

HSCT - Minimum Essential Data – A CONTENT

REGISTRATION - DAY 0

ACUTE LEUKAEMIAS (main disease code 1)

CHRONIC LEUKAEMIAS (main disease code 2)

LYMPHOMAS (main disease code 3)

MYELODYSPLASTIC SYNDROME (MDS) (main disease code 6)

COMBINED MYELODYSPLASTIC SYNDROME/MYELOPROLIFERATIVE NEOPLASM (MDS/MPN) (main disease code 6)

MYELOPROLIFERATIVE NEOPLASMS (MPN) (main disease code 6)

PLASMA CELL DISORDERS INCLUDING MULTIPLE MYELOMA (PCD)
(main disease code 4)

BONE MARROW FAILURE SYNDROMES INCLUDING APLASTIC ANAEMIA (BMF)
(main disease code 7)

HAEMOGLOBINOPATHY (main disease code 11)

SOLID TUMOURS (main disease code 5)

PRIMARY IMMUNE DEFICIENCIES (main disease code 8)

INHERITED DISORDERS OF METABOLISM (main disease code 8)

PLATELET AND OTHER INHERITED DISORDERS (main disease code 8)

HISTIOCYTIC DISORDERS (main disease code 9)

AUTOIMMUNE DISORDERS (main disease code 10)

SECOND REPORT - 100 DAYS AFTER HSCT

FOLLOW UP REPORT - ANNUAL

CELL INFUSION (CI) SHEET

CIC: _____

Hospital UPN: _____

Patient UIC: _____

HSCT Date:

yyyy - mm - dd

HSCT - Minimum Essential Data - A

REGISTRATION - DAY 0

Centre Identification

EBMT Code (CIC): _____

Contact person: _____

Hospital: _____

Unit: _____

Email: _____

Patient Data

Date of this report: _____
yyyy - mm - ddFirst transplant for this patient?: Yes No

Patient following national / international study / trial:

 No Yes: Name of study / trial _____ Unknown**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) _ family name(s))

Date of birth: _____
yyyy - mm - ddSex: Male Female
(at birth)

Primary Disease Diagnosis

Date of initial diagnosis: _____
yyyy - mm - dd
PRIMARY DISEASE DIAGNOSIS (CHECK THE DISEASE FOR WHICH THIS TRANSPLANT WAS PERFORMED)

<input type="checkbox"/> 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 <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Systemic Sclerosis <input type="checkbox"/> Haemoglobinopathy
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 Other diagnosis, specify: _____

 Complete and attach the relevant Disease classification sheet with date of HSCT and disease status at HSCT,
 then continue to Performance Score below.

HSCT**Performance score**system used Karnofsky LanskyScore 10 20 30 40 50 60 70 80 90 100

Weight (kg): _____ Height (cm): _____

Comorbidity IndexSorror et al., Blood, 2005 Oct 15; 106(8): 2912-2919: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1895304/>Was there any ***clinically significant*** co-existing disease or organ impairment at time of patient assessment just prior to the preparative regimen? No Yes

Comorbidity	Definitions	No	Yes	N/E
Solid tumour, previously present	Treated at any time point in the patient's past history, excluding non-melanoma skin cancer Indicate type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory bowel disease	Crohn's disease or ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatologic	SLE, RA, polymyositis, mixed CTD, or polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	Requiring continuation of antimicrobial treatment after day 0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	Requiring treatment with insulin or oral hypoglycaemics but not diet alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal: moderate/severe	Serum creatinine > 2 mg/dL or >177 µmol/L, on dialysis, or prior renal transplantation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatic: mild moderate/ severe	Chronic hepatitis, bilirubin between Upper Limit Normal (ULN) and 1.5 x the ULN, or AST/ALT between ULN and 2.5 x ULN Liver cirrhosis, bilirubin greater than 1.5 x ULN, or AST/ALT greater than 2.5 x ULN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	Atrial fibrillation or flutter, sick sinus syndrome, or ventricular arrhythmias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	Coronary artery disease, congestive heart failure, myocardial infarction, EF ≤ 50%, or shortening fraction in children (<28%)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebrovascular disease	Transient ischemic attack or cerebrovascular accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve disease	Except mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary: moderate severe	DLco and/or FEV1 66-80% or dyspnoea on slight activity DLco and/or FEV1 ≤ 65% or dyspnoea at rest or requiring oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	Patients with a body mass index > 35 kg/m ²	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer	Requiring treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disturbance	Depression or anxiety requiring psychiatric consultation or treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Were there any other major clinical abnormalities prior to the preparative regimen? Specify.....

CIC: _____

Hospital UPN: _____

Patient UIC: _____

HSCT Date:

yyyy - mm - dd

Type of HSCT (Autologous)

Autologous

Source of the Stem cells

(check all that apply):

Bone marrow

Cord blood

Peripheral blood

Other: _____

Graft manipulation ex-vivo

other than for RBC removal or volume reduction

No

Yes: Genetic manipulation of the graft:

No

Yes:



IF AUTOLOGOUS, CONTINUE TO "CHRONOLOGICAL NUMBER OF HSCT"

CIC: _____

Hospital UPN: _____

Patient UIC: _____

HSCT Date: _____

yyyy - mm - dd

Type of HSCT (Allogeneic)

Allogeneic

Patient CMV status Negative Positive Not evaluated UnknownMultiple donors
(including multiple CB units) No Yes: Number of donors _____

Donor 1

HLA MATCH TYPE (DONOR RELATION WITH PATIENT)

- HLA - Identical sibling (*may include non-monozygotic twin*)
 - Syngeneic (*monozygotic twin*)
 - HLA - Matched other relative
 - HLA - Mismatched relative:
- Degree of mismatch 1 HLA locus mismatch
 >=2 HLA loci mismatch

Donor ID given by the centre _____

HLA MISMATCHES BETWEEN DONOR AND PATIENT (Mismatched relatives only)

Complete number of mismatches inside each box

A B C DRB1 DQB1 DPB1

<input type="text"/>					
<input type="text"/>					

Antigenic

Allelic

0=match; 1=one mismatch; 2=2 mismatches; N/E=not evaluated

 Unrelated donor

ION code of the Donor Registry or CB Bank _____

BMDW code of the Donor Registry or CB Bank (*If ION code is unknown*) (*up to 4 characters*) _____Name of Donor Registry/ CB Bank (*If any of the above codes is unknown*) _____Donor centre name (*if applicable, optional*) _____

Donor ID given by the Donor Registry or the CB Bank listed above _____

Patient ID given by the Donor Registry or the CB Bank listed above _____

 Please enter the LABORATORY RESULTS WITH HLA TYPING into the database

Donor information

Date of birth _____

yyyy - mm - dd

OR Age at time of donation (*if date of birth not provided*) _____

month(s)

Donor Sex (*at birth*) Male FemaleDonor CMV status Negative Positive Not evaluated Unknown

Did this donor provide more than one stem cell product

 No - (*please fill "Donor 1 – Product Number 1" on next page*) Yes: Number of different stem cell products infused from this donor _____*(If 2 products e.g. BM PB, please fill "Donor 1 – Product Number 1 AND 2" on next page)*