

MYELODYSPLASTIC NEOPLASMS (MDS)

DISEASE

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

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

MDS 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 at diagnosis (WHO 2022):

MDS with defining genetic abnormalities:

- MDS with low blasts and isolated 5 q deletion (MDS-5q)
 MDS with low blasts and SF3B1 mutation (MDS-SF3B1)
 MDS with biallelic TP53 inactivation (MDS-biTP53)

MDS, morphologically defined:

- MDS with low blasts (MDS-LB)
 MDS, hypoplastic (MDS-h)
 MDS with increased blasts (MDS-IB1)
 MDS with increased blasts (MDS-IB2)
 MDS with fibrosis (MDS-f)

Childhood myelodysplastic neoplasms (MDS):

- Childhood MDS with low blasts
 Childhood MDS with increased blasts

Therapy-related MDS:

(Secondary origin)

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

(If therapy-related MDS, is Yes)

Is this a donor cell leukaemia?

- No
 Yes
 Not applicable (no previous allo HCT)
 Unknown

- IPSS-R:**
- Very Low (≤ 1.5)
 - Low (> 1.5 to 3)
 - Intermediate (> 3 to 4.5)
 - High (> 4.5 to 6)
 - Very High (> 6)
 - Unknown

- IPSS-M:**
- Very Low (≤ -1.5)
 - Low (> -1.5 to -0.5)
 - Moderate Low (> -0.5 to 0)
 - Moderate High (> 0 to 0.5)
 - High (> 0.5 to 1.5)
 - Very High (> 1.5)
 - Unknown

Extended dataset

Assessments at diagnosis

Haematological values:

Peripheral blood

Haemoglobin (g/dL): _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Platelets ($10^9/L$): _____	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
White Blood Cells ($10^9/L$): _____	<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: _____	If the precise blast count is not available, please indicate whether it is:	<input type="checkbox"/> Not evaluated
	<input type="checkbox"/> $\leq 5\%$ <input type="checkbox"/> $> 5\%$	<input type="checkbox"/> Unknown

Bone marrow investigation:

Hypocellularity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown
Fibrosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not evaluated	<input type="checkbox"/> Unknown

CHROMOSOME ANALYSIS

Describe results of all the analysis 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.

del(Y)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(5q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(20q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(7q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
inv(3)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
t(3q;3q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(3q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
del(11q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Trisomy 8	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Trisomy 19	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
i(17q)	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Other; specify _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	

OR

Transcribe the complete karyotype: _____

MOLECULAR MARKER ANALYSIS

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

- 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
CBL	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
DDX41	<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
EZH2	<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
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
PTPN11	<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
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
		TP53 mutation type: <input type="checkbox"/> Single hit <input type="checkbox"/> Multi hit <input type="checkbox"/> Unknown	
UBA1	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated
Other; specify _____	<input type="checkbox"/> Absent	<input type="checkbox"/> Present	<input type="checkbox"/> Not evaluated



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

**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