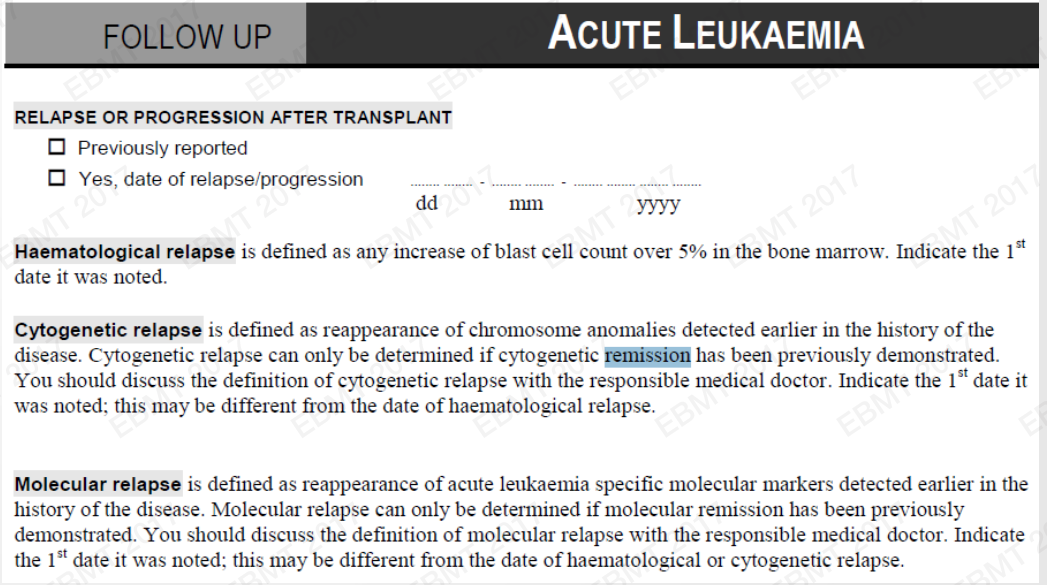
Last date assessed ..... *yyyy - mm - dd*

☐ Not evaluated during this period

General: remission status

Q: If an AML-patient is relapsed by molecular markers for example, but not in haematological methods, do I have to report this as a relapse at all? The status of CR refers to haematological CR, correct?

A: Panel…….



FOLLOW UP — ACUTE LEUKAEMIA

RELAPSE OR PROGRESSION AFTER TRANSPLANT

- ☐ Previously reported
- ☐ Yes, date of relapse/progression .... - .... - ....
  dd mm yyyy

Haematological relapse is defined as any increase of blast cell count over 5% in the bone marrow. Indicate the 1st date it was noted.

Cytogenetic relapse is defined as reappearance of chromosome anomalies detected earlier in the history of the disease. Cytogenetic relapse can only be determined if cytogenetic remission has been previously demonstrated. You should discuss the definition of cytogenetic relapse with the responsible medical doctor. Indicate the 1st date it was noted; this may be different from the date of haematological relapse.

Molecular relapse is defined as reappearance of acute leukaemia specific molecular markers detected earlier in the history of the disease. Molecular relapse can only be determined if molecular remission has been previously demonstrated. You should discuss the definition of molecular relapse with the responsible medical doctor. Indicate the 1st date it was noted; this may be different from the date of haematological or cytogenetic relapse.

Additional Treatments in MED-A?

Q: Does this include Chemo? If additional treatment is given after transplant, it's sometimes confusing if someone has entered the medication before.

- HSCT 2013/01/01
- Follow up 2016/1/1 = Additional Treatment =Yes: Lena started 2015/6/1
- Follow up 2017/1/1 = Additional Treatment =Yes: Lena.
- Treatment start date is asked again?

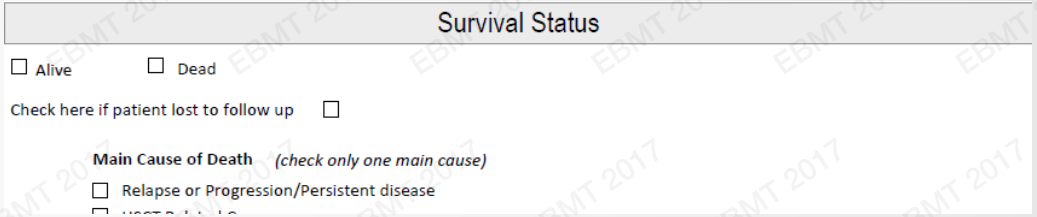
A: Panel: how relevant is this? How important is it to collect these dates in MED-A?

General: lost to follow up

Q: If a patient transfers to another hospital after the transplant and we do not receive any more information about his wellbeing, is there a place to put lost to FU?

A: Yes, at the end of the Med A annual follow up form under survival status

BUT please - don't give up too soon!



Manual:
At Annual Follow up-
The options offered here are: "1.Dead", "2.Alive" and "9.Lost to Follow Up"

Chimaerism (Med B data 100)

Q: Patient with MDS: HSCT: 2016/10/11; engraftment: 2016/10/30). The following chimaerism results exist.

Also regarding the minimal T-Cells? When will it be considered as a graft loss?

We use short tandem repeats, so it is possible to detect between 1-3% donor/recipient. Should this sensitivity be considered for the overall chimaerism decision?

How do I report these results?

Date	Days post HSCT	Cell type	% Donor cells
14.11.2016	+34	BM	82
		PB	92
		T-cell	10
06.12.2016	+56	PB	57
		T-cell	3
19.01.2017	+100	PB	18
		T-cell	Minimal, not countable

A: Report each set of results by date plus report Overall chimaerism at day 100 = mixed/partial

Panel……

Infectious complications (Med B FU)

Q: Type of infection:

Viremia

Antigenemia

Nucleid acid

- What does this mean? Where are these methods to be found?

A: panel…..

COMPLICATIONS WITHIN THE FIRST 100 DAYS.

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

INFECTION RELATED COMPLICATIONS

☐ No complications
☐ Yes

Type	Pathogen *Use the list of pathogens listed after this table for guidance. Use "**unknown**" if necessary.*	Date *Provide different dates for different episodes of the same complication if applicable.*
Bacteraemia/ fungemia / viremia / parasites		
SYSTEMIC SYMPTOMS OF INFECTION		
Septic shock		

Thank you to you all; for your perseverance in submitting high quality data and your continued support to the EBMT