

# MDS/MPN OVERLAP SYNDROMES

## DISEASE

**Note: complete this form only if this diagnosis was the indication for the HCT/CT or if it was specifically requested. Consult the manual for further information.**

Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)

MDS/MPN transformed into Acute Leukaemia and treatment was done for Acute Leukaemia?

- No (complete this form)
- Yes (complete Acute Leukaemia indication diagnosis form in addition to the current form)

### Classification (WHO 2022):

<input type="checkbox"/> Chronic myelomonocytic leukaemia (CMML): <b>CMML subtype:</b>	<input type="checkbox"/> Myelodysplastic <input type="checkbox"/> Myeloproliferative
<b>CMML subgroup:</b>	<input type="checkbox"/> CMML-1 <input type="checkbox"/> CMML-2 <input type="checkbox"/> Unknown
<input type="checkbox"/> MDS/MPN with SF3B1 mutation and thrombocytosis	
<input type="checkbox"/> MDS/MPN with neutrophilia (Atypical CML BCR-ABL1-negative)	
<input type="checkbox"/> MDS/MPN with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)	
<input type="checkbox"/> MDS/MPN not otherwise specified (NOS)	

### Therapy-related MDS/MPN:

(Secondary origin)

- No
- Yes, disease related to prior exposure to therapeutic drugs or radiation
- Unknown

CPSS (for CMML only):  Low

- Intermediate-1
- Intermediate-2
- High
- Unknown

CPSS-MoI (for CMML only):  Low

- Intermediate-1
- Intermediate-2
- High
- Unknown



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

Treatment Type  HCT  CT  IST  Other  
 Treatment Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)

*Extended dataset*

**Assessments at diagnosis**

**Haematological values:**

**Peripheral blood**

Haemoglobin (g/dL): _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Platelets (10 <sup>9</sup> /L): _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
White Blood Cells (10 <sup>9</sup> /L): _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
% blasts: _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
% monocytes: _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
% neutrophils: _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown

**Bone marrow**

% blasts: _____	<b>If the precise blast count is not available, please indicate whether it is:</b> <input type="checkbox"/> ≤ 5% <input type="checkbox"/> > 5%	<input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
Auer rods present	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown	

**Bone marrow investigation:**

Fibrosis	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not evaluated <input type="checkbox"/> Unknown
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### CHROMOSOME ANALYSIS

*Copy and fill-in this section as often as necessary.*

*Describe results of all the analyses done before HCT/CT/IST treatment*

**Chromosome analysis done before HCT/CT/IST treatment:**

- No  
 Yes:      **Output of analysis:**  Separate abnormalities       Full karyotype  
 Unknown

*Copy and fill-in this section as often as necessary.*

*If chromosome analysis was done:*

**What were the results?**

- Normal  
 Abnormal: number of abnormalities present: \_\_\_\_\_  
 Failed

**Date of chromosome analysis:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)  Unknown

For abnormal results, indicate below whether the abnormalities were absent, present or not evaluated.

<b>abn 5 type;</b> specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>abn 7 type;</b> specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>Trisomy 8</b>	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>del(20q)</b>	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>del(13q)</b>	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>Other;</b> specify: _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated

OR

Transcribe the complete karyotype: \_\_\_\_\_



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### MOLECULAR MARKER ANALYSIS

**Molecular markers analysis done before HCT/CT/IST:**

- No  
 Yes  
 Unknown

*Copy and fill-in this section as often as necessary.*

*If molecular marker analysis was done:*

**Date of molecular marker analysis:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (YYYY/MM/DD)  Unknown

Indicate below whether the markers were absent, present or not evaluated.

ASXL1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
BCOR	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
CBL	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
DNMT3A	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
ETV6	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
ETNK1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
EZH2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
FLT3	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
IDH1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
IDH2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
JAK2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
KRAS	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
NF1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
NPM1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
NRAS	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
PTEN	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
PTPN-11	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
RUNX1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present:	<input type="checkbox"/> Not evaluated
SETBP1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
SF3B1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
SRSF2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
TET2	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
TP53	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
<b>TP53 mutation type:</b> <input type="checkbox"/> Single hit <input type="checkbox"/> Multi hit <input type="checkbox"/> Unknown			
UBA1			
ZRSR2			
Other; specify _____			



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*Extended dataset*

**PREVIOUS THERAPIES  
(between diagnosis and HCT/CT)**

**Previous therapy lines before the HCT/CT:**

No

Yes: **complete the "Treatment -- non-HCT/CT/GT/IST" form**

Unknown