

BMT NETWORK NSW / ABMTRR
Survey of incidence of hepatic veno-occlusive disease (VOD) among allogeneic and autologous stem cell transplant recipients in NSW transplant centres, 2005

INTRODUCTION

This survey is being carried out in all NSW BMT centres during the calendar year of 2005. The aim of the survey is to determine the incidence of hepatic veno-occlusive disease (VOD) among autologous and allogeneic haemopoietic stem cell recipients. We ask that you submit this data recording form for any transplant recipient at your centre who displays two or more of the listed criteria post transplant. You can submit the data by sending this form to Trish Hawkins at the ABMTRR. This survey has been approved by the BMT Network NSW Executive. This document is also available for download at the BMT NSW website (www.bmtnsw.com.au) providing you have a user-account (you can apply for one by following the instructions on the site).

INSTRUCTIONS

Please submit this data recording form for any transplant recipient who displays two or more of the following criteria within 100 days post transplant:

1. Jaundice (bilirubin \geq 2 mg/dL or $>$ 34 μ mol/L)
2. Hepatomegaly with right upper quadrant pain
3. Ascites and/or weight gain ($>$ 5% over baseline, as generally accepted)

Please also submit the ABMTRR Green registration form for this transplant recipient as soon as possible. If you have any questions about this form please contact Tony Dodds (02 8382 2378, adodds@stvincents.com.au), Peter Shaw (02 9845 2756, peters@chw.edu.au), Trish Hawkins (02 8382 2699, thawkins@stvincents.com.au) or Ian Nivison-Smith (02 8382 4637, inivisonsmith@stvincents.com.au). **Please submit data recording forms as soon as possible post event. Your participation in this survey is essential and we thank you for your time and efforts.**

A. PATIENT INFORMATION

Patient UPN: _____ (i.e. unique number to identify recipient)

Hospital name: _____

First 4 letters of family name: _____

First 2 letters of first given name: _____

Sex (please circle): M / F

Date of Birth: _____ / _____ / _____
D M Y

B. CLINICAL CRITERIA

Which of the following criteria were displayed by the recipient? (please tick all that apply)

- Jaundice (bilirubin \geq 2 mg/dL or $>$ 34 μ mol/L) – days post transplant first seen: _____
- Hepatomegaly with right upper quadrant pain) – days post transplant first seen: _____
- Ascites and/or weight gain ($>$ 5% over baseline)) – days post transplant first seen: _____

OVER PAGE ->

C. PRE TRANSPLANT RISK FACTORS

Please tick as many of the following as apply to the patient pre transplant

- Elevated serum transaminases prior to the start of conditioning (> x3 ULN)
- Pre-existing viral hepatitis
- Previous autologous transplant
- Previous allogeneic transplant
- Pretransplant conditioning that included busulphan
- Haemoglobinopathy or storage disease
- Other (please specify): _____

D. PRE OR POST TRANSPLANT PROPHYLAXIS - Please tick all that apply

- Heparin / LMWH Day pre or post transplant started:
- Ursodeoxycilic acid
- Defibrotide
- Other (please specify): _____

E. DIAGNOSTIC TESTS – Please tick all that apply

- Was a liver biopsy performed?
- Was a post-mortem performed?

F. TREATMENT – Please tick one

- Defibrotide
- Fibrinolytic therapy
- Other (please specify): _____

G. TREATMENT OUTCOME – Please tick one

- Complete resolution
- Partial resolution
- Death – date of death: _____ / _____ / _____
D M Y

Cause of death: _____

THANK YOU for your time and effort. Please submit this form by sending a copy to:

Attn: Trish Hawkins
BMT Network NSW / ABMTRR
20 Leichhardt St
DARLINGHURST NSW 2010

Fax: 02 8382 4627