



Wiscott-Aldrich Syndrome Pre-HSCT Data

Registry Use Only

Sequence
Number:

Date
Received:

CIBMTR Center Number:

CIBMTR Recipient ID:

Today's Date: / /
Month Day Year

Date of HSCT for which this form is
being completed: / /
Month Day Year

HSCT type: autologous allogeneic, allogeneic, syngeneic
unrelated related (identical twin)

Product type: marrow PBSC cord blood other product,
specify: _____

This form must be accompanied by Form 2000 – Recipient Baseline Data. All information in the box above, including the date, should be identical with the corresponding Form 2000. Information should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HSCT, or abstraction of the recipient's medical records.

If this is a report of a second or subsequent transplant, check here and continue with question 7.

1. What was the date of diagnosis of Wiscott-Aldrich Syndrome (WAS)? / /
Month Day Year

Specify the WAS defining (diagnostic) criteria:

- 2. 1 yes 2 no 3 unknown Eczema
- 3. 1 yes 2 no 3 unknown Platelet count (prior to splenectomy) < 150 x 10⁹/L
- 4. 1 yes 2 no 3 unknown Small platelet size (average < 2 μ in diameter or mean platelet volume < 8.5 fL)
- 5. 1 yes 2 no 3 unknown X-linked inheritance demonstrated in family; i.e., affected male but unaffected female relatives
- 6. Was the diagnosis confirmed by molecular identification of the presence of a defect in the WAS gene?
 - 1 yes
 - 2 no
 - 3 unknown

Clinical Status of Recipient Prior to HSCT

7. Did the recipient undergo a splenectomy prior to HSCT?

- 1 yes
- 2 no
- 3 unknown

8. Was the recipient's platelet count normal immediately prior to HSCT?

- 1 yes
- 2 no
- 3 unknown

9. Did the recipient develop any autoimmune complications prior to HSCT?

- 1 yes
- 2 no
- 3 unknown

CIBMTR Center Number:

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CIBMTR Recipient ID:

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Clinical Status of Recipient Prior to Preparative Regimen

10. Did the recipient experience failure to thrive? (*decrease of 0.5 standard deviation in weight on standard growth curve or weight < 5th percentile for age*)
- 1 yes
2 no
3 unknown
11. Did the recipient experience chronic diarrhea (protracted, > 6 weeks in duration) in year prior to HSCT?
- 1 yes
2 no
3 unknown
12. Did the recipient experience respiratory impairment? (*need for chronic or intermittent support with O₂ or artificial ventilation and/or presence of persistent interstitial, nodular, or lobar pneumonia*)
- 1 yes
2 no
3 unknown

13. Signed: _____
Person completing form

Please print name: _____

Phone: (_____) _____

Fax: (_____) _____

E-mail address: _____