

EBMT FORM GENERAL INFORMATION

TEAM

EBMT Centre Identification Code (CIC)

Hospital Unit

Contact person:

Telephone Fax

e-mail

Date of this report
yyyy mm dd

UBMID (only if data is to be sent to CIBMTR):

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

Registrations will not be accepted if this item is left blank

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"/> Acute Leukaemia
<input type="checkbox"/> Myelogenous (AML)
<input type="checkbox"/> Lymphoblastic (ALL)
<input type="checkbox"/> Secondary Acute Leukaemia
<i>(do not use if transformed from MDS/MPS)</i>
<input type="checkbox"/> Chronic Leukaemia
<input type="checkbox"/> Chronic Myeloid Leukaemia (CML)
<input type="checkbox"/> Chronic Lymphocytic Leukaemia
<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Non Hodgkin
<input type="checkbox"/> Hodgkin's Disease
<input type="checkbox"/> Other diagnosis, specify: _____ | <input type="checkbox"/> Myeloma /Plasma cell disorder
<input type="checkbox"/> Solid Tumour
<input type="checkbox"/> Myelodyspl. / myeloprolifer. syndrome
<input type="checkbox"/> MDS
<input type="checkbox"/> MPS
<input type="checkbox"/> MD/MPS
<input type="checkbox"/> 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
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Systemic Sclerosis
<input type="checkbox"/> Haemoglobinopathy |
|--|---|---|

SPECIFICATIONS
OF THE DISEASE

LYMPHOMA

INITIAL DIAGNOSIS

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

- Yes: go to page 3, *Treatment given before the 1st transplant*
 No: proceed with this section

 Non Hodgkin Lymphoma (NHL)**Mature B-cell neoplasm**

- Follicular lymphoma
 Grade I II III
 Not evaluated Unknown
- Mantle cell lymphoma
- Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue (MALT-lymphoma)
- Diffuse large B-cell lymphoma
- Intravascular
- Mediastinal
- Primary effusion
- Burkitt lymphoma
- High grade B-cell lymphoma, Burkitt-like (*provisional entity*)
- Lymphoplasmacytic lymphoma
- Waldenstrom macroglobulinaemia
- Splenic marginal zone lymphoma
- Nodal marginal zone B-cell lymphoma
- Primary CNS lymphoma
- Other B-cell, specify

Mature T-cell and NK-cell neoplasms

- Angioimmunoblastic T-cell lymphoma (AILD)
- Peripheral T-cell lymphoma, all types
- Anaplastic large cell, T/null cell, primary cutaneous
- Anaplastic large cell, T/null cell, primary systemic
- Extranodal NK/T cell lymphoma, nasal type
- Enteropathy type T-cell lymphoma
- Hepatosplenic gamma-delta T-cell lymphoma
- Subcutaneous panniculitis-like T-cell lymphoma
- Adult T-cell lymphoma/leukaemia (HTLV1+)
- Aggressive NK-cell leukaemia
- Large T-cell granular lymphocytic lymphoma
- Mycosis fungoides
- Sezary Syndrome
- Other T/NK-cell, specify

Transformed from another type of lymphoma

- No Yes Unknown

 Hodgkin Lymphoma

- Nodular lymphocyte predominant Lymphocyte rich Nodular sclerosis
- Mixed cellularity Lymphoma depleted Other, specify

Other, specify

STAGE AT DIAGNOSIS

ANN ARBOR STAGING FOR ADULT NON-BURKITT'S PATIENTS
MURPHY STAGE FOR BURKITT'S DISEASE AND PAEDIATRIC PATIENTS.

- | Stage | Systemic symptoms |
|--|--|
| <input type="checkbox"/> I | <input type="checkbox"/> Absent (A) |
| <input type="checkbox"/> II | <input type="checkbox"/> Present (B) |
| <input type="checkbox"/> III | <input type="checkbox"/> Not evaluated |
| <input type="checkbox"/> IV | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Not evaluated | |
| <input type="checkbox"/> Unknown | |

DISEASE INVOLVEMENT AT DIAGNOSIS

Size of largest mass

- < 5 cm 5-10 cm > 10 cm No mass Unknown

LDH LEVELS

- Normal Elevated Not evaluated Unknown

Specific sites of involvement

- | | | |
|--|---|--|
| <input type="checkbox"/> Nodes below the diaphragm | <input type="checkbox"/> Bone marrow | <input type="checkbox"/> Extranodal (CNS) |
| <input type="checkbox"/> Mediastinum | <input type="checkbox"/> Extranodal (testis /ovary) | <input type="checkbox"/> Nodes above the diaphragm |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Liver | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Other : | | |

TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT

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

- Yes: go to page 4, "Disease History before HSCT"
- No: proceed with this section

IF THE NUMBER OF TREATMENTS GIVEN BEFORE THE 1ST TRANSPLANT IS HIGHER THAN 3, PLEASE PHOTOCOPY THIS PAGE AS MANY TIMES AS NECESSARY TO PROVIDE INFORMATION ON ALL TREATMENTS

WAS THE PATIENT TREATED BEFORE THE 1ST TRANSPLANT PROCEDURE?

- No – Proceed to page 4, "Disease History before HSCT"
- Yes **Date started**
yyyy mm dd

Sequential number of this treatment:
(counted from diagnosis)

Modality: Chemo/drug/agent No Yes: Regimen
(including MoAB, etc.) If MoAB, radiolabelled No Yes Unknown

Radiotherapy No Yes

Unknown

Response to this line of therapy

- Complete remission Partial remission (> 50 %) No response (< 50 %)

ADDITIONAL TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT?

- No – Proceed to page 4, "Disease History before HSCT"
- Yes **Date started**
yyyy mm dd

Sequential number of this treatment:
(counted from diagnosis)

Modality: Chemo/drug/agent No Yes: Regimen
(including MoAB, etc.) If MoAB, radiolabelled No Yes Unknown

Radiotherapy No Yes

Unknown

Response to this line of therapy

- Complete remission Partial remission (> 50 %) No response (< 50 %)

ADDITIONAL TREATMENT GIVEN BEFORE THE 1ST TRANSPLANT?

- No – Proceed to page 4, "Disease History before HSCT"
- Yes **Date started**
yyyy mm dd

Sequential number of this treatment:
(counted from diagnosis)

Modality: Chemo/drug/agent No Yes: Regimen
(including MoAB, etc.) If MoAB, radiolabelled No Yes Unknown

Radiotherapy No Yes

Unknown

Response to this line of therapy

- Complete remission Partial remission (> 50 %) No response (< 50 %)

DISEASE HISTORY BEFORE HSCT

DATE OF TRANSPLANT :
yyyy mm dd

TREATMENT SUMMARY

Total number of lines before this transplant
(since diagnosis if 1st transplant, or since last reported transplant)

Modality used at least once:

Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
MoAB (<i>Immunotherapy</i>)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Radiotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Splenectomy No Yes, Date :
yyyy mm dd

COMPLETE REMISSION AND RELAPSE HISTORY BEFORE THE 1ST HSCT

If patient did not have treatment before the 1st HSCT or the information requested in this section has been submitted with a previous registration for this patient go to page 5, *Status of disease at HSCT*

CR achieved before the 1st transplant:

Yes: Date of first CR:
 No yyyy mm dd

Number of induction course(s) necessary to reach this first remission:

Number of CR's

TO BE COMPLETED ONLY IF PATIENT HAD A CR BEFORE THE 1ST TRANSPLANT

1st Relapse before the 1st transplant:

Yes: Date of first relapse:
 No yyyy mm dd

BEST DISEASE RESPONSE AT 100 DAYS POST-HSCT

BEST RESPONSE AT 100 DAYS AFTER TRANSPLANTATION

- Complete remission (*maintained or achieved*)
- Unconfirmed
- Confirmed: By CT scan
- By PET
- Partial remission (> 50 %)
- Progression
- No response (< 50 %)
- Early death/Not evaluable

If Complete remission: Date of CR - -
yyyy mm dd

FORMS TO BE FILLED IN

TYPE OF TRANSPLANT

- AUTOgraft, proceed to Autograft form
- ALLOgraft or Syngeneic graft, proceed to Allograft form
 - If Cord Blood, also fill in this section in Forms Appendix
 - If Other : , contact the EBMT Central Registry Office for instructions

FOLLOW UP LYMPHOMA

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 last HSCT for this patient:
yyyy mm dd

PATIENT LAST SEEN

DATE OF LAST CONTACT OR DEATH:
yyyy mm dd

COMPLICATIONS SINCE LAST REPORT

PLEASE USE THE DOCUMENT "DEFINITIONS OF INFECTIOUS DISEASES AND COMPLICATIONS AFTER STEM CELL TRANSPLANTATION" TO FILL THESE ITEMS. THE DOCUMENT IS AVAILABLE FROM www.ebmt.org, INFECTIOUS DISEASES WORKING PARTY.

INFECTION RELATED COMPLICATIONS

- No complications
 Yes

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

CIC:

Unique Patient Number (UPN):

SCT Date.....

yyyy mm dd

Type	Pathogen <i>Use the list of pathogens listed after this table for guidance. Use "unknown" if necessary.</i>	Date <i>Provide different dates for different episodes of the same complication if applicable.</i>
ENDORGAN DISEASES		
Pneumonia		
Hepatitis		
CNS infection		
Gut infection		
Skin infection		
Cystitis		
Retinitis		
Other:		
		yyyy mm dd

CIC:

Unique Patient Number (UPN):

SCT Date.....

yyyy mm dd

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
			Papovavirus
Parasites	Toxoplasma gondii		Parvovirus
	Other:		Other:

NON INFECTION RELATED COMPLICATIONS

- No complications
 Yes

Type (Check all that are applicable for this period)	Yes	No	Unknown	Date
Idiopathic pneumonia syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EBV lymphoproliferative disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haemorrhagic cystitis, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ARDS, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Multiorgan failure, non infectious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HSCT-associated microangiopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Renal failure requiring dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Haemolytic anaemia due to blood group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aseptic bone necrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>			

yyyy mm dd

GRAFT ASSESSMENT AND HAEMOPOIETIC CHIMAERISM

GRAFT LOSS (EQUIVALENT TO APLASIA IF AUTO)

- No: If allo: Date graft assessed - -
yyyy mm dd
- Chimaerism: Full Mixed: % donor cells
- Method used for chimaerism: FISH Molecular
 Cytogenetic ABO Group
(check all that apply)
- Yes: Date graft loss - -
yyyy mm dd
- If allo: Aplasia Autologous reconstitution
- Not evaluated

CHRONIC GRAFT VERSUS HOST DISEASE (CGVHD)

(allografts only)

Presence of cGvHD

- No
- Yes: First episode
 Recurrence
- Date of onset of this episode: - -
yyyy mm dd
- Present continuously since last reported episode
- cGvHD grade Limited Extensive
- Organs affected Skin Gut Liver Mouth
 Eyes Other, specify Unknown
- Resolved: Date of resolution: - -
yyyy mm dd

SECONDARY MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFRATIVE DISORDER DIAGNOSED

- Previously reported
- Yes, date of diagnosis: - -
yyyy mm dd
- Diagnosis: AML MDS EBV lymphoproliferative disorder Other
- No at date of this follow-up

ADDITIONAL THERAPIES SINCE LAST FOLLOW UP

ADDITIONAL TREATMENT

- Treatment given since last report
- No
- Yes: Date started:
yyyy mm dd
- Unknown

CAUSE OF DEATH (if dead)

- Relapse or progression
- Secondary malignancy
- HSCT related cause :

(check as many as appropriate)

	Yes	No	Unknown
GvHD	<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"/>
<input type="checkbox"/> bacterial <input type="checkbox"/> viral <input type="checkbox"/> fungal <input type="checkbox"/> parasitic <input type="checkbox"/> unknown			
Rejection / poor graft function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veno-Occlusive disease (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"/>
EBV lymphoproliferative disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: DEACSBMR	<input type="checkbox"/>		

- Unknown
- Other :

ADDITIONAL NOTES IF APPLICABLE

COMMENTS

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IDENTIFICATION & SIGNATURE

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