



Post-Transplant Essential Data
Note: “>100 Days Report” answer since last report
 ○ = symbol for answer that is only valid on >d100 evaluation.



CENTER IDENTIFICATION
 CIBMTR Center # _____ EBMT Code (CIC) _____
 Hospital: _____
 Unit (circle)*: **A H O P** Other, specify: _____
Abbreviations, see Pre-TED, pg 2
 Contact person: _____
 Phone #: _____ Fax #: _____
 Email: _____
 Date of this Report: ____-____-____ Changed
YYYY MM DD
 Day 100 6 months Annual FU visit (____ yr post-HSCT)
 Did the recipient receive a subsequent HSCT since the date of contact from the last report? Yes No

REGISTRY USE ONLY
 Date Received: _____ DE: _____

RECIPIENT IDENTIFICATION
 CIBMTR recipient ID#: _____
 Date of Birth: ____-____-____
YYYY MM DD
 Gender: Male Female
 Disease: _____

HSCT
 Donor Type: Allogeneic Autologous
 Chronological # of this: HSCT#: _____ DCI#: _____
 Date of HSCT for this follow-up: ____-____-____
YYYY MM DD

Yes No 100 Day Report Only
 Is 'Date of HSCT' same as date given on Pre-TED?
 Was HSCT Infusion given? If **No**,:
 At least 1 dose of the prep regimen was given? If **Yes**,:
 Patient died during prep regimen?
 This HSCT is cancelled?
 This HSCT is postponed?
 New estimated date: ____-____-____
YYYY MM DD

INITIAL ANC RECOVERY
 Was $\geq 0.5 \times 10^9/L$ achieved for 3 consecutive labs?
 Yes, first date of 3 labs: ____-____-____
YYYY MM DD
 No, last assessment: ____-____-____
YYYY MM DD
 Never below Previously reported Unknown
 Did **graft failure** occur? Yes No

INITIAL PLATELET RECOVERY
(Optional for Non-U.S. Centers)
 Yes, date Platelet $>20 \times 10^9/L$: ____-____-____
YYYY MM DD
 No, last assessment: ____-____-____
YYYY MM DD
 Never below Previously reported Unknown

GRAFT VERSUS HOST DISEASE (Allo only)
 Maximum Grade of Acute GVHD
 0 I II III IV Present, grade unknown
 Maximum extent of Chronic GVHD during this period:
 None Limited Extensive Unknown
 Date of diagnosis of chronic GVHD:
 ____-____-____ Continued from last report
YYYY MM DD

DID A NEW MALIGNANCY, LYMPHOPROLIFERATIVE OR MYELOPROLIFERATIVE DISORDER OCCUR?
 Different from the disease for which HSCT performed (not recurrence or transformation).
 Yes No Unknown, If yes:
 Date of diagnosis: ____-____-____
YYYY MM DD
 Acute myeloid leukemia (AML/ANLL)
 Other leukemia (including ALL), specify: _____
 Breast cancer
 Central nervous system (CNS) malignancy (glioblastoma, astrocytoma)
 Clonal cytogenetic abnormality without leukemia or MDS
 Gastrointestinal malignancy (colon, rectum, stomach, pancreas, intestine)
 Genitourinary malignancy (kidney, bladder, ovary, testicle, genitalia, uterus, cervix)
 Hodgkin disease
 Lung cancer
 Lymphoma or lymphoproliferative disease
 Is the tumor EBV positive? Yes No Unknown
 Melanoma
 Other skin malignancy (basal cell, squamous)
 Myelodysplasia (MDS)/myeloproliferative (MPS) disorder
 Oropharyngeal cancer (tongue, buccal mucosa)
 Sarcoma
 Thyroid cancer
 Other malignancy, specify: _____
 Copy of pathology report/documentation attached? Yes No

SURVIVAL
Survival status at latest follow-up:
 Alive Dead Lost To Follow-Up (LTF)
 Latest follow-up: ____-____-____ Last known date alive: ____-____-____
YYYY MM DD Day of the month is estimated
 Main **cause of death** (check only one main cause):
 Relapse/Progression/Persistent disease
 HSCT related causes (check as many as appropriate):
 GVHD Pulmonary toxicity
 Cardiac toxicity Rejection/Poor graft function
 Infection VOD
 Other: _____
 New malignancy
 Other: _____
 Unknown

POST-HSCT THERAPY (Optional for Non-U.S. Centers)

	Yes	Masked Trial	No	Unk
FGF (velafermin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imatinib mesylate (Gleevec, Glivec)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KGF (palifermin, Kevivance)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HSCT FOR NON-MALIGNANT DISEASE ONLY
 DCI given in this period?
 Yes, **also complete 'DCI' section on pg 2**
 No, **send only pg 1**

All Abbreviations on Pre-TED, pg 2



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CIBMTR Center #: CIBMTR Recipient ID#: Report represents: Day 100 6 months Annual

MALIGNANT DISEASE EVALUATION FOR THIS HSCT
(non-malignant disease skip disease evaluation)

WAS A CR EVER ACHIEVED IN REPOSE TO HSCT
(including any therapy planned as of Day 0, excluding any change in therapy in response to disease assessment)?

- Recipient already in CR at start of preparative regimen (N/Apl)
- Yes, post-HSCT CR achieved, date: _____
 Y Y Y Y M M D D
 First CR date reported previously
- No, never in CR from HSCT, date assessed: _____
 Y Y Y Y M M D D
- Not evaluated

FIRST RELAPSE OR PROGRESSION AFTER HSCT
(in this period, any type, not persistent disease)

- Yes, answer all 3 methods. If used, give the date used and the results.
- No—(skip to 'Additional Treatment' below)

- Relapse/progression detected by **molecular method**:
- Yes, Date first seen: _____
 Y Y Y Y M M D D
 - No, Date of Assessment: _____
 Y Y Y Y M M D D
 - Previously reported Not evaluated

- Relapse/progression detected by **cytogenetic/FISH method**:
- Yes, Date first seen: _____
 Y Y Y Y M M D D
 - No, Date of Assessment: _____
 Y Y Y Y M M D D
 - Previously reported Not evaluated

- Relapse/progression detected by **clinical/hematological method**:
- Yes, Date first seen: _____
 Y Y Y Y M M D D
 - No, Date of Assessment: _____
 Y Y Y Y M M D D
 - Previously reported Not evaluated

ADDITIONAL TREATMENT?

- Yes No—(skip to 'Method' below)
- DCI (allo only)**
 (also complete 'DCI' section)
- Planned** (given regardless of disease status/assessment post-HSCT)
- Not planned** (given for relapse, progression, or persistent disease)

METHOD OF LATEST DISEASE ASSESSMENT
(record most recent of each)

* In some circumstances, disease may be detected by molecular or cytogenetic testing, but may not be considered a relapse or progression. It should still be reported.

Method	Disease detected?		
	No	Yes	Not evaluated
Molecular*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was the status considered a disease relapse or progression? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date latest assessed: _____ Y Y Y Y M M D D		
Cytogenetic/FISH*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, was the status considered a disease relapse or progression? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Date latest assessed: _____ Y Y Y Y M M D D		
Clinical/Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Date latest assessed: _____ Y Y Y Y M M D D		

If a previous HSCT was performed for a different disease than this HSCT, give status of original disease and date determined:

- CR Not in CR Date: _____
 Y Y Y Y M M D D

DONOR CELLULAR INFUSION (DCI)

Date of **first** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
- Lymphocytes Fibroblasts Dendritic cells
 - Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
- Treat disease Mixed Chimerism
- Treat PTLD, EBV-Lym Loss/Decreased Chimerism
- Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Date of **second** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
- Lymphocytes Fibroblasts Dendritic cells
 - Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
- Treat disease Mixed Chimerism
- Treat PTLD, EBV-Lym Loss/Decreased Chimerism
- Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Date of **third** DCI: _____ - _____ - _____
 Y Y Y Y M M D D

- Total # DCI in 10 weeks _____
 Type of cell(s) (check all that apply):
- Lymphocytes Fibroblasts Dendritic cells
 - Mesenchymal Other, specify: _____

Indication:

- Planned Treat GVHD
- Treat disease Mixed Chimerism
- Treat PTLD, EBV-Lym Loss/Decreased Chimerism
- Treat viral Other, specify: _____

Maximum Grade of Acute Graft Versus Host Disease (GVHD): 0 I II III IV Unknown

If another DCI was received in this reporting period, disease status before next DCI: CR Not in CR Not assessed

Were there more than 3 instances of DCI infusions in this reporting period? Yes No
 If yes, copy this page and continue numbering fourth, fifth, etc.